#ADHERENCE2016

Ending AIDS as a Public Health Threat: The Power of Change

MAY 9–11, 2016 • FORT LAUDERDALE

Jointly sponsored by

IAPAC
INTERNATIONAL ASSOCIATION OF PROVIDERS OF AIDS CARE

PIM
Postgraduate Institute for Medicine

NYCLinks

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May 9, 2016

Overall Objectives of NYLinks

- Improve Linkage to Care in NYS
- Improve Retention in Care in NYS
- Improve Viral Load Suppression in NYS

NY Links Mission

- We identify and spread innovative solutions for improving linkage and retention in HIV care that support the delivery of routine, timely, and effective care for PLWHA 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 retention, linkage, and viral load suppression in NYS.

NEW YORK STATE DEPARTMENT | Department of Health

NY Links Overview

NY Links

New York State Department of Health AIDS INSTITUTE

HRSA 'SPNS' grant received 9/1/11

- NYLinks began as a HRSA Special Project of National Significance (SPNS) grant (9/1/11 through 8/30/15) awarded to 6 states.
- Focus on improving linkage to care and retention in care through initiation and dissemination of improvement activities, driven by QI collaboratives (Breakthrough Series model adaptation)
- Sustainability of work a required part of grant

NYLINKS KEY COMPONENTS

Develop regional networks that bridge the gap between individual health and **public health**

Voluntary nature of involvement stabilizes and sustains work over time

Providers and consumers involved in planning and implementing **regional** networks that improve outcomes along the cascade of care (continuum)

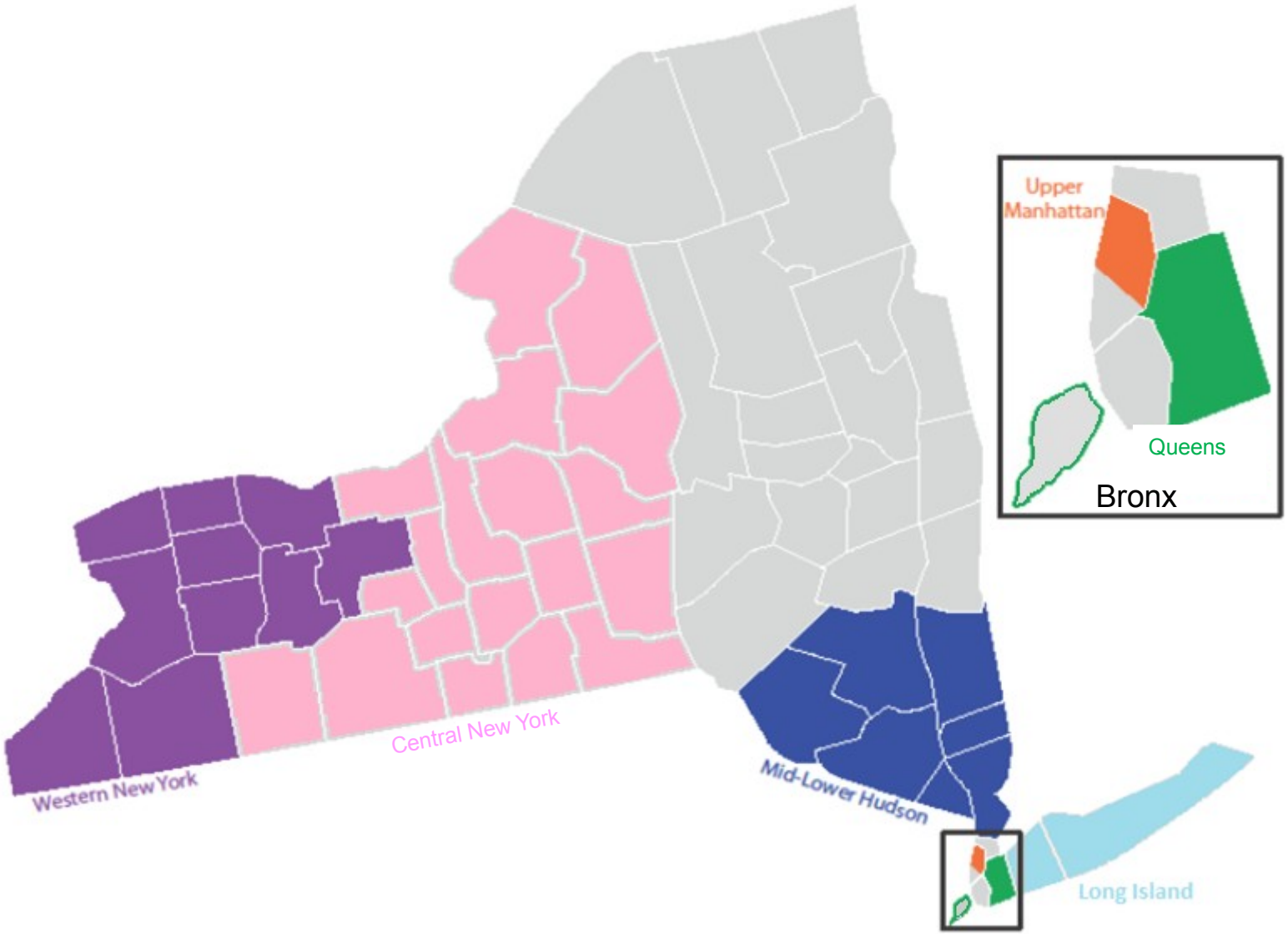
NYS surveillance data made **accessible** to frontline providers for QI efforts and to compare against **facility level reports generated as part of site-level QI**

Understanding of how facility and **local data** have regional and statewide impact is **enhanced**

Strengthened partnerships and **peer learning**

Regional Groups

Existing Regional Group locations in New York State



BUILD REGIONAL GROUPS: PART 1

- Engage all medical and non-medical organizations within a geographic area to improve linkage to care, retention in care, and viral load suppression
- Involve all types of organizations—hospitals, community health centers, CBOs, local health departments, NYS staff
- Involve all levels of individuals—consumers, front line staff, administrators, data staff, QI staff, CEOs, medical directors, medical providers

BUILD REGIONAL GROUPS: PART 2

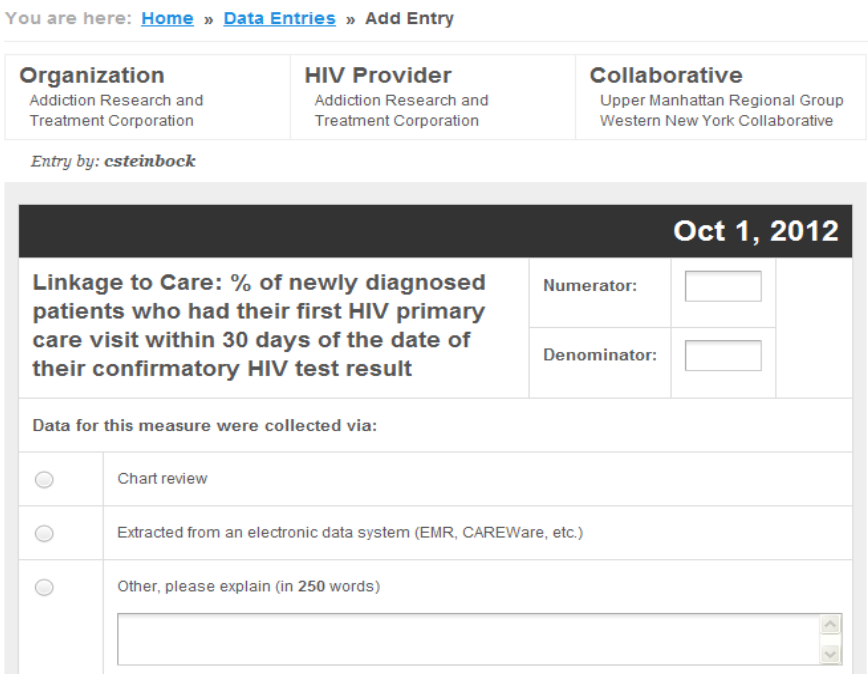
- Develop both an organizational and a community-oriented systems approach to improvement
- Use data to improve performance
- Use QI strategies to design and assess performance
- Use peer learning to spread innovation

