Quality Improvement Profile

The NYSDOH/AIDS Institute's HIV Quality of Care Program has compiled crucial information from your HIV quality improvement (QI) program into a single profile report.

This quality profile contains longitudinal performance data on key quality indicators derived from the organizational HIV treatment cascade self-review, such as viral load suppression. It highlights quality improvement plans developed by the organization based on results of the review, consumer involvement in this process, as well as feedback from the quality coach and contract manager. Capacity building information such as participation in a quality learning network or regional group is also included. Please use this report to review the HIV QM program's effectiveness and to make changes if needed. Also, please let us know if there is an update that should be made to the contact information. If you have any questions or would like to request technical assistance or coaching for your HIV QM program, please contact Dan Belanger at Daniel.Belanger@health.ny.gov.

Cascade Submission Date:
Review closed November 2022

QI Profile Completion Date:
February 2023

Last Revision Date:
October 27, 2023

Program Name: Joseph P. Addabbo Family Health Center

Clinic Information

Type of Clinic*	Clinic Name	Address	City	Zip
CBO	Addabbo Family Health Center- Arverne	6200 Beach Channel Drive	Arverne	11691
CBO	Addabbo Family Health Center- Brooklyn	120 Richards Street	Brooklyn	11231
CBO	Addabbo Family Health Center- Jamaica (Guy Brewer Blvd.)	118-11 Guy Brewer Blvd.	Jamaica	11434
CBO	Addabbo Family Health Center- Jamaica (Sutphin Blvd.)	114-49 Sutphin Blvd	Jamaica	11434

**CBO = Community Based Organization*

Important Contacts

HIV Medical Director	Dr. Ari Benjamin	abenjamin@addabbo.org	Phone number not available
HIV Program Administrator	Natana Cruickshank	ncruickshank@addabbo.org	Phone number not available
Lead QI Contact	Thomas Meyers	tmeyers@addabbo.org	(718) 945-7150
Contract Manager	N/A		
NY Links Coach	Nova West	Nova.west@health.ny.gov	(212) 417-4542

Regional Group/Learning Network Participation

Affiliation: Community Health Center Quality Learning Network (CHCQLN), New York Links
Participated in Group QI Project? Yes
Focus: Viral Load Suppression, Cascade Follow-up

Organizational HIV Treatment Cascade

Definitions of Key Indicators

On ARV Therapy: Documented prescription of one or more antiretroviral medications at any time during the review year.

Any VL Test: Documentation of at least one viral load test at any time during the review year.

VL Test within 91 Days (Newly Diagnosed Patients): Documentation of at least one viral load test performed within 91 days of initial HIV diagnosis.

Suppressed Final VL: A value of less than 200 copies/mL on the final viral load test during the review year. Patients with no documented viral load test during the review year are scored as unsuppressed.

Suppressed within 91 Days (Newly Diagnosed Patients): A value of less than 200 copies/mL on any viral load test performed within 91 days of initial HIV diagnosis. Patients with no documented viral load test during this period are scored as unsuppressed.

3-day Linkage to Care (Patients Newly Diagnosed Within the Organization): A time interval of three days or less from initial HIV diagnosis to provision of HIV care. Prior to 2019, documentation of HIV care was based exclusively on visit history (seen by a provider who could prescribe ARVs, whether or not this was done), and an exception was made in 2017 (only) for individuals seen as inpatients (linkage within 30 days); beginning in 2019, documentation of first ARV prescription was also used for this, and there were no exceptions to the 3-day limit.

NOTE: Data are not reported for subpopulations of fewer than 10 patients. This is done to address any concerns about confidentiality and avoid possible misinterpretation of results based on small populations. For brevity, throughout the profile, the number of applicable patients is reported using the "n=x" convention with x being the number of patients eligible for an indicator or within a demographic subpopulation.

