GET TESTED. TREAT EARLY. STAY SAFE.

Let’s End AIDS, Hudson Valley.
NY Links

Mid and Lower Hudson Regional Group
March 23\textsuperscript{th}, 2016

WELCOME

Systems Linkages and Access to Care for Populations at High Risk for HIV Infection in New York State
Welcome and Opening Remarks
https://www.youtube.com/watch?v=2lXh2n0aPyw

Or Governor’s speech
Introductions
Using Viral Load Suppression Data in service delivery
Regional Data
December 2015

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Lower Hudson
Mid Hudson
Combined
March 2016

Linkage: N=3/3
Retention: N=476/592
New Patient Retention: N=20/30
Clinical Engagement: N=0/0
Viral Load Suppression: N=556/643

<table>
<thead>
<tr>
<th></th>
<th>Lower Hudson</th>
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<tbody>
<tr>
<td>Linkage</td>
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Lower Hudson: 0 0 0 0 0
Mid Hudson: 100 80.4 66.66 0 86.46
Combined: 100 80.4 0 0 86.46
### PLWHA in Mid and Lower Hudson*

As of end of 2013

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*Based on most recent address
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<th>Organization</th>
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<td>NPR (T/A/S)</td>
<td>CE (T/A/S)</td>
<td>VLS (T/A/S)</td>
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**Data Submitters**

- Hudson River Healthcare (Dec/Mar)
- Greater Hudson Valley Community Health Center (Dec/Mar)
- Westchester Medical Center (Dec)
- Hope Center, St. John’s Riverside (Dec/Mar)
- Middletown Community Health Center (Mar)
The Power of Consumers in Quality
The Healthcare Stories Project
Poster/Activity Two: Understanding the Healthcare User’s Visit
March 23, 2016
Presented by Dan Tietz, Manager of Consumer Affairs
Background

*Through a Consumer’s Lens:*
Examining Ideas and Experiences of Quality in New York State HIV Health Service Programs

- Qualitative study with 45 consumers at 3 hospital-based HIV outpatient programs in NYS (data collection: 5/10-9/11)

- Conducted interviews with consumers and staff, and observed regularly scheduled visits

- **Four major findings about how consumers approach “quality”:**
  1. Used familiar terms to talk about quality, but used them in personal and creative ways
  2. Provider interactions central to perceptions of quality of care
  3. Did not take ‘quality of care’ for granted
  4. Felt they played a role in advancing and co-producing quality care

Finding 1: Familiar ‘quality of care’ terminology used but in personal ways

Finding #1: Consumers used familiar terms, but not always in expected ways

- Safety (3 uses)
  - (1) trust; familiar; care; comfort
  - (2) respectful/sense of worth
  - (3) protected; nonjudgmental (esp. in body language)

Finding #2: Consumers used terms in similar, but not synonymous ways in comparison to one another

- Knows Me (6 uses)
  - (2) literal (by name)
  - (3) "real" self
  - (4-5) entirely
  - (6) asked questions

- Decision-Making (6 uses)
  - (2) reactive
  - (3-5) shared
  - (6) options

Finding #3: Terms were bundled (i.e., linked in unique arrangements) by each consumer

- Respectful (4 uses)
  - (1) provider respects "patient decisions" because she "knows me"
  - (3) courteous, friendly staff
  - (4) mutual treatment (for one another)

Finding #4: Terms combined multiple ‘domains’ of quality
Finding 2: Provider interactions central to perceptions of quality of care

- 90% of terms indicated the importance of interpersonal relationships in defining ‘quality care’

(The term, ‘care’ was mentioned by 10/207 uses)

<table>
<thead>
<tr>
<th>QUALITY TERM</th>
<th>FREQUENCY OF USE (n=207)</th>
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<tbody>
<tr>
<td>Care</td>
<td>10</td>
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<tr>
<td>Informative</td>
<td>9</td>
</tr>
<tr>
<td>Thorough</td>
<td>8</td>
</tr>
<tr>
<td>Listens</td>
<td>7</td>
</tr>
<tr>
<td>Compassion</td>
<td>6</td>
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<td>Comfort</td>
<td>6</td>
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<tr>
<td>Beyond Scope</td>
<td>6</td>
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<td>Knows Me</td>
<td>6</td>
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<tr>
<td>Responsive</td>
<td>6</td>
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</table>
Finding 3: Quality of Care was not taken for granted

Participants explicitly expressed that making ‘quality of care’ was going beyond an expected type of care.

- ‘Going beyond’ was expressed as:
  - Doing more than providers ‘had to do’ and more than what ‘others might do’
  - Going ‘beyond a job’ rather than working within one, or ‘just getting paid’ / ‘there for a paycheck’ (even serving a ‘calling,’ said one participant)
  - In multiple interviews, praise was given to clinics that did not fail people, compared to past experiences
**Finding 4: Consumers play a role in ‘co-producing’ quality care**

- Numerous participants described how they were not passive recipients of care, but also took part in service delivery in ways they felt were significant.
- Working with the clinic:

<table>
<thead>
<tr>
<th>TYPES OF USER INVOLVEMENT</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td><strong>Ad-hoc Team Member:</strong> Takes on clinic responsibilities</td>
<td>- Accommodating to clinic in active performative fashion (e.g., cleaning up a mess made on a busy clinic day; directing provider to best way to find a medical chart) <strong>and/or through interpretation</strong> (e.g., understanding and patience)</td>
</tr>
<tr>
<td><strong>Soother:</strong> Attempts to provide emotional support in clinic</td>
<td>- Comforting providers on stressful clinical days</td>
</tr>
<tr>
<td></td>
<td>- Defusing tensions, joking, and sticking up for providers when confronted by unhappy consumers</td>
</tr>
<tr>
<td><strong>Information Sharer:</strong> Assists in passing useful information to members of clinics, including other consumers</td>
<td>- Swapping tips about clinic and other related services</td>
</tr>
<tr>
<td></td>
<td>- Providing information to clinic about new programs and other opportunities of benefit to clinical community</td>
</tr>
<tr>
<td><strong>Feedback Giver:</strong> Expresses opinions on clinic practices to produce better care</td>
<td>- Expressing feedback about systems and services</td>
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<td></td>
<td>- Sticking up for providers challenged by other hospital employees</td>
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</table>
Healthcare Stories Project

3-part poster/activity initiative of the NYSDOH AIDS Institute providing concrete tools for healthcare organizations to include consumers in Quality Improvement