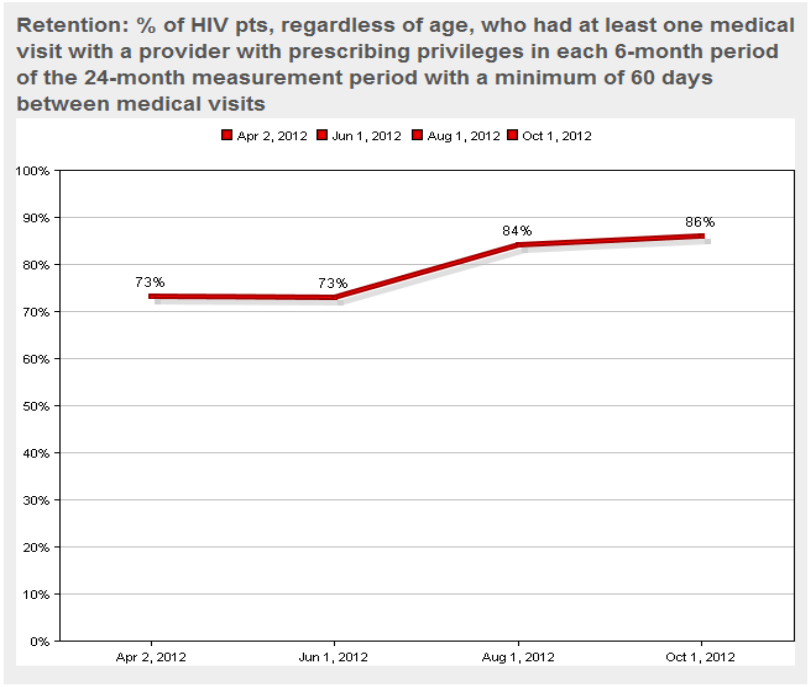
What do we ask of organizations?

- Identify leadership, data, QI, program/medical staff, consumers who will participate
- Support Staff Attending NYLinks Regional Meetings
- Generate and analyze their own data
- Use QI to initiate improvement
- Submit data related to relevant NYLinks measures
- Share results

QI Strategies

- Online reporting database to facilitate self-reporting and instantaneous benchmarking
- On-site coaching by recognized improvement experts
- Access to a range of AIDS Institute resources and training
- Integration of NYS surveillance data to create state and regional cascades which make data accessible to front line providers for QI efforts and for comparison against facility level data





QI Strategies

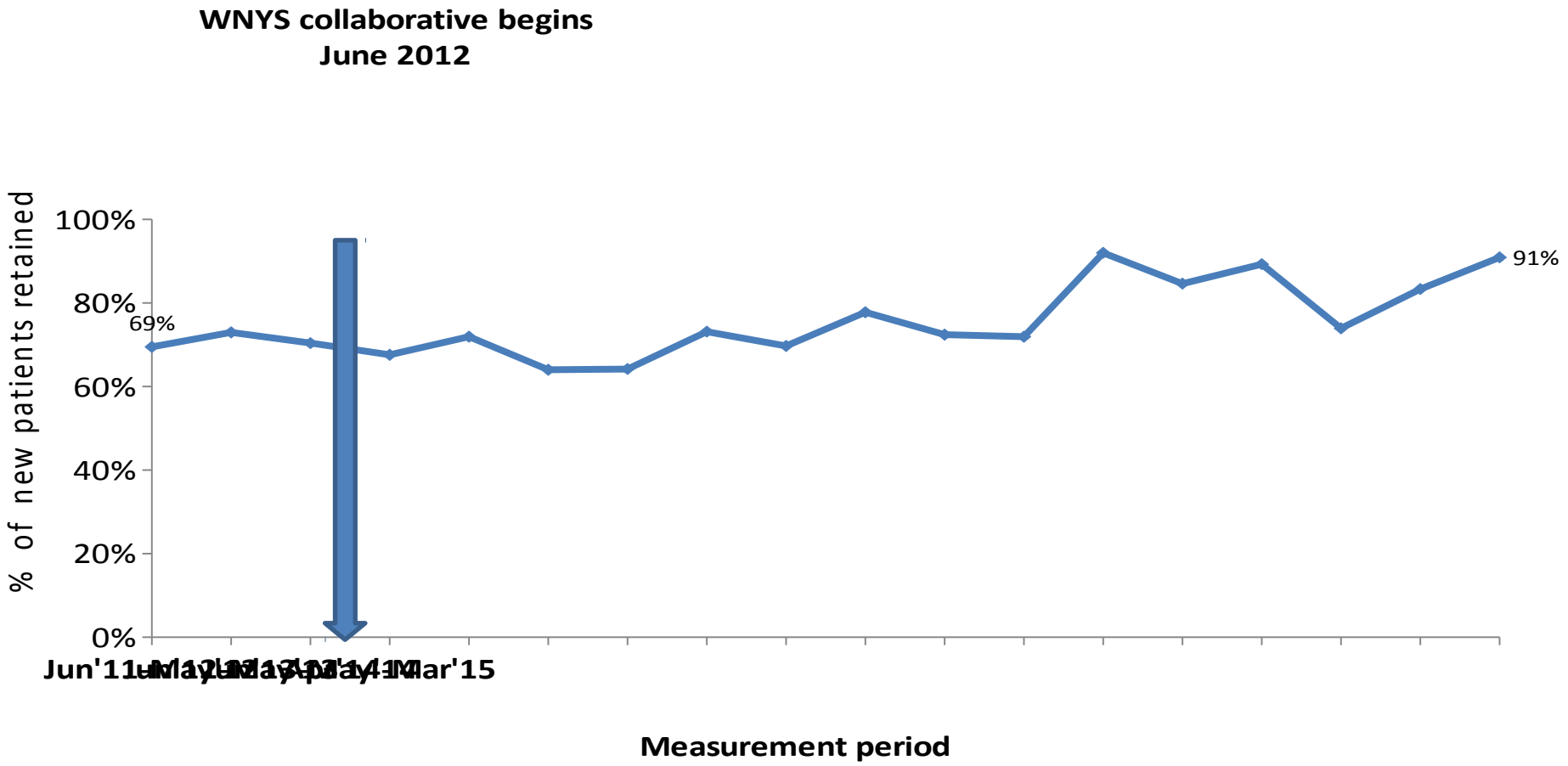
- Integration of NYS (includes NYC) surveillance teams to effectively utilize existing data sets and to make them accessible to frontline providers for QI efforts
- Providers and consumers part of planning and implementation of regional processes to foster infrastructure for sustainability of peer learning opportunities
- Consumers are full partners of NYLinks
- Regional approach to improvement
- Utilization of existing structures for support of work
- NYLinks key part of Governor's Ending the Epidemic Initiative