Key Indicators from 2017 to 2021

Figure 1: New to Care (Other than Newly Diagnosed) Viral Load Suppression Rates at Organizational Level from 2017-2021

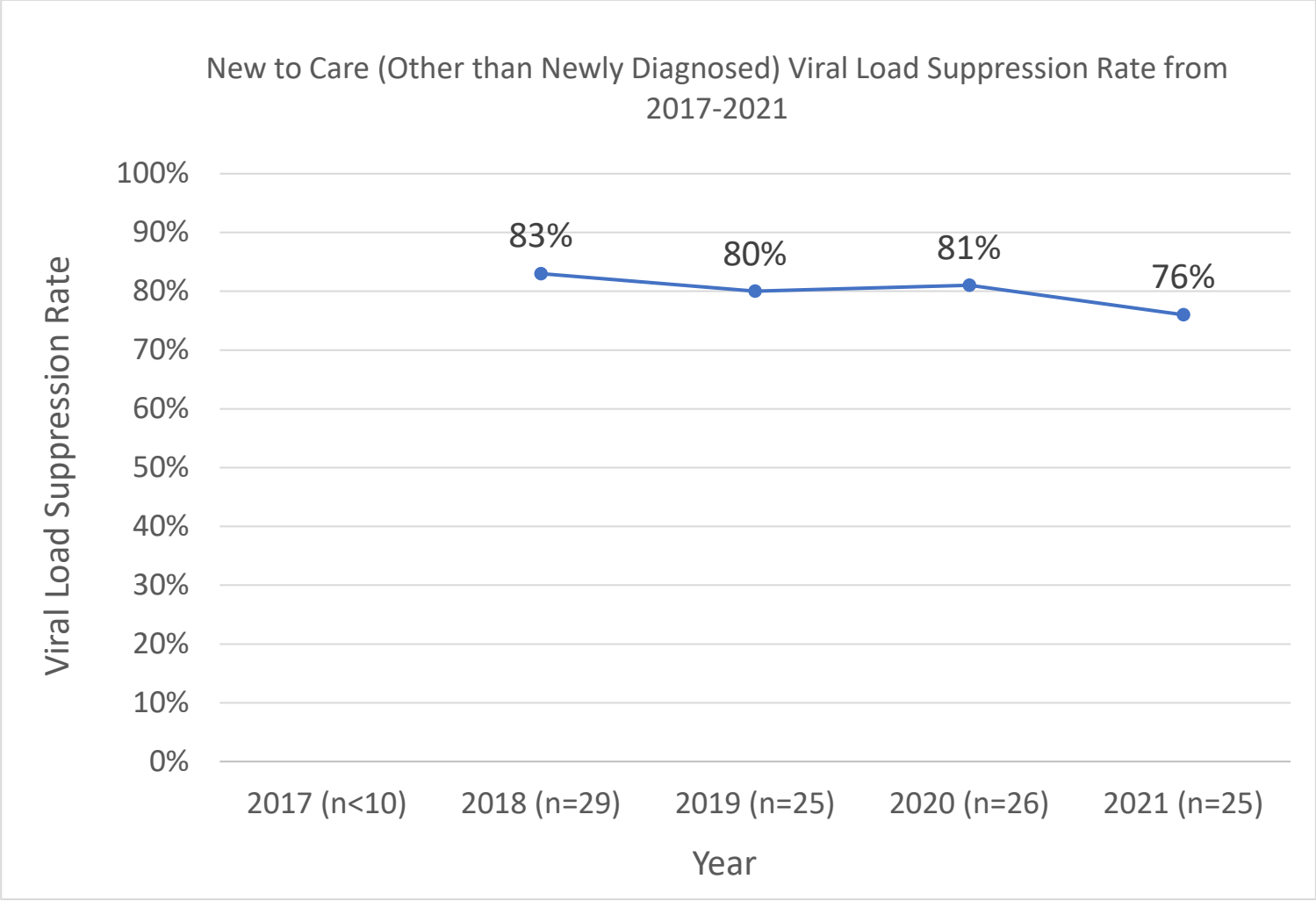


Figure 2: Established Active Viral Load Suppression Rates at Organizational Level from 2017-2021

