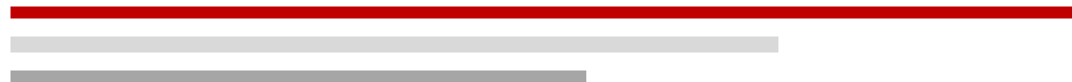
HRSA HIV/AIDS Bureau Special Projects of National Significance

Systems Linkages and Access to Care for Populations at High Risk for HIV Infection in New York State

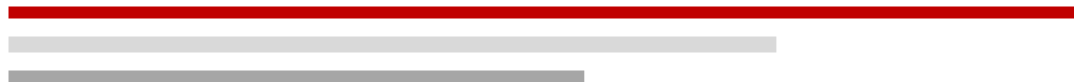
January, 2013



Ground Rules for Webinar Participation

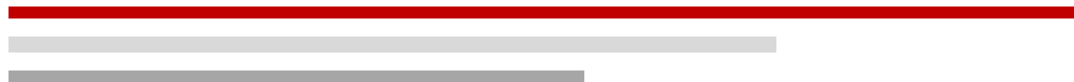
- Actively participate and write your questions into the chat area during the presentation(s)
- Discussion will occur throughout
- Do not put us on hold
- Mute your line if you are not speaking (press *6, to unmute your line press #6)
- Slides and other resources are available after the webinar

Opening Remarks



SPNS Overview

NY Links



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What are 'SPNS'?

- Special Projects of National Significance
  - Part of the Ryan White HIV/AIDS Program and administered by the HRSA HIV/AIDS Bureau
  - Aims to support the development of innovative models of HIV care that respond to emerging needs of Ryan White clients
  - Topics for SPNS funding prioritized by HRSA
  - Strong evaluation/research component to assess the effectiveness of models, and then focus on the dissemination and replication of successes at a national level

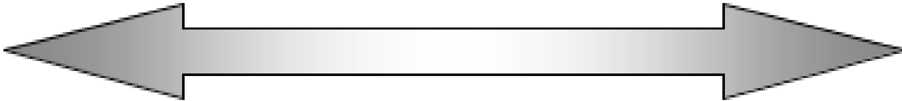
SPNS Initiative – Systems, Linkages and Access to Care

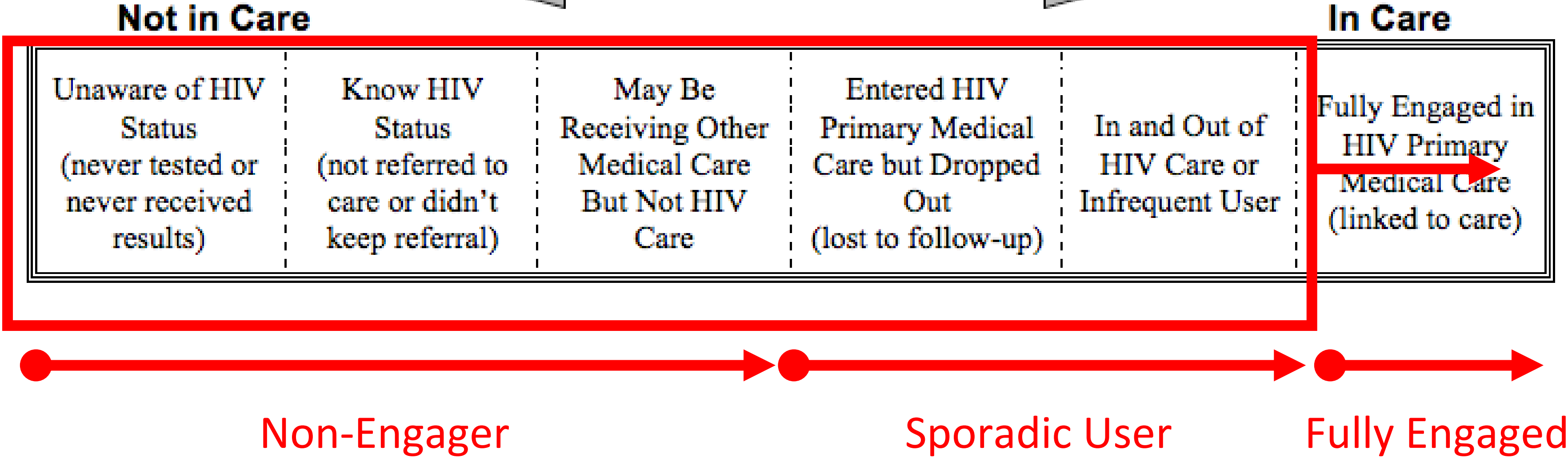
- Development of innovative and sustainable systemic models of linkage to improve access to and retention in quality HIV care
- 4-year funding cycle awarded to high incidence states: New York, Louisiana, Massachusetts, North Carolina, Pennsylvania, Virginia, and Wisconsin
- Adapted approach of the Collaborative Model developed by the Institute for Healthcare Improvement (IHI)
- Development of grantee-specific evaluation strategies to identify and document successful models
- Comprehensive multi-state evaluation led by a national evaluation center (ETAC UCSF)

