WELCOME

Systems Linkages and Access to Care for Populations at High Risk for HIV Infection in New York State
Welcome and Opening Remarks
The times they are a changin’
Relax
The best way to predict the future....
….is to CREATE IT
You are the plan

You are the change
Introductions
From SPNS to NYLinks
Timeline--Past

February 2011—CFDA No. 93.928 released Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative-Demonstrations States

April 2011—NY State submits application

August 2011—NY State receives notice of award

September 2011—NY SPNS program starts—NYLinks born

November 2011—Upper Manhattan Regional Group formed

June 2012—Western New York Regional Group formed

February 2013—Queens and Staten Island Regional Group formed

January 2014—Mid and Lower Hudson Regional Group formed
Transitions

SPNS grant (program component) ends on August 31, 2015

SPNS grant (evaluation component) ends on August 31, 2016

NYLinks Intervention implementation evaluation ends August 31, 2016

September 1, 2015 NYLinks transitions from being under SPNS to being under the Ending the Epidemic Initiative
What Remains?

Intervention Implementation data submission

Measures reporting (under revised configurations)

Regional Meetings—one, maybe two per year

Sub regional meetings—one, maybe two per year

Technical Assistance around QI

Regional focus on L & R improvement

Website, access to data, regional cascades, webinars
On June 29, 2014, Governor Andrew M. Cuomo detailed a three-point plan to move us closer to the end of the AIDS epidemic in New York State. The goal is to reduce the number of new HIV infections to fewer than 750 (from an estimated 3,000) by 2020 and achieve the first ever decrease in HIV prevalence in New York State.

http://www.health.ny.gov/diseases/aids/ending_the_epidemic/
Blueprint to End AIDS

2015 Blueprint

For achieving the goal set forth by Governor Cuomo to end the epidemic in New York State by the end of 2020.

GET TESTED.
TREAT EARLY.
STAY SAFE.

End AIDS.

health.ny.gov/ete
ETE Three Point Plan

Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

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

Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
Ending the Epidemic New York State Regional Discussions

Hudson Valley  August 24, 9 to 1:30
Report Back from Amidst the Trees That Grew Along the Hudson
Building a Mid and Lower Hudson diagram for involving consumers in VLS QI

• What four objectives need to be met to successfully involve consumers in improving rates of viral load suppression?
  – Using the System of Profound Knowledge framework, bear in mind factors related to:
    – Psychology
    – Variation
    – knowledge
    – systems
Clients At The Gate

Dan Tietz
Clients at the Gate
How Welcoming Are You?
Overview and Introductions
Learning Objectives

• Explain how first encounters relate to patient engagement, linkage, and retention
• Identify methods to determine primary engagement points for patients
• Improve knowledge on how to incorporate patient feedback into engagement improvement strategies
• Explore goal setting for engagement efforts
Webinar Agenda

• Overview and Introductions
• Initial Patient Encounter
• Tools for Encounter Improvement
• Rethinking Feedback
• Questions
• Closing
What is the Definition of Patient Engagement?

• Patient Engagement is a hot topic amorphous and appealing enough to mean many things

• According to Kaiser, Patient Engagement includes things like decreased mortality rates and fewer emergencies

• From the literature, Patient Engagement fosters a fruitful collaboration in which patients and clinicians work together to help the patient progress towards mutually agreed-upon health goals.

http://thehealthcareblog.com/blog/2013/09/12/patient-engagement-on-metrics-and-meaning/
What is Patient Engagement

- Patient engagement is a process in which patients become invested in their own care.
- Engagement develops naturally when there is regular, focused communication between patient and provider.
- It can lead to behaviors that meet or more closely approach treatment guidelines.
- Patients engaged in their own care may make fewer demands on the health care system and more importantly, they enjoy improved health.
- Research shows that informed and engaged patients take a more active role in their own care.
- Healthcare organizations are discovering how patient engagement contributes to their financial and quality objectives.
Fostering Patient Engagement

• Determine what patient engagement really means and develop metrics or outcomes to demonstrate it

• Foster collaboration between patients and clinical staff

• Establish with patients mutually agreed-upon health goals based on their needs, priorities, and preferences.