Data in, QI, Data out

Collaborative Measures

Linkage to care among newly diagnosed persons	After diagnosis, how many people are linked to care within 30 days?
Clinical Retention	Over a two year period, how many patients have been seen at least every 6 months by a medical provider?
New patient retention	If a patient is new to the clinic, are they seen at least once in each 4 month periods of that year as required by HIV care guidelines?
Clinical engagement	For non-clinical organizations, have clients who have received services in the past two months had a primary care visit during the 6 month period prior?
Viral Load Suppression	Were patients who were active in the organization over the past year virally suppressed at their last viral load test (<200mm)?

Rochester—New patient retention (2b): proportion of new patients retained in care over one year

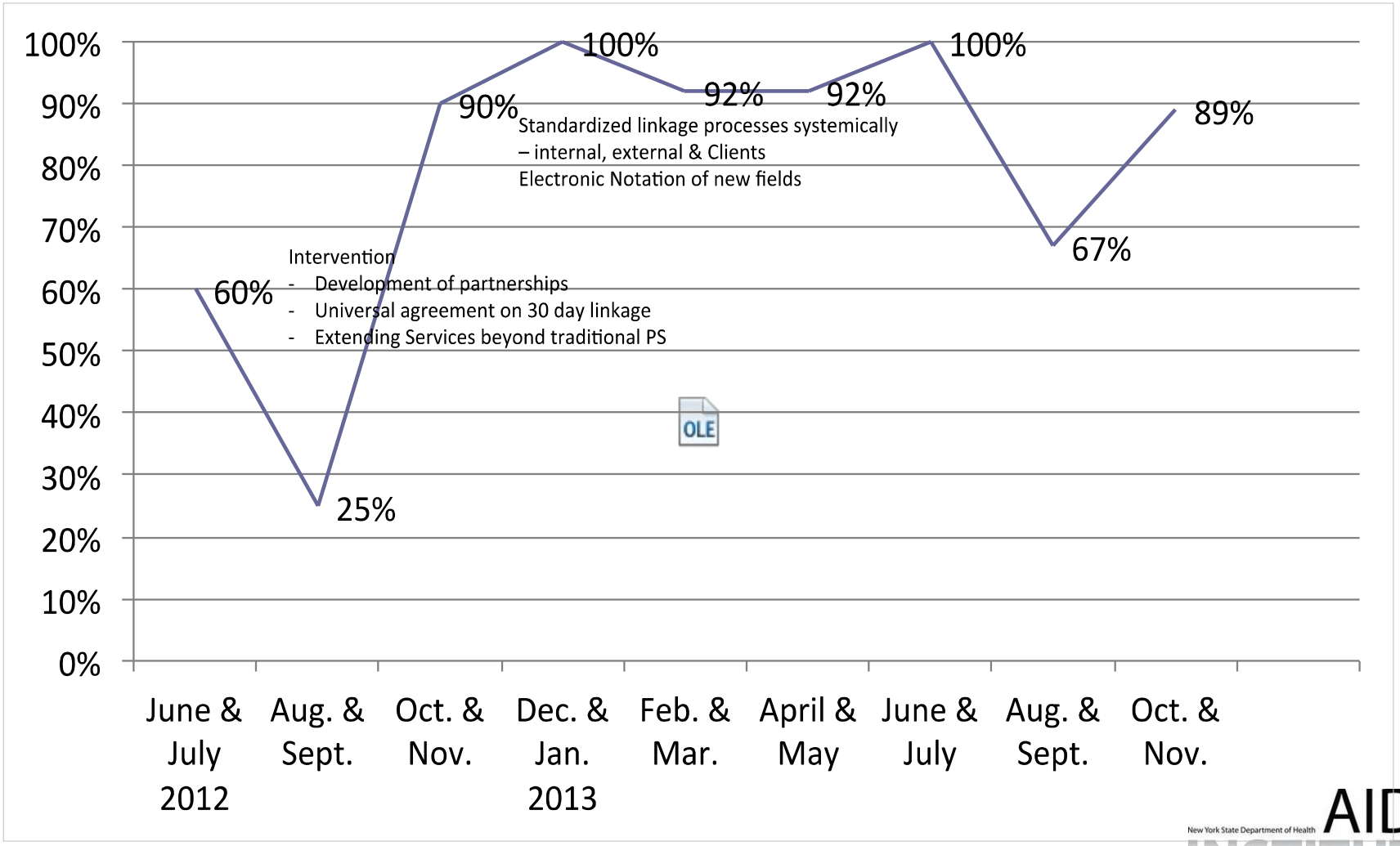


Eligible patients	95 pts	67 pts	**25 pts**	**33 pts**
Sites reporting	3/3 sites	3/3 sites	**2/3 sites**	**2/3 sites**

* Each data point represents the aggregate bi-monthly data submission from Aug 2012-Jun 2015