SPNS Initiative – Systems, Linkages and Access to Care

- Overall goals for this initiative, consistent with National HIV/AIDS Strategy, are to:
  - increase the number of individuals who know their serostatus
  - increase the number of newly diagnosed linked to HIV care within three months of diagnosis
  - increase the number of individuals who are virally suppressed
  - increase the number of people living with HIV retained continuously in quality HIV care

Engagement in Care Continuum





Non-Engager

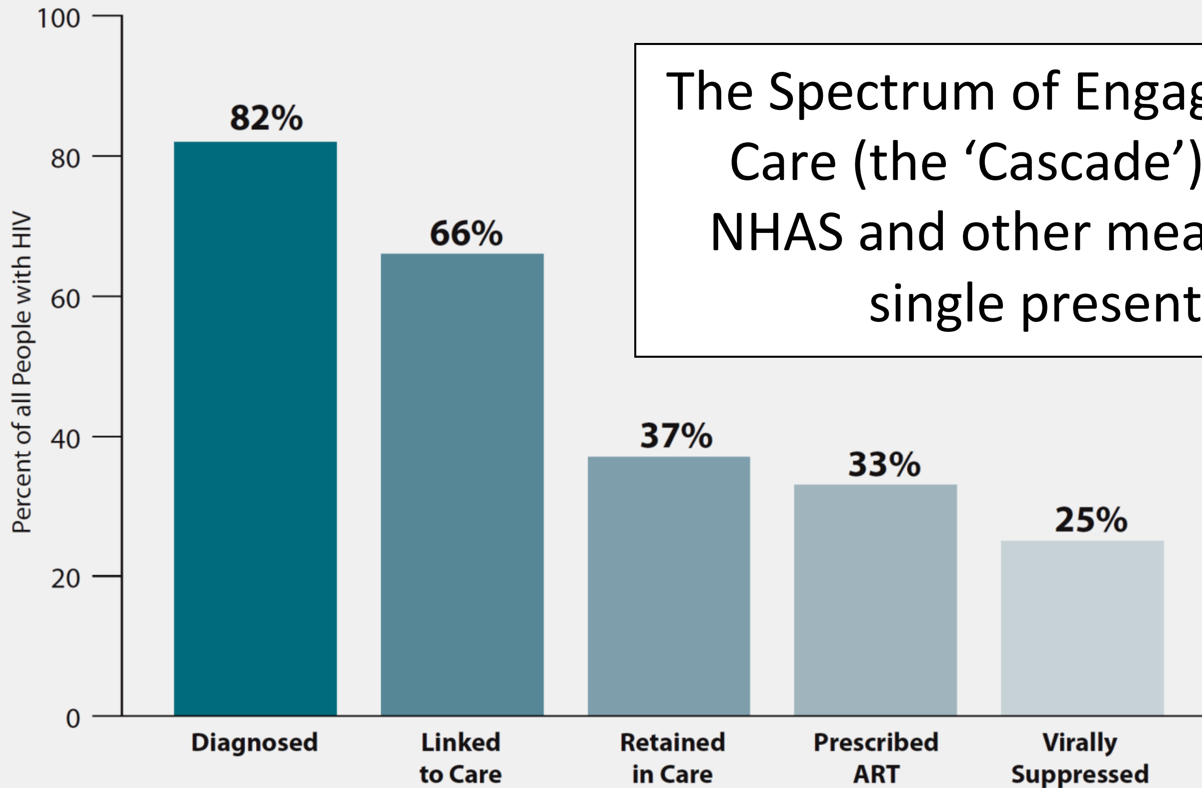
Sporadic User

Fully Engaged

[1] Health Resources and Services Administration, HAB. August 2006. Outreach: Engaging People in HIV Care Summary of a HRSA/HAB 2005 Consultation on Linking PLWH Into Care.