• Develop strategies to measure the quality of patient/provider collaborative processes.
Examples of Engagement Interventions beyond Linkage to Care

- Peer Support using consumers as patient navigators
- Appointment Reminder Procedures
- Case Management
- Case Conferencing/Consistent Messaging
- Outreach/Returning to Care
- Marketing and Engagement Efforts
Steps to Achieve Optimal Clinical Outcomes

CDC’s Care Continuum (July, 2012)

- Diagnosed: 82%
- Linked to Care: 66%
- Retained in Care: 37%
- Prescribed ART: 33%
- Virally Suppressed: 25%
Continuum of Engagement

Levels of Engagement

Direct Care
- Patients receive information about a diagnosis

Consultation
- Organization surveys patients about their care experiences

Involvement
- Hospital involves patients as advisors or advisory council members

Partnership and Shared Leadership
- Treatment decisions are made based on patients’ preferences, medical evidences, and clinical judgment

Organizational Design and Governance

Policy Making
- Public agency conducts focus groups with patients to ask opinions about health care issue

- Patients’ recommendations about research priorities are used by public agency to make funding decisions

- Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors Influencing Engagement:
- Patient (Beliefs about Patient Role, Health Literacy, Education)
- Organization (Policies and Practices, Culture)
- Society (Social Norms, Regulations, Policy)

Source:
A Multi-Dimensional Framework For Patient and Family Engagement in Health and Healthcare
Carmen K L et al. Health Aff 2013; 32:22
The “Handoff” and the “Handshake”
Predicted Value Outcome Theory

- Study with college students – “social animals”
- Established predictability based on the first encounter
- The length of the impression (three, six, or ten minutes) didn’t matter
- Negative impressions had the greatest impact over time


Perceptions formed during initial meetings still influenced relationships nine weeks
Question to Consider

How do we identify and improve encounters with patients, like a first encounter?
Tools for Encounter Improvement
Tools for Encounter Improvement

• How can our organization identify areas for organizational improvement to improve quality activities?
  – Organizational Assessment

• How can we identify other opportunities for improvement in patient engagement?
  – Touch Point Mapping

• How can we quickly gather data about one of patient engagement points?
  – Word Clouds
Organizational Assessment Tool

- Quality Management Program Infrastructure
- Leadership Buy-In
- Quality Management Team/Committee to guide, assess, and improve
- Written Quality Management Plan
- Measurement, Analysis and Use of Date to Improve Program Performance
- Staff and Patient Engagement in Quality Improvement Activities
- Achieving Outcomes
- Annual Evaluation of Organization
‘Touch Points’ and Mapping Service Delivery

(Bate & Robert, 2007)
Touch Point Definition

• The key moments or events that stand out for those involved as crucial to their experience of receiving or delivering a service.

• Touch points are the points of contact with a service and intensely personal “Big Moments” on the journey where one recalls being touched emotionally or cognitively that cause deep and lasting memories
Mapping ‘Touch Points’

Mapping touch points allows you to:

• learn from consumer experiences with clinical visits
• determine what is typical and exceptional
• probe explanations of experiences
• compare provider and users maps
• assist in linking care from ‘beginning to end’
Where does it all begin?
Getting to my clinic
A Walk Through My Clinic
Dan’s Touch Points Linking to HIV Care

1987: Diagnosed with Shingles in Emergency Room

PCP Performed HIV Test

PCP Informed me that I was HIV+ via telephone call while at work

Informed Parents who researched HIV Specialist and Advocated to Receive Medical Visit at closest facility with expertise.

