WELCOME!

Lower Manhattan Regional Group

April 3rd, 2018

Hispanic Federation: Las Americas Conference Center
Overview & Today’s Agenda

Jonathan Gómez | NYSDOH – AI
2017 Lower Manhattan Charge: Improved Patient Care and Outcomes

• By:
  • Creating new opportunities for expedited linkage to care, engagement of those lost to or never engaged in care, and increased viral load suppression at individual agencies and cross-agency collaboration

  • Building our skills in and with the use of quality improvement, including Plan, Do, Study, Act Cycles, to test out our ideas and evaluate their potential success

  • Sharing our collective experience to uncover or develop breakthroughs that improve patient care & public health outcomes
Lower Manhattan Collaborative Goals

NYLinks Lower Manhattan Regional Group Steering Committee
Lara Comstock | Isaac Evans-Frantz (Callen-Lorde Community Health Center)
Dana Diamond (Exponents)
Hannah Hirschland | Alexa Kreisberg (Gay Men’s Health Crisis)
Alison Kliegman | Leslie Pierce (Housing Works)
Toan Nguyen (Hetrick-Martin Institute)
Shruti Ramachandran | Amy Newton (Mount Sinai Health System - Institute for Advanced Medicine)
Short-Term (by September 29, 2017):
To assure that quality improvement strategies are tailored to address populations that are disproportionately experiencing poorer access to and outcomes in HIV care, each agency will drill-down patient level data for those individuals newly diagnosed with HIV that were never linked to care and all patients that were not virally suppressed in 2016, using the following categories:

• Gender
• Age Range
• Race/Ethnicity
• Risk Factors
• Housing Status
Mid-Term (by December 31, 2017):
Each clinical agency will initiate an improvement project to identify and link those HIV-positive patients entering the organization that are not engaged in HIV primary care (“open-non-active”) into primary care. For larger agencies, the project may focus on one particular department or unit.

The identification of “open non-active” HIV-positive patients will include the following information:
• Receiving HIV primary care at the organization
• Receiving ongoing HIV primary care at another organization
• Not engaged in routine HIV primary care
Lower Manhattan Collaborative Goals

Long-Term (by July 2018):

For established patients, collaboratively:

• Increase the clinic-wide rate of patients that are virally suppressed (as self-reported by Lower Manhattan agencies) from the current aggregate of 84% (2016) to 90% by July 2018.

• For new patients, collaboratively:
  • Increase the clinic-wide rate of patients linked to care within 3 days (internally) or 5 days (externally) at NYLinks participating LM regional group clinics from the current aggregate rate of 33% (2016) to 43%, or a 10 percentage point increase by July 2018;
  • Increase the percentage of patients that are prescribed ART within the review period from the current aggregate rate of 71% (2016) to 76%, or a 5 percentage point increase by July 2018;
  • Increase the percentage of patients who are virally suppressed from the current aggregate rate of 57% (2016) to 62%, or a 5 percentage point increase by July 2018.
During today’s sharing . . .

• Keep in mind the regional goals:
  ✓ How are we doing “collaboratively”?  
  ✓ Are there enough of us focused on the priority areas we’ve identified? 
  ✓ Do we have strong and useful QI and collaborative projects? 
  ✓ How might we accelerate improvement? 
  ✓ Which agencies/organizations, DOH units, individuals, etc. are still needed to help “drive” us to the End of the Epidemic?
Agenda

**Morning (9:30am – 12:15pm)**
- Welcome – Opening Remarks, Regional Goals
- 2017 Lightning Rounds: Accomplishments and Challenges
- 2017 Organizational Treatment Cascades: Frequent Questions
- Break (10 min.)
- Small Group Discussions: Data Development, QI Improvement Plans, Supportive Service Cascades

**Afternoon (12:45pm – 3:00pm)**
- Rapid Linkage and HIV Treatment
- Open Topic
- Wrap-up: Next Steps, Important Dates & Evaluations
2017 Lightning Rounds: Accomplishments and Challenges
RYAN-NENA HIV Treatment Cascade Improvement Project: UPDATE

APRIL 3, 2018
Improvement Goal

For 2017 our goals included:

1) Increase the percentage of patients on ART who are virally suppressed from 88% to 92%.

2) Increase the percentage of viral load suppression for active HIV+ patients from 87% to 89%.

Update

- At the end of 2017, 89% of patients on ART were virally suppressed
- The overall viral load suppression rate was 86%.
Improvement Strategy

-For 2017, the reasons for having an unsuppressed viral load were as follows:
1. Treatment adherence problems vs. Blip- 26 patients
2. Viral resistance- 1 patient
3. Not on ART- 4 patients

-For 2018, our plan is to focus on reasons for unsuppressed viral load for patients on ART and develop targeted PDSA cycles to address these factors. We plan to investigate after a new unsuppressed viral load to determine the occurrence of the following:
1. Forgetting to take ART due to socioeconomic factors such as housing instability, drug/alcohol use, lack of support
2. Forgetting to take ART due to memory problems
3. Missing ART due to insurance or pharmacy problems
4. Missing ART due to travel or losing medications
5. Not taking ART with or without food as indicated or at a consistent time
6. Not missing ART
For 2018 our goals include:

1) Increase the percentage of patients on ART who are virally suppressed from 89% to 92%.

2) Increase the percentage of viral load suppression for active HIV+ patients from 86% to 88%.

3) Target the open, non-active HIV+ patient population to increase the percentage of patients connected to HIV medical care.
Open, Non-Active HIV+ Patients

At the end of 2016, we had 114/263 open, non-active HIV patients seen at our site.

