Callen-Lorde Community Health Center

HIV Treatment Cascades and Quality Improvement Plan

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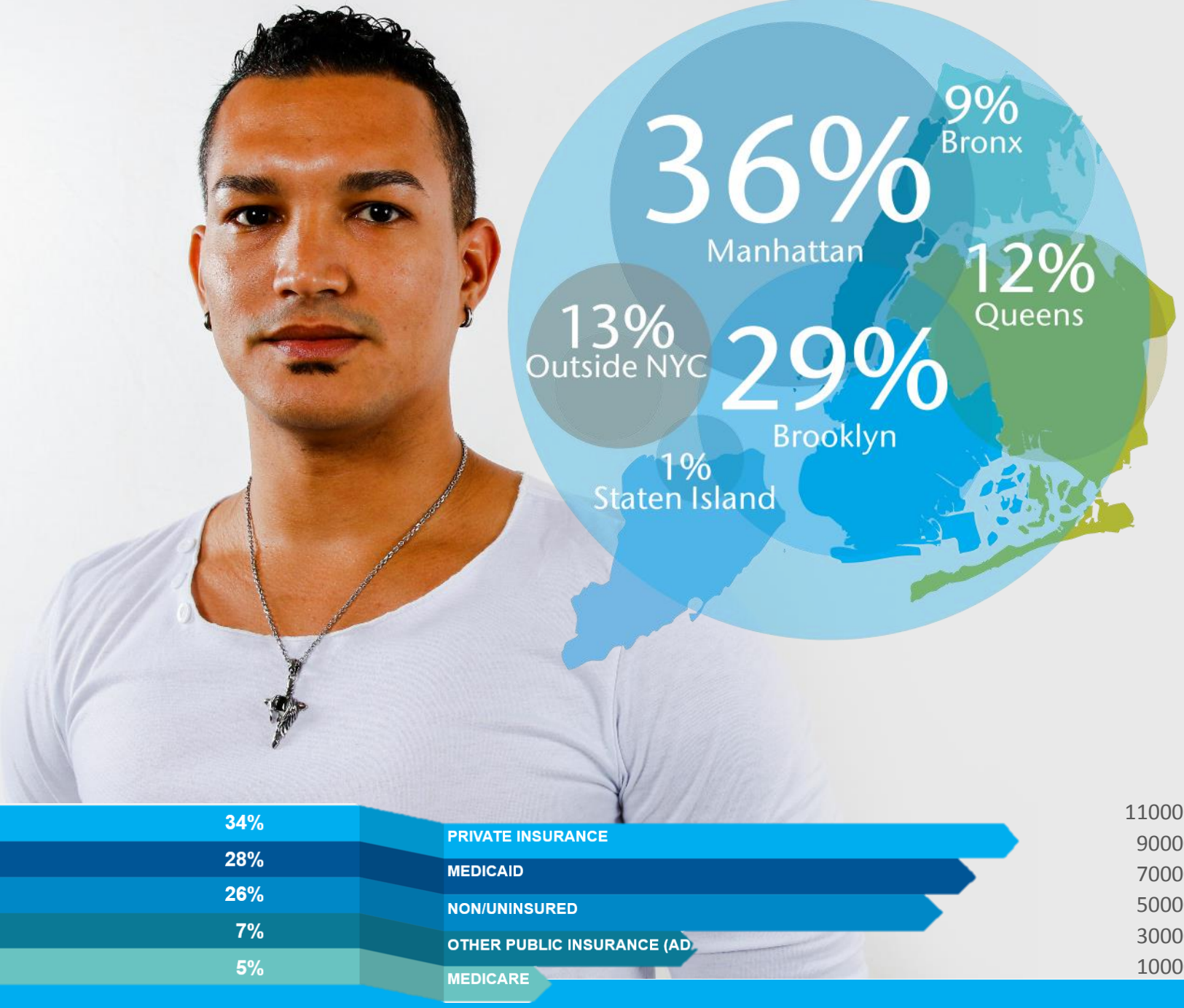
CALLEN LORDE
COMMUNITY HEALTH CENTER

ABOUT US

Services	Patients	Visits
▪ **Primary Medical Services**	14,974	53,488
▪ **Mental Health Services**	2,742	25,815
▪ **Dental Services**	2,389	9,093
▪ **HIV Specialty Care**	4,165	19,269
▪ **Enabling Services** (Including Care Coordination and Health Education)	6,921	15,654

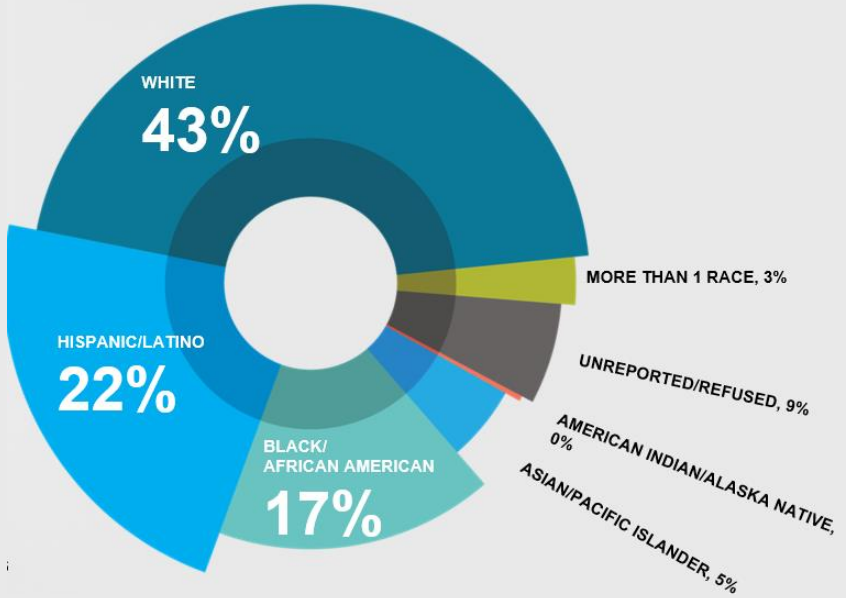
OUR MISSION

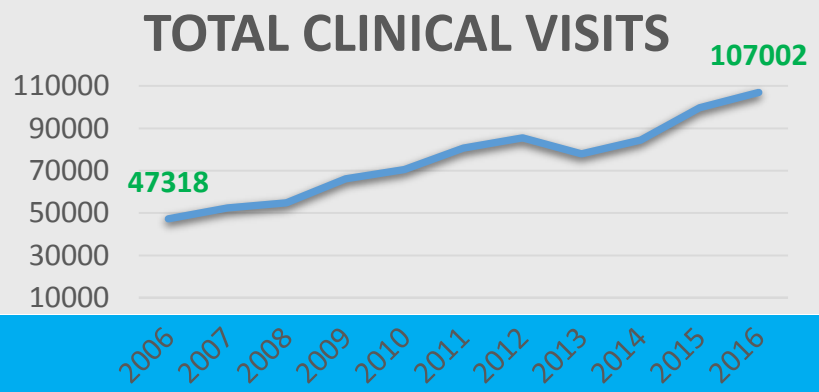
Callen-Lorde Community Health Center provides sensitive, quality health care and related services targeted to New York's lesbian, gay, bisexual, and transgender communities — in all their diversity — regardless of ability to pay. To further this mission, Callen-Lorde promotes health education and wellness,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



Where are we:

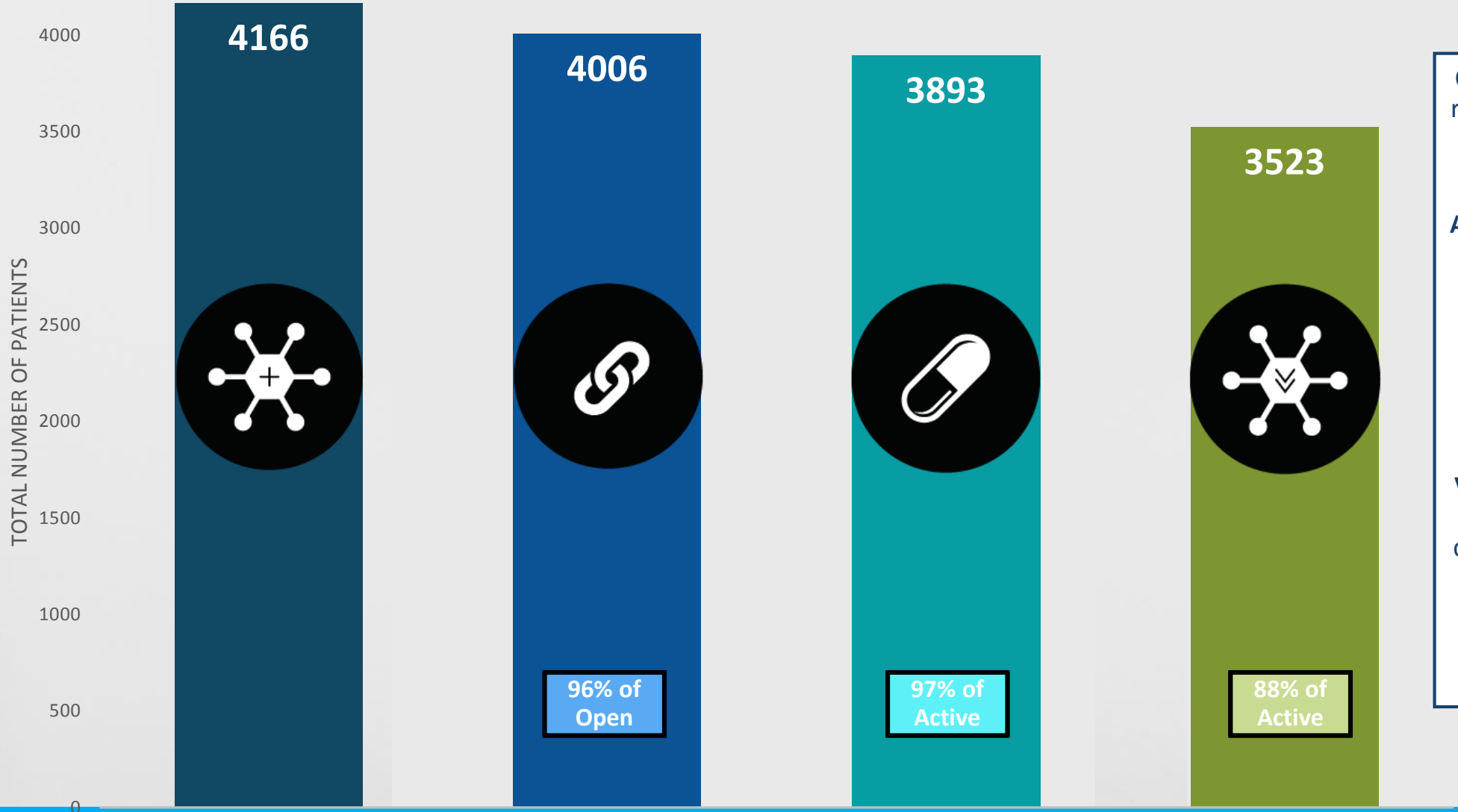
- Callen-Lorde 18th Street
- Thea Spyer Center at Callen-Lorde 17th Street
- Callen-Lorde Bronx
- COMING SOON : Callen-Lorde Brooklyn





HIV Treatment Cascades

Callen-Lorde Community Health Center
2016 HIV Treatment Cascade [By End of 2016]



Open - # of Pts living with HIV who received services from Callen-Lorde during 2016

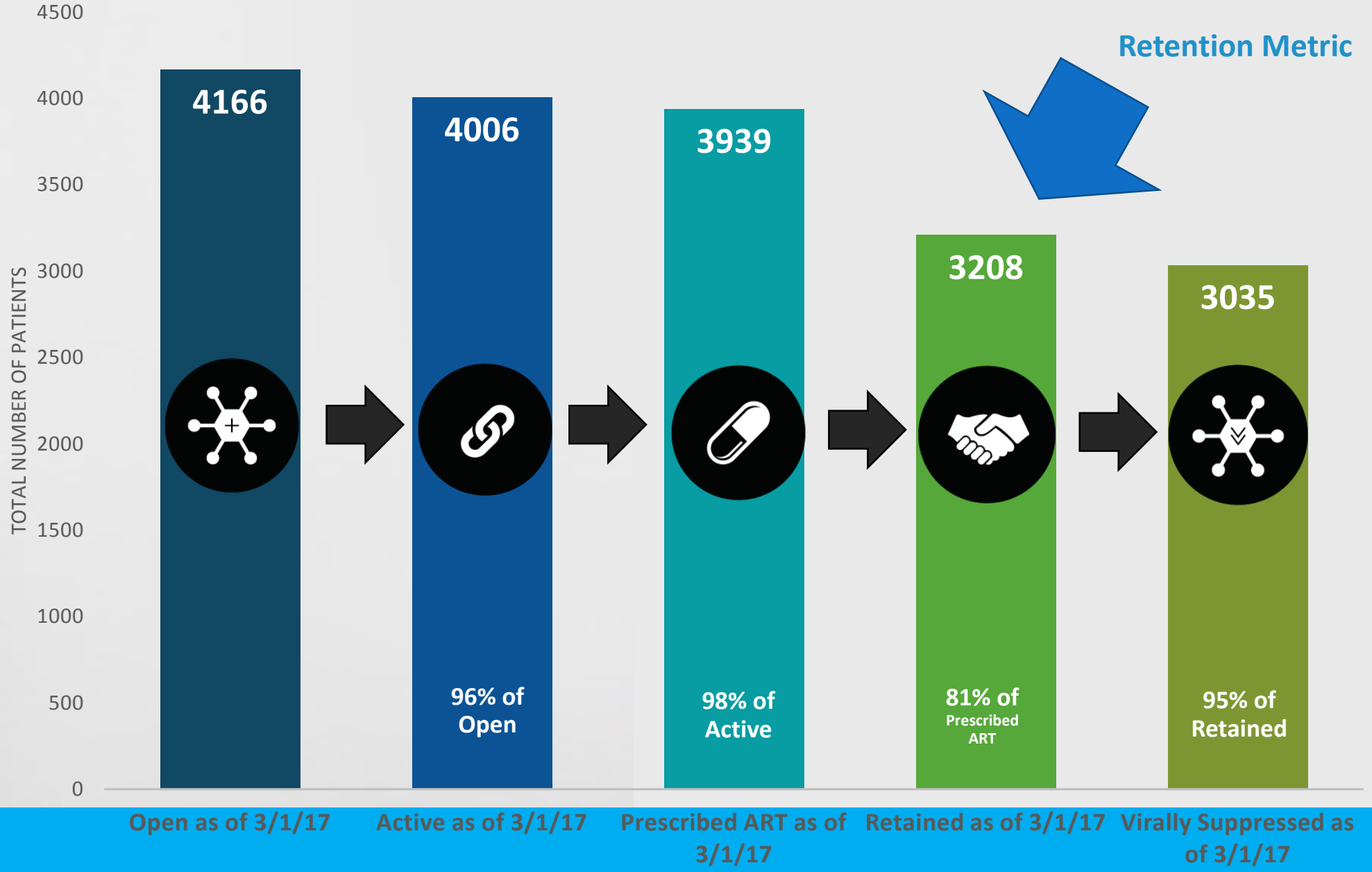
Active - # of Open Pts who received HIV Primary Care services from Callen-Lorde during 2016

Prescribed ART - # of Active Pts prescribed ART during 2016

Virally Suppressed - # of Active Pts with a HIV viral load less than 200 copies/mL at last HIV viral load test of 2016

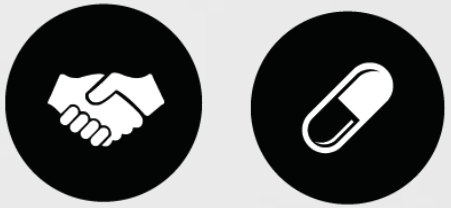
[Source: Callen-Lorde Community Health Center's electronic health records]

Callen-Lorde Community Health Center
Live Cohort Cascade through March 2017

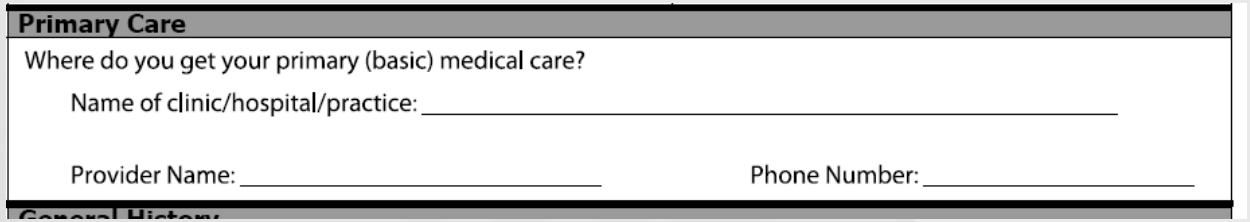


HIV Treatment Cascade Interventions Targeting Retention

Same Day Linkage and Rapid Treatment Initiation for Newly Diagnosed Patients



Enhanced Collection of External PCP Status



Population Health's Viral Load Suppression Project

Open access Model for Patients that the Traditional Model doesn't Work

Quality Improvement Plan

What are we trying to accomplish?