– Activity/Poster 1: “What words would you use?”
  Launched: April 2014

– Activity/Poster 2: “How’s your visit going?”
  Launched: December 2014

– Activity/Poster 3: “What are we doing together?”
  Launch Date: Spring 2016
Healthcare Stories Project Activity 2: Visit Experience Mapping

- **Healthcare User Visit Experience Mapping**
  A method that asks users to offer reactions to the elements of their healthcare visit

- **Touch points**
  Deeply felt moments, positive or negative, in healthcare delivery

- **Benefits of Activity 2:**
  Gain relevant information about the service delivery process
  Identify services that critically shape user experiences of “quality of care”
  Fully engage healthcare users in QI processes
Healthcare Stories Project Activity 2: Implementation Steps

Steps:

• Assemble a HCSP Team & Hold a Planning Meeting

• Distribute Experience Mapping Forms

• Display Experience Mapping Forms
Next Steps

- Mapping and Discussing

**WORKSHEET 1: Mapping Positive, Challenging, and Observational Touch Points**
Record touch points by type (Positives, Challenges, Observations).

<table>
<thead>
<tr>
<th>STATION</th>
<th>POSITIVE EXPERIENCES</th>
<th>CHALLENGING EXPERIENCES</th>
<th>OBSERVATIONS</th>
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<tr>
<td>Pre-registration</td>
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<td></td>
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<td>Registration</td>
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<tr>
<td>Waiting Room</td>
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<td></td>
<td></td>
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<tr>
<td>Vitals</td>
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<tr>
<td>Exam Room</td>
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<tr>
<td>Check Out</td>
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**WORKSHEET 6: Action Steps - Making Ideal User Visits**
Use extra sheets for additional stations.

<table>
<thead>
<tr>
<th>Station</th>
<th>Positives to Achieve</th>
<th>Concerns to Minimize</th>
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</table>

**Assessment**
This station is generally considered [by users; we'd like to be]

**Action Plan**
Consider improvement strategies and steps to implementation.

- finally, Create an Ideal User Visit Map
The Power of Consumers in Quality
Willis Easley, Peer Adherence Educator
Bill Groser, Peer Adherence Volunteer
Hudson River HealthCare

• **Who we are:** A network of 26 community health centers in the Hudson Valley and Long Island

• **Our mission:** To increase access to comprehensive primary care and preventive health care and to improve the health status of our community, especially for the underserved and vulnerable.
HRHCare New Peekskill Site
Quality Improvement Team

• Christine Kerr, MD, Clinical Director

• Catherine Grimes, N.P.

• Aarathi Nagaraja, M.D.

• Lisa Reid, LCSW, Director of Genesis Primary Care & Supportive Services
Quality Improvement Team

- Candice Melvin, LPN
- Karen Lugo, Medical Case Manager
- Adaljisa Almonte-Sazo, Medical Case Manager
- Willis Easley, Peer Adherence Educator
- Lissie Arndt, AmeriCorps
Project Background

• During our annual Organizational Assessments one area for improvement identified was to continue to increase consumer involvement in Quality Improvement.

• We were asked by the AIDS Institute to participate in a three year pilot project called “HealthCare Stories Project”.

• Peers and the Consumer Advisory Committee were asked to take a lead role in the project.
Year 1: Word Cloud Project

- **Goals of the Word Cloud Project:**
  - Collected descriptions from people living with HIV/AIDS about their healthcare experiences and created a word cloud from their comments
  - Used consumer information to improve the quality of healthcare services
Year 2: Visit Mapping Project

Goals of the Mapping Project:

• **Raise awareness, tap into the health care users’ perspectives about their services**

• **Gain insight about health care users’ perceptions of health care services**

• **Introduce the concept of co-production:** consumers and providers working together to create quality services
  
  ○ Help staff develop an understanding of co-production
  
  ○ Explore how co-production is already working
  
  ○ **Recognize how co-production can help programs better achieve quality care**
Method

• The Peer Adherence Educators were asked to lead the project explaining the process to patients and collecting visits mapping forms.

• Patients were asked to participate when they came to see their provider.

• Patients were given a visit mapping form and asked to write down comments describing their experiences at each point in their visit, positive or negative. Smile/frown faces were also used. Forms were available in English and Spanish.

• Mapping visit form comments were posted at each site.
Co-Production

How do consumers and providers interact together to create the health care services at HRHCare?

• QI team meeting discussions & PDSA (Plan, Do, Study, Act)
• Case conferencing
• Peer Support Intervention
• Work groups, event planning
• Patient education groups
• Annual Genesis Conference
• Consumer Advisory Committee
HCSP Visit Mapping Display
Method

• Patients’ mapping were typed into a spreadsheet.
• Teams comprised of staff and consumers analyzed information gathered according to positive and negative comments.
• Performance improvement projects were identified to address the negative comments.
• The teams discussed the positive comments to understand what we are doing well in order to strengthen the program and share best practices with other sites.
• Team brainstormed to create the “ideal visit”.

Project Results

97 visit mapping forms describing patient’s medical appointment experiences were collected.
• Overall, comments were positive,

• The form seemed to limit the consumer comment to a few words (small blocks on the form).

• The form did not offer the opportunity to write your name (encouraging anonymity), but one person asked not to be called and we don’t know who he/she is.
Powerful Stories: The Good

- **Phone Calls:** It's people on my phone call that have been helpful to my family and myself. Offer help when sick. Help me remember my appointments.

- **Waiting Room:** They are very courteous when I check-in and I never have to wait very long.

- **Nurse:** The nurse was great, friendly, and careful. Painless

- **Provider:** The Doctor is caring and explains everything to me.

- **MoCA (cognitive assessment):** It's a good reminder that the brain is still working.

- **Peer:** Great, makes me feel comfortable, very informative.

- **Lab:** The lady is nice and makes me laugh so I don't think about it when I need to do labs.

- **Case Manager:** Always been there for me and family. She's been so helpful in all of my issues. I wouldn't give her up for anything. Family oriented. Caring, she has a big heart.
Powerful Stories: The Not-So-Good

- **Phone Calls**: No call
- **Waiting Room**: Patient has a problem with other patients being seen before him when appointment is sooner than theirs.
- **Provider (new)**: She's okay, need to get to know her better.
- **MoCA**: It was uncomfortable.
- **Lab**: Often too busy and wait area disorganized; no way to know order of patients.
The Ideal Visit

Waiting Room:

• TV with educational information, cooking show for healthy eating.
• Reading material
• Confidential, self check-in with touch screen computer
• Pleasant, professional staff
• Minimal wait time <10 minutes
The Ideal Visit cont’.