Update:
- In our most recent evaluation during 2017, we found 121 open, non-active patients.
- We did a manual review of these 121 patients and determined:
  - 56 = PCP documented in EMR, seen by dental only
  - 48 = PCP unknown, seen by dental only
  - 4 = Lost to follow up
  - 6 = Transfer of medical care to new location
  - 4 = Newly diagnosed HIV+ or new transfer of care
  - 1 = Not HIV+
  - 2 = Deceased
- We are working with our dental department to document PCP for all HIV+ patients and continuing outreach efforts for the patients lost to follow up.
QI Contact Information

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HMI’s Prevention Cascade

Lower Manhattan NYLinks Meeting
4/3/2018
Toan Nguyen
Program Manager, Health and Wellness
Road to PrEP/PEP at HMI

1. Clients are screened for PrEP/PEP using the NYCDOHMH H-PLUS screening tool.
2. Clients are indicated for PrEP, PEP, or no applicable action.
3. Clients indicated for PrEP/PEP complete an intake session with a member of the HIV services team.
4. Clients indicate whether they want to continue with the process after completing the intake.
5. HIV services team actively links client to a clinical partner and follows-up to ensure successful linkage.
HMI Prevention Cascade: Mar – Aug 2017

- Screened for PrEP/PEP: 91
- Indicated for PrEP: 63
- Completed Intake: 47
- Wanted to continue to PrEP/PEP: 43
- Successful Linkage to PrEP/PEP: 42

- 69% of clients screened were indicated for PrEP
- 51% of indicated clients completed intake
- 47% of completed clients wanted to continue PrEP/PEP
- 46% of clients who wanted to continue were successfully linked to PrEP/PEP
HMI HIV Prevention Cascade - 2017

- **Screened for PrEP/PEP**: 125
  - March-August: 91
  - March-November: 34

- **Indicated for PrEP/PEP**: 105
  - March-August: 63
  - March-November: 42

- **Completed Intake**: 82
  - March-August: 47
  - March-November: 35

- **Wanted to continue to PrEP/PEP**: 63
  - March-August: 43
  - March-November: 20

- **Successful Linkage to PrEP/PEP**: 61
  - March-August: 42
  - March-November: 19
HMI HIV Prevention Cascade - 2017

- **Screened for PrEP/PEP**: 125
- **Indicated for PrEP/PEP**: 105 (84% of screened)
- **Completed Intake**: 82 (66% of indicated)
- **Wanted to continue to PrEP/PEP**: 63 (50% of completed intake)
- **Successful Linkage to PrEP/PEP**: 61 (49% of wanted to continue)

- Number of Clients

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HIV Prevention Cascade:

1. **Screening**
2. **Indication**
3. **Intake**
4. **Continuation**
5. **Linkage**

- 84% of screened clients were indicated for PrEP/PEP.
- 66% of indicated clients completed intake.
- 50% of clients who wanted to continue were linked to PrEP/PEP.
## Percentage changes in 2017 cascade

<table>
<thead>
<tr>
<th>Step in cascade</th>
<th>March - August</th>
<th>March - November</th>
<th>Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened for PrEP/PEP</td>
<td>100%</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Indicated for PrEP/PEP</td>
<td>69%</td>
<td>84%</td>
<td>15%</td>
</tr>
<tr>
<td>Completed Intake</td>
<td>52%</td>
<td>66%</td>
<td>14%</td>
</tr>
<tr>
<td>Wanted to continue to PrEP/PEP</td>
<td>47%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>Successful Linkage to PrEP/PEP</td>
<td>46%</td>
<td>49%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Where people heard about us - 2017

<table>
<thead>
<tr>
<th>Point of initial contact</th>
<th># of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dating apps</td>
<td>46</td>
</tr>
<tr>
<td>In-house</td>
<td>17</td>
</tr>
<tr>
<td>Word of mouth</td>
<td>4</td>
</tr>
<tr>
<td>Traditional Outreach</td>
<td>2</td>
</tr>
<tr>
<td>Facebook</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>72</td>
</tr>
</tbody>
</table>
Future improvement strategy: Concentrating on dating app outreach
HMI Dating App Outreach Cascade: 4/17-11/17

- Unique Conversations: N=464
- PrEP/PEP inquiry: N=262
- Referrals provided: N=163
- Clients enrolled: N=46
HMI Dating App Outreach Cascade: 4/17-11/17

- **Unique Conversations**: N=464 (56% of N=262) → N=163 (35% of N=163) → N=46 (10% of N=46)
QI Contact Information

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Improvement Goal

September 2017 Goal (*modified): Increase the number of virally suppressed (V1 Bucket) “combined” EtE cohort members from 28.15% to 45% by December 2017.

September 2017 Long Term Goal: Increase the number of virally suppressed “combined” EtE cohort members from 28.15% to 85% by December 2020.

Improvement Goal Update (December 2017)

<table>
<thead>
<tr>
<th>Buckets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1 &lt;200</td>
<td>678</td>
</tr>
<tr>
<td>V2 200-999</td>
<td>147</td>
</tr>
<tr>
<td>V3 1,000-9,999</td>
<td>212</td>
</tr>
<tr>
<td>V4 10,000-99,999</td>
<td>311</td>
</tr>
<tr>
<td>V5&gt;=100,000</td>
<td>105</td>
</tr>
<tr>
<td>V7 No Reported VL</td>
<td>28</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1481</td>
</tr>
</tbody>
</table>

*modified to include all cohorts
“Intriguing” Improvement Strategy

Street Outreach & Engagement Intervention contain members not engaged in care who need street-level outreach. MetroPlus Health Plan observed a trend in which members that fall out of care often are combating with barriers that impeded on their retention. These barriers include but are not limited to social and economic needs. Due to the lack of HIV care, it is possible that one cannot achieve viral load suppression.