- Promoting primary care to all Callen-Lorde patients
  - All “Open” HIV+ patients are engaged in HIV care

How will we know that this change is an improvement?

- Patients not getting primary care at Callen-Lorde will have external provider details documented
  - HIV+ patients not getting primary care at Callen-Lorde will have external provider details documented including provider assessment of engagement in HIV care

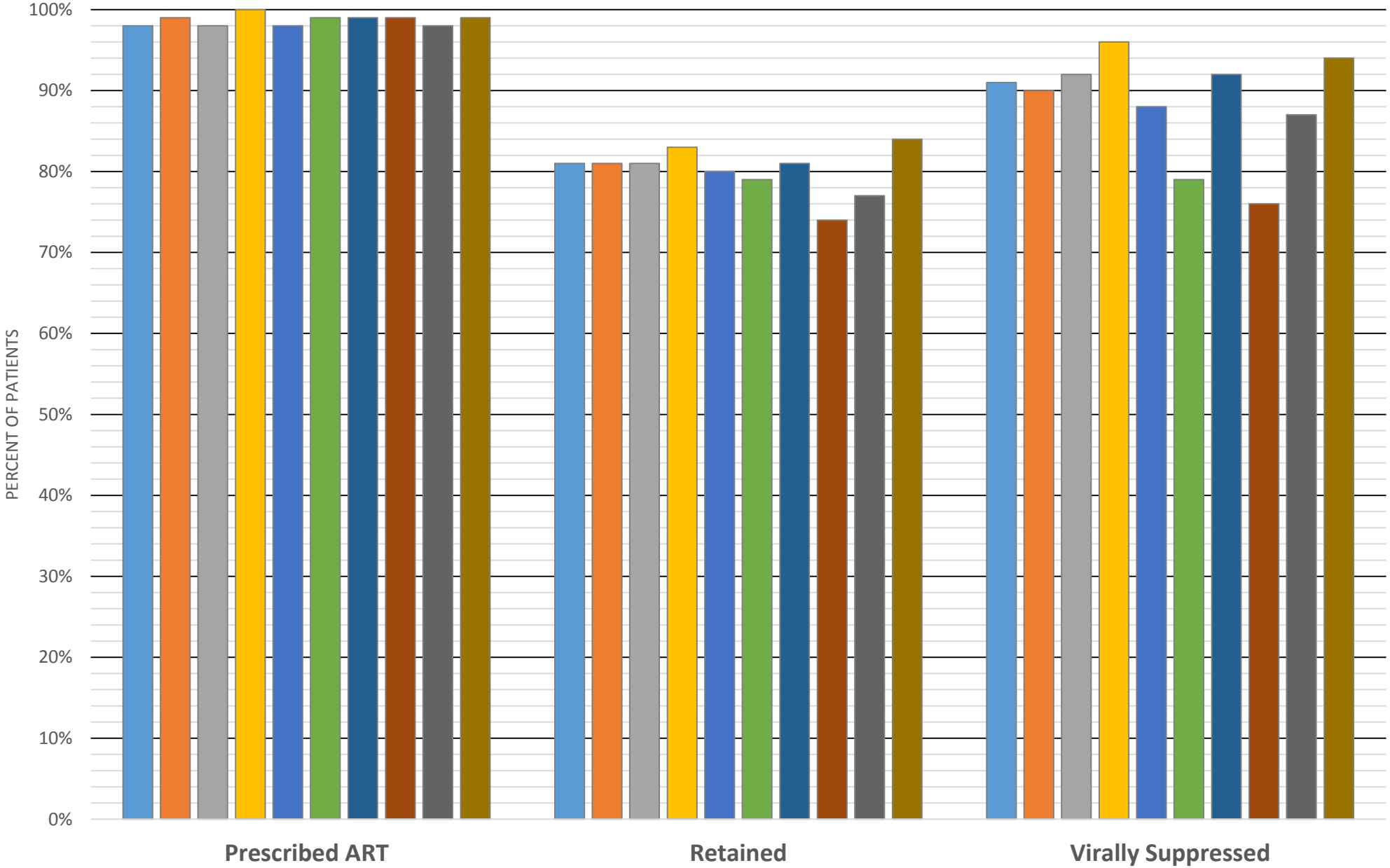
What changes can result in an improvement?

- At initial registration and at annual reregistration, all patients will complete medical history form including details of primary care provider
  - For HIV+ patients provider will address engagement in HIV care
- Through structured data, we will be able to report how many patients not getting primary care at Callen-Lorde have external primary care provider
  - Through chart review, we will be able to report how many HIV+ patients seen at Callen-Lorde in any department for any reason are engaged in HIV care (whether internally or externally)
  - When patients are not engaged in HIV care, we will engage them

HIV Treatment Cascades Subgroup Analysis

Callen-Lorde Community Health Center

2016 HIV Treatment Cascade by Population

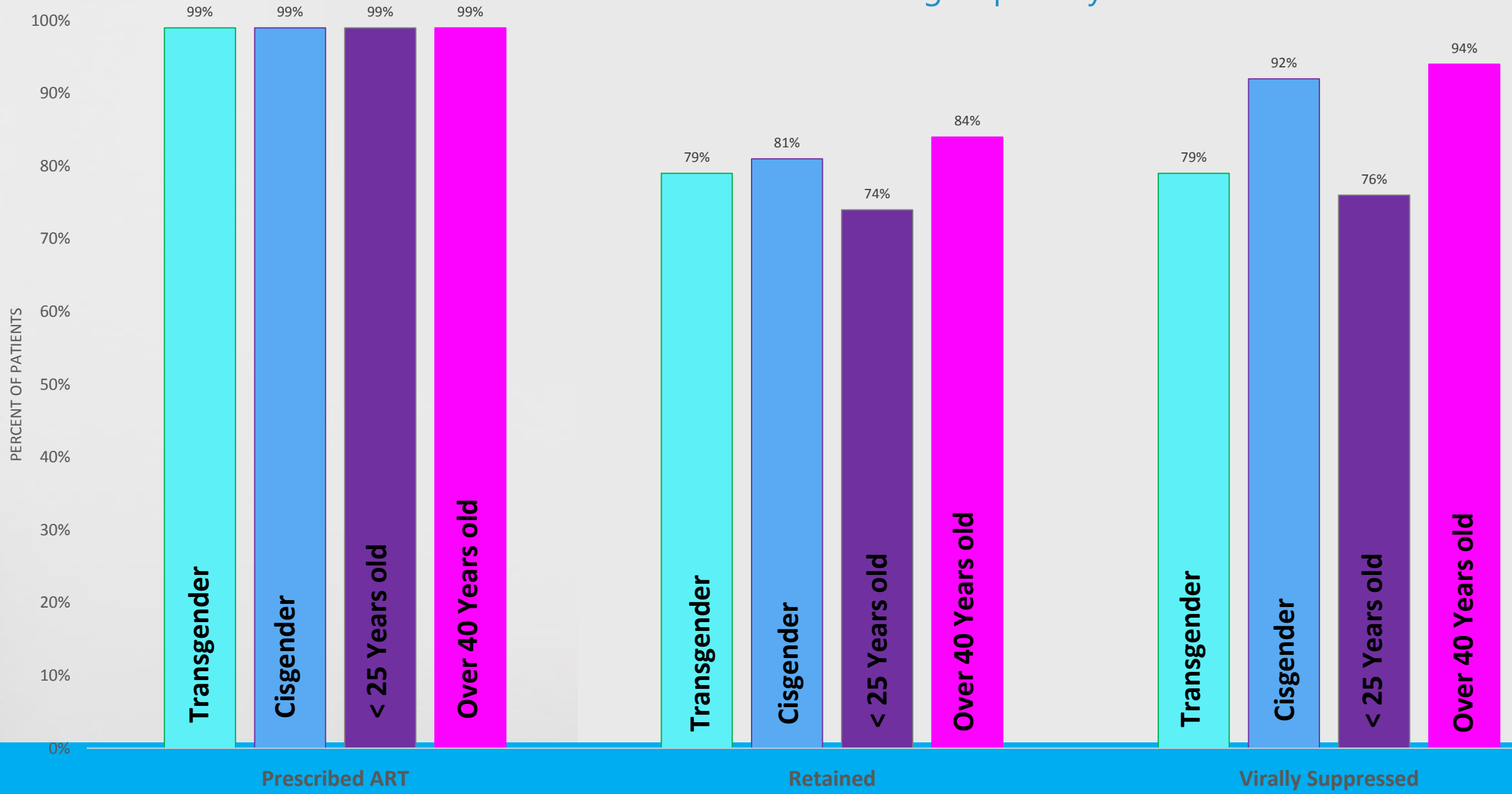


- All
- Hispanic/Latino [n=1139]
- Not Hispanic/Latino [n=2049]
- White [n=946]
- Black [n=819]
- TGNC [n=357]
- Cisgender [n=3648]
- Younger than 25 [n=133]
- Aged 25-39 [n=1718]
- Aged 40 & Over [n=2153]

[The following percentages of patients declined to give the following information:
18% Race
20% Ethnicity]

Callen-Lorde Community Health Center

2016 HIV Treatment Cascade Subgroup Analysis



HIV Sub Analysis Treatment Cascade Interventions for targeted subgroups to improve retention AND Viral Suppression

Open access Model for Patients that the Traditional Model doesn't Work

Population Health's Outreach and Engagement Project to Connect Patients to Care Coordination Programs

DSRIP "Undetectables" Incentive Program for Youth and Patients of Trans Experience

Questions?

Thank You

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CALLEN LORDE
COMMUNITY HEALTH CENTER

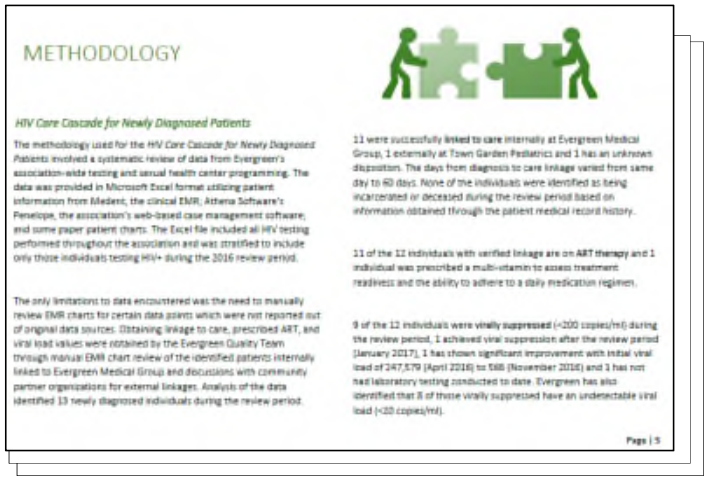
Evergreen Health

NYS DOH Clinical Advisory Committee – 6/15/17

Building the 2016 HIV Care Cascades

- Newly Diagnosed Patients
  - Methodology
  - 2016 Cascade
- Established Patients
  - Methodology
  - 2016 Cascade
- Improvement Plans
- Utilization of Care Cascades
- Current Improvement Initiatives

Methodology (Newly Diagnosed)



METHODOLOGY

HIV Care Cascade for Newly Diagnosed Patients

The methodology used for the *HIV Care Cascade for Newly Diagnosed Patients* involved a systematic review of data from Evergreen's association-wide testing and sexual health center programming. The data was provided in Microsoft Excel format utilizing patient information from Medent, the clinical EMR; Athena Software's Penelope, the association's web-based case management software; and some paper patient charts. The Excel file included all HIV testing performed throughout the association and was stratified to include only those individuals testing HIV+ during the 2016 review period.

The only limitations to data encountered was the need to manually review EMR charts for certain data points which were not reported out of original data sources. Obtaining linkage to care, prescribed ART, and viral load values were obtained by the Evergreen Quality Team through manual EMR chart review of the identified patients internally linked to Evergreen Medical Group and discussions with community partner organizations for external linkages. Analysis of the data identified 13 newly diagnosed individuals during the review period.

11 were successfully linked to care internally at Evergreen Medical Group, 1 externally at Town Garden Pediatrics and 1 has an unknown disposition. The days from diagnosis to care linkage varied from same day to 60 days. None of the individuals were identified as being incarcerated or deceased during the review period based on information obtained through the patient medical record history.

11 of the 12 individuals with verified linkage are on ART therapy and 1 individual was prescribed a multi-vitamin to assess treatment readiness and the ability to adhere to a daily medication regimen.

9 of the 12 individuals were virally suppressed (<200 copies/ml) during the review period, 1 achieved viral suppression after the review period (January 2017), 1 has shown significant improvement with initial viral load of 247,579 (April 2016) to 586 (November 2016) and 1 has not had laboratory testing conducted to date. Evergreen has also identified that 8 of those virally suppressed have an undetectable viral load (<20 copies/ml).