[2] Eldred L, Malitz F. Introduction [to the supplemental issue on the HRSA SPNS Outreach Initiative]. AIDS Patient Care STDS 2007; 21(Suppl 1):S1–S2.

CDC's National 'Cascade' (July, 2012)



The Spectrum of Engagement in HIV Care (the 'Cascade') assembles NHAS and other measures into a single presentation

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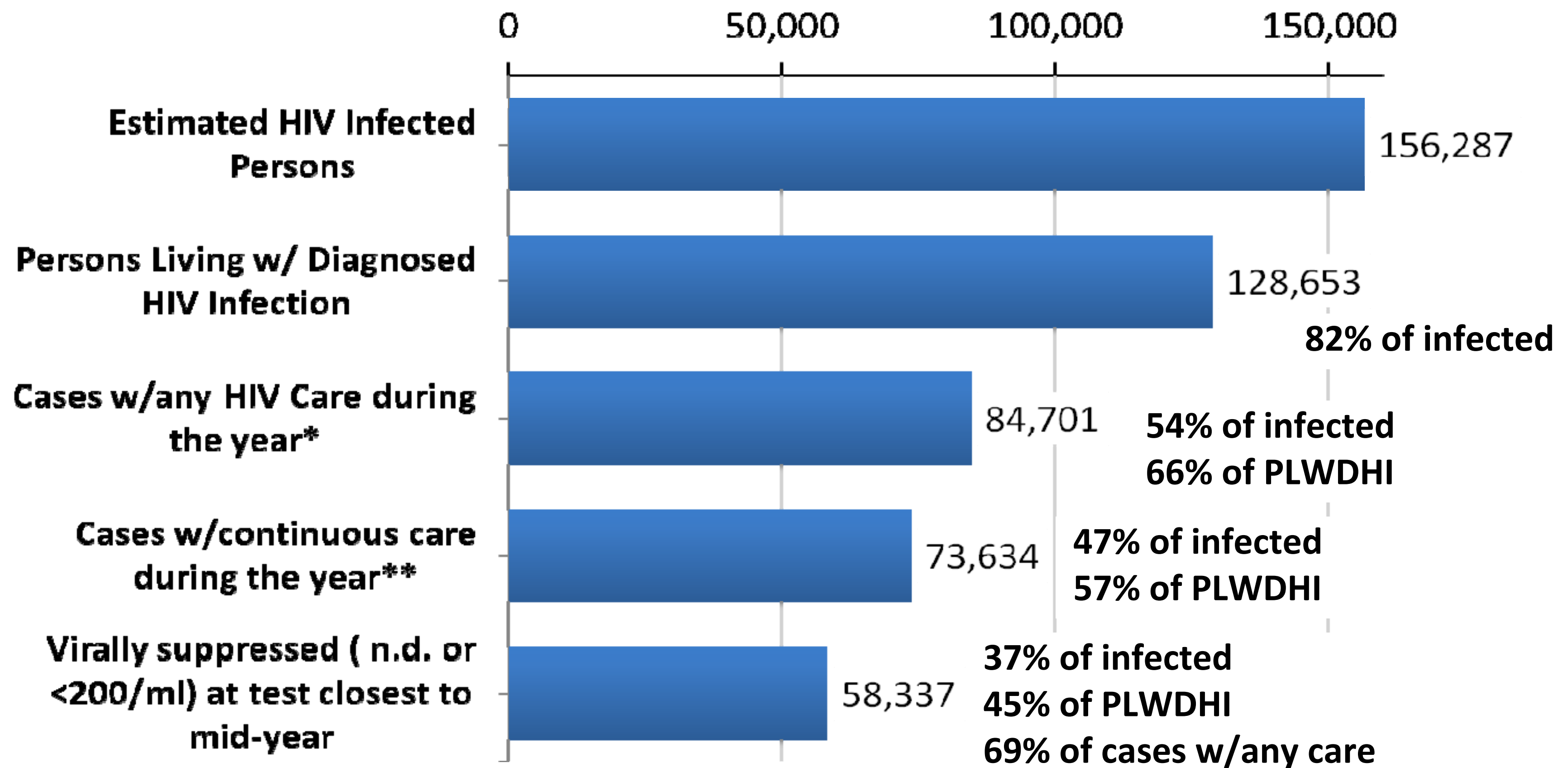
Cascade of HIV Care
New York State, 2010