**Nursing:**
- Cheerful, professional, skilled, informative nurse who explains what she is doing; reading materials in the treatment rooms.

**Provider:**
- Good listener; shows concern for all aspects of a person’s wellbeing; empathetic, knowledgeable, assesses and refers.

**MoCA:**
- Staff explains the purpose of the test and puts you at ease, makes you feel comfortable.
The Ideal Visit cont’

• Peer:
  • Explains things so you understand them; Supportive, available, genuine, open, respectful, remind you that you are someone; confidential; identifies with patients, provides hope and reassurance.

Lab:
• Skilled, able to stick successfully; well-trained.
• Case Manager:
  • Supportive, good listener; compassionate, understanding; knowledgeable of HIV treatment and community resources.
Benefits of Implementation

• An alternative way to obtain feedback and assessing our services
• One of the first Peer lead projects
• Provided staff recognition for a job well done
• A valuable contribution by the Consumer Advisory Committee
• Demonstrated the quality improvement process and co-production for all to learn
• Vehicle to address systemic issues
• Communicated the HIV team’s accomplishments to the Administration, Board of Directors
Benefits of Implementation

• Increased exposure of HIV services to other departments
• Promoted integration of services between departments and roles between staff and consumers
• Stepping stone to other opportunities for consumer involvement in quality improvement
• Project results were presented at the Annual Genesis Conference
Next Steps...
Next Steps

• Complete the implementation of the action plans for performance improvement projects to support the “ideal visit”.

• Expand the role of consumers to encourage opportunities for co-production.

• Build co-production into the ongoing organizational activities so that it becomes a standard part of operations.
Thank You!!
Lesson From the Field
Hudson River HealthCare

- A network of 26 community health centers in the Hudson Valley and Long Island

- **Mission:** To increase access to comprehensive primary care and preventive health care and to improve the health status of our community, especially for the underserved and vulnerable.
During annual Organizational Assessments one area for improvement identified was to continue to increase consumer involvement in Quality Improvement.

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Hudson River Healthcare

Goals of the Mapping Project:

• **Raise awareness, tap into the health care users’ perspectives about their services**

• **Gain insight about health care users’ perceptions of health care services**

• **Introduce the concept of co-production**: consumers and providers working together to create quality services
  
  - Help staff develop an understanding of co-production
  - Explore how co-production is already working
  - Recognize how co-production can help programs better achieve quality care
The Peer Adherence Educators were asked to lead the project explaining the process to patients and collecting visits mapping forms.

Patients were asked to participate when they came to see their provider.

Patients were given a visit mapping form and asked to write down comments describing their experiences at each point in their visit, positive or negative. Smile/frown faces were also used. Forms were available in English and Spanish.

Mapping visit form comments were posted at each site.
Hudson River Healthcare
(Visit Mapping Display)
Hudson River Healthcare

- Patients’ mapping were typed into a spreadsheet.
- Teams comprised of staff and consumers analyzed information gathered according to positive and negative comments.
- Performance improvement projects were identified to address the negative comments.
- The teams discussed the positive comments to understand what we are doing well in order to strengthen the program and share best practices with other sites.
- Team brainstormed to create the “ideal visit”.
97 visit mapping forms describing patient’s medical appointment experiences were collected.

- Overall, comments were positive,

- The form seemed to limit the consumer comment to a few words (small blocks on the form).

- The form did not offer the opportunity to write your name (encouraging anonymity), but one person asked not to be called and we don’t know who he/she is.
Hudson River Healthcare
(Powerful Stories: The Good)

- **Phone Calls:** It's people on my phone call that have been helpful to my family and myself. Offer help when sick. Help me remember my appointments.
- **Waiting Room:** They are very courteous when I check-in and I never have to wait very long.
- **Nurse:** The nurse was great, friendly, and careful. Painless
- **Provider:** The Doctor is caring and explains everything to me.
- **MoCA (cognitive assessment):** It's a good reminder that the brain is still working.
- **Peer:** Great, makes me feel comfortable, very informative.
- **Lab:** The lady is nice and makes me laugh so I don't think about it when I need to do labs.
- **Case Manager:** Always been there for me and family. She's been so helpful in all of my issues. I wouldn't give her up for anything. Family oriented. Caring, she has a big heart.
Phone Calls: No call

Waiting Room: Patient has a problem with other patients being seen before him when appointment is sooner than theirs.

Provider (new): She's okay, need to get to know her better.

MoCA: It was uncomfortable.

Lab: Often too busy and wait area disorganized; no way to know order of patients.
Hudson River Healthcare
(The Ideal Visit)

Waiting Room:

• TV with educational information, cooking show for healthy eating.
• Reading material
• Confidential, self check-in with touch screen computer
• Pleasant, professional staff
• Minimal wait time <10 minutes
Hudson River Healthcare
(The Ideal Visit)

**Nursing:**

- Cheerful, professional, skilled, informative nurse who explains what she is doing; reading materials in the treatment rooms.

**Provider:**

- Good listener; shows concern for all aspects of a person’s wellbeing; empathetic, knowledgeable, assesses and refers.

**MoCA:**

- Staff explains the purpose of the test and puts you at ease, makes you feel comfortable.
Hudson River Healthcare
(The Ideal Visit)

• Peer:
  • Explains things so you understand them; Supportive, available, genuine, open, respectful, remind you that you are someone; confidential; identifies with patients, provides hope and reassurance.

Lab:
• Skilled, able to stick successfully; well-trained.

Case Manager:
• Supportive, good listener; compassionate, understanding; knowledgeable of HIV treatment and community resources.
Hudson River Healthcare
(Visit Mapping Benefits of Implementation)

• An alternative way to obtain feedback and assessing our services
• One of the first Peer lead projects
• Provided staff recognition for a job well done
• A valuable contribution by the Consumer Advisory Committee
• Demonstrated the quality improvement process and co-production for all to learn
• Vehicle to address systemic issues
• Communicated the HIV team’s accomplishments to the Administration, Board of Directors
Hudson River Healthcare
(Visit Mapping Benefits of Implementation)

• Increased exposure of HIV services to other departments
• Promoted integration of services between departments and roles between staff and consumers
• Stepping stone to other opportunities for consumer involvement in quality improvement
• Project results were presented at the Annual Genesis Conference
Lesson From the Field
Mission Statement: We foster healthy communities by providing medical, supportive and behavioral services to individuals and families in Western New York, especially those in marginalized populations and/or challenged by chronic or life threatening diseases.
Evergreen Health Services
(Ideal Visit Map)

PRIMARY CARE: MODEL VISIT #1

BEFORE VISIT
staff sounds happy and friendly on telephone.

