CNY NYLinks Group Meeting
WELCOME
Mind, Body and Soul Conference

To keep the meeting moving we will be have a parking lot of questions/concerns/topics that the group can work to address at the end of the meeting.

Lunch

Restrooms
Introductions:

• Name
• Organization
• Role in Quality Improvement
Meeting Outcomes

• Understand Quality Improvement and its’ role in Ending the Epidemic.

• Explore how different forces impact our ability to change outcomes and the role of stakeholders in addressing those forces.
  Stakeholders include: supportive service agencies, consumers, clinical programs, internal agency departments and County Health Departments.

• Learn about the “Living Cascade” and see how it may benefit your respective agency and CAB.

• Develop an action plan for next steps including needs for QI training.
NYLinks Background
NYLinks

Started September 2011 (HRSA SPNS Project)
11 regions across New York State
261 organizations involved
2,449 distinct individuals involved
89 regional meetings held
10 coaches
5 Interventions developed and disseminated
45 webinars held for 1,849 people
30 blog posts
2,976 visitors in 2016 to the NYLinks Website
In 2016 53,000 patients positively impacted
Defining the “End of AIDS”

A 3-Point plan announced by the Governor on June 29, 2014

1. Identify all persons with HIV who remain undiagnosed and link them to health care.

2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.

3. Provide Pre-Exposure Prophylaxis (PrEP) for persons who engage in high-risk behaviors to keep them HIV negative

Reduce the number of new HIV infections to just 750 [from an estimated 3,000] by 2020
NYSDOH AIDS Institute
Quality of Care Program
Mission and Quality Statement

Mission: The NYS Department of Health AIDS Institute is committed to spreading a culture of quality improvement to every provider of HIV clinical care and supportive services in NYS to end the HIV epidemic in NYS by 2020.

Quality Statement: The NYS QOC Program is dedicated to ensuring equitable access to HIV care that promotes the health and well-being of all people living with HIV (PLWH) in NYS. The QOC Program collects data on the performance of HIV providers, uses these data to identify areas for improvement, and fosters improvement activities both by engaging providers in improvement efforts and by providing quality improvement capacity building activities.
Quality of Care Standards

The QOC Program Standards outline the expectations for all HIV providers in NYS regardless of their caseload, location or service delivery model.

All HIV ambulatory programs are expected to establish a QM program to assess the extent to which HIV health services provided to patients are consistent with outlined QOC Program Standards to include five domains:

- Infrastructure of HIV Quality Management (QM) Program
- Performance Measurement
- Quality Improvement Activities
- Staff Involvement
- Consumer Involvement
Quality Improvement Infrastructure and Stakeholders

• The QOC Program’s work is informed by
  • Advisory bodies, including committees of providers (Quality Advisory Committee) and consumers (Consumer Advisory Committee/Young Adult Consumer Advisory Committee)
  • AIDS Institute quality programs, including the AIDS Drug Assistance Program Quality Management Program and the Office of Medicaid Policy and Planning.
• The QOC Program also engages with numerous other programs on quality work, including
  • The NYC EMA QM Program,
  • National Quality Center (NQC)
  • Department of Corrections and Community Supervision (DOCCS)
2017 Statewide QOC Program Performance Review

• All HIV clinical providers are expected to submit performance data as part of the annual performance review.

• Based on the recommendations of the NYS HIV Quality of Care Committee, the EtE subcommittee, and the CAC/YACAC, this year’s review has adopted the submission of the HIV treatment cascade for health care organizations, in alignment with the Ending the Epidemic initiative.

• This year’s review consists of the following components: organizational HIV treatment cascades (open and active), eHIVQUAL, stigma, and tobacco cessation.
2017-2018 Improvement Goals

• Goal 1: Increase viral suppression of PLWH who are served by ambulatory HIV providers in NYS.

• Goal 2: Continue implementation of organizational HIV treatment cascades to reduce gaps in HIV care and guide regional and local improvement activities.