Out of the 405 member’s referred to the Alliance for Positive Change (a 125 member increase since the September presentation), 137 members (33.8%) have been re-engaged into care, a 11.2% drop from September 2017. Members remaining on the outreach list are becoming more challenging to engage.
Next Steps

Adherence Technology
The newly designed intervention was roll-out in January 2018. The selected Adherence Technology Coordinator is working closely with HealthCrowd; a vendor currently managing the delivery of text messages to MetroPlus members. Additionally, the Adherence Technology Coordinator is working on the program workflow and data base. Members will be offered a text messaging support, including medication refill reminders.

Peer Care Connect Program Update
The PCC intervention offers educational workshops, creative arts events and engagement of members at their medical home. The members are now able to attend the educational workshops and creative arts are offered across three boroughs (Manhattan, Bronx and Brooklyn). The schedule flexibility allowed members to attend groups across different boroughs and has been well received.

Creative Events Planning
A comprehensive calendar was executed to support creative/EtE marketing events across the four (4) boroughs. Members will be invited to unconventional events; 1) vision board design, 2) transformational art, 3) introduction to photography and 4) “telling your story” - how to write about your experience. During these workshops, the staff introduce the EtE interventions and offer the members an opportunity to enroll.
QI Contact Information

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Supportive Service: GMHC
Drilling-Down Data for Quality Improvement Projects
April 3, 2018

NON-CLINICAL
Organizational HIV Treatment Cascades

• **Timeframe**
  – Quarter 4 of 2016 through 2017; Q4 of 2016 is Baseline

• **“Open” clients** (all HIV+ patients that touched your org):
  – Baseline – 1918; Q1 – 1981; Q2 – 1957; Q3 – 2085; Q4 – 2071

• **Active clients** (received any service, any HIV-status):
  – Baseline – 4573; Q1 – 5081; Q2 – 5081; Q3 – 5222; Q4 – 4775

• **Known viral load test:**
  – Baseline – 786; Q1 – 950; Q2 – 1037; Q3 – 1263; Q4 – 1333

• **Suppressed viral load** (<200 cps. ml) at last test:
  – Baseline – 729; Q1 – 832; Q2 – 939; Q3 – 1139; Q4 – 1196
Linkage & Engagement Partnerships
Positive Health Outcomes

Where clients receive HIV primary care. (most common)
- Mt. Sinai, Callen-Lorde, NY Pres, Montefiore

Unique partnerships
- Strong partnership with Mt. Sinai IAM clinic on 7th Ave for linking newly diagnosed clients to care at preliminary positive test
• Unknown responses have significantly reduced from 2016 to 2017; 59% unknown viral load in 2016 to 35.6% in 2017.
• The percentage of clients reporting a suppressed viral load increased from 37.6% in 2016 to 57.7% in 2017.
GMHC
Toward an Improvement Strategy

- GMHC expanded primary care status measure data collection to all clients who had three encounters in a quarter. There are two main phases of the improvement project:
  - **Goal 1:** To increase the percentage of regularly-engaged HIV+ clients reporting HIV care cascade metrics, including viral load test results.
  - **Goal 2:** To increase the percentage of regularly-engaged HIV+ clients who are virally suppressed.
Agency Name
Results & Next Steps

**Results:** While we were able to significantly improve the percentage of clients in the target population reporting viral load data, there is room for further improvement. We will continue to work on improving our data completeness. We will also leverage this data source to develop and test new interventions to increase the percentage of our clients reporting suppressed viral loads.

**Next Steps:**

- Continue to monitor viral load suppression rate and other cascade metrics through quarterly reporting.
- Leverage new data set to conduct more complex exploratory data analyses that can be used to develop highly targeted interventions to improve viral load suppression rate.
- Develop and implement more robust follow-up processes for clients appearing as not engaged in care on quarterly reports.
- Add resources such as volunteer and peer navigators to assist clients in accessing their medical information, navigating patient portals, talking with their doctors and discussing any barriers to care.
QI Contact Information

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**Improvement Goal**
Increase viral load suppression at the IAM from 86% to 90% by April 2018

**Investigating the Problem**

- Drilled down data for active patients unsuppressed at two most recent VLs by demographics & other variables

<table>
<thead>
<tr>
<th></th>
<th>Total Patients Seen in 2016</th>
<th>Total Patients Unsuppressed at Any Time 1/1/16-7/1/17</th>
<th>Total Patients Unsuppressed at Most Recent Viral Load 1/1/16-7/1/17</th>
<th>Total Patients Unsuppressed In Both of Two Most Recent Viral Loads 1/1/16-7/1/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downtown</td>
<td>4,128</td>
<td>831</td>
<td>374</td>
<td>240</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Peter Krueger</td>
<td>1,135</td>
<td>336</td>
<td>146</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>IAM Total</td>
<td>10,202</td>
<td>2583</td>
<td>1255</td>
<td>869</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
</tbody>
</table>

- Disparities in VLS exist for African Americans overall and specifically for African American women and MSM
- Disparities also exist for youth between the ages of 18-24 and 25-29, who are more likely to be unsuppressed
- Low utilization of supportive services (i.e., care coordination & health homes)
Mount Sinai Institute for Advanced Medicine
Improvement Strategy

▪ Peter Krueger Clinic utilizing Chart Review/Case Conference Strategy – Providers conducted chart reviews of unsuppressed patients to identify barriers to VLS and present at provider meetings to create tailored treatment plans.

▪ Comprehensive Health Center’s Care Team Strategy – Care team made up of a Provider, Social Worker, and Nurse, who meet weekly to review list of chronically unsuppressed patients with upcoming appointments either that day or week and collaborate on treatment plan.

▪ Rapid Treatment Program – AIDS Institute pilot project at Comprehensive Health Center for same-day ART initiation for uninsured/underinsured newly diagnosed.

