

*The fourth meeting of the NYS SPNS Upper Manhattan Regional Group was held on Thursday, July 19<sup>th</sup>, 2012.*

*This newsbrief provides an overview of the topics discussed, a review of the interventions presented by providers, and important next steps and resources.*

*We would like to thank everyone who attended the meeting, all presenters, and our dedicated planning committees.*

**IMPORTANT ITEMS FOR YOUR REVIEW**

1. [NY Links Performance Measurement Database](#)
2. [NY Links General Website](#)

**MEETING PARTICIPANTS**

- 29 Participants Representing 14 Agencies
- 5 Representatives from the NYCDOHMH
- 16 AIDS Institute and other SPNS Staff
- 50 Total



We are pleased to announce the publishing of Dr. Agins' article "[Retention in HIV Care: The Scope of the Problem](#)" in the Medscape "[Retention in HIV Care](#)" Series.

Dr. Agins' article is the first in the series, in which leaders in the clinical research field of HIV retention address key issues and implementation strategies to improve retention in care.

**IMPORTANT RESOURCE**

*All resources from NY Links and the Upper Manhattan Regional Group can be found online: [NewYorkLinks.org](http://NewYorkLinks.org)*

**PRESENTATIONS SUMMARY**

*All ppts are available for download on our website.*

**The Upper Manhattan Experience: HIV Epidemiology Update**

**Monica Sweeney, MD**

Dr. Sweeney reviewed recent epidemiologic data for Upper Manhattan and Upper Manhattan Extended regions including new HIV diagnoses, timeliness of care and viral suppression. She emphasized the importance of meeting the patient where they are in order to retain them in care.

**Working to Reduce Health Disparities and Promote Health Equity**

**Roger Hayes, MA**

Roger Hayes presented the efforts of the East and Central Harlem District Public Health Office to partner with the DOHMH and community stakeholders to reduce health disparities, specifically childhood asthma and obesity. Many of these lessons of collaboration can be applied to improving HIV linkage and retention.

**Measuring Our Collaborative Progress: Linkage and Retention in Upper Manhattan**

**Diane Addison, MPH, MIA**

Diane Addison outlined the UMRG participation and data submission rates and presented the results from the April and June site-based measures. Diane also showed examples from published studies of how data helps measure the effectiveness of quality improvement interventions.

**Linkage and Retention: Whose system is it anyway?**

**Bruce Agins, MD, MPH**

Dr. Agins stressed the importance of system performance and understanding normal variation to underscore that the entire system involved in linkage and retention must evolve in order to increase performance rates and retain the most challenging patients in care. He ended with a call to action.



**Linkage and Retention: Interventions in Upper Manhattan Sites**

Interventions shared by meeting participants in Breakout Session I:

| <b>Linkage Interventions</b>   | <b>Retention Interventions</b>  |
|--|---|
| <p><b>Harlem Hospital</b></p> <p><i>Target issue for intervention:</i><br/>--In-patients who are HIV+ who are not linked to a primary care doctor</p> <p><i>Intervention:</i><br/>--Approaching all in-patient HIV+ clients and asking if they have a primary care doctor<br/>--Linking and referring within Harlem hospital to a primary care doctor or to a physician at a location that is more convenient for the client<br/>--Using a database spreadsheet to track effectiveness</p> | <p><b>New York Presbyterian Hospital</b></p> <p><i>Target issue for intervention:</i><br/>--Long wait times</p> <p><i>Intervention:</i><br/>--Conducted a survey in waiting room: 35% of respondents said one of their biggest problems is wait time.<br/>--Followed 2 patients a day through flow to figure out where the bottlenecks are: found that nurses and doctors were the issue.<br/>--Used a PDSA cycle to identify a solution: assign 1 nurse for 3 doctors so each doctor knows which nurse he is working with: reduced wait time by 75%<br/>--Expanding to include front desk staff: the nurse-doctor-front-desk team approach reduced wait time by 95%.</p> |
| <p><b>The William F. Ryan Community Health Center</b></p> <p><i>Target issue for intervention:</i><br/>--Linkage to care after positive test</p> <p><i>Intervention:</i><br/>--Getting client into medical appointment the same day as preliminary positive even when the test occurred out in the field</p>   | <p><b>African Services</b></p> <p><i>Target issue for intervention:</i><br/>--Cultural nuances and beliefs around HIV care (for example, the use of traditional medicine) among clients</p> <p><i>Intervention:</i><br/>--Support groups have both doctors and indigenous leaders to address cultural nuances of HIV care for clients</p>   |
| <p><b>Columbia Presbyterian and Boriken Neighborhood Health Center</b></p> <p><i>Target issue for intervention:</i><br/>--Linkage of patients who are newly diagnosed in the ED to care</p> <p><i>Intervention:</i><br/>--Quickly identify newly diagnosed patients<br/>--Making sure there are clear steps for follow up and linkage to care<br/>--Further making sure they get to their appointments on time</p>   | <p><b>Institute for Family Health</b></p> <p><i>Target issue for intervention:</i><br/>--Increase patient ownership over labs, doctors appointments and overall health</p> <p><i>Intervention:</i><br/>--Introduce the use of client journals.<br/>    --The journals have slots for viral load/CD4 values and upcoming appointments<br/>    --The journals give patients ownership over their labs and allows for everyone on the team help the client understand the information about their labs<br/>--Before the patient leaves make sure they have a next appointment and give hard copy version of the appointment details to patient for the journal</p>           |