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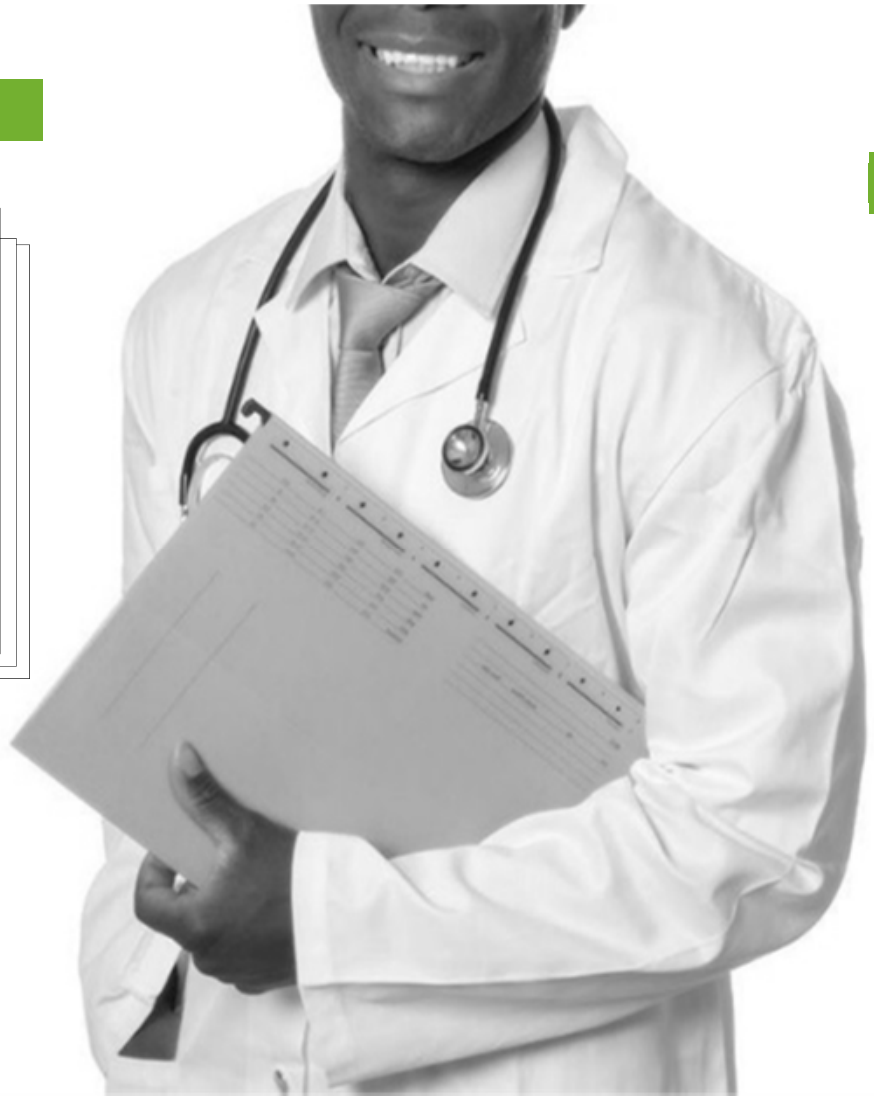
Data Review

Multiple systems used to store testing data

- Excel workbook tracked all the testing and new positive rapid tests
- Medent, Penelope and paper charts
- Compared positive patients to obtain data points



Limitations

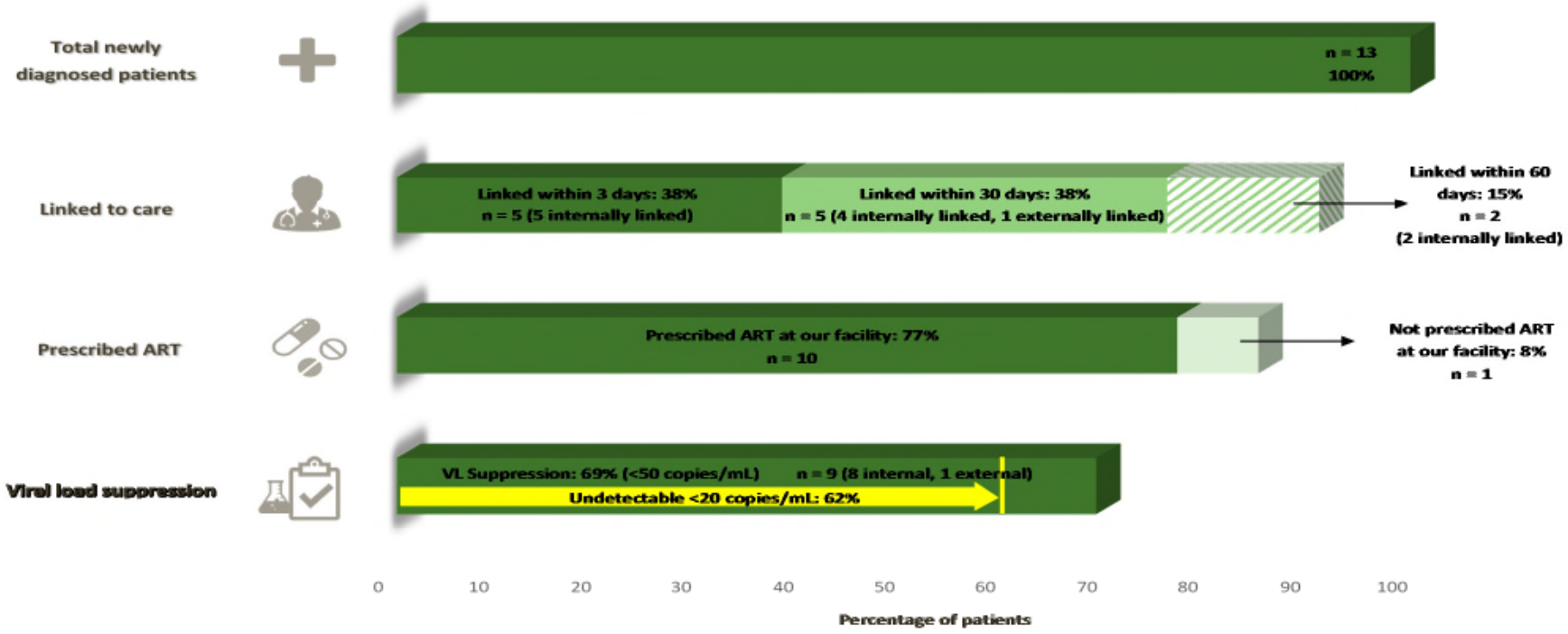
Manual chart review of data

New Measure of Linkage to Care change

NY Links = 30 days

eHIVQUAL = 3-5 days

HIV Care Cascade for Newly Diagnosed Patients (2016)



Total newly diagnosed patients: Number of patients newly diagnosed with HIV in the last 12 months

Linked to care: Number of newly diagnosed patients with 1 HIV medical visit within 3 days of diagnosis if internally linked, 5 days if externally linked

Prescribed ART: Number of newly diagnosed patients prescribed ART (11/13)

Viral Load suppression <200: Number of newly diagnosed patients with viral load <200 copies/mL (9/13)

Data Source: EMR (Medent)

Data Review

EMR reporting from Medent (EMR)

Differentiate between
- Active/Inactive
- Open to Active

Obtain
- ART prescription
- Viral Load results

Methodology (Established Patients)

HIV Care Cascade for Established Patients

The methodology used for the *HIV Care Cascade, Established Patients* involved a systematic review of data obtained through direct EMR reporting and manual chart reviews primarily from Medent, the clinical EMR. This included active/inactive Evergreen Medical Group patients, testing and sexual health program data and medical case management services provided to individuals that did not engage in HIV care during the review period.

Limitations of the data sources

- The EMR reporting has its own limitations that need to be addressed through the vendor and Evergreen staff (not all VL testing was properly included, thus requiring manual review; addition of new HIV medications is needed for report accuracy; etc.).
- The intake, workflow and documentation processes are being revised to centralize and more accurately capture and update patient statuses to include deceased and incarcerated.
- Mental Health/CADAS programming has substantially added staff members and evolved in 2016-2017 moving from paper charts to Penelope and finally to the EMR. As a result, we were unable to include these patients in this review through an automated process.
- The Evergreen Association provides a wide-array of supportive and wrap-around services. There are at least 7 additional software/database systems utilized outside of Medent and Penelope. Since the launch of the new EMR (7/2016), Information Systems has been in development of a data warehouse, striving to bring together these disparate systems. The data warehouse and business intelligence software will yield much faster, comprehensive, uniform and accurate data across the organization. At this point of development, limitations of reporting across the entire organization are recognized.

- Approximately 1,330 unique HIV+ individuals have been identified as receiving some service in 2016 resulting in 460 HIV+ individuals that could potentially be included in this review. However, due to the complexity of systems described above, the non-clinical nature of the programs, and inconsistency of required data points, it is prohibitive to include them in this review.

With the above limitations considered, a comparative review of the EMR's HIV+ patient panel report from 1/1/16 and the report from 12/31/16 was conducted by the Evergreen Quality Team. This established the criteria of how the **open and active caseloads were differentiated**. 20 individuals were identified as appearing on the January report but not the December report. The Evergreen Quality team investigated disposition of these 20 individuals through manual EMR chart review of the identified patients linked to Evergreen Health and discussions with community partner organizations for external linkages. It was determined that of the 20 individuals, 12 had an unknown care status, 3 received only specialty Anoscopy services at Evergreen – with HIV care provided at other organizations, 1 transferred care and 1 was incarcerated. No HIV+ patients from this review were identified as deceased in 2016.

Obtaining those who were prescribed ART, and viral load values were determined primarily through EMR reporting and some manual chart reviews. The review showed only 4% of the entire HIV+ patient panel were not **receiving ART** (81% non-progressors, 10% contemplating treatment, 25% voluntarily refused treatment and 28% did not follow-up to begin treatment).

83% of the entire HIV+ patient panel was virally **suppressed** (<200 copies/ml), and of those, 78% were undetectable (<20 copies/ml).

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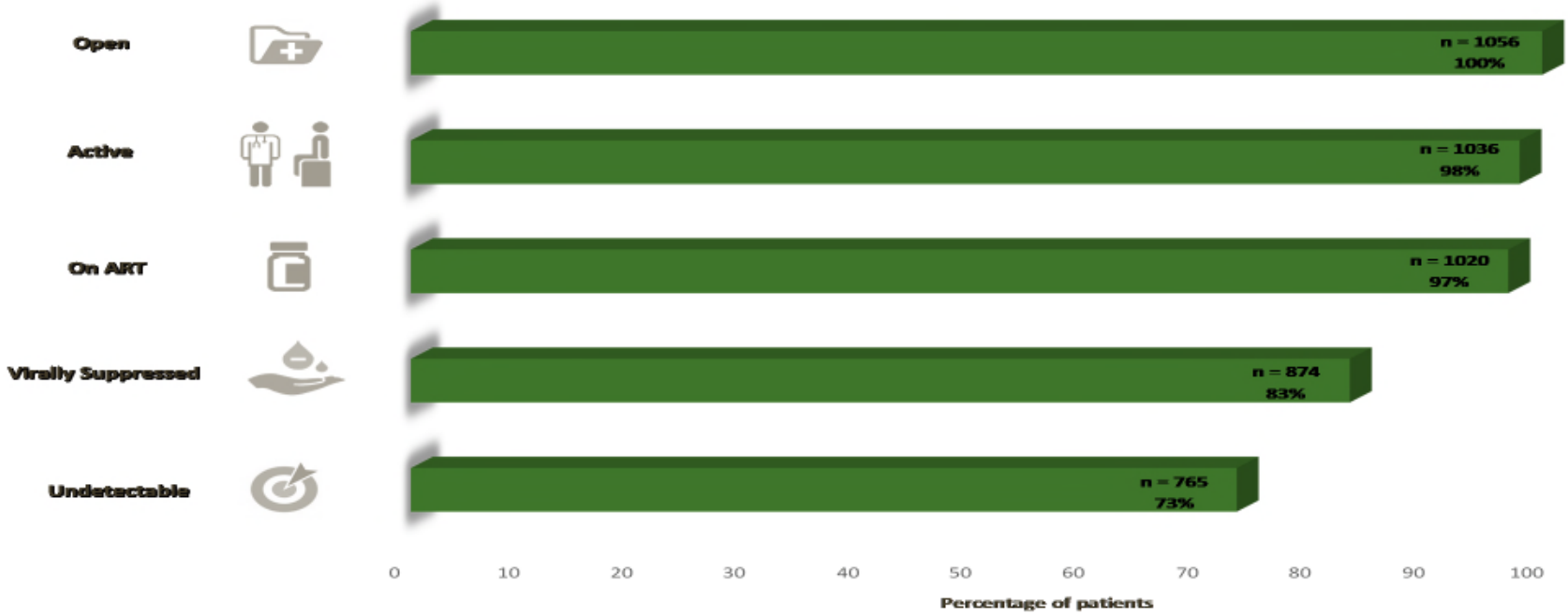
Limitations

- No agency wide systems beyond medical care and testing
- Manual chart review for medications and viral load

HIV Care Cascade for Established Patients (2016)



Open: All HIV+ pts with any visit in the last 12 months

Active: Number of HIV+ pts with a HIV medical visit in the last 12 months (1,036/1,056)

On ART: Number of patients with ART prescription from open caseload (1,020/1,048)

Virally Suppressed: Number of patients with Viral Load <200 copies/mL from open caseload (874/1,048)

Undetectable: Number of patients with Viral Load <20 copies/mL from open caseload (765/1,048)

Data Source: EMR (Medent)

Improvement Plan

IMPROVEMENT PLAN

HIV Care Cascade for Newly Diagnosed Patients

A review of the HIV Care Cascade for Newly Diagnosed Patients shows strong performance in prescription of ART (85%) and achievement of viral load suppression (69%). The viral suppression measure could actually be reported higher (77%) taking into account the individual achieving viral suppression after the review period. Although 93% were linked to care, only 58% were linked (internally) within the 3 day measurement goal. This appears to be the most apparent area for improvement.

Improvement Goal 1

Improve new HIV diagnosis to care linkage within 3 days from 58% to 78%. An increase of 40%-may seem ambitious, but looking at actual patient numbers brings this into perspective. Analyzing Evergreen's data over the past five years reveals that there is an average of 23 new HIV+ diagnosis annually. Utilizing the 2016 data, the 40% increase would result in approximately 5 additional patients being linked to care – an additional 11 based on the 5-year average. Although aggressive, we feel the goal is realistic and attainable.

ACTION STEPS/TASKS	COORDINATION/LEAD RESPONSIBLE PARTIES	TIMELINE
Working with the leaders of Testing, Medical Services, Patient Adherence (RAP) and Medical Case Management, the Quality team will coordinate a discussion, detailing (who, what, when, where, how), moving towards development and implementation of a newly HIV+ diagnosed process model to ensure timely association/wide communication of all reactive tests and linkage activities.	AVP of Quality Director of Quality AVP of Administration AVP of Clinical Services Director of Patient Adherence	3rd Quarter 2017
Immediately inform and involve the Medical Director, Retention and Adherence Program Team (RAP), Medical Case Management, and Data Reporting Specialist surrounding all newly diagnosed individuals tested/diagnosed anywhere within the organization.	Director of Testing Director of Patient Adherence AVP of Administration (MOM)	Upon Completion of Process Model Same day of a reactive test
A RAP Team member(s) and/or medical case manager will be available to assist in patient education, barrier assessments, scheduling linkage appointments, retention/adherence needs and peer support.	Director of Patient Adherence AVP of Administration (MOM)	Upon Completion of Process Model Within 1 days of reactive test

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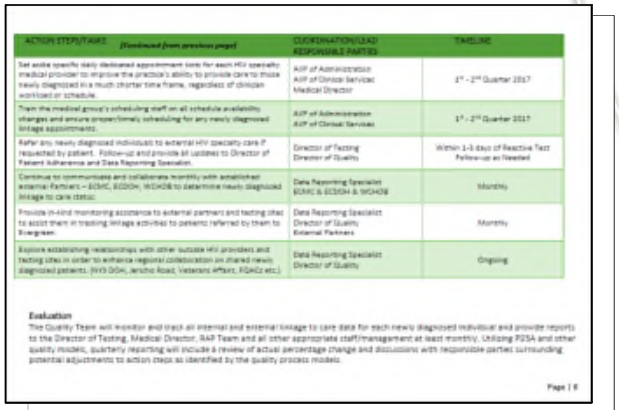

ACTION STEPS/TASKS *(Continued from previous page)*	COORDINATION/LEAD RESPONSIBLE PARTIES	TIMELINE
Set aside specific daily dedicated appointment slots for each HIV specialty medical provider to improve the practice's ability to provide care to those newly diagnosed in a much shorter time frame, regardless of clinician workload or schedule.	AVP of Administration AVP of Clinical Services Medical Director	1st - 2nd Quarter 2017
Train the medical group's scheduling staff on all schedule availability changes and ensure proper/timely scheduling for any newly diagnosed linkage appointments.	AVP of Administration AVP of Clinical Services	1st - 2nd Quarter 2017
Refer any newly diagnosed individuals to external HIV specialty care if requested by patient. Follow-up and provide all updates to Director of Patient Adherence and Data Reporting Specialist.	Director of Testing Director of Quality	Within 1-3 days of Reactive Test Follow-up as Needed
Continue to communicate and collaborate monthly with established external Partners – ECMC, ECDOH, WCHOMB to determine newly diagnosed linkage to care status.	Data Reporting Specialist ECMC & ECDOH & WCHOB	Monthly
Provide in-kind monitoring assistance to external partners and testing sites to assist them in tracking linkage activities to patients referred by them to Evergreen.	Data Reporting Specialist Director of Quality External Partners	Monthly
Explore establishing relationships with other outside HIV providers and testing sites in order to enhance regional collaboration on shared newly diagnosed patients. (VVS DOH, Jericho Road, Veterans Affairs, FQHCs etc.)	Data Reporting Specialist Director of Quality	Ongoing

Evaluation

The Quality Team will monitor and track all internal and external linkage to care data for each newly diagnosed individual and provide reports to the Director of Testing, Medical Director, RAP Team and all other appropriate staff/management at least monthly. Utilizing PDSA and other quality models, quarterly reporting will include a review of actual percentage change and discussions with responsible parties surrounding potential adjustments to action steps as identified by the quality process models.