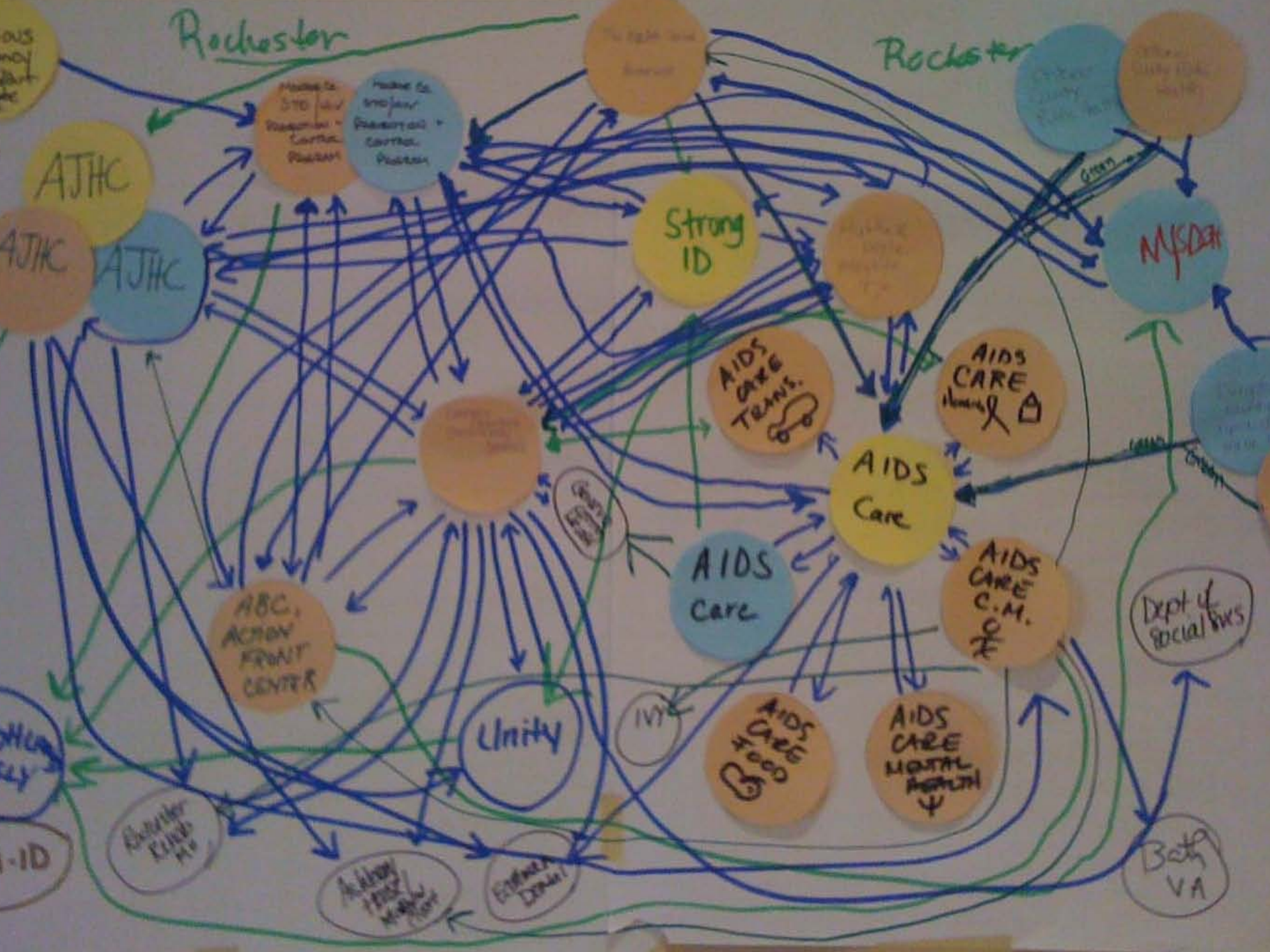
Data Source: NYLinks facility-level measures, updated: June 23, 2015

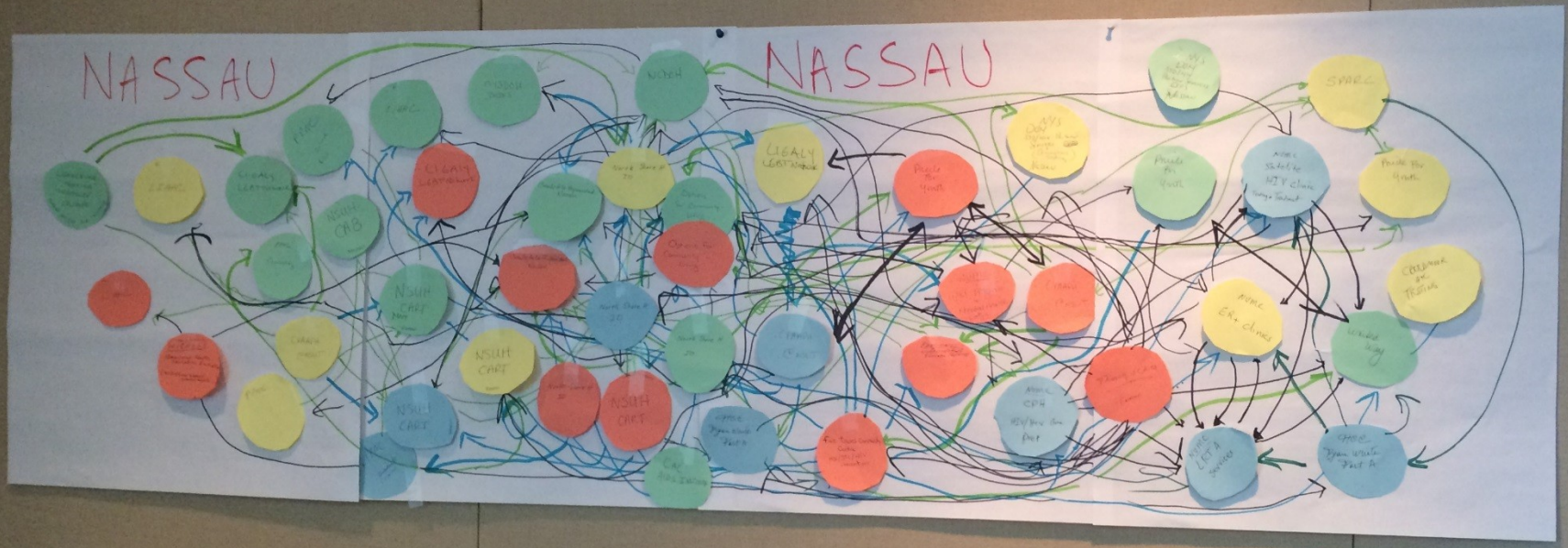
Monroe County Department of Public Health



AIDS INSTITUTE
New York State Department of Health

Continuum of Care


Rochester
Rochester
AJHC
AJHC
AJHC
Strong ID
MSDH
AIDS CARE TRANS.
AIDS CARE
AIDS Care
AIDS Care
AIDS CARE C.M.
ABC, ACTION FRAUT CENTER
Unity
IVH
AIDS CARE FOOD
AIDS CARE MENTAL HEALTH
Dept of Social Svcs
Bath VA