• Goal 3: Assess HIV-related stigma at the HIV provider level and development of organization-specific improvement plans to reduce stigma.

• Goal 4: Promote tobacco screening to measurably reduce tobacco use among PLWH in NYS.

• Goal 5: Increase consumer involvement in local QM programs and in regional quality improvement efforts.
Measuring and Addressing Stigma in Healthcare Settings

- Administration of a survey to healthcare workers designed to measure levels of HIV-related and key population-related stigma in the healthcare practice site
- Solicitation of consumer feedback on stigmatizing experiences in the healthcare practice site
- Development of an action plan to address stigma that incorporates consumer input and feedback
HIV Tobacco Cessation Improvement Campaign

- [Image](#)

- [www.HIVTobaccoFreeNY.org](http://www.HIVTobaccoFreeNY.org)
- Providers across NYS are expected to complete quarterly reporting on tobacco cessation measures for all patients living with HIV.
  - Campaign database for data reporting and access to campaign data reports (organization, county, and state level).
  - Consumers will self-reporting on measures and have access to campaign data reports.
Consumer Involvement

• Consumer involvement in QI is an essential element for HIV QM programs in NYS, helping programs to achieve sustainable health outcomes.

• It is an expectation of all HIV providers, defined explicitly in the QOC Standards, and assessed in the organizational assessment of HIV QM programs.

• The QOC Program offers the following consumer involvement capacity building activities:
  • Training Consumers in Quality (TCQ)
  • Training Consumers in Quality Training-of-Trainer Program (TCQPlus)
  • Consumer Quality Training Academy
  • Health Care Stories Project
  • The Living Cascade
Quality Improvement- Why is it important?

Quality Improvement consists of **systematic and continuous actions** that lead to **measurable improvement in health care services and the health status** of targeted patient groups.

If you cannot measure it... You cannot improve it.
Linking QI with Public Health Outcomes

Bruce Agins, MD, MPH, NYSDOH AIDS Institute, IAPAC Presentation, May 9, 2016.
Rapid Improvement

• Start small
• Theory of “1”
• PDSA

Start with an idea…

Small continuous improvement- make adjustments as needed

And REMEMBER!.....
Taking a step
Backwards after a step forward
Is not a disaster,
It’s a cha-cha!
How are we able to see progress towards that 2020 goal?

• Surveillance Data
Surveillance data

### Table 2A
NEW YORK STATE: Includes all 62 Counties
Living HIV and AIDS Cases as of December 2015, by Sex at Birth, Race/Ethnicity and Risk

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<tr>
<th>Category</th>
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<th>Prevalence Rate</th>
<th>Number</th>
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<tr>
<td>Total</td>
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<td>32,438</td>
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<td></td>
<td>66,005</td>
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### Table 2B
NEW YORK STATE: Includes all 62 Counties
Newly Diagnosed HIV Cases* 2015 by Sex at Birth, Age, Race/Ethnicity and Risk

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<th>Category</th>
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<th>Concurrent HIV and AIDS B</th>
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<th>All HIV Diagnoses**</th>
<th>%</th>
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<td>80.3</td>
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<tr>
<td>Age at Diagnosis</td>
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<td>1,215</td>
<td>48.3</td>
<td>673</td>
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<td>4.9</td>
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<td>Race/Ethnicity</td>
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<td>48.3</td>
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<td>26.9</td>
<td>122</td>
<td>4.9</td>
<td>2,010</td>
<td>80.3</td>
<td>4.6</td>
<td>10.1</td>
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</tbody>
</table>
New York State Cascade of HIV Care, 2015

Persons Residing in NYS† at End of 2015

- Estimated HIV-Infected Persons‡: 122,000
- Persons Living w/Diagnosed HIV Infection: 112,000 (92% of infected)
- Cases w/any HIV care during the year*: 90,000 (74% of infected, 81% of PLWDH)
- Cases w/continuous care during the year**: 74,000 (61% of infected, 66% of PLWDH)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 75,000 (62% of infected, 67% of PLWDH, 83% of cases w/any care)

† Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 8% were infected and unaware (CDC estimate)
* Any VL, CD4, genotype test during the year;
** At least 2 tests, at least 91 days apart.
Cascade of HIV Care: Syracuse Ryan White Region

Persons Residing in the Syracuse Ryan White Region† at End of 2015 (excludes prisoner cases)

- Estimated HIV-Infected Persons‡: 2,490
- Persons Living w/Diagnosed HIV Infection: 2,170 (87% of infected)
- Cases w/any HIV care during the year*: 1,760 (71% of infected, 81% of PLWDHI)
- Cases w/continuous care during the year**: 1,510 (61% of infected, 70% of PLWDHI)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 1,550 (62% of infected, 71% of PLWDHI, 88% of cases w/any care)

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 13% were infected and unaware (CDC estimate)
* Any VL, CD4, genotype test during the year; ** At least 2 tests, at least 91 days apart
Cascade of HIV Care: Binghamton Ryan White Region
Persons Residing in the Binghamton Ryan White Region† at End of 2015 (excludes prisoner cases)

- Estimated HIV-Infected Persons‡: 560
- Persons Living w/Diagnosed HIV Infection: 490 (87% of infected)
- Cases w/any HIV care during the year*: 370 (66% of infected 76% of PLWDHI)
- Cases w/continuous care during the year**: 300 (54% of infected 61% of PLWDHI)
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 330 (59% of infected 67% of PLWDHI 89% of cases w/any care)

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
‡ 13% were infected and unaware (CDC estimate)
* Any VL, CD4, genotype test during the year; ** At least 2 tests, at least 91 days apart
How are we able to see progress towards that 2020 goal?

• Surveillance Data

• ETE Dashboard  [http://etedashboardny.org](http://etedashboardny.org)
ETE Metrics
NYS Progress to End the AIDS Epidemic by the end of 2020

NEW HIV INFECTIONS (INCIDENCE)
Reduce the number of estimated new HIV infections to
Target 750
Actual 2,436

NEW HIV DIAGNOSES
Reduce the number of new HIV diagnoses by 55% to
Target 1,515
Actual 3,155

LINKAGE TO CARE
Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis to at least
Target 90%
Actual 73%
How are we able to see progress towards that 2020 goal?

• Surveillance Data

• ETE Dashboard  http://etedashboardny.org

• Facility level cascade development and sharing with regional partners
Agency level cascades (previously shared cascades)
**Open caseload:** Number of patients, regardless of age, with a known diagnosis of HIV who received services in the organization—whether routine, urgent, or emergent—during the measurement year

**Active caseload:** Number of patients, regardless of age, with a known diagnosis of HIV who received services in the HIV program of the organization during the measurement year
“Open Cases – No Record of Care”

• Persons living with HIV require linkage and ongoing engagement in medical care to improve clinical outcomes and reduce the risk of onward HIV transmission

• 2016 Organizational HIV Treatment Cascades reveal a large number of PLWH “touching” our systems with little/no information about their engagement in HIV medical care.

• Many are entering the system through ER, Urgent Care & as in-patients. It’s likely that these same individuals are also accessing supportive services.