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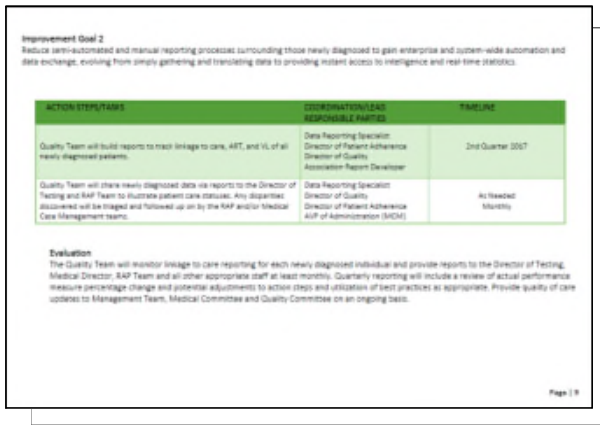

Improvement Goal 2

Reduce semi-automated and manual reporting processes surrounding those newly diagnosed to gain enterprise and system-wide automation and data exchange, evolving from simply gathering and translating data to providing instant access to intelligence and real-time statistics.

ACTION STEPS/TASKS	COORDINATION/LEAD RESPONSIBLE PARTIES	TIMELINE
Quality Team will build reports to track linkage to care, ART, and VL of all newly diagnosed patients.	Data Reporting Specialist Director of Patient Adherence Director of Quality Association Report Developer	2nd Quarter 2017
Quality Team will share newly diagnosed data via reports to the Director of Testing and RAP Team to illustrate patient care statuses. Any disparities discovered will be triaged and followed up on by the RAP and/or Medical Case Management teams.	Data Reporting Specialist Director of Quality Director of Patient Adherence AVP of Administration (MOM)	As Needed Monthly

Evaluation

The Quality Team will monitor linkage to care reporting for each newly diagnosed individual and provide reports to the Director of Testing, Medical Director, RAP Team and all other appropriate staff at least monthly. Quarterly reporting will include a review of actual performance measure percentage change and potential adjustments to action steps and utilization of best practices as appropriate. Provide quality of care updates to Management Team, Medical Committee and Quality Committee on an ongoing basis.

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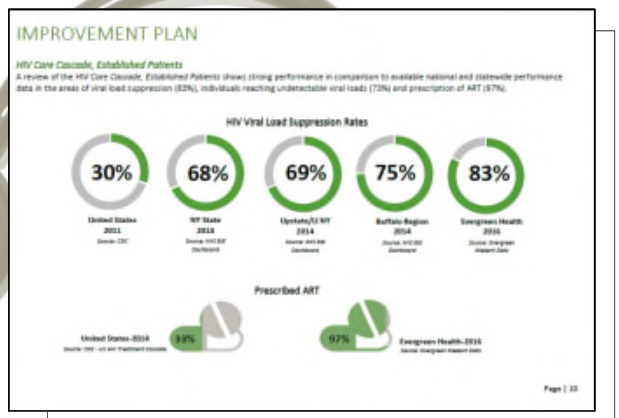

IMPROVEMENT PLAN

HIV Care Cascade, Established Patients

A review of the HIV Care Cascade, Established Patients shows strong performance in comparison to available national and statewide performance data in the areas of viral load suppression (83%), individuals reaching undetectable viral loads (73%) and prescription of ART (97%).

HIV Viral Load Suppression Rates

Prescribed ART

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Improvement Plan (Newly Diagnosed)

Goal 1:

- Improve newly diagnosed linkage to care.
  - Meet new 3-5 day standard
  - Increase from 38% to 78%
  - Utilize multidisciplinary team approach

Goal 2:

- Improve data tracking and reporting systems.
  - All testing tracked within EMR
  - Notification of Newly Diagnosed to appropriate staff

Improvement Plan (Established Patients)

Goal 1:

- Improve automated data surrounding Open vs. Active caseloads, ART, and Viral Load results.
  - Expand data marts
  - Establish data warehouse

Goal 2:

- Maintain high percentage of patients on ART.

Goal 3:

- Improve viral suppression rates.
  - Increase from 83% to 88%
  - Expand notification of cascade/VL throughout association

Utilization of Care Cascades & Improvement Plans

- Communication of Cascades
- Consumer Partnership/Co-Production
- Clinical Commitment

Current Improvement Initiatives

- Improved intake and data collection process
- Established new positive communication process
- Data drill-down of unsuppressed patients, shared info with RAP/LRTA and clinicians
- Direct Observed Therapy intervention pilot (5 patients)
  - Prelimiary three months data – all five show significant improvement
    One reached viral suppression. Two achieved undetectable VL
    Overall improved quality of life (reduced substance use, reduced anxiety, improved hygiene, and clean stable housing)

Evergreen Health

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Questions

Stony Brook Medicine

Stony Brook Children's

Stony Brook Medicine: Organizational HIV Treatment Cascade

DAC Quality Manager - Cristina Witzke, MPH
Director of SBM DAC - Jack Fuhrer, MD
Director of Peds/Adolescent HIV – Sharon Nachman, MD

Suffolk County

Newly Diagnosed Patient Cascade

Data Collection

- Report Request: *"Patients tested for HIV within the health system"*
  - Patient Name
  - Patient MRN
  - Patient Demographics: race, ethnicity, age, etc
  - Testing Setting: Inpatient, Outpatient, Emergency Room
  - HIV 1/2 Ab/Ag Test Results
  - Differentiation HIV 1 Results
  - Differentiation HIV 2 Results

Data Limitations

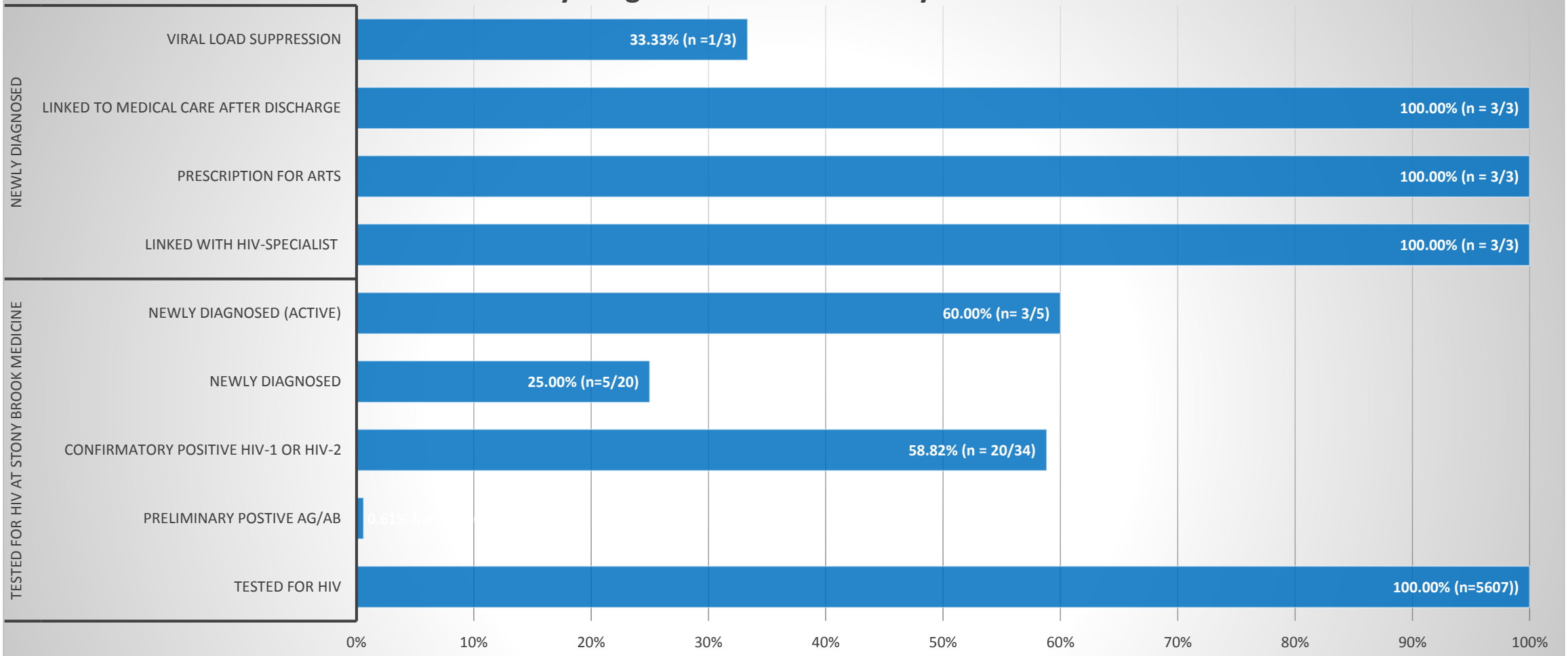
- Not all laboratories are electronically entered into the EMR system (reported are scanned in)
- Data does not capture those on different EMR system (affiliated hospitals, clinics, Stony Brook Dental Clinic, Long Island State Veterans Home)

Newly Diagnosed Patient Report

Report Example

MRN	Test Name	Result	Differentiation HIV - 1	Differentiation HIV - 2	Encounter Type	Date	Gender	Race	Ethnicity	Age
1	HIV 1 /2 Ag/Ab	Non-Reactive			Outpatient	08/1/16	Male	White	Non-Hispanic	42.08
2	HIV 1 /2 Ag/Ab	Reactive	Non-Reactive	Non-Reactive	Inpatient	01/19/16	Female	Black	Non-Hispanic	24.88
3	HIV 1 /2 Ag/Ab	Reactive	Reactive	Non-Reactive	Emergency	11/22/16	Male	White	Hispanic	54.70

2016 Newly Diagnosed Cascade: Stony Brook Medicine



Patients Tested For HIV: Patients seen at SBM (ambulatory, in-patient, outpatient) who received an HIV Test.
Preliminary Positive Ag/Ab: Patients with a reactive HIV Ag/Ab test / Patients tested for HIV
Confirmatory Positive for HIV-1 or HIV-2: Patients with a reactive result for HIV-1 or HIV-2/ Patients with a reactive HIV Ag/Ab test
Newly Diagnosed: Patients newly diagnosed with a HIV / Patients with a reactive result for HIV-1 or HIV-2
Newly Diagnosed Active: Patients newly diagnosed (not deceased after test results)/ Patients newly diagnosed with a HIV
Newly Diagnosed- Linked with HIV-specialist: Patients Newly Diagnosed Active, within 3 days and under the care of an HIV-specailist / Patients Newly Diagnosed Active
Newly Diagnosed- Prescription for ARTs: Patients Newly Diagnosed Active and prescribed ARTs / Patients Newly Diagnosed Active
Newly Diagnosed Viral Load Suppression: Patients Newly Diagnosed Active with a HIV Viral Load less than 200 copies/mL at last HIV vitral load test during 2016/ Patients Newly Diagnosed Active

Stony Brook Medicine

Stony Brook Children's

Improvement Plan: Newly Diagnosed

Goal: Our program proposes to maintain prompt linkage to care and prescriptions for ARTs at >95% of newly diagnosed patients identified throughout SBM. In addition, suppressed viral loads achieved for all those newly diagnosed who are linked internally to SBM.

Action Steps:

- Provide in-service trainings to ensure all staff are aware of proper protocols for diagnosing, linking, and treating newly diagnosed patients. As well as updates to the HIV Testing Law.

Measurement:

- Number of patients tested for HIV
- Number of patients newly diagnosed
- Number of patients linked with an HIV-specialist
- Number of patients prescribed ARTs
- Number of patients with a suppressed viral load

Time: January 2017 – December 2017

Evaluation: Analyze 2017 data and compare to 2016.

Stony Brook Medicine

Stony Brook Children's

Establish Patient Cascade – Open

Data Collection

- Working with Department of Biomedical Informatics
- Population Health System extracts data from different EMR systems
- Data Report included for each patient
  - Patient Demographics: race, ethnicity, age, etc
  - Medical Visit Dates
  - Medical Visit Setting
  - Medical Visit Physician
  - Viral Load Dates and Results
  - ART Specific Medications
  - STI Test Dates and Results

Data Limitations

- Data does not include SBM Dental Clinic, Long Island State Veterans Home, Southampton Hospital's David E. Roger's HIV Center, or Eastern Long Island Hospital.
- Patient data is incomplete and cannot be verified by staff (HIV status, race, gender identities other than male/female, transmission risk)
- Data still must be reviewed and drilled down by staff

Analysis

- Reviewed data removing patients not seen in 2016, HIV exposed children, HIV negative patients.

Establish Patient Cascade - Active

Data Collection

- Spreadsheet of all patients who receive HIV primary care at SBM.
  - Patient Demographics: race, ethnicity, age, etc
  - Patient Insurance
  - Patient Status (newly dx, continuing patient, transferred in, transferred out, pregnant, incarcerated, deceased, etc)
  - HIV Medical Visit Dates by quarter
  - Viral Load Dates and Results by quarter
  - ART Medication Status
  - STI Test Dates and Results

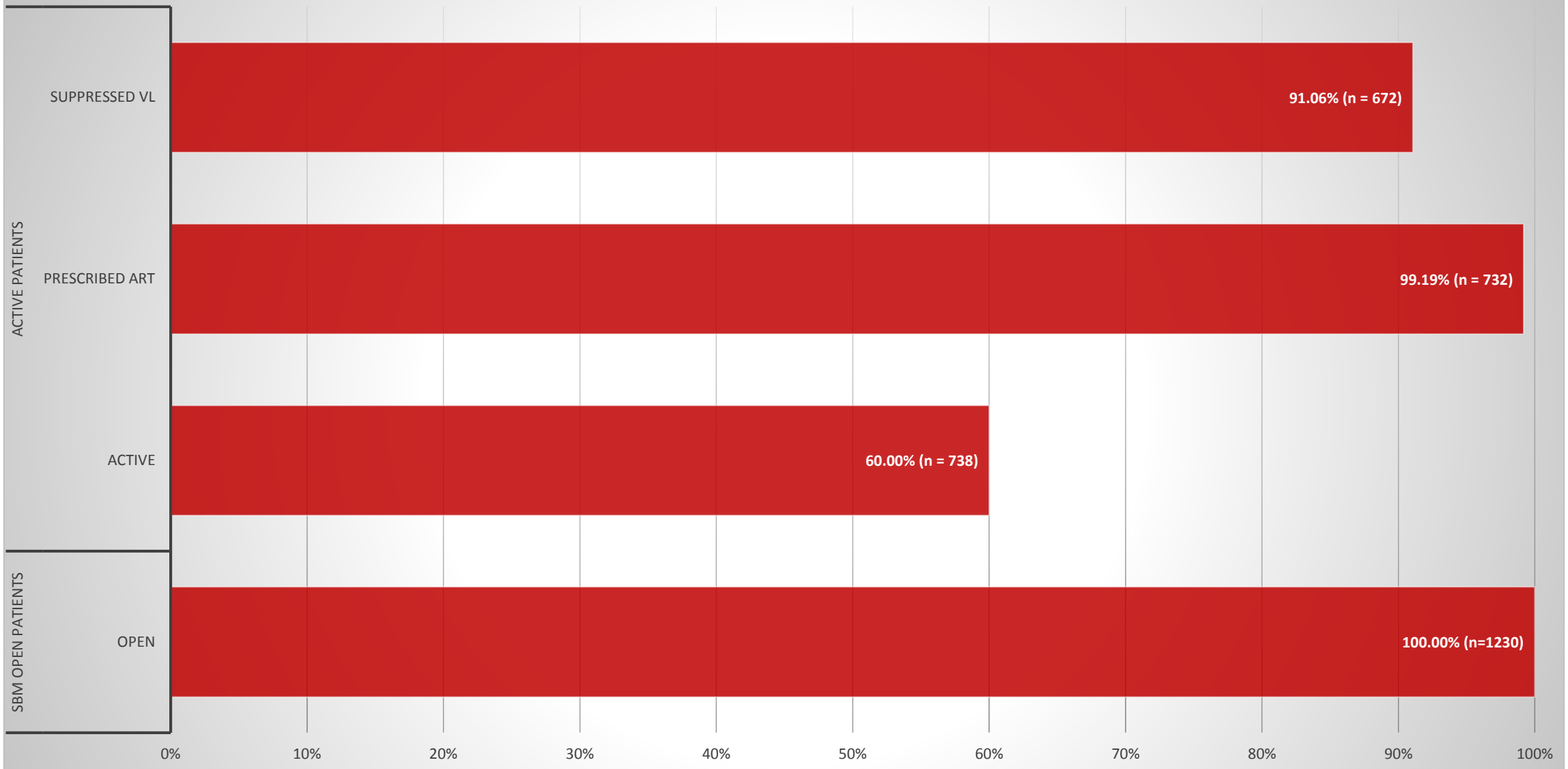
Data Limitations

- Collecting data is time consuming

Analysis

- Used excel and CDC Program “EpiInfo”

2016 HIV Care Cascade: Stony Brook Medicine



SBM Open Patients: Patients with a known diagnosis of HIV who received services in the SBM organization during 2016.
Active Patients: Patients with a known HIV diagnosis who received services in the HIV Program at SBM during 2016/Open Patients
Prescribed ART: Patients prescribed ART during the measurement year/ Active Patients
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV viral load test during 2016 / Active Patients

Improvement Plan: SBM Patients

Goal: To maintain a viral load suppression rate of Active SBM patients in 2017 of >90%.