Initial Meeting with Case Manager and Clinician.
Questions to Consider

• How are your patients “introduced” to your clinic?
• Is the moment of first contact the receptionist or perhaps it occurs during a separate registration process?
• Was the patient’s first encounter with a provider or a visit to have blood drawn at a separate lab?
• How does the “hand-off” occur between your clinic and external community-based organizations conducting HIV screening?
Word Clouds

• Word clouds are graphical representations of word frequency
• The larger the word in the visual, the more common the word was used
• This type of visualization can assist with exploring and analyzing words
• It can also be used to communicate the most salient points or themes
What does Quality Care mean to you and why?
‘Touch Points’ and Word Clouds

• Create a ‘touch point’ map for your organization or clinic to identify key moments in care
  – Brainstorm ‘touch points’ with your Consumer Advisory Board and compare with your version

• Use the “touch point” map to solicit feedback on flow stations to identify what encounters might need improvement

• Pair ‘touch points’ with ‘word clouds’ to further your data on patient experience in your clinic
The Secret Shopper

- Commercially used to report on the quality of services to a corporate headquarters
- The person doing the evaluation is unknown to the service provider
- Useful to see what a potential patient may go through as they try to enroll or access services
Encounter improvement also requires ...

- Addressing Health Disparities
  - Using your selected measures, identify whether you have disparities present in your patient population
- Collaborating versus Competing
  - Working together, sharing ideas, setting goals
- Implementing Lessons Learned From the Field
  - Example: Engage your patients in the process of improving engagement!
Rethinking Feedback
What Ernesto Sirolli learned in Zambia
How do we avoid the Hippos?

“What you do [to provide better aid is] you shut up. You never arrive in a community with any ideas.”

~ Ernesto Sirolli
Moving to Improvement

So you have ...

- Assessed your organization
- Mapped your ‘touch points’
- Solicited feedback via a ‘word cloud’
- Identified an opportunity for improvement
- Determined how to ask the right questions
- Now what?
Comments/Questions?
Thanks for attending and contact information

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Adam Thompson  
NQC Peer Consultant  
adamtthompson@gmail.com
Lunch
Regional Data
NYLinks Measures
<table>
<thead>
<tr>
<th>Measure</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Linkage</td>
<td>All Programs that Conduct HIV Testing</td>
</tr>
<tr>
<td>2A. Retention</td>
<td>All Programs that provide HIV clinical care</td>
</tr>
<tr>
<td></td>
<td>Same as LRTA and in+care Campaign</td>
</tr>
<tr>
<td>2B. New Patient Retention</td>
<td></td>
</tr>
<tr>
<td>3. Clinical Engagement</td>
<td>All Supportive Service(^1), General Medical(^2), &amp; Dental Providers</td>
</tr>
<tr>
<td>4. Viral Load Suppression</td>
<td>All Programs</td>
</tr>
</tbody>
</table>
Changes

Change in frequency from every other month to quarterly

For Retention and New Patient Retention all exclusions, except for death, are dropped. The only exclusion that will remain will be death.

For supportive service providers, the new patient measure is dropped.

A measure on Viral Load Suppression (the same measure as in EHIVQUAL has been added for all providers.
Do You Know The Drill?
Do you know the drill?
Drilling down data exercise

NY Links Mid and Lower Hudson Regional Group Meeting
Tuesday, July 28, 2015
Agenda

- Review of exercise
- Drilling down data exercise
- Developing regional quality improvement interventions
- Report back
Learning Objectives

• Practice with drilling down regional viral load suppression rates

• Learn how to match QI activities to meet the needs of patient groups as suggested by the data.

• Consider how the county, the supportive services and the clinics can work together to improve VLS in Mid-Hudson Region?

• Identify specific roles and responsibilities that the county, supportive services and clinic’s can take in working together to improve VLS rates regionally.
## Do you know the drill?