NASSAU
NASSAU

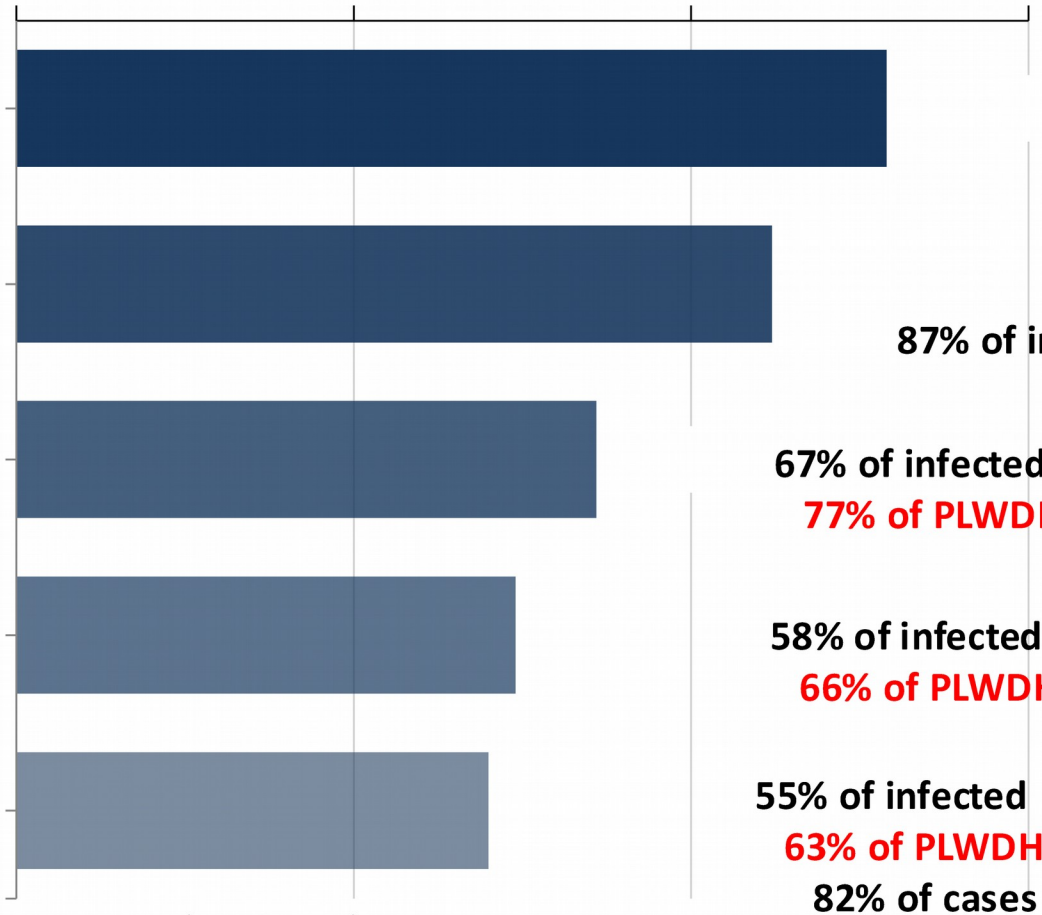
Cascades

Data processes improved through stakeholder collaboration

Facility	NYLinks	Ryan White Region	NYS
✓Better ability to interpret & understand data ✓identification of gaps in care ✓Increase data-driven HIV care	✓Improve HIV care outcomes though stakeholder collaboration ✓Improve local ability to understand & interpret data ✓Collaboratively created data packages	✓Data-driven HIV care ✓Improve HIV care outcomes ✓Regional HIV cascades	✓Few new infections by end of the decade ✓Promote data-driven HIV care ✓Statewide HIV care Cascades

New York State Cascade of HIV Care, 2013

Persons Residing in NYS† at End of 2013



* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart

†Persons presumed to be residing in NYS 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.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Hudson River Healthcare's Linkage, Retention and Viral Load Suppression Data Compared with Mid and Lower Hudson Regional Collaborative and 2013 New York State Surveillance Data

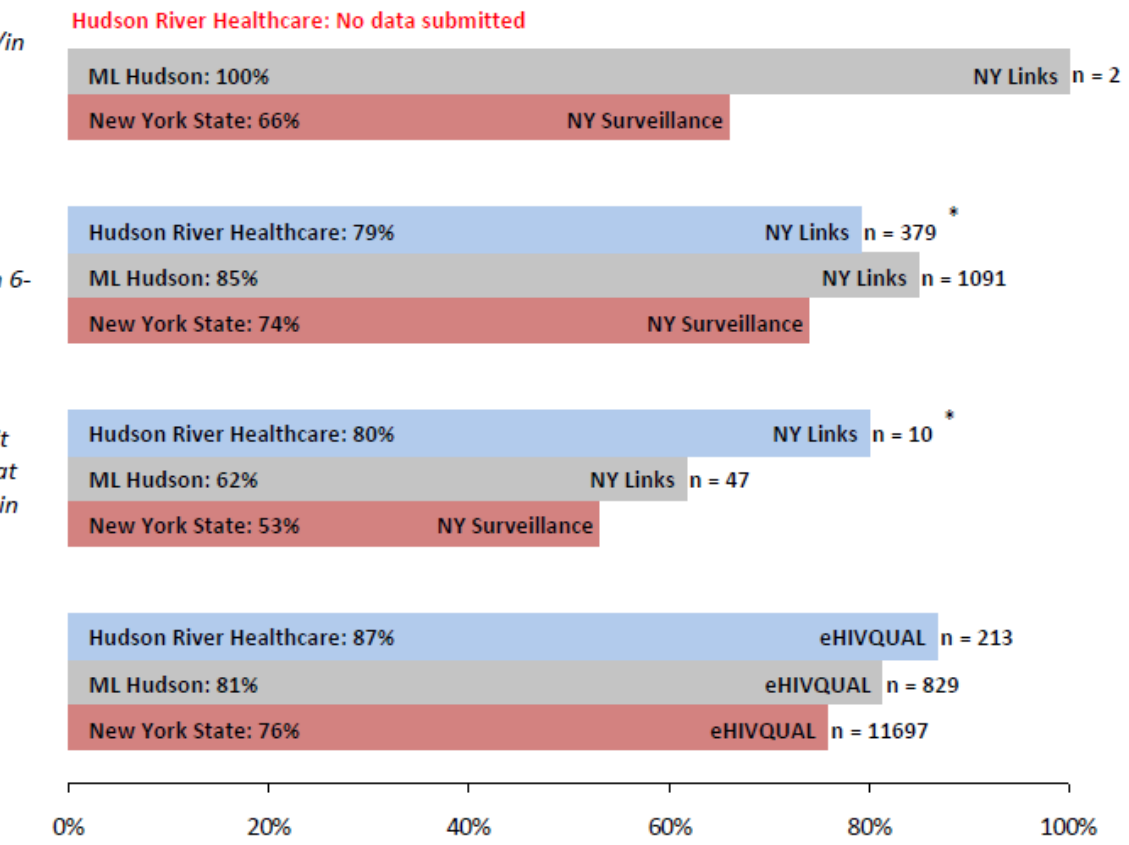
NYLinks Most Recent Report: 10/01/2015

Linkage
Patients newly diagnosed and linked w/in 30 days (Please refer to notes page)
(Apr 2015 - Sep 2015)

2 Year Retention
Patients with at least 1 HIV care visit between Jun 2013 - Mar 2014 and each 6-mo period of the following 18 months
(Jun 2013 - Mar 2014)

New Patient Retention
New patients with their 1st HIV care visit between Jun 2014 - Jan 2015 who had at least one visit in each 4-mo period within 12-mo of the first visit
(Jun 2014 - Jan 2015)