Action Steps:

- Refer patients to SBM's Linkage Treatment Adherence and Retention (LRTA) Program
- Refer patients to Chronic Disease Self-Management Program (CDSMP) classes facilitated by SBM HIV staff and/or Peers.
- Refer patients to Peer Program for individual HIV support from Peers.

Measurement:

$$\frac{\text{Number of patients with a Viral Load < 200 copies/mL at last viral load in 2017}}{\text{Number of Active Patients in 2017}}$$

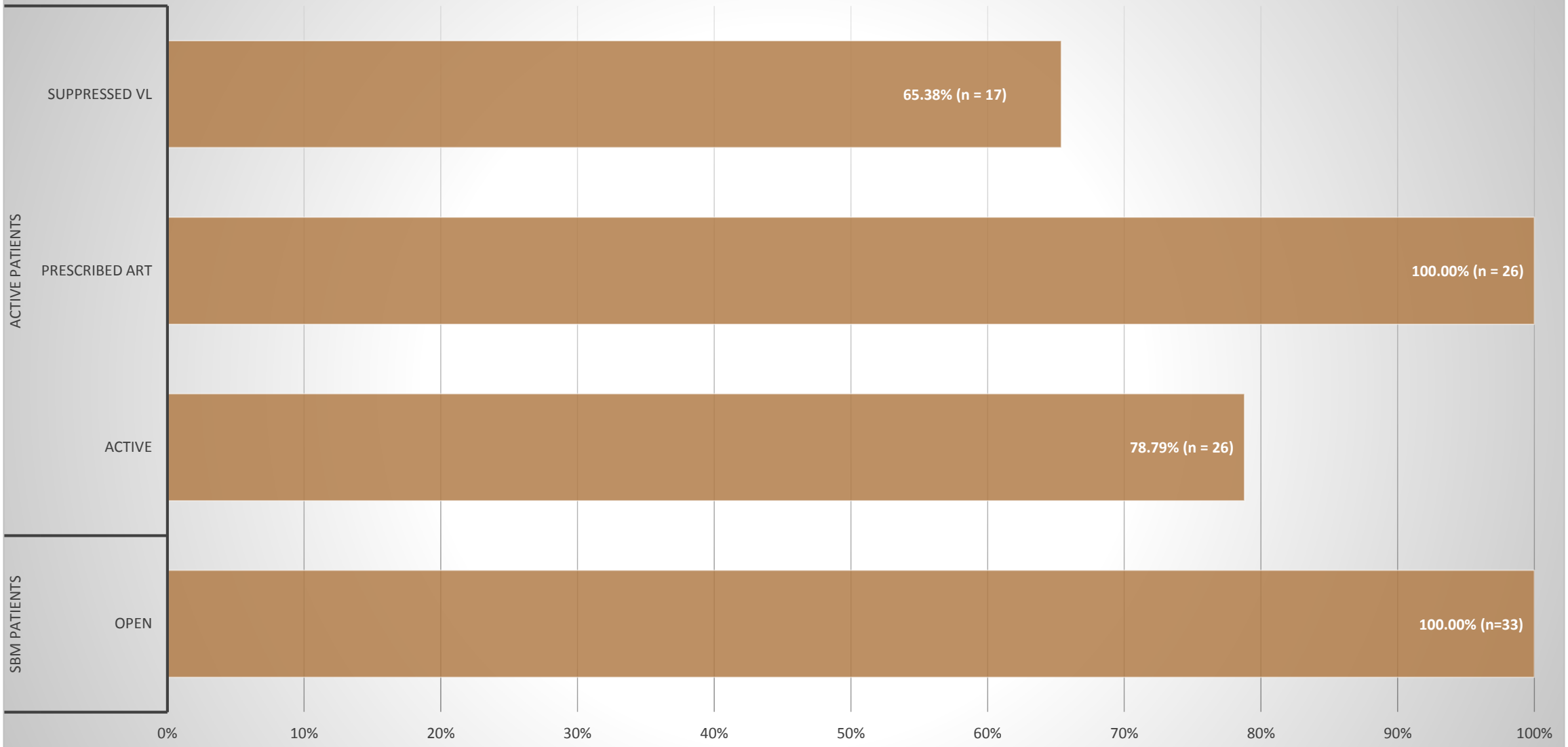
Time: January 2017 – December 2017

Evaluation: Analyze 2017 viral load data and compare to 2016.

Stony Brook Medicine

Stony Brook Children's

2016 HIV Care Cascade: Stony Brook Children's Hospital



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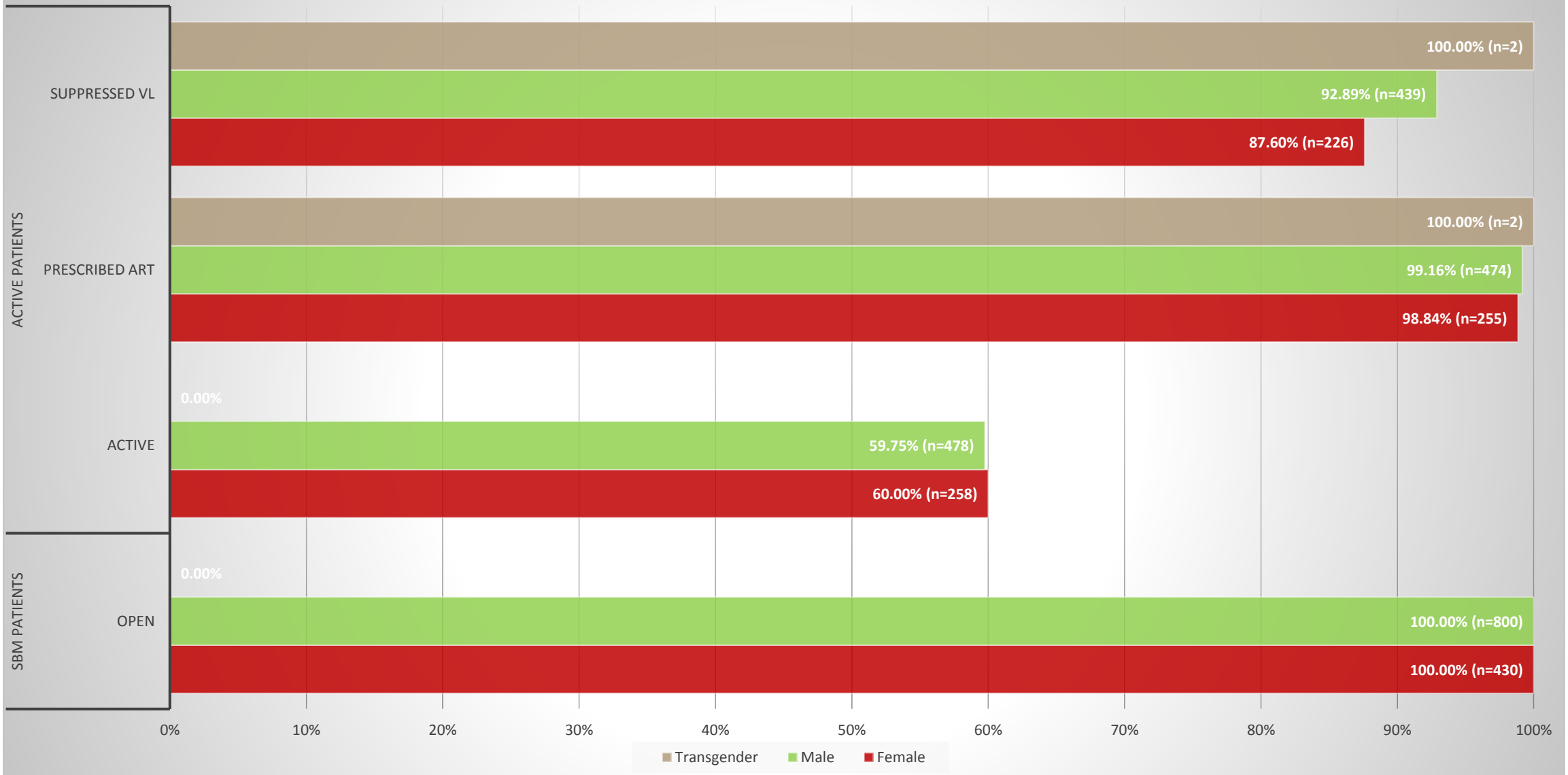
2016 HIV Care Cascade: Stony Brook Medicine by Sex



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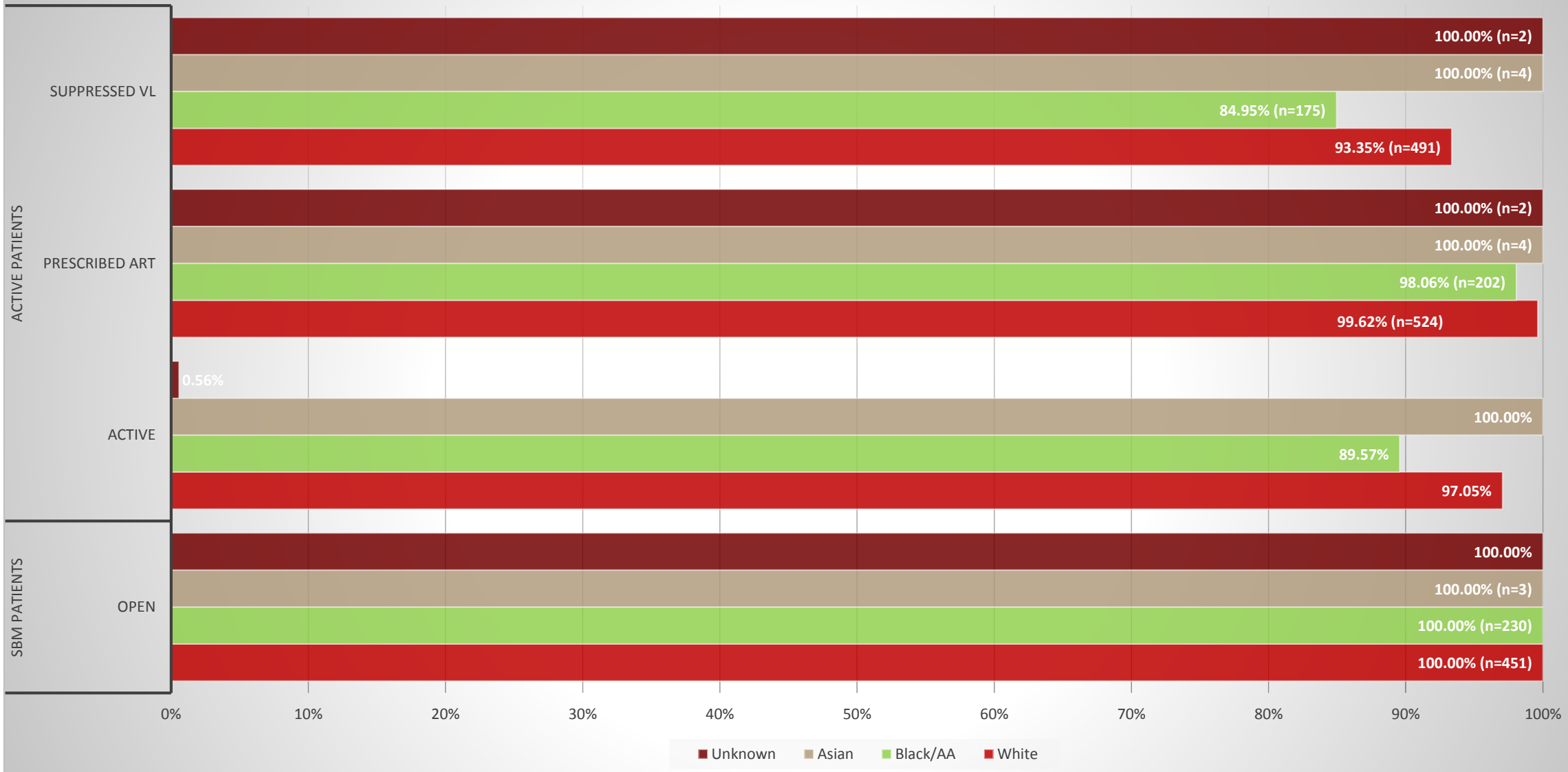
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV viral load test during 2016 / Active Patients