• Non clinical service providers?
New York State Cascade of HIV Care, 2015
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  - 74% of infected
  - 81% of PLWDHI
- Cases w/any HIV care during the year*: 90,000
  - 74% of infected
  - 61% of PLWDHI
- Cases w/continuous care during the year**: 74,000
  - 62% of infected
  - 67% of PLWDHI
- Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year: 75,000
  - 83% of cases w/any care

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
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NEW YORK STATE OF OPPORTUNITY | Department of Health
Ending the Epidemic

• The organizational treatment cascade is a key tool for ending the HIV epidemic in New York State by 2020

• Focusing on the gap between open and active patients and identifying the number of open patients who are not currently in care to ensure that they are brought into the fold of care will be a crucial factor in ending the epidemic

• Ensuring that patients have access to ART will increase VLS, as well as the health and well being of people living with HIV, while significantly contributing to the prevention of the spread of HIV in the community

• Documentation and dissemination of best practices in Quality Improvement activities is important
NYSDOH Expanded Partner Services- 
Reaching out of care patients and their partners
NYS Department of Health
CNY Region: HIV/STD Partner Services
Kelly Firenze, Lisa Harder, & Rebecca LaPlante
Bureau of HIV/STD Field Services
Disease Intervention Specialists/Partner Services

March 21, 2018
NYS Reportable Infections

- HIV (Newly dx & Out of Care)
- Syphilis
- Gonorrhea
- Chlamydia
HIV/STD Field & Partner Services

• A CDC evidence-based free voluntary and confidential service delivered by DIS for patients diagnosed with the following reportable sexually transmitted diseases (STDs):
  – Chlamydia, Gonorrhea, Syphilis and HIV/AIDS
• Provides patients with options about how their sex or needle-sharing partners can learn of their exposure to STDs, including HIV and referrals for testing/treatment.
Why Partner Services Helps

• Prevents further transmission of disease through partner notification
  – Provides an immediate link between health care providers, patients & partners
  – Facilitates partner notification while maintaining confidentiality
  – Works with patients to develop a notification plan
We Specialize In Many Areas & Projects

- Disease Investigation
- Assist Counties During Disease Outbreaks
- Field Work
- PrEP, ExPS
- ETE
- Internet PS & Texting
- Referrals to medical care & CBO services
- Graphing Cases
- Presentations
Ending the Epidemic

Three Point Plan

1. Identify all persons with HIV who remain undiagnosed and link them to health care

2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission

3. Provide Pre-Exposure Prophylaxis for high risk persons to keep them HIV negative

GET TESTED. TREAT EARLY. STAY SAFE.

End AIDS.
How Expanded Partner Services Begins

• The Statewide initiative utilizes HIV surveillance data to identify previously known HIV positive individuals who appear to be out-of-care (no viral load (VL) or CD4 labs reported in the past 13 months)

• Presumed out-of-care individuals are contacted by staff with the specific objectives of re-engaging these individuals in medical care and notifying and testing/treating partners if necessary
ExPS In Practice

• Previously known positive persons identified as out-of-care are interviewed and offered comprehensive partner notification services:
  • linkage to medical care;
  • referrals for identified supportive services;
  • risk reduction counseling; safer sex supplies.
• Any identified partners are contacted & offered HIV and STD testing as indicated
• This service is VOLUNTARY

ExPS Case Examples:
• Insurance
• Transportation
• Moved
• They just 😔
Why Is Medical Care Important?

• Ensuring People living with HIV receive on-going care & treatment is one of the most effective ways to protect their health and to reduce HIV transmission

• Treating people living with HIV lowers the amount of virus in the body which can dramatically reduce the transmission to others
ExPS Is A Collaborative Effort
Questions/ Comments?

NYS DOH CNYRO
Dana Rinaldo- STD Coordinator
ExPS Advocates:
Lisa Harder
Kelly Firenze
Rebecca LaPlante
LaShawnda McClarin
Carol O’Neill
Colleen Shoemaker

Onondaga County:
Towanna Morgan- STD Supervisor
Debra Crouch- ExPS Advocate
Force Field Analysis- Kurt Lewin
A Culture is not a painted picture; it is a living process, composed of countless social interactions... The culture pattern of a people at a given time is maintained by a balance of counteracting forces.

– K. Lewin, Social psychologist late 1800’s
Force Field Analysis - Kurt Lewin

- Driving Force
- Desired State
- Restraining Force
Force Field Analysis - Kurt Lewin

Driving Forces

Desired State

Restraining Forces
Force Field Analysis- Kurt Lewin

Driving Forces

Desired State

Restraining Forces
The Process....