When possible, always answer the phone. Try not to let clients reach voicemail.

AT CHECK-IN
staff has good attitude, and creates a welcoming environment.

Make sure that all clients in the waiting room have checked in.

IN THE WAITING ROOM
keep clients informed.

During busy times, communicate with clients about their waiting times.

THE EXAM ROOM
is clean and well-appointed.

Check the exam rooms to make sure they are comfortable for clients.

SUPPORT & SPECIALTY SERVICES
staff is knowledgeable about internal and external programming.

Follow up with clients about their care plans (referrals, retention, and adherence).

AT CHECK-OUT
staff is friendly, happy, compassionate.

Follow up with clients about their upcoming and missed appointments.

LAB WORK
is fast and accurate, causing little to no pain/damage during tests.

Be patient with clients. Be sensitive to the fact that this is only one component of their visit.

Evergreen Medical Group
Providing Individualized Medical Care Since 1996.

EMC patients provided feedback to determine the ideal patient visit. Their responses helped us develop the Model Visit poster series. Part of Healthcare Stories Project, NYS DOH AI.
Web Link
(Healthcare Stories Project Activity 2)

Thank you!

Questions/Comments

Contact Information
Daniel Tietz
daniel.tietz@health.ny.gov
(518)473-7542
Regional Data
March 2016

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PLWHA in Mid and Lower Hudson*

As of end of 2013

Estimated number of people infected 6,000
Number of diagnosed 5,300
Number in Care (any visit during 2013) 4,200
Retained in Care (at least 2 visits, 3 months apart during 2013) 3,500
Virally Suppressed (<200 at test closest to end of year) 3,600

*Based on most recent address
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**Data Submitters**

- Hudson River Healthcare (Dec/Mar)
- Greater Hudson Valley Community Health Center (Dec/Mar)
- Westchester Medical Center (Dec)
- Hope Center, St. John’s Riverside (Dec/Mar)
- Middletown Community Health Center (Mar)
Ending the Epidemic in the Hudson Valley
GET TESTED.
TREAT EARLY.
STAY SAFE.

End AIDS.

Ending the Epidemic:
Update and Steering Committee Overview
Defining the “End of AIDS”

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

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

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

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

4. Recommendations in support of decreasing new infections and disease progression (i.e., housing, drug user & LGBT health, etc.)

Reduce the number of new HIV infections to just 750 [from an estimated 3,000] by 2020.
ETE Update for the Hudson Valley

• Regional forum held in late Summer 2015
• Needs and gaps related to ETE assessed by community members
• Development of regional specific Meeting Summary and Action Plan documents
• What’s next – ETE Steering Committee Implementation . . . discussion today on organization and functioning
ETE Regional Steering Committees

Desired Outcomes

• Renew the ongoing efforts in each region, eliminate duplication and enhance coordination among regional providers, networks, Links, faith initiatives, and other local initiatives, invite new participants to the process to address new or emerging areas reflected in the ETE Blueprint;

• Review the information provided by participants at the regional meetings, including the needs and gaps information, the Action Plan, the funded Contracts and HIV and Syphilis data.

• Determine:
  – What needs, gaps or action items are already being addressed, and by whom;
  – Which items are the priority for addressing over the next 12-24 months; and
  – Which additional organizations or partners are needed to address the prioritized items?

• Develop a local Action Plan for the next 12 months.
ETE Regional Steering Committees
AIDS Institute Support

• Provide Steering Committees limited staff support:
  – Assistance with the scheduling of meetings, if needed.
  – An AI representative attending or participating by phone, to provide input and guidance.
  – Assistance with the preparation of meeting summaries and follow-up on Action Plans.
  – Providing data or other resources generally available, such as regional or statewide cascades of care.
  – Helping to resolve questions/areas of concern, directly or by referral to other state agencies.

• Convene the regional ETE Chairs and Co-chairs quarterly, for information sharing, best practices and a review of the progress to date.
Mapping ETE in the Hudson Valley

Goal: To build synergy and bidirectional communication across the Hudson Valley

- Please take time to visit the ETE wall that maps out the Blue Print Recommendations

- Use a post-it note with your agency’s full name and include the interventions your staff are using, i.e., ARTAS, PrEP, etc..

- Is there something missing . . . where does it “fit” within the framework of ETE?
Visit the ETE Dashboard at
WWW.ETEDASHBOARDNY.ORG

Deborah Dewey, Assistant Director
Office of Planning & Community Affairs
AIDS Institute
deborah.dewey@health.ny.gov
(518) 473-2903
Meet the ETE Dashboard
Tracking and Disseminating Information on Progress Towards Ending the AIDS Epidemic in New York: A Dashboard System

Benjamin Katz
CUNY School of Public Health

3/24/2016
Outline

• Genesis of the ETE Dashboard System project
• Overview of the purposes of the ETE Dashboard System
• Demo of the system
• Future directions
Blueprint recommendation 29

• Extend and enhance the use of data to track and report progress
  
  “The creation of a web-based, public facing, Ending the Epidemic Dashboard system is recommended to broadly disseminate information to stakeholders on the [ETE] initiative’s progress.”
Key Purposes of ETE Dashboard

• Measure, track and disseminate actionable information on progress towards achieving the Ending the Epidemic (ETE) Initiative’s goals in NYS to all who need to know

• Disseminate key metrics aligned with the ETE blueprint aims:
  – Identify persons with HIV who remain undiagnosed and link them to care
  – Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent future transmission
  – Facilitate access to PrEP for persons who engage in high-risk behaviors to keep them HIV negative

• Create a visual and interactive experience that allows stakeholders (users) to get the information they want in visual and tabular format
  – Content and geographically-driven
  – Integrated at the geographic level (GIS driven)
Data sources, content, and functionality

• ETE-related aggregate data from different realms and data sources
  – **Realms**: e.g., prevention, incidence, testing, new diagnoses, prevalence and care, AIDS diagnoses and deaths
  – **Data sources**: e.g., HIV surveillance, vital statistics, eHIVQual, CHS/BRFSS, STD surveillance, NY Links, Medicaid
  – ZIP/county-level aggregate ‘data streams’
  – Updated frequently (e.g., quarterly when available)
  – Integrate by geography and calendar time