* Any VL or CD4 test during the year

** At least 2 tests, at least 3 months apart

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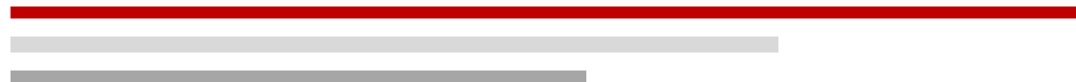
NY Links Overview



NY Links Mission

Together, we

- identify innovative solutions for improving linkage to and retention in HIV care to support the delivery of routine, timely, and effective care for PLWHA in New York State; and

- bridge systemic gaps between HIV related services to achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS.

Timeline

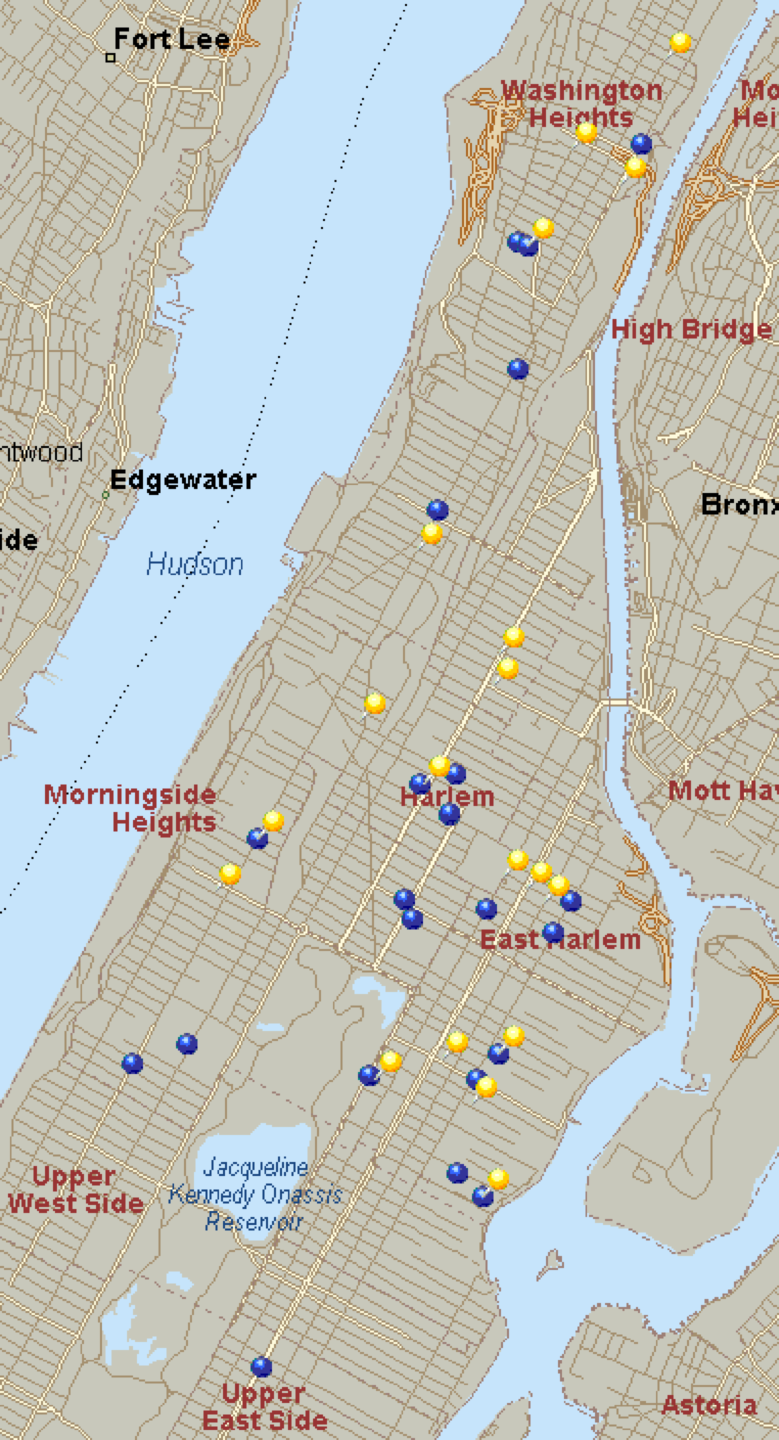
Collaborative Development | Statewide Dissemination

