#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
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.
NY Links Overview
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

WNYS collaborative begins
June 2012

% of new patients retained

Measurement period

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

- Standardized linkage processes systemically
  - internal, external & Clients
- Electronic Notation of new fields

Intervention:
- Development of partnerships
- Universal agreement on 30 day linkage
- Extending Services beyond traditional PS

Legend:
- OLQ
- June & July 2012
- Aug. & Sept.
- Oct. & Nov.
- Dec. & Jan. 2013
- Feb. & Mar.
- April & May
- June & July
- Aug. & Sept.
- Oct. & Nov.
Continuum of Care
Data processes improved through stakeholder collaboration

<table>
<thead>
<tr>
<th>Facility</th>
<th>NYLinks</th>
<th>Ryan White Region</th>
<th>NYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓Better ability to interpret &amp; understand data</td>
<td>✓Improve HIV care outcomes through stakeholder collaboration</td>
<td>✓Data-driven HIV care</td>
<td>✓Few new infections by end of the decade</td>
</tr>
<tr>
<td>✓Identification of gaps in care</td>
<td>✓Improve local ability to understand &amp; interpret data</td>
<td>✓Improve HIV care outcomes</td>
<td>✓Promote data-driven HIV care</td>
</tr>
<tr>
<td>✓Increase data-driven HIV care</td>
<td>✓Collaboratively created data packages</td>
<td>✓Regional HIV Cascades</td>
<td>✓Statewide HIV care Cascades</td>
</tr>
</tbody>
</table>
New York State Cascade of HIV Care, 2013
Persons Residing in NYS† at End of 2013

87% of infected
67% of infected
77% of PLWDHI
58% of infected
66% of PLWDHI
55% of infected
63% of PLWDHI
82% 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 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.
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)

**Hudson River Healthcare: No data submitted**

**ML Hudson: 100%**  
**New York State: 66%**

**NY Links n = 2**  
NY Surveillance

**Hudson River Healthcare: 79%**  
**ML Hudson: 85%**  
**New York State: 74%**

**NY Links n = 379**

**Hudson River Healthcare: 80%**  
**ML Hudson: 62%**  
**New York State: 53%**

**NY Links n = 47**

**Hudson River Healthcare: 87%**  
**ML Hudson: 81%**  
**New York State: 76%**

**eHIVQUAL n = 213**

**eHIVQUAL n = 829**

**eHIVQUAL n = 11697**

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

n - number of eligible patients during review period
Jordan Health HIV Care Cascade*

- **Primary care cases**: 177
  - 96% of infected

- **≥1VL w/in one year**: 170
  - 75% of infected

- **Cases with continuous care (≥2 VL)**: 132
  - 81% of infected

- **Virally Suppressed (last vl <200 copies/mL)**: 143

*HIV care evaluated from August, 2014 to July, 2015*
HIV CARE CASCADE 2014
INSTITUTE FOR ADVANCED MEDICINE

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

Data Source: Calendar Year 2014 Epic + Climas
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.I. To what extent does the HIV program routinely generate and use facility level cascades to drive improvement and address gaps in care?

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>Facility does not report required rates of retention, treatment and viral load suppression.</th>
</tr>
</thead>
</table>
| Planning and initiation | 1 | Facility:  
| Reports required rates of treatment, retention, and viral load suppression. |
| 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:**
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 Agnis 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...
Playing With Numbers

Posted on November 4, 2013

When you begin a process of change it is important to have a solid understanding of where you are starting. This allows you to begin to think about where you are going to focus your change efforts. A big part of knowing where you are starting is having strong baseline data. You also need to know what you will be measuring and what your expected outcomes might be. For example, when we go on a diet we should know what our starting weight is, we should have some idea of what efforts we are going to undertake—adding in exercise, changing food choices, changing eating habits, etc.—and we should have a goal in mind. Keeping with this we need to decide whether we are going to use weight or inches as our measure. It does not do us a lot of good if our baseline data is in pounds but our hoped for outcome is in inches. Not impossible mind you just hard to connect one to the other and measure as we progress.
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 for 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
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.

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