• Display high level ETE metrics on a splash page to allow stakeholders to assess status/progress ‘at a glance’

• Ability for users to ‘drill down’ for further detail across and within realms for specific geographic areas and population groups (e.g., gender, race/ethnicity, transmission risk)
Prevention
- PrEP/nPEP
- Condom use
- STI incidence
- Syringe exchange

Incidence
- New infections

HIV testing
- Recent HIV testing
- Ever HIV testing

State and federal HIV funding

ETE Dashboard
By County/ZIP
By site

New diagnoses and linkage to care
- New diagnoses
- Acute infections
- Concurrent HIV/AIDS
- Linkage to care

Prevalence and care
- Estimated PLWH and undiagnosed
- HIV care continuum
- Quality of care

Social determinants

Housing, employment, non-medical needs

AIDS diagnoses and deaths
- Number of new AIDS diagnoses
- Number of deaths among PLWH
- HIV deaths

Statewide or citywide

Social determinants

Housing, employment, non-medical needs

AIDS diagnoses and deaths
- Number of new AIDS diagnoses
- Number of deaths among PLWH
- HIV deaths
System launched in September 2015

- Email blast announced the system launch on September 21
  - Targeted over 900 persons
    - task force members, affiliates, key stakeholders
    - those who submitted emails requesting notification

- Register to receive communications on ETE updates, new data sources, visualizations, blog posts, announcements, etc.

- Dashboard mailing list provides additional content and links to important new research and HIV/AIDS initiatives in New York and across the globe
Live demo of the ETE Dashboard

Follow this link!
Integrating Social Media

Strengths of Facebook/Twitter

- Routine communication with key stakeholders and the general public
- Easy and fast way to receive and disseminate new content (blog posts, new visualizations, events, etc.)
- 165 page visits to the ETE twitter profile in the past month
Site Usage

- Site has been accessed from 60+ countries
- 22,000 page views
- 3,000 unique users
- 5,900 total active sessions
Across the U.S...

...throughout New York State
Most visited pages

• HIV Care Cascades
• Maps
• Prevention
• Blog posts
Key challenges

• Timeliness of some metrics
  – Significant lag time for some data sources (e.g., case surveillance)

• Data needs and gaps
  – E.g., PrEP and nPEP indicators; harm reduction, prevention cascade; supportive services, housing stability, vocational opportunity

• Availability of data at the county or ZIP code level with further ability to stratify
  – Small numbers may prevent inclusion of some data stratified by gender, race/ethnicity, transmission risk, etc due to confidentiality issues

• Trends: not all metrics will be available routinely
Key strengths

• Comprehensiveness
  – Wide array of relevant ETE indicators in one place, from prevention to HIV-related deaths

• Integration
  – Brings together previously siloed data across various realms and data sources

• Visual and interactive
  – Provides the potential to lead to new insights

• Accessibility
  – Content useful to a wide range of stakeholders with different data needs

• Tailored to the ETE initiative
  – Will help track and disseminate information about the ETE Initiative's progress
  – Can help target resources, programmatic efforts, and advocacy where they are needed most
Future directions

• Curating additional key data streams and integration of data
  – E.g., routine surveillance, HIV testing, vital registration, eHIVQual, SPARCS, census, PrEP
  – Data Portal (facility reported data)
  – Cataloging and describing ETE implementation activities
    • Who is implementing what, why, where, and when?

• Development of interactive components, visualizations, and maps
  – Ability to drill down on metrics from state to local level
    • Unified at lowest level by geography
  – Blog posts
  – Enhance social media presence
  – Community forum
  – Events calendar/announcements
Preview of the HIV testing interactive visualization
Acknowledgements

Hunter College
CUNY School of Public Health
AIDS Institute
NYS DOH
NYC DOHMH
ETE Task Force Stakeholders
ETE Task Force Data Committee
Visit the ETE Dashboard at
WWW.ETEDASHBOARDNY.ORG

Send suggestions, ideas, comments to
feedback@etedashboardny.org

Follow us on Twitter
@etedashboardny

Visit our Facebook page
Ending the Epidemic Dashboard NY
Ranking Experiences
It was so great I’m bringing my mom next time and making you come too!

On the wall you will notice a scale from 1 to 10

I am going to ask you to think about some processes.

Consider your most recent experience with that process and then go stand along the scale.

1 is terrible, 5 is neutral, 10 is excellent
Last meal eaten out
Last visit to a healthcare provider
Lunch
GET TESTED. TREAT EARLY. STAY SAFE.

Let’s End AIDS, Hudson Valley.
Attack of the Living Cascade
“The Living Cascade”
Focusing on the Care in the Care continuum
Improving Viral Load Suppression
in the Mid and Lower Hudson Regions
“If you can’t describe what you are doing as a process, you don’t know what you are doing.”

~ W. Edwards Deming
Agenda

• Introduction to the Living Cascade
• Greater Hudson Valley Family Health Center QI Storyboard
• VLS QI Project Charter
• VLS QI Project Reporting
• The Living Cascade Exercise
• The Cascades Spring to Life!
Learning objectives

• Learn how one program dramatically improved viral load suppression rates through the use of quality improvement activities
• Gain knowledge through collaborative process investigation as to what processes can be eliminated, added or changed at each step along the care continuum to improve care along the continuum and support viral load suppression outcomes.
• Learn about the 2016 Community Health Center Quality Learning Network Viral Load Suppression Quality Improvement Project
• Develop collaborative improvement activities to improve regional viral load suppression outcomes
Method-

• CHCQLN clinic participants will act as viral load suppression (VLS) improvement hubs, involving nonclinical supportive services, and county programs. Consumers and other stakeholders in their area on VLS improvement teams.

• Each hub will submit a single QI report for the collaborative effort.

• New hubs may emerge in each region, other HIV clinics that will work with nonclinical and supportive service providers as well as other stakeholders in their community to improve VLS. This will spread and increase the improvement.
Greater Hudson Valley Family Health Center

Positive Choices Center

Viral Load Suppression Update 2015
• Suppressed - 84%
  • 113 clients
• Unsuppressed – 15%
  • 21 clients
• No test – 1%
  • 1 client

• Undetectable – 82%
  • 93/113 suppressed clients

Entire Caseload
Viral Load Suppression 2015
• **Goal**: Sustain a Viral Load Suppression rate of 84% for 2015.