<table>
<thead>
<tr>
<th>Patient</th>
<th>Last VLS</th>
<th>Race/Ethnicity</th>
<th>Housing</th>
<th>Age/Gender</th>
<th>Risk Factor</th>
<th>Mental health</th>
<th>Transportation</th>
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</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>&lt;200</td>
<td>Black</td>
<td>homeless</td>
<td>26 male</td>
<td>MSM</td>
<td>Depression</td>
<td>Issue</td>
</tr>
<tr>
<td>Patient 2</td>
<td>500</td>
<td>Hispanic</td>
<td>housed</td>
<td>30 trans-F</td>
<td>IDU</td>
<td>Anxiety</td>
<td>Issue</td>
</tr>
<tr>
<td>Patient 3</td>
<td>2000</td>
<td>White</td>
<td>housed</td>
<td>45 female</td>
<td>Sex/hetero</td>
<td>PTSD</td>
<td>Non-issue</td>
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<tr>
<td>Patient 4</td>
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<td>22Trans-M</td>
<td>IDU</td>
<td>Dom. V.</td>
<td>Issue</td>
</tr>
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<td>Black</td>
<td>housed</td>
<td>18 female</td>
<td>IDU</td>
<td>Depression</td>
<td>Non-issue</td>
</tr>
<tr>
<td>Patient 6</td>
<td>&lt;200</td>
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<td>homeless</td>
<td>28 male</td>
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<td>Issue</td>
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<td>MSM</td>
<td>PTSD</td>
<td>Issue</td>
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<tr>
<td>Patient 8</td>
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<td>19 male</td>
<td>MSM</td>
<td>PTSD</td>
<td>Issue</td>
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<tr>
<td>Patient 9</td>
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<td>homeless</td>
<td>40 female</td>
<td>IDU</td>
<td>Dom. V.</td>
<td>Non-issue</td>
</tr>
</tbody>
</table>
Data Drill Down (60 minutes)

Using the data worksheet, please answer the following questions:

1. Review aggregate VLS outcome data and patient characteristics for the region (page 2) and for those patients who are not suppressed in the region (page 3).

2. After reviewing the results use the data spreadsheet to compare patient characteristics and to identify issues that may be impacting specific groups of patients.

3. Does the data suggest that there are subgroups (a percentage of patients who are not suppressed who have a similar set of characteristics)? EXAMPLE: 40% of unsuppressed patients are YMSM of color, 20% are homeless substance users with a diagnosis of depression.
Data worksheet questions continued

4. What regional strategies (process changes) could you make to help patients who are not suppressed to become and sustain viral load suppression? How can you tailor your improvement activities to meet the needs of the identified subgroups?

5. What is the role of the county? What is the role of the supportive service agency? What is the role of the HIV clinic? How will you know if a change is an improvement?
Developing a Plan

• Each group identifies a facilitator, recorder and reporter.

• Discuss the results of your data drill down exercise.

• Develop a collaborative quality improvement activity to improve the regional rate of VLS.

• Reporter and team reports back to the larger group.
Discussion: Real Life Drill Down

• How can each of the two regions represented in this group work collaboratively to improve the rate of viral load suppression?

• What are the opportunities of a collaborative regional approach to improving the rate of viral load suppression?

• What are the challenges?

• How can challenges be overcome and opportunities be capitalized upon to move from ideas to action?
Homework

• Each region reviews regional VLS data, develops and implements a regional VLS QI project.

• Using the VLS QI project reporting form, each region reports back on July/August/September QI project activity.
A Viral Load Suppression Reporting Template
VLS Project Reporting Form

Site: [ ] Prepared By: [ ] Report Period: [ ]

# of Unsuppressed Patients

# of Patients From the Green Box who Received a VL Suppression QI Intervention in 2015

# of Patients From the Purple Box who Received a VL Test After Receiving the QI Intervention in 2015

# of Patients from the Orange Box...

- Suppressed at First VL Test After Receiving the QI Intervention
- Suppressed at Most Recent VL Test Since Receiving the QI Intervention
- Suppressed at All VL Test(s) Since Receiving the QI Intervention

<200

Predominant Subgroups* among Unsuppressed Patients

(Please enter subgroup titles on the lines below & enter number of patients in each subgroup in the box below the corresponding title)

A. [ ] B. [ ] C. [ ]

# of Patients in Each Subgroup Identified Above

A. [ ] B. [ ] C. [ ]

A. [ ] B. [ ] C. [ ]

A. [ ] B. [ ] C. [ ]
Baseline Data

Number of unsuppressed patients, regardless of time on ART

20

Predominant Subgroups* among Unsuppressed Patients
(Please enter subgroup titles on the lines below & enter number of patients in each subgroup in the box below the corresponding title)

A. IVDU 10
B. YMSM 4
C. Spanish speakers 6

Enter titles of subgroups on these lines based on your own clinic’s population
Number of YMSM in each suppression category