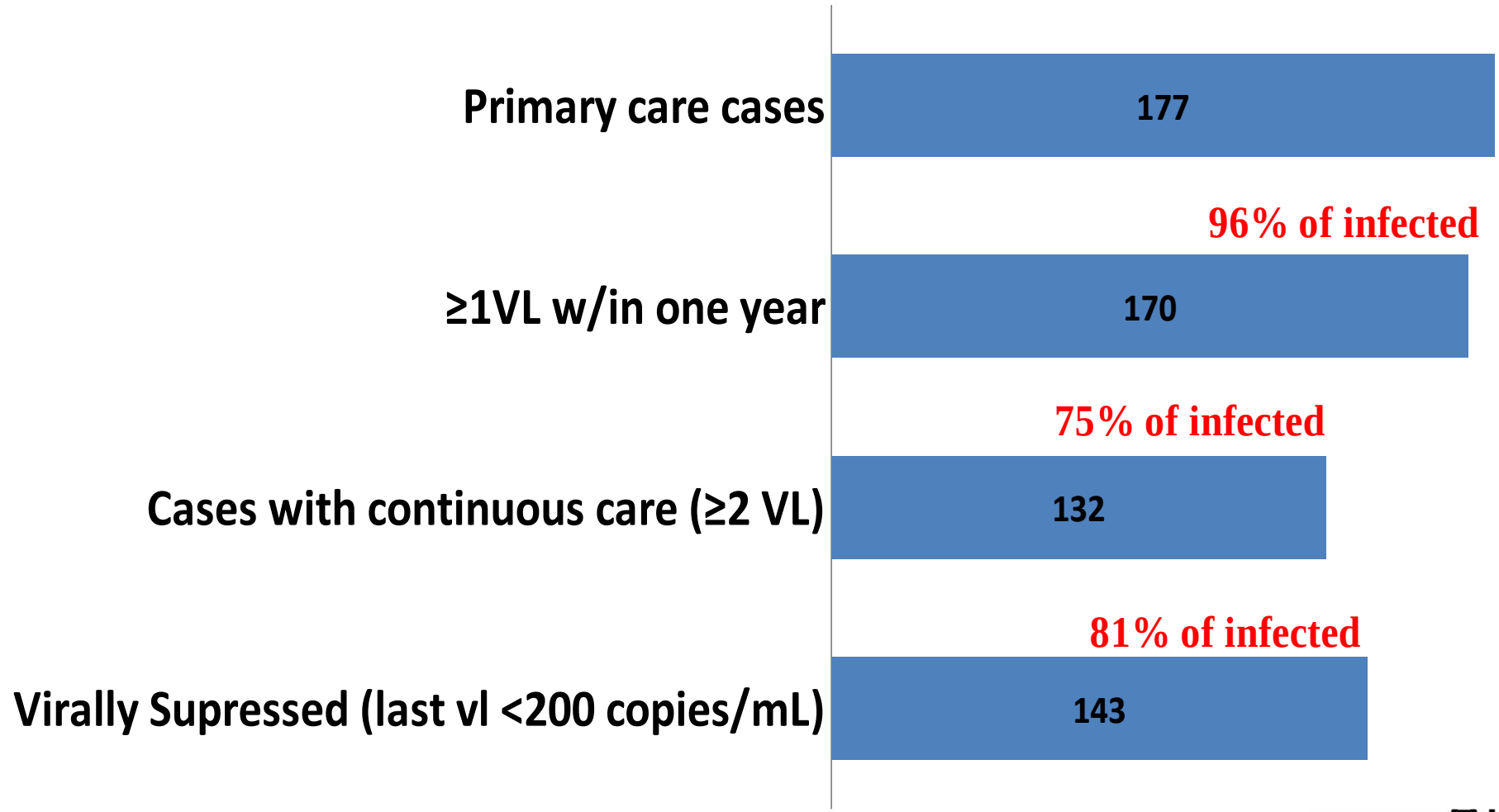
eHIVQUAL Viral Suppression
Percentage of patients who were suppressed at last HIV viral load test in 2013
(Jan-Dec 2013)



MISSING DATA:
* data submitted for only 1 of 3 period

n = number of eligible patients during review period

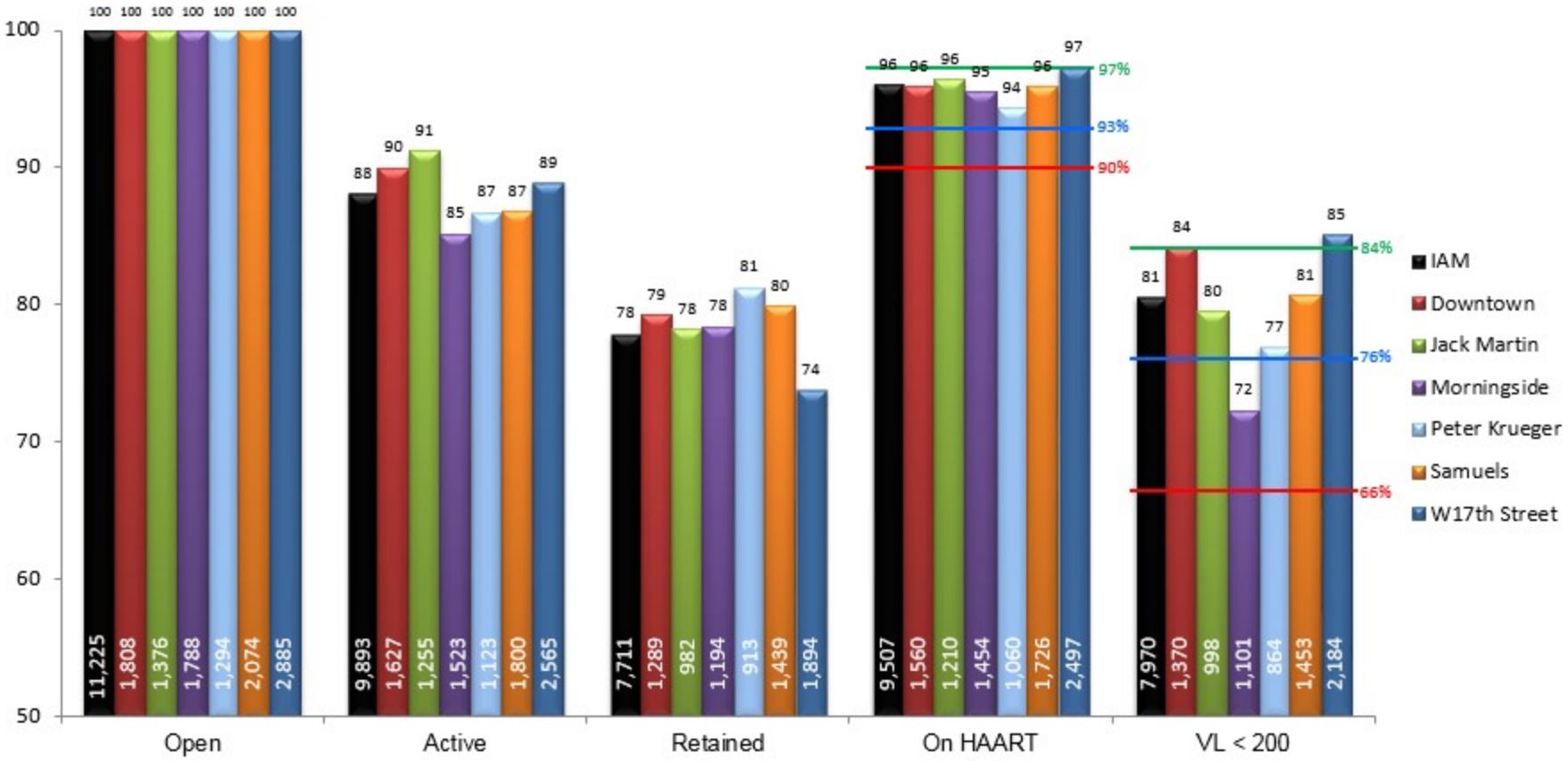
Jordan Health HIV Care Cascade*



*HIV care evaluated from August, 2014 to July, 2015

HIV CARE CASCADE 2014

INSTITUTE FOR ADVANCED MEDICINE



Mount Sinai *Institute for Advanced Medicine*

NYS 2013 eHIVQual Benchmarks:
- Top 25%
- Median
- Bottom 25%

Data Source: Calendar Year 2014 Epic + Climacs
Open: 1+ PC visits in past 24 months
Active: Open pts with 1+ PC visits in past 12 months
Retained: Active pts with 1+ PC visits in each half of past 12 months
On HAART: Active pts prescribed HAART anytime in past 12 months
VL <200: Active pts with last viral load in past 12 months below 200

Quality Management Organizational Assessment: The "Cascade Domain"

H. Ending the Epidemic Initiative

GOAL: To assess how the HIV program generates and uses facility level cascades to identify opportunities for improvement and develop data-driven improvement plans, to align initiatives, and to ensure that accurate and timely information about the care engagement and viral load suppression status of patients is available to all members of the facility so that they can effectively achieve both patient and public health outcomes as New York State accelerates its work to end the HIV epidemic.