• **During 2014 clients received incentives for:**
  - Obtaining Viral Load Suppression - $50
  - Attending all required medical visits/completing labs - $25
  - Specific Case Management visits, e.g. Reassessments, Tx. Adherence, Tx. Adherence Group - $15
• We focused our attention on our unsuppressed clients. We increased Case Management efforts and encounters and tracked them. Efforts included:
  • Care Coordination
  • Teachbacks
  • Tx. Adherence Counseling
  • Tx. Adherence Groups
  • CD4/VL Visuals

*Although we focused on our unsuppressed clients, we still provided these services for our suppressed clients because we didn’t want them to become unsuppressed.
• We reviewed the list of all unsuppressed clients on our Viral Load Suppression Project and we “drilled down the data”.
• We looked at what factors could potentially cause barriers to obtaining suppression such as:
  • Behavioral Health Issues
  • Substance Abuse Issues
  • Age
  • Sexual Orientation
• We found that most of our unsuppressed clients have a combination of Mental Health and Substance Abuse issues. A separate PDSA was created to increase Behavioral Health engagement and treatment.
VLSP Unsuppressed Client Details

December 2013 Unsuppressed Clients: 21

**Housing**

- Stable: 12 (57%)
- Unstable: 2 (10%)
- Supportive: 4 (19%)
- Unknown: 3 (14%)

**Mental Health Services**

- In Need: 12 (57%)
- Receiving: 4 (19%)
- No Need: 5 (24%)

**Substance Abuse**

- In Need: 6 (29%)
- Receiving: 2 (10%)
- No Need: 43 (61%)

**Risk Factors**

- IDU: 1 (5%)
- Perinatal: 1 (5%)
- Hetero: 1 (5%)
- Hetero & IDU: 1 (5%)
- MSM: 0 (0%)
- MSM & IDU: 1 (5%)
VLSP Unsuppressed Client Details

**Gender**
- Male: 12 (57%)
- Female: 9 (43%)
- Transgender: 0

**Race**
- White: 4 (19%)
- Black: 11 (52%)
- Hispanic: 6 (29%)
- Other: 0

**Age**
- 18-25: 1 (14%)
- 25-39: 8 (38%)
- 40-49: 3 (14%)
- 50-59: 4 (19%)
- 60+: 0

**Language**
- English: 16 (76%)
- Spanish: 5 (24%)
- Other: 0

December 2015 Unsuppressed Clients: 21
• Case Management efforts were discussed on a monthly basis at CQI Meetings to gain input from all HIV CQI Sub-Committee members, which includes all levels of staff from Providers to Program Assistants. Ideas and techniques were shared.

• At the bi-monthly CAB meeting clients were asked for input on these efforts. The CAB committee spoke highly of the need for visual aids.

• PCC and CAB collaborated in developing a visual aid that would help low-literacy clients understand viral load and CD4 in a simple, graphic format. This visual was coupled with laboratory graphs generated from our EMR software to help clients fully understand their results.
**CD4 Count**

- **Very Low**
  - Less than 200 cells/mm

- **Low**
  - 200-500 cells/mm

- **Good**
  - Over 500 cells/mm

**Your CD4:**

**Your Goal:** Above 200 cells/mm

---

**Viral Load**

- **High**
  - Over 10,000 copies

- **Low**
  - Less than 10,000 copies

- **Suppressed**
  - Less than 200 copies

**Your VL:**

**Your Goal:** Below 200 copies/mm
HIV & CD4 Visuals
• Continue with PDSA cycles
  • Behavioral Health
  • Viral Load Suppression
• Increase goal to end 2016 with an 89% Viral Load Suppression Rate
Viral Load Suppression
Quality Improvement Project Charter
Purpose:

• To significantly improve health outcomes for PLWH and reduce transmission of HIV by increasing HIV viral load suppression (VLS) rates at participating sites.

• To engage health centers in strategic initiatives contributing to achieving the goals of the Blueprint to End the Epidemic in 2020.
Goals

• To improve average clinic-wide VLS rates of participating sites by 8% by the end of 2016.

• To sustain throughout the year, a minimum VLS rate of 80% in patients that achieved VLS after receiving a QI intervention and VL test in 2015.

• Among patients with elevated viral load levels recorded in 2016, we will compare rates of subsequent suppression among those who receive or do not receive a QI intervention in 2016.

• To achieve and maintain 90% rates of submission of quarterly data reports by participating sites in 2016.

• To increase the number of participating sites from 24 in 2015 to 28 in 2016.

• Encouraging sites to build systems for automated reporting of VLS rates for their entire clinic population.
Overview

• The Quality of Care Program in collaboration with the NYSDOH/AIDS Institute strives to improve VLS rates for patients living with HIV through the use of peer learning and the Institute for Healthcare Improvement approach to quality improvement (IHI-QI) as informed by Lean methods and values.

• Interdisciplinary care teams develop interventions to improve clinic viral load suppression focused upon supporting patients with challenges to their becoming and sustaining viral load suppression.

• Teams use QI methods, running PDSA ("Plan, Do, Study, Act") cycles to test and implement changes. Data from all participating sites are collected and aggregated, quarterly and presented at in-person meetings and webinars, which also provide opportunities for peer learning and exchange.
Reporting

• A tracking tool will be provided to participating sites to track unsuppressed patients on several identified measures.
• We encourage sites to build systems for automated reporting of VLS rates for their entire clinic population.
• Sites will report on their improvement activities, including the changes tested and process analysis used to guide decisions about which interventions are tested, as well as their methods used to perform data analysis.
Process Measures

- The percent of patients living with HIV, unsuppressed at any point in 2016, who are engaged in a test of change/QI intervention
- The percent of unsuppressed patients living with HIV who received a VL test after engagement in the test of change/QI intervention
- Percent of previously unsuppressed patients who became suppressed in 2015 and sustained VLS in 2016
Outcome measures

• Sustained VLS-Percent of previously unsuppressed patients who became suppressed in 2015 and sustained VLS in 2016

• Achieved VLS-Percent of current 2016 patients living with HIV who became virally suppressed after engagement in a test of change/ QI intervention and follow up VL test subsequent to being unsuppressed in 2016

• Clinic wide VLS rate of patients with HIV seen at least once in the past 12-months for primary care who are VL suppressed (<200 copies) on the most recent VL test
Demographic Factors

- Gender
- Race/ethnicity
- Exposure category (risk)
- Primary language
- Mental health
- Current substance use
- Housing status
- Tobacco use
- Age
2016 Tracking Tool & Reporting Workbook

Step 1

Start in PatientData tab

- Enter unique patient identifiers for all patients who were unsuppressed at any point in 2015 in separate lines
- Did the patient receive a VLS QI interventions in 2015 subsequent to an unsuppressed viral load test?
- What was the suppression status on last VL test in 2015?
- Was the patient suppressed at most recent test after the intervention?
- Did the patient receive a VL test after receiving the QI intervention?
- Did the patient receive a subsequent QI intervention?
- Was the patient suppressed at most recent test after the intervention?