Testing strategies on a small scale and measuring/assessing success:

▪ Testing care team and rapid tx strategies at the Downtown practice

▪ Plans to expand care team strategy to other locations and outcomes

▪ Measuring viral load suppression
Downtown Care Team Results

- 265 unsuppressed patients between July 2017 – January 2018
- 77% (203) completed one or more visit
- 77% (205) had a viral load taken
- 66% (136) of patients with a viral load taken became suppressed (VL < 200)
Mount Sinai Institute for Advanced Medicine
Next Steps for Viral Suppression and Open Patients

• Share lessons learned of provider chart review at Peter Krueger
• Refine and expand care team approach at Downtown Clinic to other IAM clinics
• Submit all patients out of care for > 1 year to NYC DOHMH’s online Care Status Report
• Determine method to collect and document HIV primary care status information in Epic across inpatient and ED departments
• Intensify linkage to care efforts with Inpatient and ED departments across the system
• Create real-time care continuum report that tracks newly diagnosed and new to treatment patients
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Organizational HIV Treatment Cascades – Frequently Asked Questions

Quality of Care Program
AIDS Institute
April 2018
Overview of the Organizational HIV Treatment Cascades

- Part of NYS Quality of Care Program’s Annual Review of HIV clinical providers
- Due Thursday, May 31
- Submission components
  - Methodology Section
  - Results Section
    - Newly Diagnosed/New-to-Care Cascade
    - Previously Diagnosed Cascades
      - Open Caseload Cascade
      - Active Caseload Cascade
    - Table of service delivery locations for non-active patients
    - Cascades or tables of demographic information for active patients
  - Analysis and Improvement Plan
NEWLY DIAGNOSED/
NEW-TO-CARE CASCADE
### Newly Diagnosed/New-to-care Cascade: Summary

<table>
<thead>
<tr>
<th>Newly Diagnosed/New-to-care Caseload</th>
<th>Linked to Care</th>
<th>Prescribed ART</th>
<th>Received Viral Load Test</th>
<th>Virally Suppressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>All newly diagnosed patients and all patients who are new to an organization’s HIV program, regardless of the year in which they were diagnosed.</td>
<td>Percentage of people diagnosed with HIV at the organization in 2017 linked to care within 3 days.</td>
<td>Percentage of newly diagnosed and new-to-care patients who were prescribed ART in 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
<td>Percentage of newly diagnosed and new-to-care patients with a recorded viral load test in 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
<td>Percentage of newly diagnosed and new-to-care patients with viral load &lt;200 copies/mL at last test of 2017. May exclude patients newly diagnosed at the organization who were linked externally.</td>
</tr>
</tbody>
</table>
## Newly diagnosed/new-to-care cascade

<table>
<thead>
<tr>
<th>Stage</th>
<th>Percentage</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly diagnosed/new-to-care</td>
<td>85%</td>
<td>45/53</td>
</tr>
<tr>
<td>Prescribed ART</td>
<td>83%</td>
<td>44/53</td>
</tr>
<tr>
<td>Received Viral Load Test</td>
<td>74%</td>
<td>39/53</td>
</tr>
<tr>
<td>Virally suppressed</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

- **N=56**
- **Data Source**: Infinity EMR
- **Newly diagnosed/new-to-care**: # of pts newly diagnosed with HIV in 2017 and all patients new to care in the HIV program in 2017, regardless of HIV diagnosis date
- **Prescribed ART**: Percentage of newly diagnosed and new-to-care pts prescribed ART in 2017
- **Received Viral Load Test**: Percentage of newly diagnosed and new-to-care pts with a documented viral load test in 2017
- **Virally suppressed**: Percentage of newly diagnosed and new-to-care pts with viral load <200 copies/mL

*Denominator excludes 3 patients newly diagnosed with HIV at the organization who were linked to care externally.*
Newly diagnosed/new-to-care cascade

TIP: Make sure you report each group that makes up the total caseload:
- All patients newly diagnosed in 2017 at your organization
- All patients new to care at your organization in 2017
  - Diagnosed in 2017
  - Diagnosed before 2017

All newly diagnosed patients and all patients who are new to an organization’s HIV program, regardless of the year in which they were diagnosed.
and those linked to care elsewhere.  
Susan Weigl, 3/30/2018

Right - but not from this first bar - only from subsequent bars.  
Bezruki, Anna R (HEALTH), 4/2/2018
Linkage to Care

**Definition of Diagnosis:**
Diagnosis = when a provider, based on all available evidence and in-line with his or her clinical judgement, determines that the patient has HIV.

**Definition of Linkage to Medical Care:**
Linkage = A patient has an HIV-related visit with a medical provider with prescribing privileges within 3 calendar days of diagnosis. This visit can occur at the diagnosing agency or an external care provider.

Percentage of people diagnosed with HIV at the organization in 2017 linked to care within 3 days.
Examples of how to report linkage to care

Linked to Care Within 3 Days, 2017

- 65% (13/20) linked to care within 3 days
- 15% (3/20) linked internally
- 20% (4/20) not linked to care within 3 days

Measure
Linked to Care: Percentage of people diagnosed with HIV at the organization in 2017 linked to care within 3 days

Presentation
- Title
- Legend: Include definition and source
- Measures are labeled
- Include raw numbers and percentages

Linkage to care: # of patients newly diagnosed at the organization with an HIV medical visit within 3 days of diagnosis/# of patients newly diagnosed at the organization

Data source: Infinity EMR
Examples of how to report linkage to care

Table 1. Linkage to Care within 3 Days for Newly Diagnosed Patients, 2017

<table>
<thead>
<tr>
<th>Linked to care internally within 3 days</th>
<th>Number of patients newly diagnosed at the organization in 2017</th>
<th>Percentage of patients newly diagnosed at the organization in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linked to care externally within 3 days</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td>Not linked to care within 3 days</td>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
</tr>
</tbody>
</table>

Linkage to care: # of patients newly diagnosed at the organization with an HIV medical visit within 3 days of diagnosis/# of patients newly diagnosed at the organization

Data source: Infinity EMR
Newly diagnosed/new-to-care measures

- Prescribed ART
- Received Viral Load Test
- Virally Suppressed

**Exclusions:**
May exclude patients newly diagnosed at the organization in 2017 who were linked externally, who died by the end of 2017 or who were incarcerated at end of 2017. BUT report number excluded and reasons in the methodology section.
according to slide 6 - those incarcerated and dead at the end of the review period can also be excluded (and reported?)