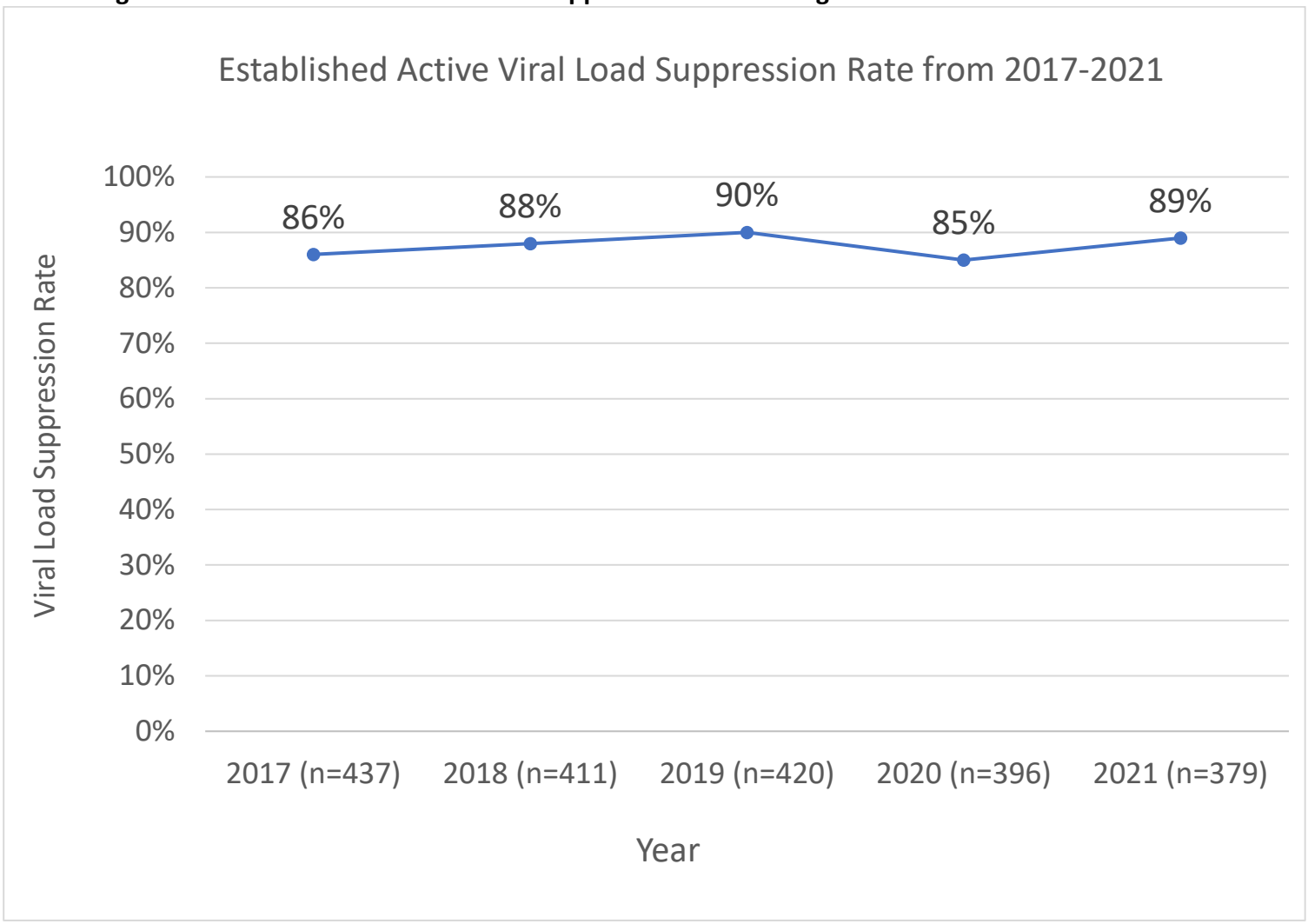


Figure 3. 2021 Viral Load