Step 2

- After entering all 2015 unsuppressed patients, enter any patients that are unsuppressed in 2016
- Repeat 4x

For all patients unsuppressed at any time in 2016,

Enter the demographic information indicated
<table>
<thead>
<tr>
<th>Patient Identifier (e.g., MRN)</th>
<th>Suppression Logic</th>
<th>Missing Logic</th>
<th>Demographics</th>
<th>Did the patient receive a QI intervention in 2015 subsequent to an unsuppressed viral load in 2015? (Yes/No)</th>
<th>If the patient received a QI intervention in 2015, what was their suppression status on last VL in 2015? (Yes/No)</th>
<th>Suppressed at any time in Q1 of 2016? (Yes/No)</th>
<th>Received subsequent VLS QI intervention in Q1 if unsuppressed in Q1 of 2016? (Yes/No)</th>
<th>Received subsequent VL Test in Q1 after Intervention in Q1 if unsuppressed in Q1 of 2016? (Yes/No)</th>
<th>Suppressed at most recent VL test after Intervention in Q1 of 2016? (Yes/No?)</th>
<th>Unsuppressed at any time in Q1 or 2016?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015_1 OK</td>
<td>OK</td>
<td>Yes</td>
<td>Suppressed</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2015_2 OK</td>
<td>Missing</td>
<td>Yes</td>
<td>Unsuppressed</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No Intervention/test</td>
<td>Yes</td>
<td>No Interven/No Test</td>
<td>No Interven/No Test</td>
</tr>
<tr>
<td>2015_3 OK</td>
<td>OK</td>
<td>Yes</td>
<td>No follow-up VL in 2015</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2015_4 OK</td>
<td>OK</td>
<td>Yes</td>
<td>Unsuppressed</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Intervention/test</td>
<td>Yes</td>
<td>No Interven/No Test</td>
<td>No Interven/No Test</td>
</tr>
<tr>
<td>2015_5 OK</td>
<td>OK</td>
<td>Yes</td>
<td>Suppressed</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
</tr>
<tr>
<td>2015_6 OK</td>
<td>OK</td>
<td>Yes</td>
<td>No follow-up VL in 2015</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
</tr>
<tr>
<td>2016_1 OK</td>
<td>OK</td>
<td>No</td>
<td>Suppressed</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
</tr>
<tr>
<td>2016_2 OK</td>
<td>OK</td>
<td>No</td>
<td>No VLS intervention in 2015</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2016_3 OK</td>
<td>OK</td>
<td>No</td>
<td>No VLS intervention in 2015</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2016_4 OK</td>
<td>Missing</td>
<td>No</td>
<td>No VLS intervention in 2015</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
<td>No Intervention/test</td>
</tr>
</tbody>
</table>
## 2016 Tracking Tool & Reporting Workbook

### CHCQLN Viral Load Suppression Project 2016 Reporting Form

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>January - June</td>
<td>7/11/2016</td>
</tr>
<tr>
<td>January - September</td>
<td>10/10/2016</td>
</tr>
<tr>
<td>January - December</td>
<td>1/9/2017</td>
</tr>
</tbody>
</table>

### 2016 Clinic-Wide Viral Load Suppression Rate

<table>
<thead>
<tr>
<th>Month</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>82</td>
<td>91</td>
<td>90</td>
<td>93</td>
</tr>
<tr>
<td>June</td>
<td>66</td>
<td>76</td>
<td>74</td>
<td>81</td>
</tr>
<tr>
<td>September</td>
<td>80%</td>
<td>84%</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>December</td>
<td>80%</td>
<td>85%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

- Total # of HIV+ patients seen at least once in past 12 months for primary care
- # of these patients with a VL suppressed result as of the last VL test in 2015
- Clinic-Wide VLS Rate

### 2015 Patients Cohort: Sustained VLS

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- # of patients that received a CI intervention and subsequent VL test in 2015
- # of these patients that were suppressed at last test in 2015

### Sustained VLS in 2016

<table>
<thead>
<tr>
<th>Month</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- # of patients that became suppressed in 2015 that sustained suppression up to and through most recent test

### 2016 Unsuppressed Patients

- This table will automatically calculate
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2016 VLS Project Narrative Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Please describe your quality improvement intervention(s), including how process changes are tailored to meet the needs of identified subgroups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>How are you measuring the success of the interventions? How are you accounting for and measuring the impact of unexpected, unintended influences of viral load suppression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Have you made any changes since the last reporting period? If so, please describe. How many tests of change did you perform in each quarter? Have you implemented your change clinic wide? Why or why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>March (Q1)</td>
<td>June (Q2)</td>
<td>September (Q3)</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>What challenges have you faced while implementing your QI intervention? What lessons have you learned?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Living Cascade
The Living Cascade: Focusing on the Care in the Care Continuum

Hypothesis-

• If you improve the steps along the continuum there will be an increased chance that patients will sustain Viral Load Suppression.

• Each process step along the continuum involves a human interaction. All of the steps together are a journey the consumer takes. Working together, we can improve the consumer journey and help the consumer to arrive at sustained suppression.

• Focusing on improving processes for the smaller group of unsuppressed patients will help patients to become suppressed.