Susan Weigl, 3/30/2018
PREVIOUSLY DIAGNOSED CASCADES
Terminology Overview

**Previously diagnosed patients**
All patients diagnosed with HIV before 2017, who received services from the organization during 2017

**Open patients**

- **Active patients**
  All open patients who received HIV primary care services within the organization in 2017. Exclude all new-to-care patients.

- **Non-Active Patients**
  All open patients who received services from the organization in 2017, but did not receive HIV primary care services.

**Deceased by end of 2017**

**Incarcerated at end of 2017**

**Confirmed in HIV care elsewhere at end of 2017**

Cascade Populations
## Open Caseload Cascade Measures: Summary

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open Caseload</strong></td>
<td>All previously diagnosed patients who received services from an organization within 2017, except those who were deceased by the end of the year, incarcerated at the end of the year, or were confirmed to be in care elsewhere by the end of the year</td>
</tr>
<tr>
<td><strong>Active Caseload</strong></td>
<td>Percentage of open patients who received HIV primary care services within 2017. Exclude all patients new-to-care at the organization in 2017.</td>
</tr>
<tr>
<td><strong>Prescribed ART</strong></td>
<td>Percentage of open patients who were prescribed ART in 2017.</td>
</tr>
<tr>
<td><strong>Received Viral Load Test</strong></td>
<td>Percentage of open patients with a recorded viral load test in 2017.</td>
</tr>
<tr>
<td><strong>Virally Suppressed</strong></td>
<td>Percentage of open patients with viral load &lt;200 copies/mL at last test of 2017</td>
</tr>
</tbody>
</table>
Example: Open Caseload Cascade

HIV Treatment Cascade, Previously Diagnosed Open Patient, 2017

- **Open**: # of PLWH, diagnosed before measurement year, with any visit in 2017, except those confirmed to be in care elsewhere, deceased, or incarcerated
- **Active**: percentage of open patients with HIV visit in 2017, excluding those new-to-care in 2017
- **Prescribed ART**: percentage of open patients with ART prescription in 2017
- **Received Viral Load Test**: percentage of open patients with documented viral load test in 2017
- **Virally Suppressed**: percentage of open patients with viral load <200 copies/mL at last viral load test in 2017

Data Source – Infinity EMR
Open caseload

TIP: Make sure you report all patients who make up the open caseload:
- # of active patients
- # of non-active patients

TIP: While not a bar on the cascade, report number of patients who were:
- Incarcerated at the end of the year
- Confirmed in care elsewhere by the end of the year
- Deceased by the end of the year

Open Caseload

All previously diagnosed patients who received services from an organization within 2017, except those who were deceased by the end of the year, incarcerated at the end of the year, or were confirmed to be in care elsewhere by the end of the year.
Open caseload cascade measures

- Prescribed ART
- Received Viral Load Test
- Virally Suppressed

NOTE: Proportion of open caseload, not just active caseload
Virally Suppressed

Percentage of *open* patients with viral load <200 copies/mL at last test of 2017.

**NOTE:** Patients without a documented viral load test in 2017 should be counted as if they are *unsuppressed*.
This is a bit confusing when viewed in light of the term "at last test". If patients did not have a viral load test in 2017, they should be counted as unsuppressed . . . perhaps you can clarify/state that this means they are included in the denominator but not in the numerator?

Susan Weigl, 3/30/2018
IDENTIFY SERVICE DELIVERY POINT FOR NON-ACTIVE PATIENTS
Example: Identify Service Delivery Points for Non-active Patients

Table of Service Delivery Points for Non-active patients, Southwest Hospital, 2017

<table>
<thead>
<tr>
<th>Service delivery point</th>
<th>Number of non-active patients who received services during CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health services</td>
<td>88</td>
</tr>
<tr>
<td>Dental clinics</td>
<td>15</td>
</tr>
<tr>
<td>Emergency Departments</td>
<td>150</td>
</tr>
<tr>
<td>Inpatient units</td>
<td>123</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>8</td>
</tr>
<tr>
<td>Substance use services</td>
<td>64</td>
</tr>
<tr>
<td>Supportive housing services</td>
<td>35</td>
</tr>
</tbody>
</table>

**TIP:** No set categories for service delivery points – up to each organization

**Presentation:**
- Include
  - Title (with name of org, year, and caseload)
  - Clear measure labels

**TIP:** Do not need to de-duplicate.
DRILL DOWN ACTIVE CASELOAD
BY KEY CHARACTERISTICS
## Definitions: Drill Down by Key Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Categories (adapted from CDC, NYS Bureau of HIV/AIDS Epidemiology, and HUD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>0-12; 13-19; 20-24; 25-29; 30-39; 40-49; 50-59; 60+; Unknown</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Male; Female; Transgender; Unknown</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td>Non-Hispanic White; Non-Hispanic Black; Hispanic; Asian/Pacific Islander; Native American; Multi-Race; Unknown</td>
</tr>
<tr>
<td><strong>Risk Category</strong></td>
<td>Men who have Sex with Men (MSM); Intravenous Drug Users (IDU); MSM/IDU; Heterosexual; Pediatric risk; Unknown/other</td>
</tr>
<tr>
<td><strong>Housing Status</strong></td>
<td>Stable permanent housing; Temporary housing; Unstable housing; Unknown</td>
</tr>
</tbody>
</table>