Suppression Rates by Age at Organizational Level

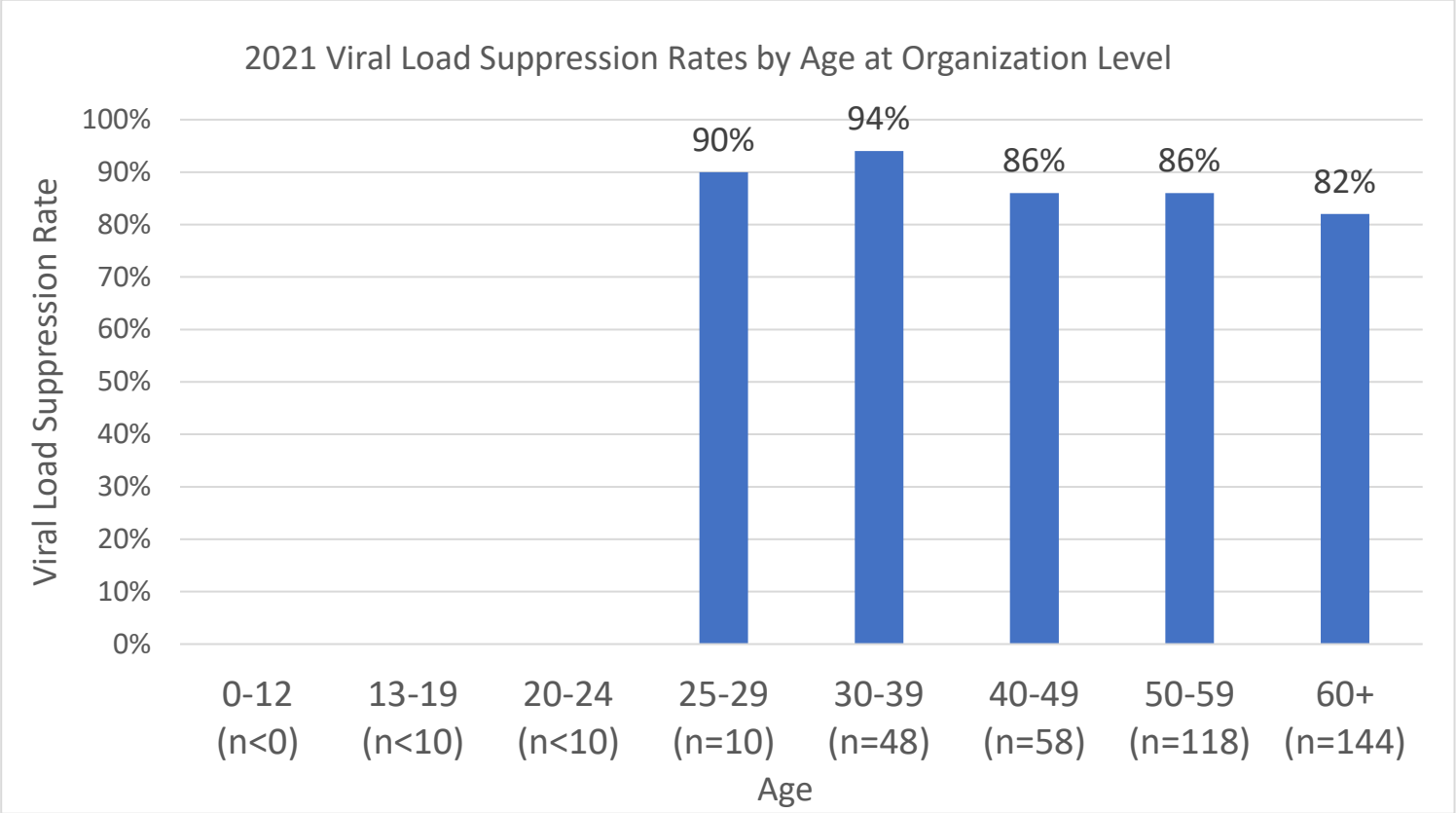
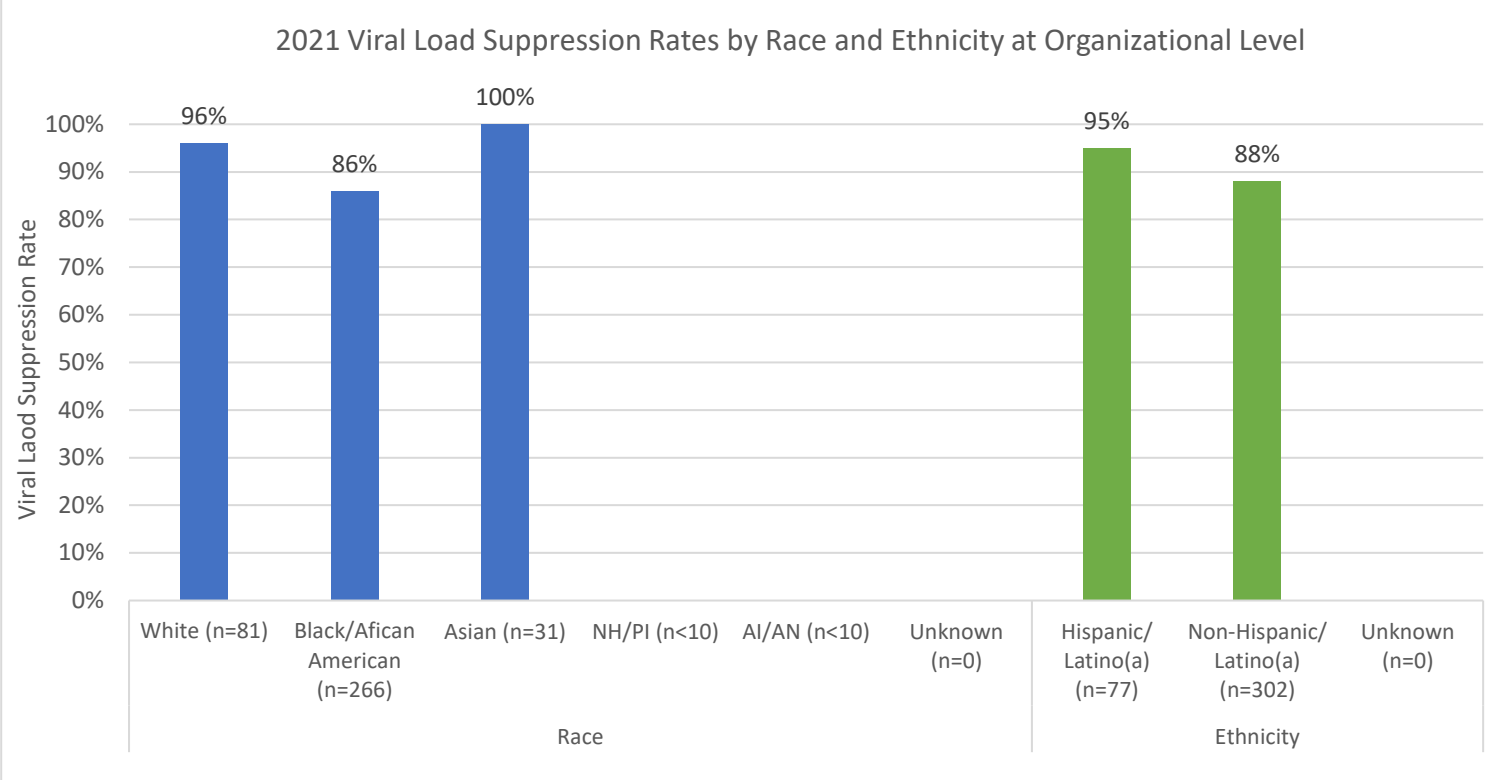