The Ending the Epidemic section assesses how the program selects, gathers, analyzes and uses data based on the cascade of care to improve performance. This includes how cascade data are collected and used by leaders, staff and the quality program to improve outcomes along the cascade throughout the entire healthcare agency and to achieve program goals.

H.1. To what extent does the HIV program routinely generate and use facility level cascades to drive improvement and address gaps in care?

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Getting Started	0	☐ Facility does not report required rates of retention, treatment and viral load suppression.
Planning and initiation	1	Facility: ☐ Reports required rates of treatment, retention, and viral load suppression.
Beginning Implementation	2	Facility: ☐ Can annually construct a cascade that reports rates of retention, prescribed ART, and viral load suppression.
Implementation	3	Facility: ☐ Can conduct an analysis, based on its facility level cascade, to understand why patients do not meet expected outcomes and develop an intervention plan based on its analysis. ☐ Facility leaders, quality committee members, including providers and consumers, and facility staff use facility level cascade to develop and implement a quality improvement plan. ☐ Implements quality improvement plan, tracks the impact of interventions on facility level cascade rates, and responds to the results of QI projects. ☐ Involves community service agencies, including health homes, in process analysis and improvement plans to address linkage, engagement, re-engagement, and viral suppression. ☐ Makes its cascade visible to its internal stakeholders, and discusses it with its community advisory board.
Progress toward systematic approach to quality	4	Facility: ☐ Can measure whether or not HIV+ patients are linked to medical care when they engage with any unit of the facility (including, but not limited to emergency room and supportive services) and can identify the status of every HIV+ patient ever seen at the facility ☐ Can stratify data to identify potential disparities in care provided to sub-populations. ☐ Identifies patients who are lost to follow up and reaches out to its local health department or the State or other source to determine whether or not each patient has been engaged in care elsewhere.
Full systematic approach to quality management in place	5	Facility: ☐ Produces, at least annually, a full cascade that includes facility wide testing and linkage rates within the institution, including, but not limited to emergency departments, inpatient units and appropriate ambulatory care clinics ☐ Follows longitudinal cohorts of patients enrolled in care at the facility over a 24 month period to assess retention, treatment, and suppression.

Comments:

Communication

NY Links Website

home about ny links events measures and data webinars interventions resources

Welcome to NY Links

NY Links focuses on 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 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 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.

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

Dr. Bruce Agins leads a discussion at the January 23, 2013 Upper Manhattan Learning Session.

New York State Ending the Epidemic Initiative

On June 29, 2014, Governor Andrew M. Cuomo detailed a three-point plan to move us closer to the end of

Sign-in to database

Regional Group Listings

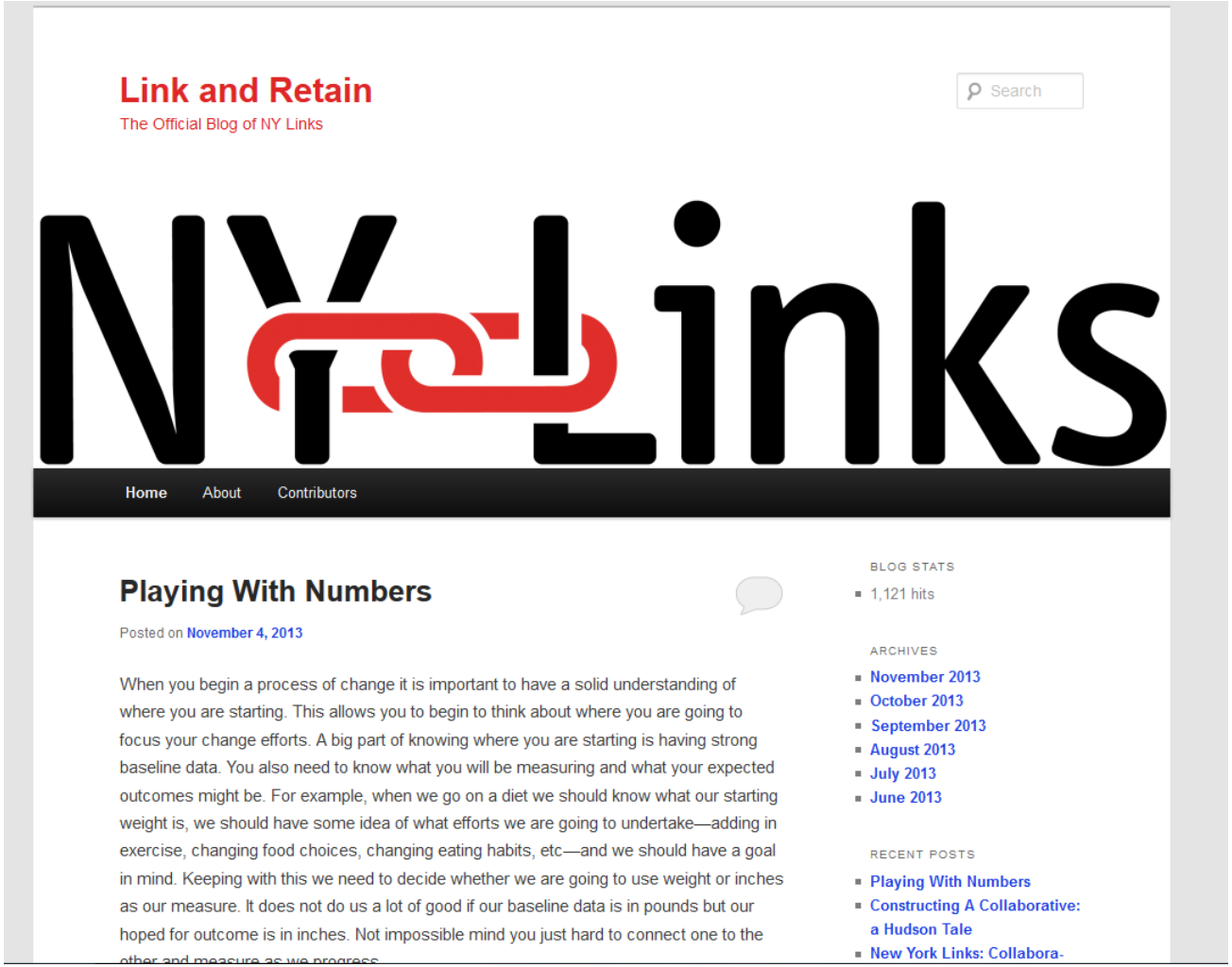
Long Island
Mid and Lower Hudson Valley
Queens
Upper Manhattan
Western New York

Have Questions?