- Organizations with transgender patients are encouraged to further disaggregate their transgender patient caseloads by male-to-female (MtF) and female-to-male (FtM).
- Defined as short-term arrangement with family or friends, transitional housing or temporary institutional placement including substance abuse treatment facilities and psychiatric hospitals.
- Defined as emergency shelters, jail/prison, places not meant for human habitation.
Example: Drill Down of Active Caseload

HIV Treatment Cascade, Previously Diagnosed Active Patients, Breakdown by Housing Status, 2017

- **Active**: # of patients diagnosed with HIV before 2017, who received HIV primary care services in 2017, by housing status
- **Prescribed ART**: percentage of active patients receiving ART prescription in 2017
- **Received Viral Load Test**: percentage of active patients with a documented VL test in 2017
- **Virally Suppressed**: percentage of active patients who had VL <200 copies/mL in last VL test of 2017
## Example: Drill Down of Active Caseload

### Active Patients of Southwest Hospital, Disaggregated by Age, 2017

<table>
<thead>
<tr>
<th>Age (as of 1/1/2017)</th>
<th>12 &amp; under</th>
<th>13-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60+</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Unique Active Patients</strong></td>
<td>0</td>
<td>16</td>
<td>58</td>
<td>77</td>
<td>43</td>
<td>51</td>
<td>63</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of Active Patients Prescribed ART in 2017</strong></td>
<td>0</td>
<td>16</td>
<td>48</td>
<td>77</td>
<td>42</td>
<td>50</td>
<td>61</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td><strong>Percentage Active Patients Prescribed ART in 2017</strong></td>
<td>N/A</td>
<td>100%</td>
<td>82.8%</td>
<td>100%</td>
<td>97.7%</td>
<td>98%</td>
<td>96.8%</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Number of Active Patients with Documented VL in 2017</strong></td>
<td>0</td>
<td>16</td>
<td>50</td>
<td>74</td>
<td>42</td>
<td>51</td>
<td>57</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td><strong>Percentage of Active Patients with Document VL in 2017</strong></td>
<td>N/A</td>
<td>100%</td>
<td>86.2%</td>
<td>96.1%</td>
<td>97.7%</td>
<td>100%</td>
<td>90.5%</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Number of Active Patients Suppressed on Final VL in 2017</strong></td>
<td>0</td>
<td>13</td>
<td>41</td>
<td>70</td>
<td>42</td>
<td>50</td>
<td>55</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td><strong>Percentage of Active Patients Suppressed on Final VL in 2017</strong></td>
<td>N/A</td>
<td>81.3%</td>
<td>70.7%</td>
<td>90.9%</td>
<td>97.7%</td>
<td>98%</td>
<td>87.3%</td>
<td>91.3%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Drill Down of Active Caseload

**TIP:** Not necessary to report key characteristics by site

**TIP:** If data is missing this year, strategize in improvement plan how to begin collecting that data for next year
Drill Down of Active Caseload – housing question

**Question:**
How should organizations categorize patients whose housing status may be in flux or has changed throughout the year?

**TIP:**
Document, and be consistent in applying, criteria for deciding borderline cases.
ANALYSIS & IMPROVEMENT PLAN
## Analysis and Improvement Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report progress on 2017 cascade improvement plan</td>
<td>Analyze all gaps in care in 2017 data; compare to 2016 data</td>
</tr>
<tr>
<td>List staff responsible for implementing each step of the improvement plan</td>
<td>Explain how consumers were involved in development of improvement plan and improvement activities</td>
</tr>
<tr>
<td></td>
<td>Plan for dissemination of the cascades to stakeholders</td>
</tr>
<tr>
<td></td>
<td>Develop specific, time-bound, measurable goals for each gap identified in 2017 and steps/activities planned to achieve goals</td>
</tr>
</tbody>
</table>
Reminders

• Submission due Thursday, May 31
• Weekly Guidance Forums (webinars), every Tuesday 12:00-1:00 p.m., until May 22
• Opportunity to learn about specific aspects of submission & ask questions
• Upcoming topics:
  – April 3: Presentation from the NYC DOMHM on the NYC Care Status Reports System & how to construct the newly diagnosed/new-to-care cascade
  – April 10: Presentation from the NYS DOH on the NYS Provider Portal & how to construct the previously diagnosed cascades (open and active)
  – April 17: How to construct the service delivery point table & how to prepare the drill downs for key populations
  – April 24: How to analyze your results and construct an improvement plan (Part 1) – including an introduction to QI tools that can be used to brainstorm interventions
  – May 1: How to analyze your results and construct an improvement plan (Part 2) – including an introduction to improvement plans, including how to set reasonable improvement goals
Questions?

Contact us at qocreviews@health.ny.gov
Toward 2017 Organizational HIV Treatment Cascades: Data Development, QI Plans, Supportive Service Cascades

Facilitators:
Christopher Wells | NYSDOH AIDS Institute
Nova West | NYSDOH AIDS Institute
Toan Nguyen | HMI
Alexa Kreisberg | GMHC
Small Group Discussion - Guidance

- Total Time: 65 minutes (50 minutes discussion + 15 minutes wrap-up and report back)
- Each group has a facilitator(s) and recorder.
- Facilitators:
  - Discuss the discussion goal;
  - Guide each agency in sharing progress, challenges, questions;
  - Allow time for group members to provide input and expertise; to help the sharing agency move forward with their QI work & plan next steps.
- Recorders: Keep time; Document success, challenges, ideas and any needed TA; **Report back** the one common theme from the discussion and one strategy for moving forward;
Toward Organizational HIV Tx Cascades: Wrap-Up

- **Report Back**: One Theme and One Next Step

- **HIV Clinical Programs**: Be in touch with your coaches sending drafts of your cascades prior to May 31st. This will assure complete submission.

- **Supportive Service Programs**: For TA on cascade development and/or QI plans contact coaches.