2016 HIV Care Cascade: Stony Brook Medicine - by Race



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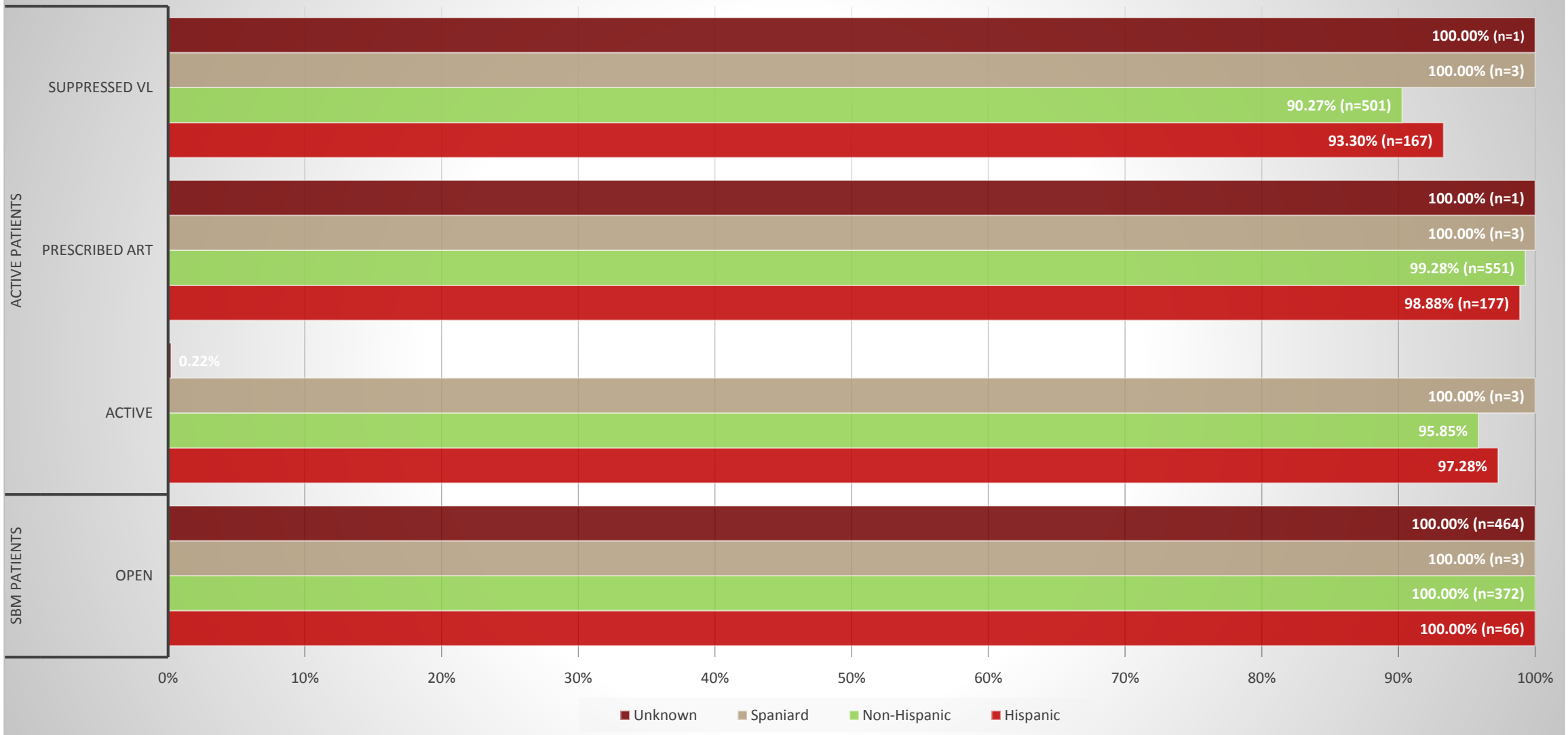
Active Patients: Patients with a known HIV diagnosis who received services in the HIV Program at SBM during 2016/Open Patients
Prescribed ART: Patients prescribed ART during the measurement year/ Active Patients
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV viral load test during 2016 / Active Patients

2016 HIV Care Cascade: Stony Brook Medicine - by Ethnicity



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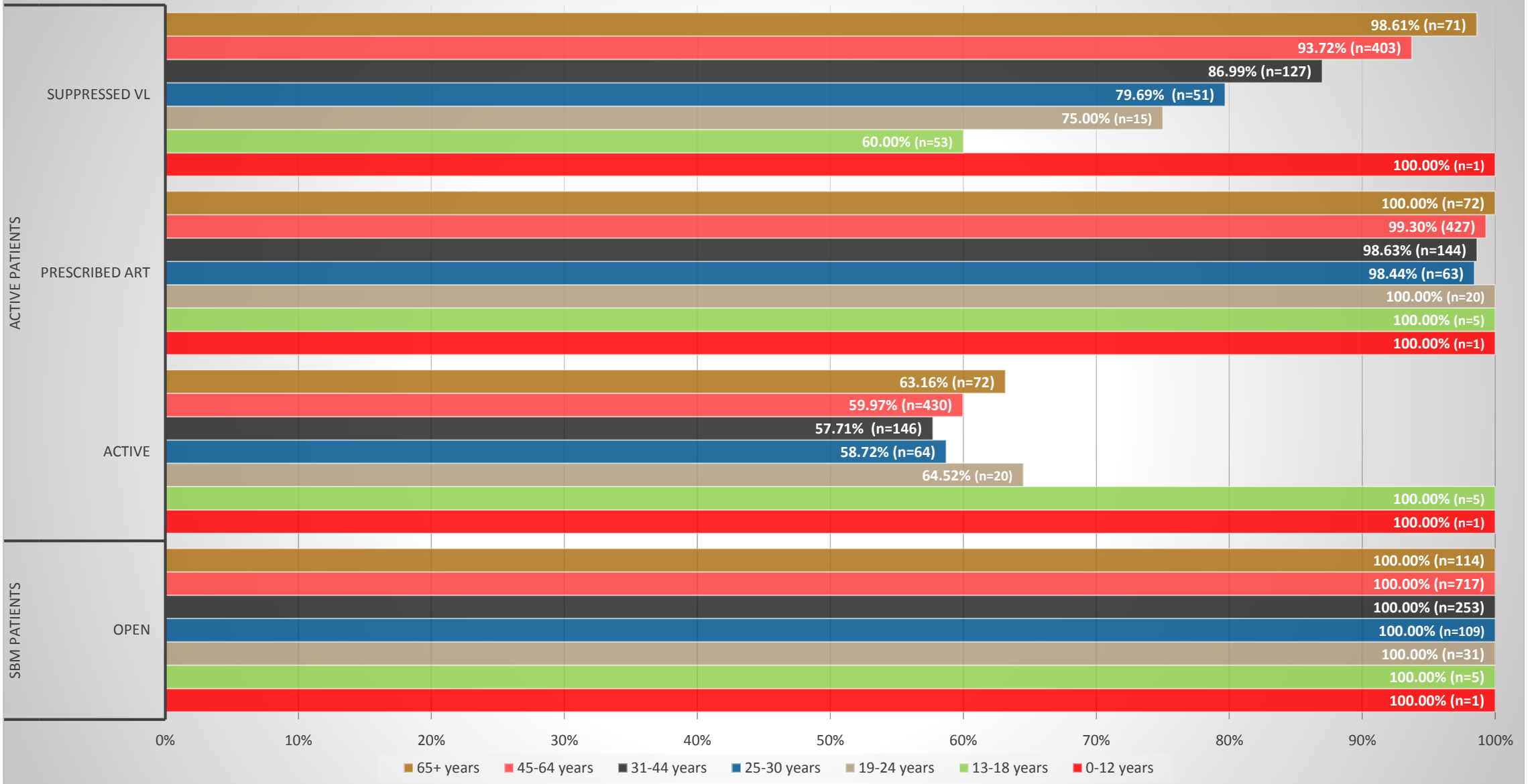
Active Patients: Patients with a known HIV diagnosis who received services in the HIV Program at SBM during 2016/Open Patients
Prescribed ART: Patients prescribed ART during the measurement year/ Active Patients
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV viral load test during 2016 / Active Patients

2016 HIV Care Cascade: Stony Brook Medicine - by Age



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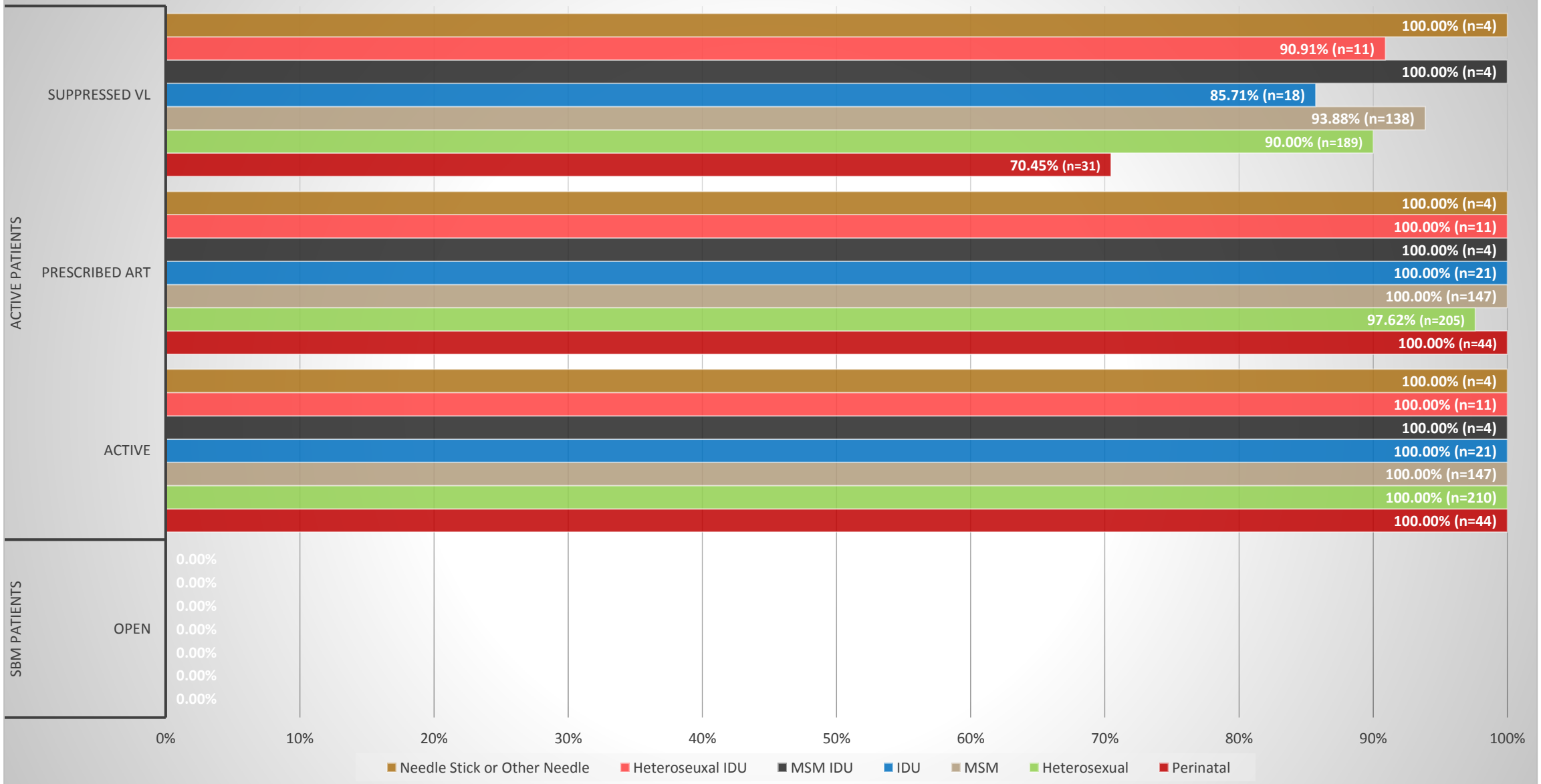
Active Patients: Patients with a known HIV diagnosis who received services in the HIV Program at SBM during 2016/Open Patients
Prescribed ART: Patients prescribed ART during the measurement year/ Active Patients
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV viral load test during 2016 / Active Patients

2016 HIV Care Cascade: Stony Brook Medicine - by Transmission



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Prescribed ART: Patients prescribed ART during the measurement year/ Active Patients
Viral Load Suppression: Patients with a HIV Viral Load less than 200 copies/mL at last HIV vitral load test during 2016 / Active Patients

Improvement Plan: Youth & Females

Goal: To increase the viral load suppression rates in:

- Youth ages 13-24 years receiving HIV primary medical care to 80%
- Females receiving HIV primary medical care at SBM in 2017 to >90%.

Action Steps:

SBM's Part D Program- Suffolk Project for AIDS Resource Coordination (SPARC) received one-time supplemental funding to provide incentives in the form of grocery store gift cards (up to $200) to youth and female SBM HIV patients who are not virally suppressed. Patients must meet one or more of the following to receive an incentive:

- Patient goes for VL blood work
- Patient's viral load decreases
- Patient's viral load is suppressed
- Patient's viral load is undetectable
- Patient maintains an undetectable viral load for 2 blood draws at least 3 months apar
- Patient reaches an undetectable viral load and maintains an undetectable viral load

Medical Case Managers, Social Workers, Care Coordinators, and/or Retention Specialist will enroll patients into the incentive program.

Measurement:

$$\frac{\text{Number of patients with a Viral Load < 200 copies/mL at last viral load in 2017}}{\text{Number of Active Patients in 2017}}$$

Time: January 2017 – July 2017

Evaluation: Analyze 2017 viral load data and compare to 2016.

Stony Brook Medicine

Stony Brook Children's

Improvement Plan: Blacks/ AA & Males

Goal: To increase the viral load suppression rates in:

- Blacks/African Americans receiving HIV primary medical care to 90%,
- Males ages 25 to 30 receiving primary medical care at SBM in 2017 to 85%
- Males ages 31 to 44 receiving primary medical care at SBM in 2017 to 90%.

Action Steps:

- Refer patients to SBM's Linkage Treatment Adherence and Retention (LRTA)
- Refer patients to Chronic Disease Self-Management Program (CDSMP) classes facilitated by SBM HIV staff and/or Peers.
- Refer patients to Peer Program for individual HIV support from Peers.

Measurement:

$$\frac{\text{Number of patients with a Viral Load < 200 copies/mL at last viral load in 2017}}{\text{Number of Active Patients in 2017}}$$

Time: January 2017 – July 2017

Evaluation: Analyze 2017 viral load data and compare to 2016.

Stony Brook Medicine

Stony Brook Children's

Data Collection Moving Forward

- Still working out the “kinks” with the Population Health System
  - List of those with a known HIV dx from the EMR not just a HIV/AIDS diagnosis code
  - List of only those with HIV dx to list of those with an HIV dx with a visit within the last 3 years.

- Hopefully moving from “hand collecting” patient information to using only the Population Health System

- Still somewhat time consuming: Staff will still be tasked with reviewing data obtained through the Population Health System to identify those who are actually HIV+, those who are open, and those seen for HIV primary care.