• Define the change you want to see
• Brainstorm the Driving Forces (Those that favor change)
• Brainstorm the Restraining Forces (Those that oppose change)
• Evaluate The forces on a scale of 1(weak)-5(strong) give rating OR you can leave the numbers out and focus holistically on the impact each has.
• Review the forces- What has some flexibility for change to occur?
• STRATEGIZE! What changes can you suggest? What partnerships or collaborations can you undertake to raise the scores of the Driving Forces or lower the scores of the Restraining Forces?
• Prioritize the action steps. What action steps can you take to achieve the greatest impact?
Group Presentations

Quick round the room

• What was your desired state?
• Top three Forces for change?
• Top three forces Against change?
• Strategies developed?
NYS DOH AI Living
Cascade Pilot Project
SUNY UPSTATE ADOLESCENT & YOUNG ADULT SPECIALIZED CARE CENTER
The Living Cascade

- Consumer driven tool
- October 1-November 10, 2017
- Corresponds with the Treatment Cascade for each Facility or Program
- Provides qualitative data and personal experience about the patient experience
- Engages and educates consumers
Process

- Create a team
  - Create structure for delivery, completion and analysis of worksheets
- Consumers complete the worksheet
  - Questions relate to 4 different aspects of the cascade
    - Open (Linkage to care)
    - Active (Retention in care)
    - On ART (adherence)
    - Virally Suppressed
  - Challenges, Barriers and Best Practices
  - Offer a copy of the completed living cascade to the consumer
- Analyze and Aggregate data
Lessons Learned So Far

- Consumers have been willing to participate
- Highlights barriers/challenges to retention and adherence
- Affirms role of support network in all aspects of the cascade
- Provides context for understanding prevention strategies and QI
Next Steps

- Complete data collection
- Analyze data
  - Qualitative
- Aggregate data
- Report back
CNY Regional Center for Tobacco Health Systems at St. Joseph's Health

Christopher Owens
Deb Mendzef
Julie Seaman
Who We Are...
TCP PHILOSOPHY: The NYS Tobacco Control Program (TCP) uses a population-based, policy-driven, cost-effective approach designed to prevent youth from smoking and to help adult smokers to quit.

TCP MISSION: To reduce illness, disability and death related to tobacco use and secondhand smoke exposure, and to alleviate the social and economic burden caused by tobacco use in New York State.

TCP PROGRAMS: (All 62 counties in NY are covered)
• Advancing Tobacco-Free Communities: Community Engagement and Reality Check programs
• Health Systems for a Tobacco-Free New York
• The New York State Smokers' Quitline
• Surveillance, Evaluation and Research

MORE INFORMATION: https://www.health.ny.gov/prevention/tobacco_control/
Health Systems for a Tobacco-Free NY
FOCUS: Individuals with low educational attainment, low socioeconomic status, and mental illness

GOAL: Work with Community Health Centers, Federally Qualified Health Centers and Mental Health Clinics to create and/or strengthen organizational systems to identify, document tobacco use and treat every tobacco user, every time within their Electronic Health Record.

www.tobaccofreeny.org

Guided by the Clinical Practice Guidelines on Tobacco Use and Dependence, which emphasize the use of “System Strategies” to achieve tobacco cessation goals.
The 5A’s: Ask, Advise, Assess, Assist, Arrange
Why Focus On Tobacco Use...
Single most preventable cause of disease AND death in the US

Mokdad AH, et. al. 2004; CDC 2006; Kochanek et al., 2004; CDC 1991; Fisher et al. 2007
Percentage of Tobacco Users in Central NY