Data and Systems Integration

SPNS Evaluation

<u>Years 1 & 2 Collaborative Development</u>
- I: Upper Manhattan Regional Group
- II: Western New York State Regional Group
- III: Queens and Staten Island Regional Group

<u>Years 3 & 4 Statewide Dissemination</u>
- Identification of Successful Linkage/Retention Interventions
- Statewide Processes to Promote Successful Interventions—Conferences, papers, etc
- Webinars, Conference Calls, etc.
- Posting on AIDS Institute and other QI Websites



Upper Manhattan Regional Group

- **Engagement of all medical and non-medical providers in the Upper Manhattan geographic area to improve linkage to and retention in HIV care. Initiated 11/11.**
- **Current Progress:**
  - 5th Learning Session: January or February, 2013
  - Provider driven interventions currently being tested and evaluated.

- **Blue**-Clinical Program Participating in the Upper Manhattan Regional Group
- **Yellow**-Supportive Service Program Participating in Upper Manhattan Regional Group

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WNY Collaborative Members by Zip Codes

- **Red**-Programs Participating in the WNYS Regional Collaborative

As of April 26, 2012

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Western New York State Collaborative

- **Engagement of all HIV medical and non-medical providers in the Western NY geographic area (Rochester and Buffalo) to improve linkage to and retention in HIV care. Initiated 6/12**

- **Current Progress:**
  - 3rd Learning session scheduled for February/March
  - Providers working on utilizing data, as a system and individually, to locate areas where interventions would have the most impact.

A sample of UMRG preliminary types of strategies being tested or implemented

Site name	Strategy Category	Strategy	Target populations
Columbia Presbyterian	Systems development & tracking those lost to care	Developing database that contains a registry of HIV + pts. Will be used to identify pts who are out of care.	Those lost to care
Mount Sinai	Linkage w/ other organizations	Testing: New linkage with NYC DOHMH's Harlem STD Clinic, which has begun bringing over persons with positive preliminary HIV tests for confirmatory testing and linkage to care.	Newly diagnosed patients
Institute for Family Health	Self management	Testing: A sample of patients from the Care Coordination program were given client journals to document upcoming appointments, as well as current medications and lab results.	All patients
William F. Ryan Center	Same day services	Provide the option to clients upon initial preliminary positive test to meet with a provider the same date that they test preliminary positive.	Newly diagnosed patients

Data Source: Intervention Strategy Tracking Tool, UMRG— August 28, 2012

A sample of UMRG preliminary types of strategies being tested or implemented

Site name	Strategy Category	Strategy	Target populations
Iris House	Streamlining referrals	Link newly diagnosed clients into care with 72 hours, by utilizing a daily testing and referral log.	High risk, but unaware of HIV status/newly diagnosed clients
Center for Comprehensive Health Practice	Staff engagement & tracking those lost to care	Individual behavioral risk assessments used to detect high risk cases and stratify interventions. Multiple members of the treatment team intervene with the client at different times delivering the "same message"	Patients thought to be at high risk of dropping out of care/ newly diagnosed patients
St. Luke's	Tracking those lost to care	Re-instated Care Coordination outreach to patients who have not had a primary care visit within 9 months. Modified RHIV testing database to capture exact linkage date and RHIV CQI project to include HIPAA capture rate, to verify outside linkage to care.	Those lost to care
Renaissance	Linkage w/ other organizations	Collaboration with Iris House to establish a more formal referral/linkage system for individuals testing preliminarily positive.	Newly diagnosed patients