Number of IVDU in each suppression category

Number of Spanish speakers in each suppression category

<table>
<thead>
<tr>
<th></th>
<th>A. IVDU</th>
<th>B. YMSM</th>
<th>C. Spanish speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>12</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>
Review of the 2015 reporting form

Site: [ ] Prepared By: [ ] Report Period: January-March 2015

**# of Unsuppressed Patients**

**# of Patients From the Green Box who Received a VL Suppression QI Intervention in 2015**

**# of Patients From the Purple Box who Received a VL Test After Receiving the QI Intervention in 2015**

**# of Patients from the Orange Box...**
- Suppressed at **First VL Test After Receiving the QI Intervention**
- Suppressed at **Most Recent VL Test Since Receiving the QI Intervention**
- Suppressed at **All VL Test(s) Since Receiving the QI Intervention**

*Please feel free to list any subgroup you have observed in your clinic. Such groups could include, but are not limited to women of color, MSM, substance users, etc.*
Qualitative Questions

1. How can we work together regionally to improve the rate of VLS? What is the county role? What is the role of supportive services? What is the role of clinical care? How will you know if the work you are engaged in is successful at bringing patients to VLS?

2 Please describe your quality improvement collaborative/regional VLS improvement intervention and how this intervention is tailored to target the identified subgroups:

3 How can your quality improvement activities be tailored to more effectively support patients from these subgroups? Have you made any changes to improve processes to support patients in these subgroups? Are you planning any changes towards this end going forward? Please explain.
Qualitative Questions

4. Have you made changes to the quality improvement intervention since the last reporting period? If so, please describe these changes:

5. What challenges have you faced while implementing your quality improvement intervention? What lessons have been learned?

6. What steps have you taken to involve more patients in the quality improvement intervention?

7. What steps have you taken to help patients to sustain their viral load suppression?
Know the Drill: Drilling Down Data Exercise

- Each group identifies a facilitator, recorder and reporter.
- Develop a collaborative quality improvement activity to improve the regional rate of VLS. Reporter and team reports back to the larger group.
- Discuss the results of your data drill down exercise.

Using the data worksheet, please answer the following questions:

1. Review aggregate VLS outcome data and patient characteristics for the region (page 2) and for those patients who are not suppressed in the region (page 3).
   Notes:

2. After reviewing the results use the data spreadsheet to compare patient characteristics and to identify issues that may be impacting specific groups of patients.
Force Field Analysis

1) Define the desired change or action (agree on a simple statement).
2) Brainstorm the driving forces & restraining forces
3) Prioritize the driving forces & restraining forces (identify the critical few- rank order the top 3)
   List actions to be taken (focusing on the critical few driving & restraining forces)

Desired Change: Implementing a regional VLS QI project

<table>
<thead>
<tr>
<th>Driving Forces</th>
<th>Restraining Forces</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Those which currently exist &amp; support or drive the desired change)</td>
<td>(Forces that may inhibit the implementation of the desired change.)</td>
</tr>
</tbody>
</table>
Wrap Up: Summation

Steve Sawicki
UPCOMING STAKEHOLDER MEETINGS

August 19—Queens
August 24—Long Island
August 27—Western New York
Early October—Upper Manhattan
Next Mid and Lower Hudson Meeting? Sub-regional?
DATA DEADLINES

August 1, 2015—NYLinks Bi-Monthly measures

August 15, 2015—Intervention data for previous month

September 15, 2015—Intervention data for previous month

January 1, 2016—NYLinks Quarterly measures
Webinars

August 12 1:00, NYLinks Interventions evaluation data so far

August 19 3:00, NYLinks Interventions (final packages for wider scale implementation)

September ?? ?:??, How to construct an intervention from the ground up
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.

www.NewYorkLinks.org
Evaluation

Sign in sheet
Contact Information

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• Bruce D. Agins, Medical Director,
bda01@health.state.ny.us

• Blog at http://linkandretain.wordpress.com/

• Website at http://www.newyorklinks.org
Adjourn! Thank you!