Have any questions for us or NY Links? Feel free to contact us! Please put 'Help' in the subject line.
info@newyorklinks.org
212-417-4730

www.NewYorkLinks.org

Blog



NY Links

New York State Department of Health AIDS INSTITUTE

WEBINAR SERIES

Rotate through the following webinars on a quarterly basis:

- Introduction to NYLinks
- Introduction to Measures and Data
- Introduction to Interventions

Interspersed with:

- Reports from the Field
- Quality Improvement Work
- Peer Sharing

Successes & Way Forward

Shared Successes

Widespread use of QI to improve linkage, retention & VLS

Upper Manhattan sets regional goals (next slide)

Monrore County develops **McPEtE**: Plan to End the Epidemic

Family Services of Westchester uses VLS data to focus services

Jordan Health used LEAN tools to improve VLS for new patients

Monroe County (and others) develop Crisis Captain model

Multiple clinical providers network with CBOs to improve linkage to care

UMRG Goals

By the end of 2016

- Improve linkage to care from 76% to 81%
- Increase retention in care from 62% to 75%
- Improve new patient retention from 58% to 68%
- Increase the percentage of PLWHA who are virally suppressed from 71% to 81%
- Reduce disparities in outcomes and access to care fro priority communities in Upper Manhattan
  - Young MSM of color
  - Transgender
  - Individuals with Mental Health/Substance use issues
  - Women of Color

State-City Partnership

- New York Links -- New York Knows

New York Knows

NY Links

Ending The Epidemic

Ending the Epidemic

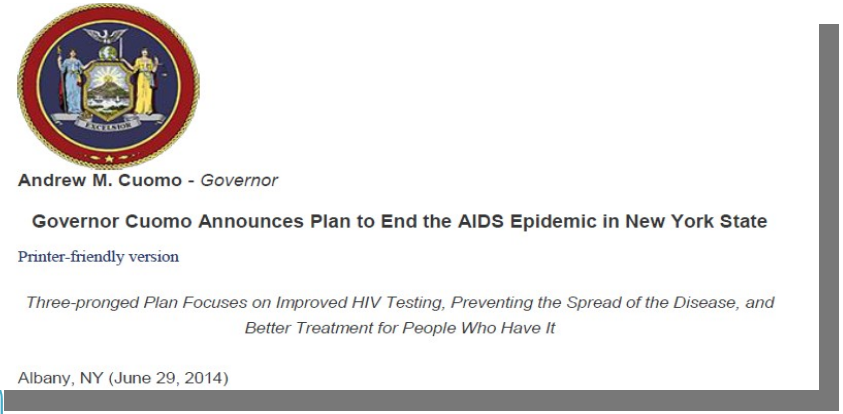
Defining the "End of AIDS"

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



Andrew M. Cuomo - *Governor*

Governor Cuomo Announces Plan to End the AIDS Epidemic in New York State

Printer-friendly version

Three-pronged Plan Focuses on Improved HIV Testing, Preventing the Spread of the Disease, and Better Treatment for People Who Have It

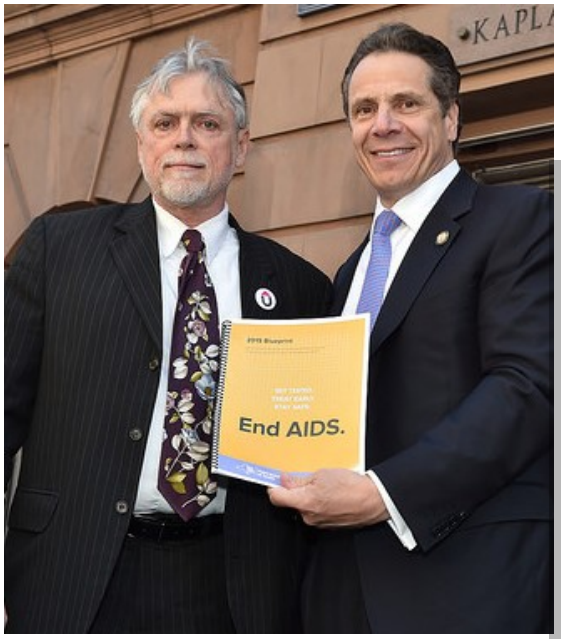
Albany, NY (June 29, 2014)

Reduce the number of new HIV infections to just 750 [from an estimated 3,000] by 2020

NY-Links

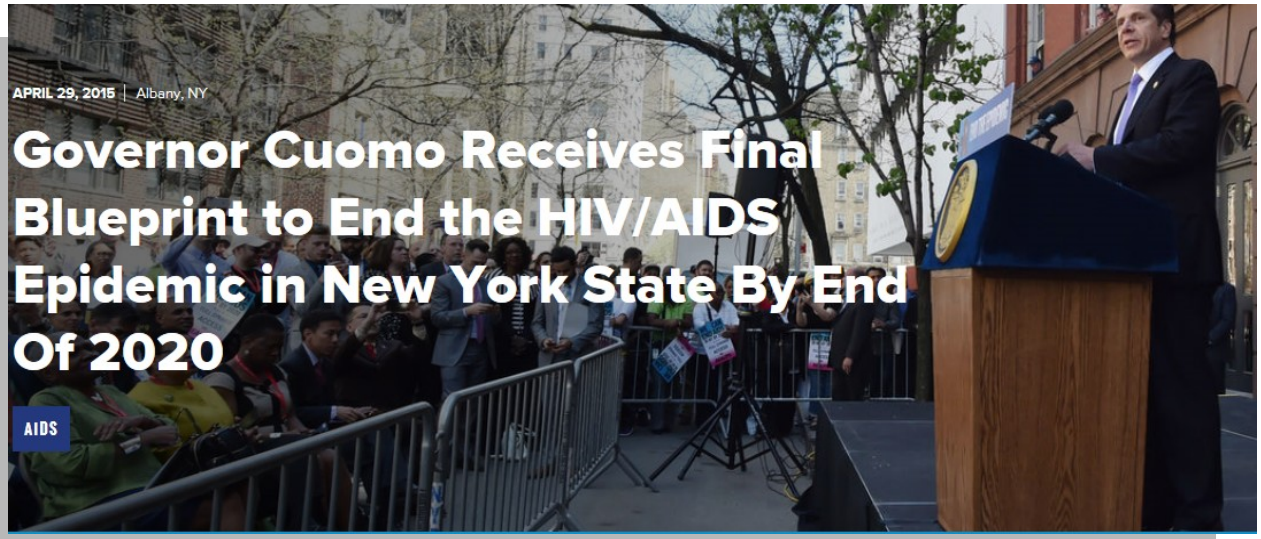
NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Release of the Blueprint



April 29, 2015

We must add AIDS to the list of diseases conquered by our society, and today we are saying we can, we must and we will end this epidemic. ~Governor Cuomo



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