• These activities will increase the clinic’s overall viral load suppression rates and regional VLS rates in the mid and lower Hudson.
Cascade of HIV Care: Mid-Hudson Ryan White Region

Persons Residing in the Mid-Hudson Ryan White Region†, at End of 2013 (includes prisoner cases)

- Estimated HIV Infected Persons: 2,800
- Persons Living w/ Diagnosed HIV Infection: 2,400
- Cases w/any HIV Care during the year*: 1,800
- Cases w/continuous care during the year**: 1,500
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 1,500

- 87% of infected
- 64% of infected
- 61% of PLWDHI
- 55% of infected
- 63% of PLWDHI
- 86% of cases w/any care

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
†Persons presumed to be residing in the Mid Hudson RWR based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
Cascade of HIV Care: Lower Hudson Ryan White Region

Persons Residing in the Lower Hudson Ryan White Region†, at End of 2013 (includes prisoner cases)

- Estimated HIV Infected Persons: 4,300
- Persons Living w/ Diagnosed HIV Infection
- Cases w/any HIV Care during the year*: 3,700
- Cases w/continuous care during the year**: 2,800
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 2,400
- 85% of cases w/any care

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
†Persons presumed to be residing in the Lower Hudson RWR based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
The Living Cascade Exercise

Lower Hudson Hubs
  • Westchester Medical Center
  • Open Door

Mid Hudson Hub
  • Hudson River Healthcare
  • Greater Hudson Valley Family Health Center
The Upstreamest: Social determinants of health outcomes
Improve the VL Suppression rate by 10% across 7 community health centers by 12/31/12
Primary Outcome | Primary Drivers | Secondary Drivers

- Increase the viral load suppression rate for participating patients by 10% across clinics over a 12 month period
- Psycho-Social Support
  - Housing
  - Substance Use
  - Mental Health
  - Appointments
- Retention
  - Transportation
  - Continuity of care
- ARV Adherence
  - Treatment Education
  - Health Literacy
  - Health Insurance
Talking points included in your packet

- Each VLS Team meets at the suppression hub to discuss the current processes for the following:
  - Testing and Linkage
  - Early Engagement and Retention
  - Viral Load Suppression
Each VLS Team will designate an artist to draw the process flow map for each step in the cascade (40 minutes)

• VLS teams review the current process steps for linkage, engagement, retention, and viral load suppression, the team artist drawing a process flow map for each of these areas.

• Each team identifies ways that these processes can be improved, streamlined or strengthened by eliminating unnecessary steps, adding steps or improving steps.

• Team artist re-draws the processes for each area along the continuum incorporating the VLS Team’s suggested improvements.

• The team puts the improved processes together into a single process flow that begins with testing and culminates with suppression.
Most Commonly Used Flowchart Symbols

- Activity
- Terminator
- Decision
- Wait symbol
- Connecting lines
- Page connector
Flow Chart: Is This an Efficient Process?

Patient arrives at front desk → Staff asks name, searches database for file → Patient in system?

Yes → Staff asks patient to be seated

No → Staff asks patient to provide information → Patient waits → Nurse takes patient to exam room
QI Flow Chart – Pap

I. New Patient: 1st Visit

PCP visit →

Pt. needs GYN exam/visit

yes

PCP documents need for GYN exam @ next visit →

Next appointment is scheduled

no

GYN exam completed during PCP visit →

Possible chart review in the future & assessed again

II. Return Visit

need for GYN determined via: chart review, excel

yes

PCP Appointment visit kept

no

Possible chart review in the future & reassessed

Test/s completed and sent to lab

PCP

GYN testing completed

yes

determine reason: new OB, GYN care elsewhere, PCP not comfortable doing GYN exam, or patient scheduled for exam at a future appointment

no

a. If patient cancelled, reschedule appointment
b. If no show, check again at next PCP visit
The “Cascades” Spring to Life!!!
The Play is the Thing

• Each team will act out the step by step process of their care continuum, pointing out where steps have been eliminated, added or improved (10 minutes).

• The “Cascade Committee” will announce winners of Niagara Awards for the following categories:
  • Best Picture (of your Cascade Flow)
  • Most original cascade process improvements to support VLS
  • Best proposed collaboration between all service providers
  • Best acting
Cascade Talking Points
What is your process: Linkage to Care

• What are the human interactions to linking patients to care?
  • Staff and consumers
  • Staff and leadership
  • Staff at testing and supportive service programs
  • The county and state DOH and staff at clinical care programs

• How can the human interactions that make up the process steps of successfully linking patients to care be improved?

• As you talk, complete the current process map and the improved process map for this important portion of the care continuum
What is your process: Engagement and Retention

• What are the human interactions for engaging and retaining patients in ongoing care?
  • Staff and consumers
  • Staff and leadership
  • Staff at testing and supportive care programs
  • the county and state DOH and staff at clinical care programs

• How can the human interactions that make up the process steps of successfully engaging patients in care be improved?

• How can the human interactions that make up the process steps of successfully retaining patients in care be improved?

• As you talk, complete the current process map and the improved process map for this important portion of the care continuum
What is your process: Viral Load Suppression

• What are the human interactions that support sustained viral load suppression?
  • Staff and consumers
  • Staff and leadership
  • The county and state DOH
  • Staff at testing programs and staff at clinical care programs

• Working together, how can we improve the human interactions that make up the process steps of successfully helping patients to viral load suppression?

• As you talk, complete the current process map and the improved process map for this important portion of the care continuum
What’s the Plan

• Aim
• Innovation (process changes)
• Hypotheses
• Work plan
  • Who
  • What
  • When
  • Where
Next Steps

- PDSA Report submission date: March 28, 2016
- VLS QI Project Q1 data submission date: April 11, 2016
TA and Coaching is available

Please contact:
Dan Belanger
Director, NYS Quality of Care Program
(212) 417-5131
daniel.Belanger@health.ny.gov
Q & A
Thank you!!!
Building a Better Regional Group

Steve Sawicki
Goals for Region

- Improved linkage to care
- Improved engagement in care
- Improved retention in care
- Improved viral load suppression
- Utilization of Quality Improvement methods
- Utilization of data to establish baseline and measure progress
- Fit within the Ending the Epidemic Framework
- Focus on regional improvement through distinct organizational efforts, networking, peer sharing, and increased city/state partnerships
Wrap Up: Summation

Steve Sawicki
UPCOMING STAKEHOLDER MEETINGS

May 4—Introduction to NYLinks Measures and Data webinar
May 11—Central New York Regional Group Meeting
June 22—Eastern NY Regional Meeting
September ?—Next M&LH Regional Meeting
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

December 1, 2015—NYLinks Quarterly measures
Webinars

August 25  3:00, NYLinks Interventions (final packages for wider scale implementation)

September ??  ?:??, How to construct an intervention from the ground up
NY Links Website

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 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

• Steven Sawicki, NYSDOH, SPNS Lead
  steven.sawicki@health.ny.gov, 518-474-3813

• Deborah Dewey, Assistant Director,
  Deborah.dewey@health.ny.gov

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

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

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