Figure 4. 2021 Viral Load Suppression Rates by Race and Ethnicity at Organizational Level



Note: NH/PI = Native Hawaiian/Pacific Islander; AI/AN = American Indian/Alaska Native.

Table 1: Indicator Scores at Organization Level for 2017-2021

Patient Group	Indicator	2017		2018		2019		2020		2021	
		Org. Score	State Median	Org. Score	State Median	Org. Score	State Median	Org. Score	State Median	Org. Score	State Median
Newly Diagnosed	3-day Linkage to Care	-- (n<10)*	65%	-- (n<10)*	41%	-- (n<10)*	52%	-- (n<10)*	55%	-- (n<10)*	61%
	On ARV Therapy	90% (n=10)	91%	-- (n<10)*	96%	-- (n<10)*	100%	-- (n<10)*	100%	-- (n<10)*	100%
	VL Test within 91 Days	**	**	-- (n<10)*	93%	-- (n<10)*	95%	-- (n<10)*	95%	-- (n<10)*	92%
	Suppressed Final VL	70% (n=10)	65%	**	**	**	**	**	**	**	**
	Suppressed within 91 Days	**	**	-- (n<10)*	45%	-- (n<10)*	50%	-- (n<10)*	46%	-- (n<10)*	50%
	Baseline Resistance Test	**	**	**	**	-- (n<10)*	74%	-- (n<10)*	80%	-- (n<10)*	82%
Other New to Care	On ARV Therapy	-- (n<10)*	96%	97% (n=29)	97%	100% (n=25)	100%	100% (n=26)	100%	100% (n=25)	100%
	Any VL Test	-- (n<10)*	97%	97% (n=29)	99%	96% (n=25)	98%	100% (n=26)	100%	96% (n=25)	100%
	Suppressed Final VL	-- (n<10)*	70%	83% (n=29)	74%	80% (n=25)	78%	81% (n=26)	77%	76% (n=25)	69%
Established Active	On ARV Therapy	98% (n=437)	99%	99% (n=411)	99%	99% (n=420)	99%	100% (n=396)	93%	100% (n=379)	99%
	Any VL Test	95% (n=437)	99%	98% (n=411)	99%	99% (n=420)	99%	94% (n=396)	97%	98% (n=379)	98%
	Suppressed Final VL	86% (n=437)	88%	88% (n=411)	88%	90% (n=420)	89%	85% (n=396)	87%	89% (n=379)	88%
Open Previously Diagnosed (Active & Inactive)	On ARV Therapy	94% (n=460)	92%	99% (n=420)	95%	97% (n=433)	96%	99% (n=413)	96%	98% (n=389)	97%
	Any VL Test	95% (n=460)	92%	96% (n=420)	93%	97% (n=433)	93%	90% (n=413)	90%	97% (n=389)	94%
	Suppressed Final VL	83% (n=460)	80%	86% (n=420)	80%	88% (n=433)	83%	81% (n=413)	77%	87% (n=389)	79%

*** Data redacted due to small number of applicable patients (fewer than 10).**

**** Data for this indicator were not requested for this review.**

Table 2: Viral Load Suppression by Established Active Patient Demographic Group at Organization Level for 2021

AGE															
0-12		13-19		20-24		25-29		30-39		40-49		50-59		60+	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
<10*	--	<10*	--	<10*	--	10	90%	48	94%	58	86%	118	86%	144	92%
GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Unknown Gender					
n	%	n	%	n	%	n	%	n	%	n	%				
211	90%	168	88%	<10*	--	<10*	--	<10*	--	<10*	--				
RACE															
White		Black/African American		Asian		Native Hawaiian/PI		American Indian/ AN		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%				
81	96%	266	86%	31	100%	<10*	--	<10*	--	<10*	--				
ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
77	95%	302	88%	<10*	--										
RISK FACTOR															
IDU Risk		Heterosexual Risk		MSM		Hemophilia or Coagulation		Blood Transfusion		Perinatal		Other Risk		Unknown	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
19	89%	270	89%	92	89%	<10*	--	<10*	--	<10*	--	<10*	--	<10*	--
HOUSING STATUS															
Stable Housing		Unstably Housed		Temporarily Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
364	90%	13	69%	<10*	--	<10*	--								
INSURANCE TYPE															
ADAP		Dual Eligible		Medicaid		Medicare		Private Insurance		Veteran's Admin		Other		No Insurance	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
54	94%	62	95%	208	86%	25	88%	30	93%	<10*	--	<10*	--	<10*	--
Unknown															
n	%														
<10*	--														