Throughout the day additional intervention strategies emerged from the discussion. These included:

- Involving family members in retention
- Exploring patient advocates
- Being persistent and consistent with reminders
- Using tools to help patients understand their health (i.e. lab value guides)



**COLLABORATIVE UPDATES**

**Data Submission:**

August 1, 2012

**Next Learning Session:**

October 31, 2012

**Consumer Subcommittee:**

Consumers participated in a QI 101 training and "satisfaction of care" workshop. Based on the first round of data collection, consumers provided recommendations to NYLinks, including: further stratify the data to determine which UM demographics are not linked to and retained in care; encourage UM providers to make further follow-up phone calls; determine how recently incarcerated populations fit into linkage and retention; determine if low linkage in summer months were an anomaly. The Consumer Subcommittee will soon be integrated into provider learning sessions to better facilitate communication and set goals.

**IMPORTANT CONTACTS**

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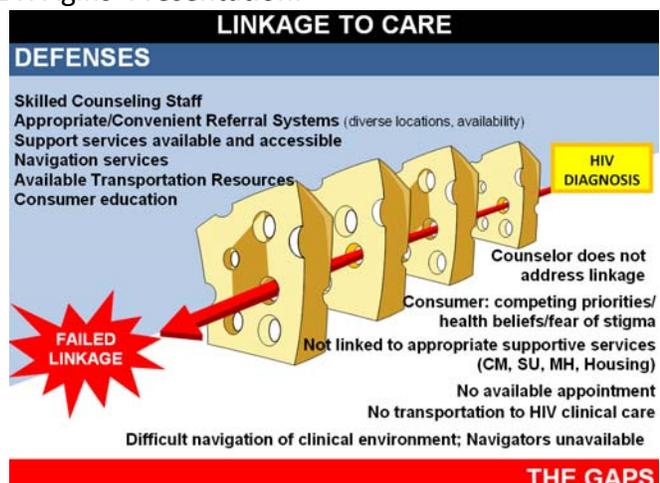
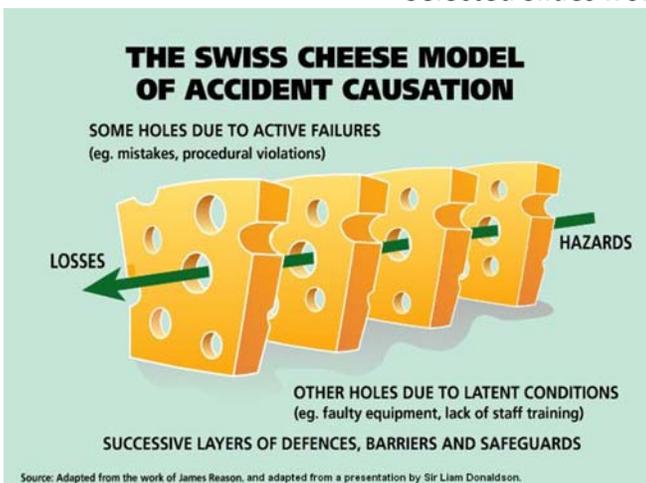
**PERFORMANCE MEASUREMENT**

**REMINDER!** Measure your program's progress in improving linkage and retention in HIV primary care using the NY Links Database. This online application allows clinical and supportive service agencies to self-report their performance measurement data. Measure domains include: (1) linkage; (2A) retention; (2B) new patient retention; (3A) clinical engagement; (3B) new client clinical engagement. Data submission deadlines to date: April 1, June 1 and August 1.

**ACCESS THE NY LINKS DATABASE NOW → [NewYorkLinks.org/database/](http://NewYorkLinks.org/database/)**

If you have any questions regarding the measures or would like to request technical assistance in data collection or quality performance measurement, please email Annelise Herskowitz at [axh18@health.state.ny.us](mailto:axh18@health.state.ny.us).

Selected Slides from Dr. Agins' Presentation:



Adapted from the work of James Reason and Sir Liam Donaldson