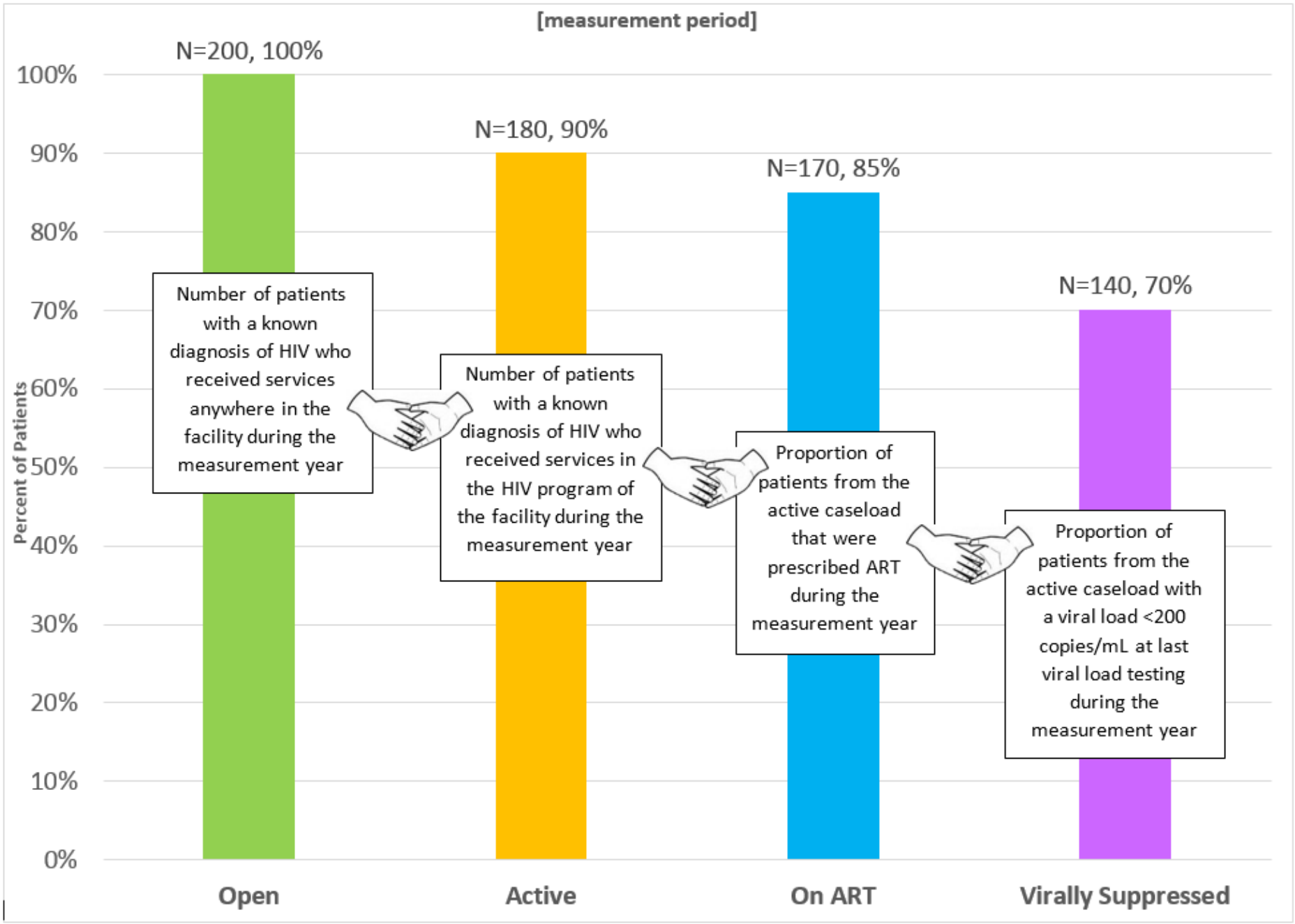
The Living Cascade

Worksheet Tool

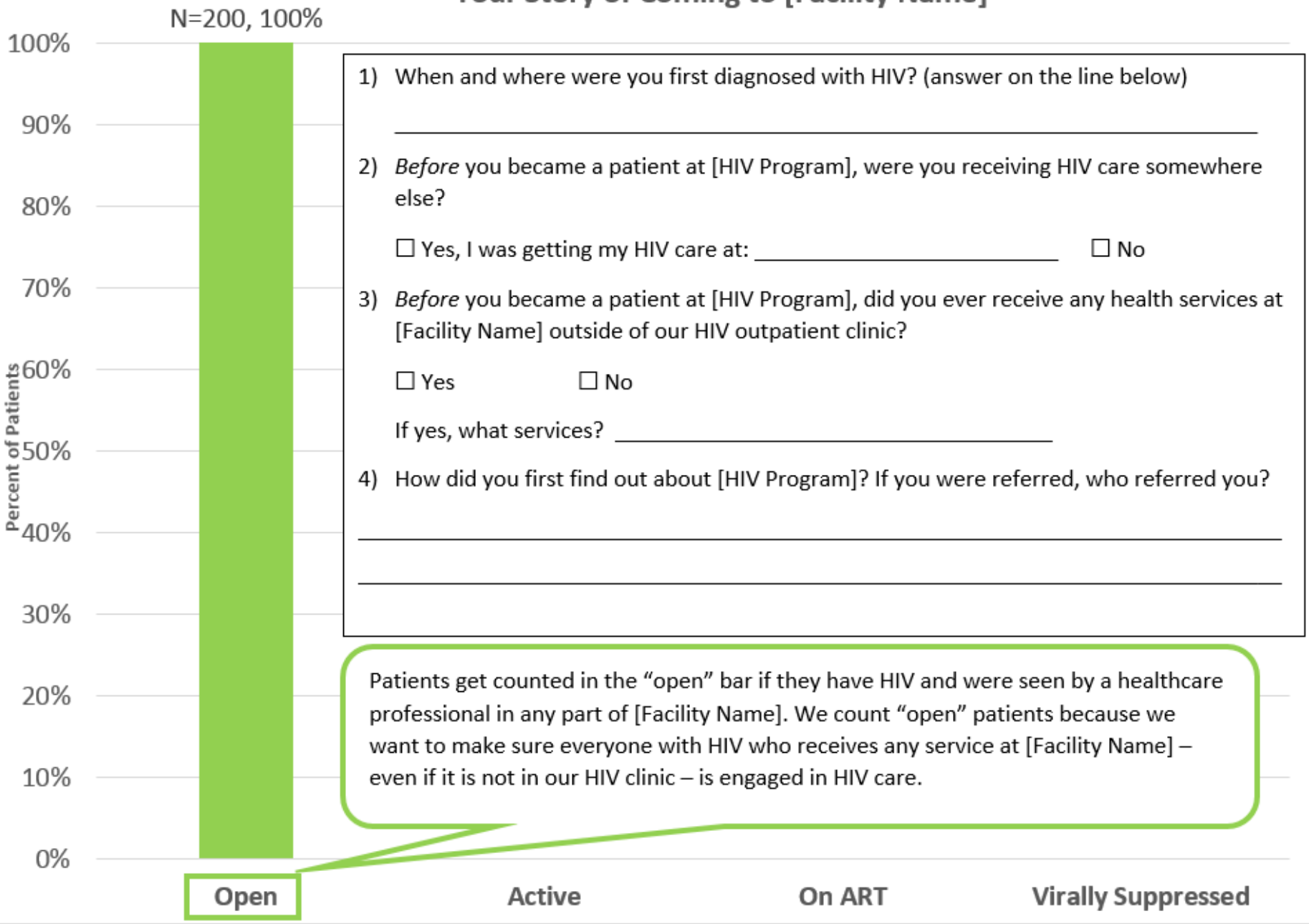
Concept: N =

Purpose

- Educate consumers about facility-level cascades
- Share timely data with consumers
- Use patient experience data for QI


Help Us Bring [Facility Name]'s Cascade to Life!
[measurement period]
N=200, 100%
N=180, 90%
N=170, 85%
N=140, 70%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent of Patients
Number of patients with a known diagnosis of HIV who received services anywhere in the facility during the measurement year
Number of patients with a known diagnosis of HIV who received services in the HIV program of the facility during the measurement year
Proportion of patients from the active caseload that were prescribed ART during the measurement year
Proportion of patients from the active caseload with a viral load <200 copies/mL at last viral load testing during the measurement year
Open
Active
On ART
Virally Suppressed

Your Story of Coming to [Facility Name]



1) When and where were you first diagnosed with HIV? (answer on the line below)

_____

2) *Before* you became a patient at [HIV Program], were you receiving HIV care somewhere else?

☐ Yes, I was getting my HIV care at: _____ ☐ No

3) *Before* you became a patient at [HIV Program], did you ever receive any health services at [Facility Name] outside of our HIV outpatient clinic?

☐ Yes ☐ No

If yes, what services? _____

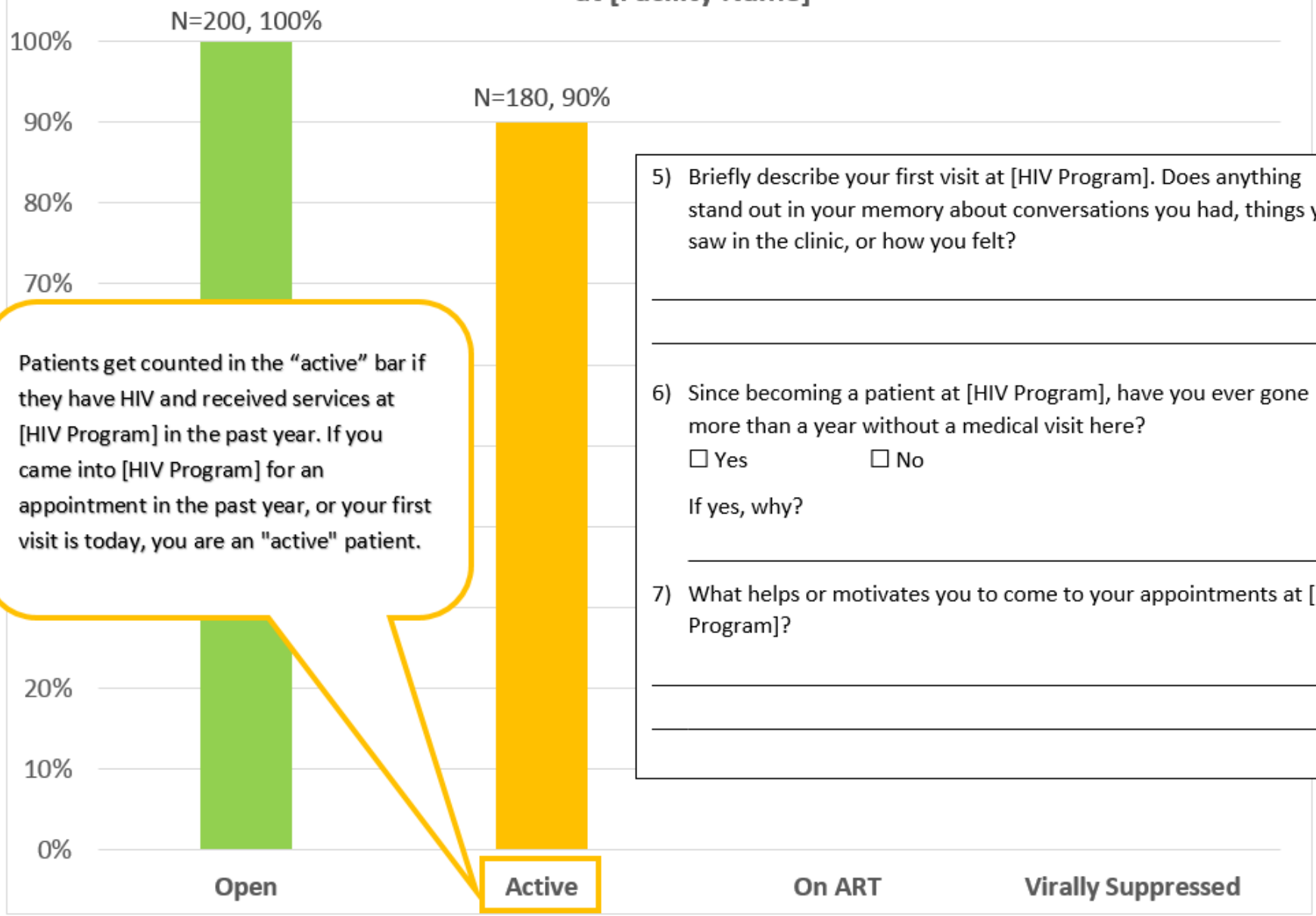
4) How did you first find out about [HIV Program]? If you were referred, who referred you?

_____

_____

Patients get counted in the "open" bar if they have HIV and were seen by a healthcare professional in any part of [Facility Name]. We count "open" patients because we want to make sure everyone with HIV who receives any service at [Facility Name] – even if it is not in our HIV clinic – is engaged in HIV care.

Your Story of Becoming an "Active" Patient at [Facility Name]



Patients get counted in the "active" bar if they have HIV and received services at [HIV Program] in the past year. If you came into [HIV Program] for an appointment in the past year, or your first visit is today, you are an "active" patient.

5) Briefly describe your first visit at [HIV Program]. Does anything stand out in your memory about conversations you had, things you saw in the clinic, or how you felt?

_____

_____

6) Since becoming a patient at [HIV Program], have you ever gone more than a year without a medical visit here?

☐ Yes ☐ No

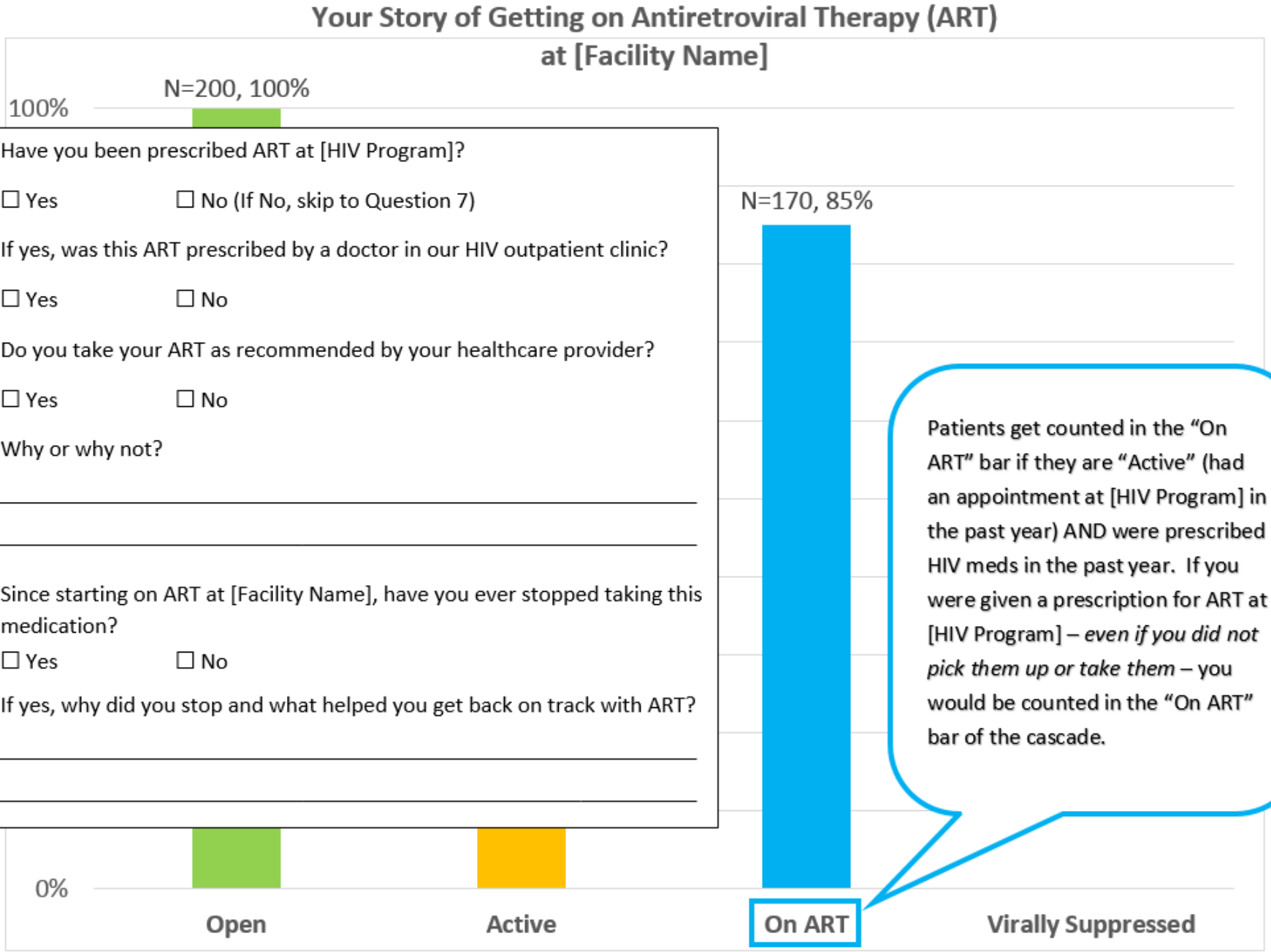
If yes, why?