- **Consumers**: Contact Dan Tietz [daniel.tietz@health.ny.gov](mailto:daniel.tietz@health.ny.gov) about building your expertise and involvement in QI at your agency
Collaborating to End the Epidemic
- Find current or new partners – discuss ways to strengthen existing or build new partnerships
- Meet-up with colleagues to cascade development
- Connect with AI staff – check-in, get input, schedule TA
Rapid Linkage and HIV Treatment

John Bosco & Isaac Evans-Frantz | Callen-Lorde CHC
RAPID TREATMENT

Same-Day Initiation of ART
At Callen-Lorde Community Health Center

John Bosco, RN
Isaac Evans-Frants, MPA CPHQ, Quality & Performance Improvement Coordinator
RAPID TREATMENT

An Introduction

Isaac Evans-Frantz, Quality & Performance Improvement Coordinator
OUR MISSION

Callen-Lorde Community Health Center provides sensitive, quality health care and related services targeted to New York’s lesbian, gay, bisexual, and transgender communities — in all their diversity — regardless of ability to pay. To further this mission, Callen-Lorde promotes health education and wellness, and advocates for LGBT health issues.
BENEFITS OF RAPID TREATMENT

- Improves morbidity and mortality in all stages of infection
- In acute HIV infection limits reservoirs and hyper-infectivity
- Reduces transmission

Test. Treat. Track.
CONCERNS THAT LED TO PILOT PROGRAM

In San Francisco

- Concerns about linkage to care
- Public health concerns about unsuppressed viral loads
- Looking for way to empower patients
RAPID TREATMENT COMES TO CALLEN-LORDE

- **January 2016**: NYC DOH considering rolling out Rapid Treatment at all STI Clinics across city.
- **August 2016**: Callen-Lorde launched NY’s first pilot of Rapid Treatment.
- **August 2017**: Callen-Lorde had initiated Rapid Treatment with 51 patients who had tested positive for the first time.
RAPID TREATMENT ACCELERATES VIRAL SUPPRESSION

Collapsing the Left Side of the TREATMENT Cascade into 1 Single Day
HOW DOES RAPID TREATMENT WORK AT CALLEN-LORDE?

John Bosco, RN
STEP 1: REACTIVE HIV TEST

Prevention & Outreach Staff [POP] performs a 2\textsuperscript{nd} rapid test as a temporary confirmation

POP introduces the patient to the Rapid Treatment program

POP completes the PRF-FSU Survey

patient readiness; including a suicide screening & a check for Callen-Lorde eligibility
What about false positives?

- The confirmatory blood test will be back within approximately 2 days
- So, in the case of a false positive, the patient is on unnecessary ARVs for approximately 2 days
- For reference, if the patient was on PEP and they weren’t actually exposed to HIV, they would be on unnecessary ARVs for 30 days
- And as far as we know, this has yet to happen anywhere for Rapid Treatment patients (including in San Francisco)
STEP 2: CASE MANAGEMENT

- another assessment of patient readiness CM assesses for
- CM completes a full psychosocial assessment
- CM orients patient to the clinic & HIV treatment
- CM assesses for insurance status
- CM enrolls the patient into the Retention & Adherence Program [RAP]
CASE MANAGEMENT

What about uninsured folks?

- Barriers
  - Medicaid takes 24 hours
  - Have to be a documented citizen & make below a certain amount of $
  - Standard ADAP takes 2 weeks to approved
  - This is all after patient and provider get documents together

- ADAP Stepped Up
  - Created a temporary Rapid Treatment Access Card system
  - Temporary ID immediately available via a 24/7 automated telephone system
  - Pays for labs, doctor’s visits, medications – EVERYTHING standard ADAP pays for
STEP 3: NURSING APPOINTMENT

- Nurse & CM case conference about the patient’s readiness, drug use & a brief
- Nurse performs a full separate medical evaluation
- Nurse teleconferences with Medical Provider [PCP]
- Nurse schedules PCP follow-up for Patient (Patient will also see CM during this follow-up)
- Patient takes their first dose of ART with the Nurse before leaving
- PCP sends Rx to Pharmacy, where Nurse obtains it for the patient
HOW DO YOU PICK THE RIGHT REGIMEN?

- Genotype takes 6 weeks
- High resistance barrier & low side-effects & among the newest generation of drugs
- Interactions
- Pill Burden/Pill Size
- Preferred and most utilized regimen: TAF/FTC/DTG – 2 small pills taken once daily with or without food. Low side effect profile. Low risk of interactions.
STEP 4: REFERRALS

If needed, patient is sent for a Mental Health walk-in appointment.

If needed, patient is sent to see a Facilitated Enroller for Medicaid coverage.
STEP 5: FOLLOW UP

RAP CM calls the next day to assess for adherence, side effects & well-being

Within as early as a week, Patient returns for a complete HIV appointment with a PCP & a follow-up with CM

Follow-ups with PCP & RAP CM continue every 3 months for the next year

Within as early as a month, Patient returns for PCP follow-up [Genotype is back by this point, and patient has been on ART for a full month]
DOES RAPID TREATMENT WORK?

Evaluating Effectiveness of Rapid Treatment at our Community Health Center

Isaac Evans-Frantz, Quality & Performance Improvement Coordinator
RAPID TREATMENT: SAFE & EFFECTIVE

- Average of **10 Days** to 1st Comprehensive HIV Appointment with Med Provider. [17 days prior to Rapid Treatment implementation]
- **92%** were Virally Suppressed at their Follow-up PCP Visit. [2% for Usual Care]
- **55%** have utilized a Rapid Treatment Access Card to pay for their first round of ART.
- **0 false positives** & **1 patient** has needed to change initial ART regimen due to resistance.
- During 2017, approx. **75%** of all Newly Diagnosed patients opted into Rapid Treatment at time of diagnosis.
WE DECREASED TIME TO VIRAL SUPPRESSION BY 47%

That means people get healthier faster and are less likely to pass the virus to others in the meantime.