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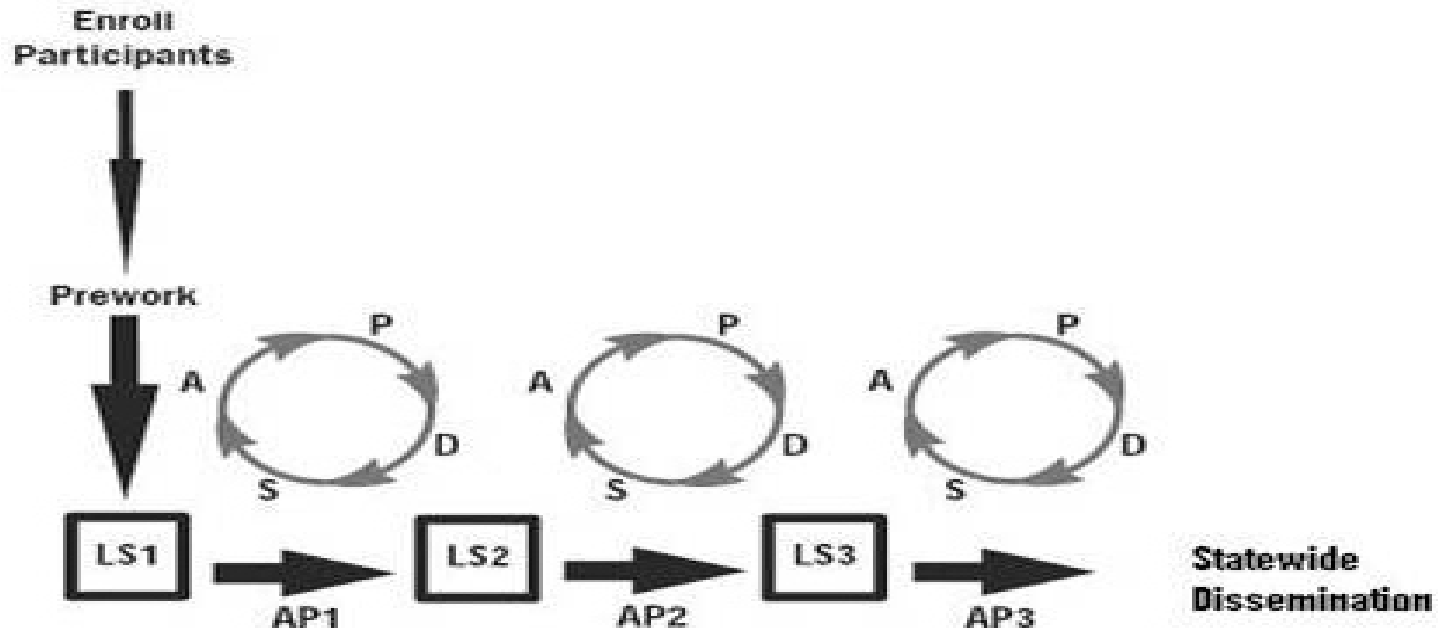
Data Source: Intervention Strategy Tracking Tool, UMRG— August 28, 2012

IHI Adapted Collaborative Model



Supports
Email – Visits – Phone Conferences – Monthly Team Reports - Assessments

LS = Learning Session
AP = Activity period
PDSA = Plan, Do, Study, Act

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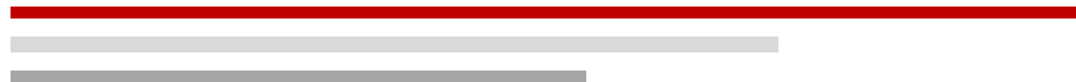
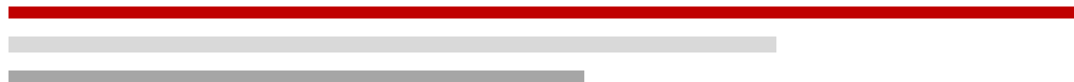
NY Links Performance Measures



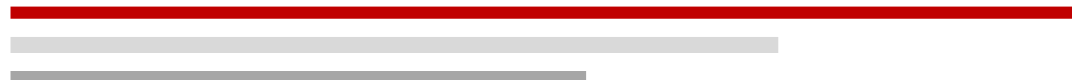
Brief Overview of NYS Links Measures

Measure	Program Type	
1. Linkage	All Programs that Conduct HIV Testing	
2A. Retention	HIV Clinical Care	**Same as in+care Campaign**
2B. New Patient Retention		
3A. Clinical Engagement	Supportive Service, General Medical, & Dental	
3B. New Client Clinical Engagement		



LINKAGE to care among newly diagnosed persons

Percentage of newly diagnosed patients in the reporting period who had their first HIV primary care visit within 30 days of the date of their confirmatory HIV test result



RETENTION Retention Measure

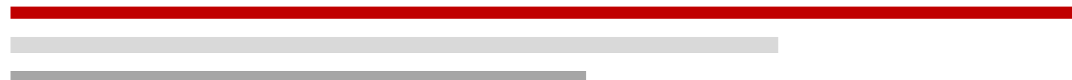
Percentage of patients with at least one HIV clinical care visit during the first 6 months of the 24-month measurement period, who had at least one HIV clinical care visit in each 6-month period of the remaining 18 months of the measurement period with a minimum of 60 days between HIV clinical care visits