NYS RATE 14.4%
About 1 in 5 U.S. adults smoke. Among adults living with HIV, the number of people who smoke is 2 to 3 times greater. People with HIV who smoke have a greater chance of developing a life-threatening illness that leads to an AIDS diagnosis. People who smoke and live with HIV also have a shorter lifespan than people living with HIV who do not smoke.
85% of smokers’ regret ever starting

70% of smokers want to quit

Every year 42% of smokers try to quit

7% of smokers achieve long-term abstinence alone

With physician assistance, this increases to 30%

Source:
“The single most powerful intervention in clinical practice.”
Woolf SH. JAMA 1999; 282 (24) 2358-65

Clinicians can make a difference with even a minimal (less than 3 minutes) intervention

Even when patients are not willing to make a quit attempt at this time, clinician-delivered brief interventions enhance motivation and increase the likelihood of future quit attempts

Source: Evidence Based Psychosocial Treatment for Smokers in Behavioral Health by Marc L. Steinberg, PhD
Other Resources

- Health Systems for a Tobacco-Free NY: [www.tobaccofreeny.org](http://www.tobaccofreeny.org)
  - Tobacco Health System Technical Assistance, Provider Training, Educational Resources, Billing and Coding Resources

- NYS Smokers’ Quitline website has FREE educational resources to print/order: [www.nysmokefree.com](http://www.nysmokefree.com)

- Health Provider Resources: [http://talktoyourpatients.ny.gov/](http://talktoyourpatients.ny.gov/)

- NYS Medicaid Managed Care and Family Health Plus drug: [http://mmcdruginformation.nysdoh.suny.edu/search/](http://mmcdruginformation.nysdoh.suny.edu/search/)
Contact Us!

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Legal Services of Central New York-
AIDS Law Project
THE AIDS LAW PROJECT

LEGAL AID PROVIDED BY LEGAL SERVICES OF CENTRAL NEW YORK

FAMILY STABILIZATION SUPPORT SERVICES PROVIDED BY ACR HEALTH
WHO WE ARE

- The AIDS Law Project is funded through a grant from the AIDS Institute of the New York State Department of Health.
- We are dedicated to improving the lives of individuals living with HIV and their families.
WHERE WE WORK

- We cover fourteen counties in Central New York:

  Onondaga  Broome
  Cayuga     Chenango
  Cortland   Herkimer
  Jefferson  Lewis
  Madison    Oneida
  Oswego     St. Lawrence
  Tioga      Tompkins
LEGAL SERVICES

• Legal Services of Central New York is a non-profit law firm that provides free civil legal assistance to low-income households and people with difficulty accessing the justice system throughout Central New York.

• We do not handle criminal or traffic cases.
LEGAL ISSUES WE CAN ASSIST YOU WITH

• Advance Planning (Wills, Health Care Proxies, Standby Guardianships)
• Landlord-Tenant Problems
• Public Benefits (overpayments, fair hearings and intentional program violations)
• Family Court Matters
• Discrimination in Employment or Housing
• Unauthorized Disclosure of HIV status by Health Care Provider
• Access to Health Care
• Consumer/Debt Problems
• Language Access
• Name Changes
SERVICES OFFERED

• Advice and Counsel
• Negotiation
• Representation in State and Federal Courts
• Representation before Administrative Agencies
• Wills and Health Care Proxies
• Powers of Attorney
• Community Education
FAMILY STABILIZATION SUPPORT SERVICES
PROVIDED BY ACR HEALTH

Keeping the community informed and healthy
WHO WE ARE

• MISSION
  • To create healthy communities by opening doors to service that enhance the wellbeing of all.

• VISION
  • A community in which every person has the opportunity to achieve optimal health and equality.

• VALUES
  • We Believe In:
    • Commitment to Excellence
    • Respect for People & Community
    • Wellbeing
    • Integrity
    • Empowerment
    • Teamwork.
A SAMPLE OF OUR SERVICES

• **Support Services** We have a dedicated team of people who work specifically with person living with HIV/AIDS.