_____

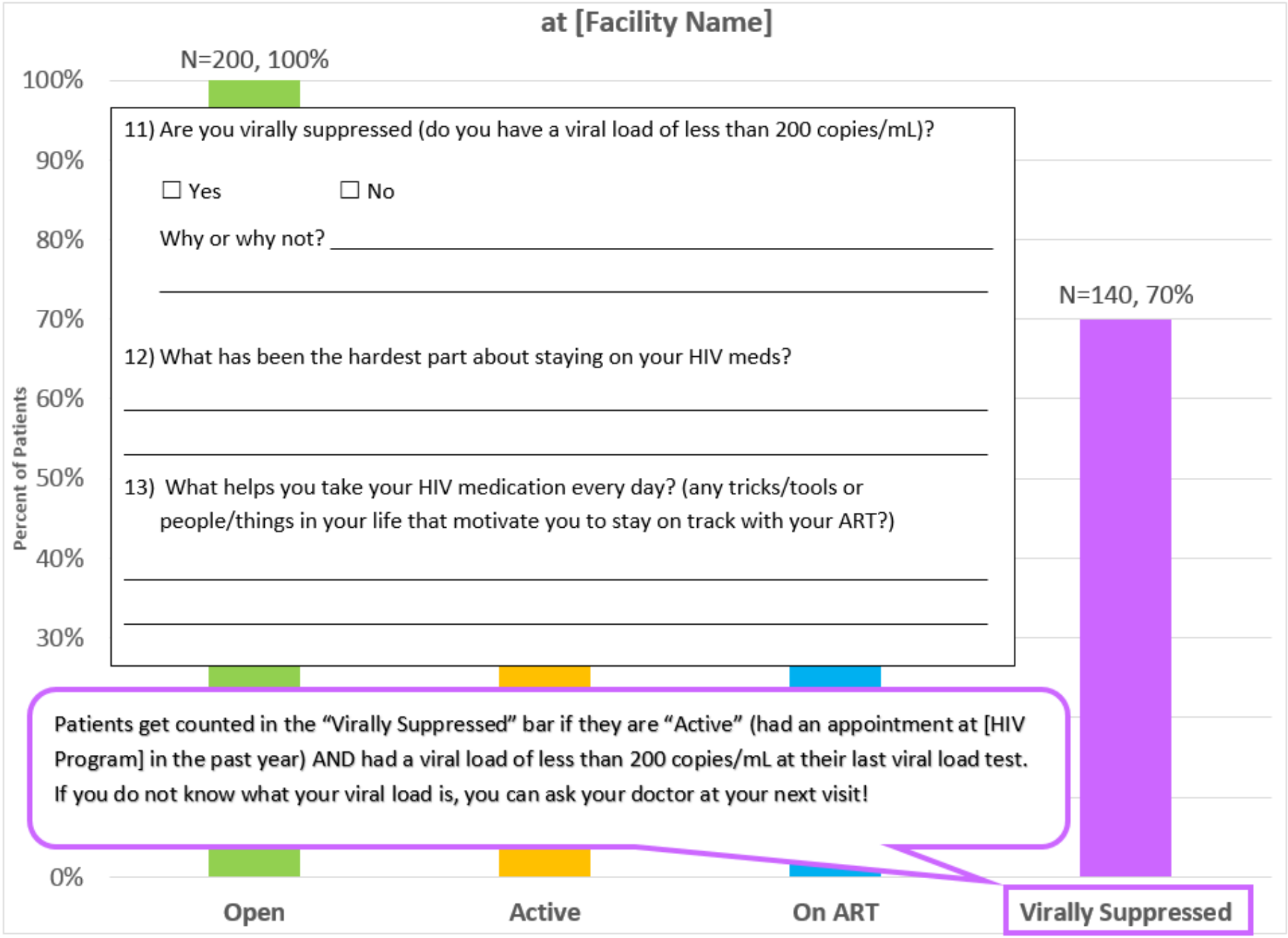
7) What helps or motivates you to come to your appointments at [HIV Program]?

_____

_____


Your Story of Getting on Antiretroviral Therapy (ART) at [Facility Name]
N=200, 100%
100%
N=170, 85%
0%
Open
Active
On ART
Virally Suppressed
8) Have you been prescribed ART at [HIV Program]?
☐ Yes ☐ No (If No, skip to Question 7)
If yes, was this ART prescribed by a doctor in our HIV outpatient clinic?
☐ Yes ☐ No
9) Do you take your ART as recommended by your healthcare provider?
☐ Yes ☐ No
Why or why not?
10) Since starting on ART at [Facility Name], have you ever stopped taking this medication?
☐ Yes ☐ No
If yes, why did you stop and what helped you get back on track with ART?
Patients get counted in the "On ART" bar if they are "Active" (had an appointment at [HIV Program] in the past year) AND were prescribed HIV meds in the past year. If you were given a prescription for ART at [HIV Program] – *even if you did not pick them up or take them* – you would be counted in the "On ART" bar of the cascade.

Your Story of Becoming Virally Suppressed at [Facility Name]



11) Are you virally suppressed (do you have a viral load of less than 200 copies/mL)?

☐ Yes ☐ No

Why or why not? _____

_____

12) What has been the hardest part about staying on your HIV meds?

_____

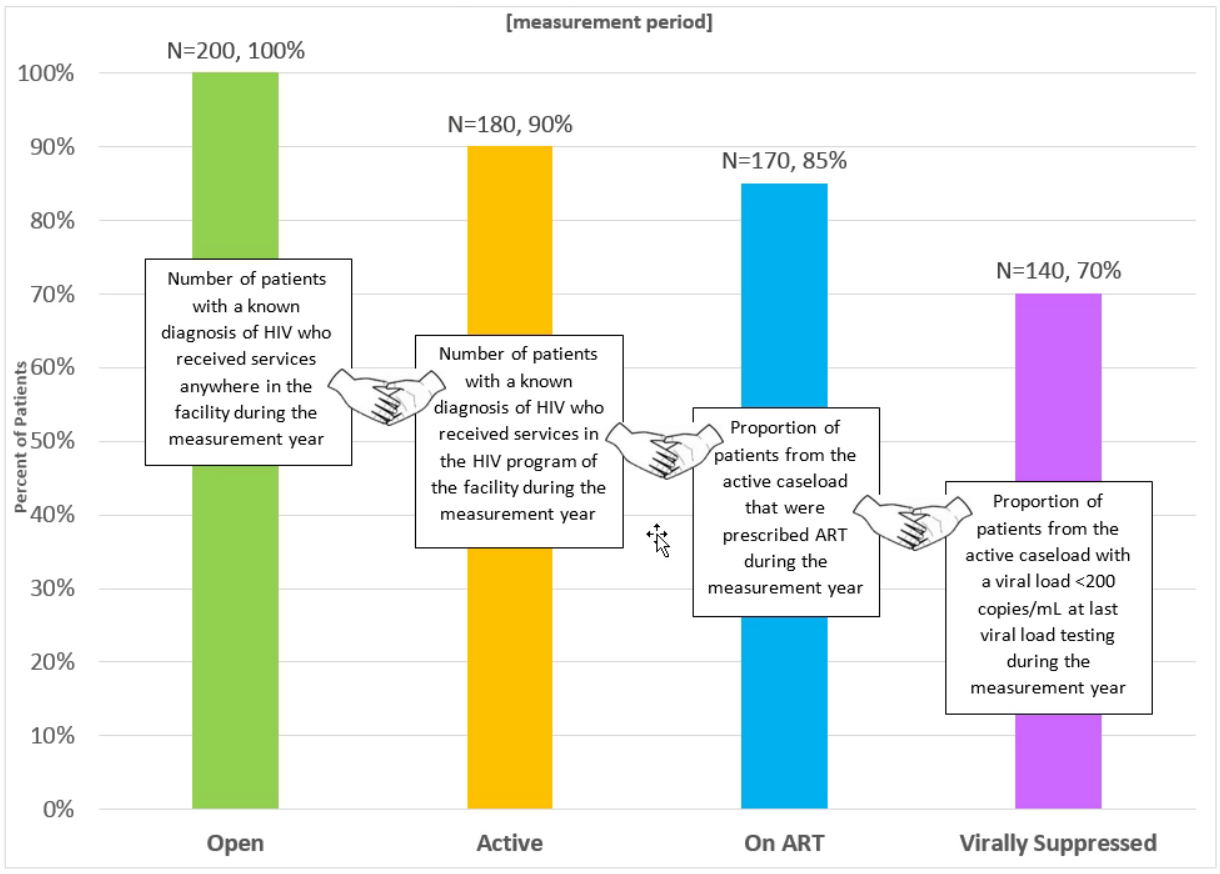
_____

13) What helps you take your HIV medication every day? (any tricks/tools or people/things in your life that motivate you to stay on track with your ART?)

_____

_____

Patients get counted in the "Virally Suppressed" bar if they are "Active" (had an appointment at [HIV Program] in the past year) AND had a viral load of less than 200 copies/mL at their last viral load test. If you do not know what your viral load is, you can ask your doctor at your next visit!


Help Us Bring [Facility Name]'s Cascade to Life!
[measurement period]
Percent of Patients
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
N=200, 100%
N=180, 90%
N=170, 85%
N=140, 70%
Number of patients with a known diagnosis of HIV who received services anywhere in the facility during the measurement year
Number of patients with a known diagnosis of HIV who received services in the HIV program of the facility during the measurement year
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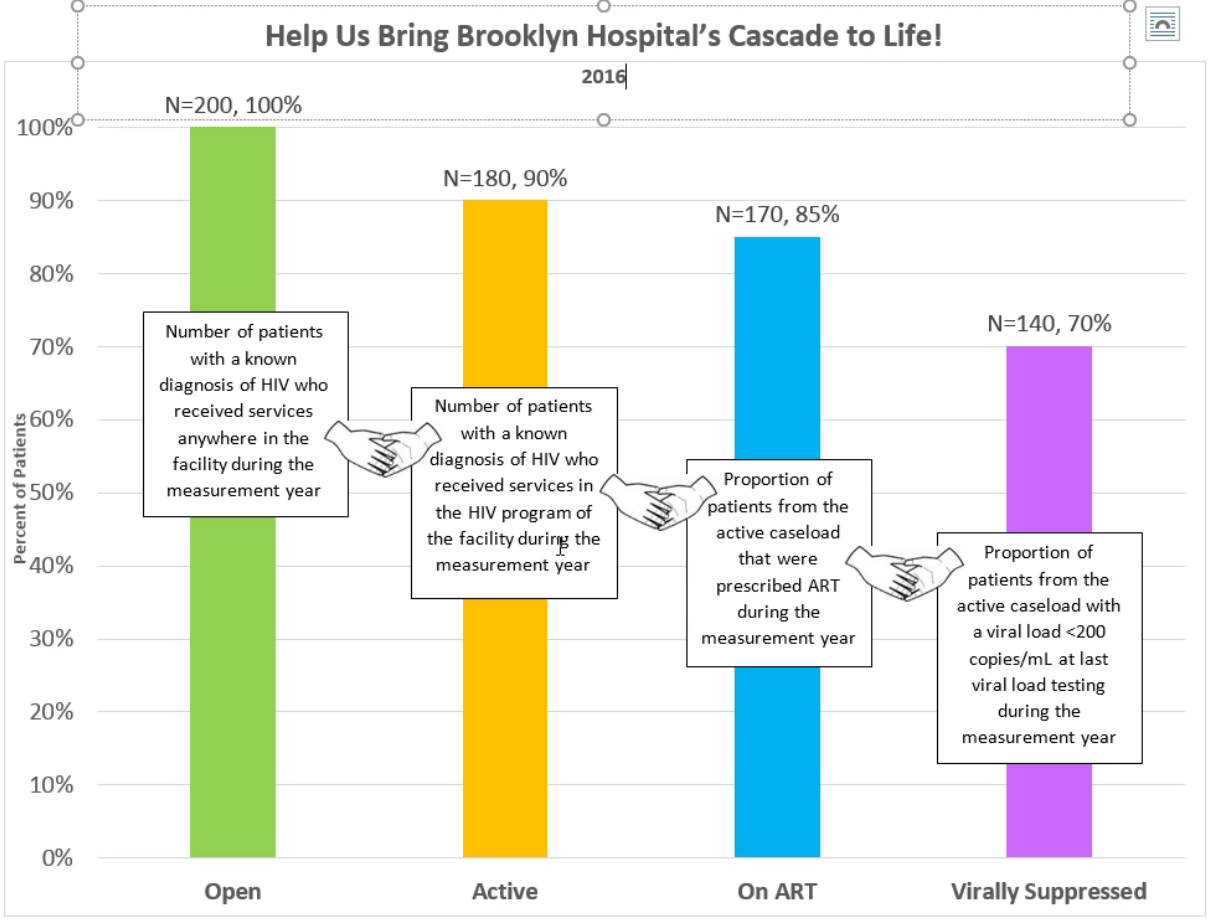
Open
Active
On ART
Virally Suppressed


Help Us Bring Brooklyn Hospital's Cascade to Life!
2016
Percent of Patients
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
N=200, 100%
N=180, 90%
N=170, 85%
N=140, 70%
Number of patients with a known diagnosis of HIV who received services anywhere in the facility during the measurement year
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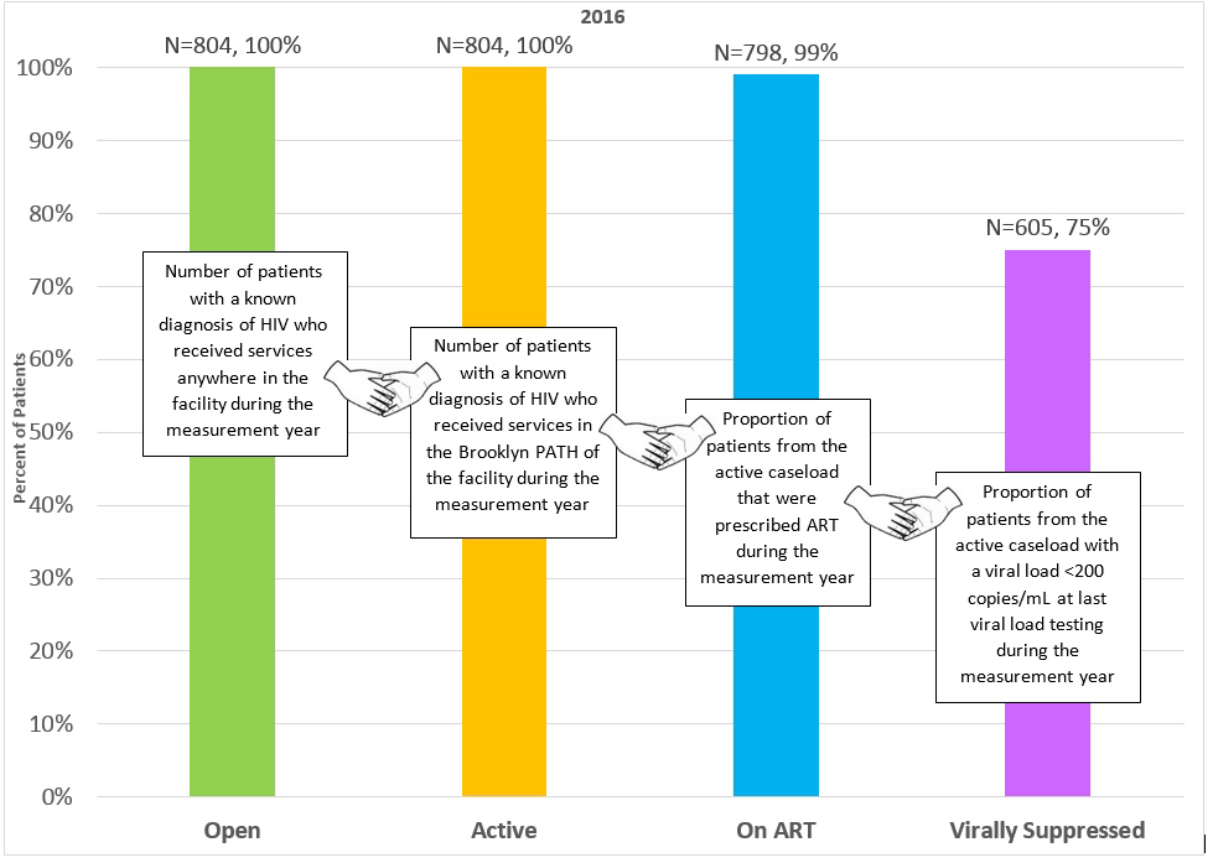
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