NEW PATIENT RETENTION

Percentage of new patients who have their initial HIV clinical care visit during their first four months of the 12-month measurement period who had an HIV clinical care visit in each of the subsequent 4-month periods in the measurement period

CLINICAL ENGAGEMENT

Percentage of active HIV clients/patients with a supportive service, general medical, or dental visit during the reporting period who have a documented or self-reported HIV clinical care visit within the prior 6-month period



NEW CLIENT CLINICAL ENGAGEMENT

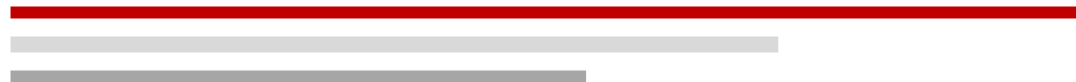
Percentage of new clients/patients to the supportive service, general medical, or dental program without an HIV clinical care visit within the 6-months prior to enrollment that subsequently have a HIV clinical care visit within 30 days of enrollment in the supportive service, general medical or dental program

Performance Measurement Expectations

- Self reporting of NY Links measures every 2 months (Anticipated April 1, 2013 start)
- Submission of performance measurement data to NY Links online data base (www.newyorklinks.org/database)
- Upcoming Webinar on Measures and Data will provide more in-depth information

Queens & Staten Island Collaborative

NY Links



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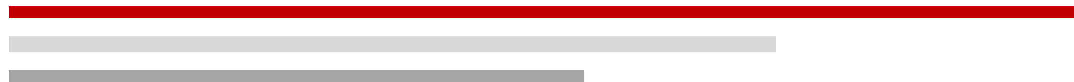
Benefits of Collaborative Membership

- Improved patient care;
- Improved Linkage and Retention outcomes;
- Regional networking in an environment conducive to cross-agency collaboration;
- Participating in National Initiative that will produce state-wide and nationally recognized evidence based interventions;
- Early alignment with Federal and NYS focus on linkage and retention outcome measures for future funding (CDC Treatment as Prevention, HRSA/RYAN White, ACA, HHS Core Indicators, Medicaid/Medicare/Health Homes outcomes)
- Access to nationally recognized technical assistance around Quality Improvement and QI team development

Expectations of Collaborative Membership

- Identify internal QI team to participate in collaborative;
- QI team attends introductory meeting;
- QI team attends quarterly Learning Sessions;
- QI team participates in Webinars and Workshops as needed;
- Data, related to appropriate measures, is provided bi-monthly;
- Identify and test interventions related to Linkage and Retention;
- Progress on interventions is shared with other collaborative members and with statewide evaluation team;
- Keep NY Links staff updated about staff/organizational changes.

Collaborative Team



Collaborative Team

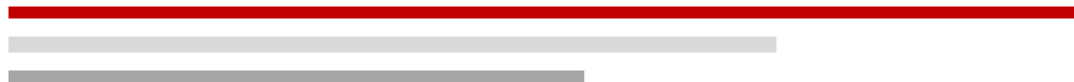
- Identify a leader who will drive change, support quality improvement activities, direct resources and facilitate communication within the organization in support of the agency specific NY Links activities;
- Form a multidisciplinary team, including expert staff (data and evaluation, quality improvement, clinical providers, consumer involved in QI) to participate as a team in the Q&SI Collaborative; and
- Members of the Collaborative Team attend all learning sessions and champion linkage-retention activities in the agency.

Quality Improvement Team

Staff to take on the following responsibilities:

- Senior Leader/Collaborative Lead -
- Point of Contact – person who serves as the bridge between NYLinks and the organization
- Data Manager
- Quality Improvement leader
- Clinical Provider or Program Manager
- PLWHA actively participating in QI

Consumer Involvement

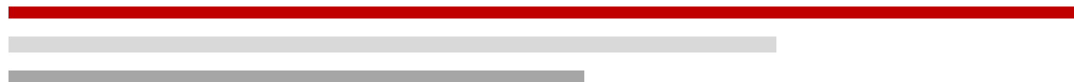


Key Roles Played by Consumers

- Consumer involvement is a critical component of our success.
- Consumers are members of each Collaborative's planning group as well as each each Collaborative's Response Team
- Consumers are members of each organization's Quality Improvement Team