Looking before and after the Rapid Treatment program implementation, we decreased the average time it takes patients newly diagnosed with HIV to achieve viral suppression, from 89 to 47 days. That’s a 47% decrease in the average number of days to achieve viral suppression.
RAPID TREATMENT EMPOWERS PEOPLE

In the words of a consumer...

“With R apid Treatment, you feel like you’ll be taken care of immediately. I started taking my HIV meds the next day. I would’ve freaked out if I had had to wait.”

-Callen-Lorde patient
WHAT DOES THIS LOOK LIKE IN REAL LIFE?

Connecting the Numbers to People’s Stories

John Bosco, R N
CASE STUDY #1

- 25 year-old uninsured Limited-English Proficient MS M newly immigrated to NYC. Last negative test 2-3 months prior.

- Baseline labs: VL – 107,000; CD4 – 129/18.4%;

- Patient seen by medical provider 3 days after diagnosis and rapid start. Pt reported doing well, adjusting to diagnosis, denies side effects to ARVs.

- Patient currently insured and actively engaged with in-house case management
CASE STUDY #2

- 33 year-old uninsured LEP Latino MS M w/ unstable housing who never received medical care. Last negative test was 20 months prior to diagnosis.

- **Baseline Labs:** VL – 27,369; CD4 – 384/17.5%; Patient seen by medical provider 5 days after discharge and rapid start.

- **Labs 4wks:** VL – 50; CD4 – 539/18.6

- **Labs 1yr:** VL – Undetectable; CD4 – 624/23.8%

- Patient is currently insured, has stable housing, and is doing well.
CASE STUDY #3: AJ

- Patient presented to initiate PrEP
  - Rapid Testing was Non-Reactive
  - Confirmatory Testing came back Reactive

- Clinic attempted outreach for 17 days to alert him to his HIV status, but patient did not respond to outreach

- Patient met with RAP Specialist that day & was initially resistant to starting on ART
  - RAP Specialist validated patient’s concerns & connected their homeopathic and “natural” practices to potential ART as another tool in their wellness toolbox

- Patient ultimately decided to start Rapid Treatment THAT DAY

- Patient misses first regular appointment with medical provider, follow-up labs show (very low CD4 & very high VL) – Case manager again begins outreach
  - Outreach goes on, un-responded to, for 30 days

- Patient self-presented at front desk again, when he was out of ARVs

- Despite showing no outward “signs” that he was “adherent,” patient had clearly committed to his care and treatment

- Patient has since been active in Medical and Case Management care and obtained Insurance, Housing, Mental Health services, and become Virally Suppressed
WHAT’S NEXT FOR RAPID TREATMENT?

Opportunities at Callen-Lorde & Beyond

Isaac Evans-Frantz, Quality & Performance Improvement Coordinator
EXTENDING SUPPORT TO ALL

Opportunity to explore with **patients who aren’t ready to engage** – including discussion of oppression, stigmatization, abuse & trauma

Opportunity to focus specific sub-interventions on patients dealing with **homelessness & substance use**

Opportunity to increase accessibility and provision of Rapid Treatment at our **Bronx site** (and eventually **Brooklyn**)

Opportunity to provide culturally relevant services to **Spanish & Russian-speaking patients**
WHAT QUESTIONS DO YOU HAVE?

How can we support you with implementing Rapid Treatment at your organization?

We thank you for your attention, and we thank you in advance for sharing ideas from today’s presentation with your colleagues, and helping people in Lower Manhattan achieve viral suppression as quickly as possible.
PLEASE CONTACT US

We would like to hear from you!

John Bosco, RN:
jbosco@callen-lorde.org

Isaac Evans-Frantz,
Quality Coordinator:
iefrantz@callen-lorde.org
Open Topic
Chosen Topics

• **Quality Management & Best Practices in QI**: How do agencies organize and implement their quality management programs/QI activities? How do quality improvement teams function best what methodology, project tools, and structures are used at agencies?

• **Rapid Tx**: Models of immediate linkage for newly diagnosed PLWH, systems of engagement of PLWH not yet engaged in care ("open-non-active"). What works . . . what is most challenging?
Open Topic Discussion – Ground Rules and Report Back

- Total Time: 60 minutes (45 minutes discussion + 15 minutes wrap-up and report back)
- Each group has a facilitator and a recorder.
- Facilitators:
  - Guide each participant in sharing questions, challenges, and accomplishments of the topic at hand in “round robin” format
  - Allow time for group members to provide input and expertise
- Recorders: Document successes, challenges, ideas, and any needed TA on the topic; **Report back** the one common theme from the discussion and one strategy for moving forward
Wrap Up: Consumer Involvement in QI Survey, Important Dates & Evaluation

Daniel Tietz | NYSDOH - AI
Jonathan Gómez | NYSDOH – AI
Important Dates

• **April 12th, 10am** – Lower Manhattan Steering Committee Meeting

• **May 17th and 18th**– Training of Consumers in Quality at Las Americas Conference Center

• **May 31st** – HIV Medical Programs - cascades, methodology, and QI plan submissions due

• **June 26th** – Next Regional Group Meeting!!

• To accelerate progress to End the Epidemic NYSDOH-AI asks that you provide a cascade-related QI update to your coach, and request any necessary technical assistance, by the following dates:
  - First update: Friday, **June 29, 2018**
  - Second update: Friday, **September 28, 2018**
  - Third update: Friday, **December 21, 2018**

Stay Tuned:

• Scheduling of Quality Management Program Organizational Assessments
For QI/QM Questions or Assistance Contact

Jonathan Gómez
212-417-4757
jonathan.gomez@health.ny.gov

Susan Weigl
sweigl@yahoo.com
Thanks!!

Lower Manhattan Steering Committee, AI Coaches, & All Participants @ Today’s meeting