• **Health Homes Care Management** Care Managers work one-on-one with members to identify needs and link them with services.

• **Health Insurance Programs:** NY State of Health Navigators are available to guide you through Affordable Care Act enrollment. We also have people who can assist with other health insurance items, enroll in Medicaid for Aged, Blind, Disabled, assist with Long Term Care coverage needs, and enroll in ADAP/APIC programs.

• **Prevention Services:** ACR Health’s prevention initiatives are comprised of social media public health campaigns, harm/risk reduction services, targeted outreach, community education and HIV, sexually transmitted infection and Viral Hepatitis C testing; Speakers and Educators are available upon request. Prevention staff also provide Narcan Overdose Training.

• **Syringe Exchange Program:** Safe Injection education and needle exchange program.

• **Youth Services:** The Adolescent Health Initiative equips young people at risk for unintended pregnancy, sexually transmitted diseases, and alcohol and substance use with information and skills to make health choices throughout their lives. We also have Q Center youth centers in Syracuse, Utica and Watertown.
FAMILY STABILIZATION SUPPORT SERVICES

- Permanency Planning (Dependent Children Living Arrangements)
- Disclosure of HIV Status
- Transitional Services (Stabilization of Blended Families)
- Grief and Bereavement Support
- Referral and Linkage
FAQ’S

• Can the AIDS Law Project take my legal case even if I am an individual without any children?
  • Yes. We provide legal services to anyone who is HIV+, whether or not they have children.

• What if I do not have HIV but someone in my family does?
  • You are still eligible! Dependents and caregivers of HIV+ person are also eligible for our services.

• Do I need to have both a legal case and a family stabilization case?
  • A.: No. You can contact us for just legal services, just family stabilization and support services, or both.
WHO TO CONTACT:

• ANNE AUGUSTINE, ESQ – STAFF ATTORNEY – LEGAL SERVICES OF CNY
  • 221 SOUTH WARREN STREET, SYRACUSE, NY 13202
  • MAIN #: 315-703-6500   DIRECT: 315-703-6569   TOLL FREE#: 1-866-475-9967   FAX#: 315-703-6520
  • EMAIL: AAUGUSTINE@LSCNY.ORG

• ROBERT W. LUKOW, ESQ – STAFF ATTORNEY – LEGAL SERVICES OF CNY
  • 221 SOUTH WARREN STREET, SYRACUSE, NY 13202
  • MAIN #: 315-703-6500   DIRECT: 315-703-6529   TOLL FREE#: 1-866-475-9967   FAX#: 315-703-6520
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• JENNIFER ROST, MSW – SUPPORT SPECIALIST – ACR HEALTH
  • 990 JAMES STREET, SYRACUSE, NY 13203
  • MAIN#: 315-475-2430   EXT:   TOLL FREE#: 1-800-475-2430   FAX#: 315-472-6515
  • EMAIL: JROST@ACRHEALTH.ORG
What do you see as important next steps for our collaborative work?
Important Follow-Up and Dates

- **October 31** – 2\textsuperscript{nd} Submission of the Stigma Reduction Plan Due
  - Third Submission: **January 31**
- **October 31** – 1\textsuperscript{st} Data Submission for the HIV Tobacco Cessation Improvement Campaign
  - Second Submission: **January 31**
- **January 25, 2018** Next CNY NYLinks Meeting (Feedback on topics)
- Check in with individual programs
  - Monthly check in’s with QI Project progress and add Open Cases
  - Periodic Peer Exchange and Coaching webinars - Interest???
- Stay Tuned:
  - Guidance for 2017 Quality of Care Review; disparity data with Care Cascades
  - Final NYS QM Plan, Program Standards
- Training offerings- TCQ?
Contact Information

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Director, Consumer Affairs:
  • Daniel Tietz- Daniel.tietz@health.ny.gov

Director, NYS Quality of Care Program:
  • Daniel Belanger- Daniel.Belanger@health.ny.gov