Introductory Visits

NY Links



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Purpose of Introductory Visit

- We learn more about your agency and your participation in current HIV activities and coalitions/networks
- Meet with your staff who will be involved in the NY Links Initiative; including representation from agency's Primary Care, Supportive Service, HIV Testing, and Quality Management Programs
- Strengthen your agency's understanding of the Q&SI Links Collaborative project
- Components
  - Complete a Collaborative Assessment
  - Address any questions regarding Q&SI Collaborative
  - Identify team members for NY Links collaborative participation
  - Follow-up on pre-work for the next Learning Session

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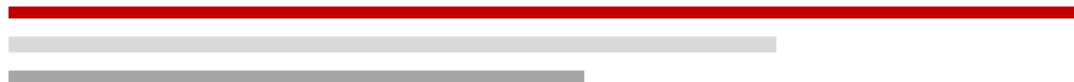
Introductory Visit Logistics

- Visit duration: 60-90 minutes
- Visits led by NYSDOH QI Consultant Johanna Buck, NYCDHMH Senior Program Manager Lenee Simon, or NY Links Project Director Steven Sawicki, and possibly, a contract manager or project officer.
- Visit Participation:
  – Executive leader(s), QI program coordinator, data/IT coordinator, program staff
- Aim to complete site visits by the 1st Learning Session

Collaborative Response Team



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Q&SI Response Team

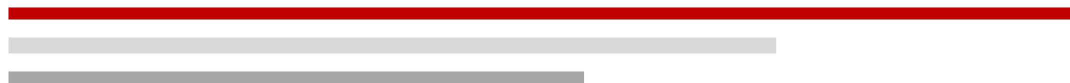
A Response Team is a self-organizing, peer-driven group made up of 5-10 voluntary leaders with various skill sets and roles who participate in the Q&SI Collaborative.

Purpose:

- Streamline communication
- Strengthen leadership capacity
- Support & direct collaborative
- Increase collaborative sustainability

Web Site

NY-Links



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New York Links Website

- Visit the website at: NewYorkLinks.org
- Information on all collaboratives
- Data entry portal
- Events listing
- Resource page

Welcome to NY Links

NY Links identifies innovative solutions for improving linkage to and retention in HIV care to support the delivery of routine, timely, and effective care for Persons living with HIV/AIDS in New York State. We will bridge systemic gaps between HIV related services and achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS. Region by region, we will utilize the learning collaborative model to fortify the links holding together communities of practice, and the links grounding them in the communities of consumers they serve.

This effort is a supported by the HRSA HIV/AIDS Bureau (HAB)-sponsored Special Projects of National Significance (SPNS) and the NYSDOH AIDS Institute.

NY Links Timeline

Sign-in to database

Upcoming Events

UMRG Learning Session (Rescheduled from 10/31)

January 23, 2013,

WNYS Rochester Collaborative Meeting -- Jan. 10

January 10, 2013,

Popular Campaign Resources

ASCNYC-NYPH_Collaboration

Upper Manhattan Meeting Slides

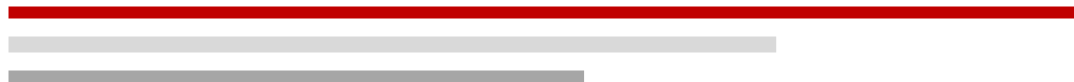
Dr Sweeney Presentation

IAPAC webinar slideset pdf

HAVE QUESTIONS?

Have any questions for us on NY Links? Feel free to contact us! Please put 'Help' in the subject line.

Next Steps



Next Steps

- Repeat Introductory Webinar
- Measures and Data Webinar
- Continued Scheduling of introductory visits
- Site specific pre-Learning Session work/TA activities as needed
- 1st Collaborative Learning Session planned for February/March, 2013

NY Links

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Contact Information

Clemens Steinbock, Director of National Quality Center, cms18@health.state.ny.us

Steve Sawicki, SPNS Lead, svs03@health.state.ny.us

Annelise Herskowitxz, Program Assistant with the SPNS Initiative, axh18@health.state.ny.us

Johanna Buck, RN, MA, Senior Quality Consultant, johanna_buck@att.net

Lenee Simon, Senior Program Manager, lsimon1@health.nyc.gov

Generic information, info@newyorklinks.org.