*** Data redacted due to small number of applicable patients (fewer than 10).**

Table 3: Indicator Scores at Clinic Level for 2017-2021

Year	Clinic	Newly Diagnosed	Other New to Care			Established Active		
		Baseline Resistance Test	On ARV Therapy	Any VL Test	Suppressed Final VL	On ARV Therapy	Any VL Test	Suppressed Final VL
2017	Arverne	**	**	**	**	98% (n=167)	98% (n=167)	84% (n=167)
	Jamaica (Sutphin Blvd.)	**	**	**	**	98% (n=204)	99% (n=204)	90% (n=204)
	Redhook	**	**	**	**	97% (n=66)	80% (n=66)	80% (n=66)
2018	Arverne	**	100% (n=16)	94% (n=16)	75% (n=16)	99% (n=164)	97% (n=164)	85% (n=164)
	Brooklyn	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=57)	100% (n=57)	86% (n=57)
	Jamaica (Sutphin Blvd.)	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	99% (n=190)	99% (n=190)	90% (n=190)
2019	Arverne	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=177)	99% (n=177)	86% (n=177)
	Brooklyn	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=58)	100% (n=58)	90% (n=58)
	Jamaica (Sutphin Blvd.)	-- (n<10)*	100% (n=17)	100% (n=17)	82% (n=17)	98% (n=185)	99% (n=185)	94% (n=185)
2020	Arverne	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=155)	86% (n=155)	77% (n=155)
	Brooklyn	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=53)	96% (n=53)	85% (n=53)
	Jamaica (Guy Brewer Blvd.)	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Jamaica (Sutphin Blvd.)	-- (n<10)*	100% (n=15)	100% (n=15)	80% (n=15)	99% (n=187)	99% (n=187)	91% (n=187)
2021	Arverne	**	**	**	**	100% (n=141)	96% (n=141)	85% (n=141)
	Brooklyn	**	**	**	**	100% (n=48)	100% (n=48)	92% (n=48)
	Far Rockaway	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Jamaica (Guy Brewer Blvd.)	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Jamaica (Sutphin Blvd.)	**	**	**	**	100% (n=190)	100% (n=190)	92% (n=190)

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**** Data for this indicator were not requested for this review.**

Quality Improvement Interventions for 2022 (Self-Reported based on 2021 results)

Methodology

Joseph P. Addabbo Family Health Center uses an integrative and comprehensive Electronic Medical Record (eClinicical Works/eCW). We have built out our EMR to capture all pertinent data for the patients who are living with HIV. eCW allows us a secure platform to input and track patient information and is used throughout our system. Each patient as a unique medical record number that is assigned and follows the patient through their trajectory of care to ensure no duplication. Our Ryan White program staff collect and input these data points into the patient's medical records along with their medical providers. While different programs have varying metrics to track for their programs, we ensure that key data points related to quality of care are universally tracked for our patients, regardless of program enrollment. Our Quality Improvement Data Specialist, Mayra Torres continuously tracks and reviews data in the EMR through reporting and individual chart review to ensure data integrity. In this role she is responsible for extracting the data, completing the Excel template and, together with the Director of Programs and Training, reviews for completeness and accuracy. The Director of Programs and Training, Natana Cruickshank, is responsible for the analysis of the cascade results working with our Chief Medical Officer Dr. Ari Benjamin and the CQI team. Key instruments of analysis included graphic displays.

Key Findings

Despite operating within the confines of the COVID-19 pandemic in 2021, JPAFHC was still able to maintain a high percentage of viral load testing across our patient population. This indicator speaks to JPAFHC's efforts to support our patients and retain them in care throughout the course of the pandemic. Our improvement goals set for 2021, was to increase viral load suppression rates for established patients from 85% to 87%. Overall, we were able to surpass that goal with a viral load suppression rate of 89% among our established patients.

JPAFHC's HIV care continuum data in 2021 has had an overall improvement in rates of viral load suppression across age ranges when compared to the data in 2020. Of note however, was a decrease in viral load suppression among our 40-49 group (from 78% in 2020 to 76%) and our 50-59 group (from 90% to 86%). With the impact of the COVID-19 pandemic centered around older adults and patients with compromised immunity, many of our patients expressed trepidation in leaving their homes to engage in care. This might be a factor contributing to this slight decrease among this patient subset.

Our lowest viral load suppression rates are reflected among our unstably housed patients, with a viral load suppression rate of 67%. This rate is down from 75% in 2020. Though unstably housed patients only make up about 6% of our established patient population, it is concerning. For unstably housed patients, there are usually several psychosocial factors that affect their ability to secure stable housing and more routinely engage in medical care. These factors include but are not limited to mental illness, substance use, health literacy and immigration status. Therefore, to address this issue will take a multi-pronged approach.

Additionally, patients new to care at JPAFHC appear to have lower rates of viral load suppression at 78% compared to our established patients. The relationships Ryan White funded staff have been able to build with our established patients have gone a long way in fostering trust and engagement. The staff have been able to know and understand patients and their barriers to care. This knowledge has allowed us to have tailored interventions to coach patients towards viral load suppression. The COVID-19 pandemic has limited the interactions and relationship building that happens when patients present for care.

QI Projects

QI Project #1
Indicator: VL suppression among new-to-care patients
2021 rate for this indicator: 76%
Overall 2022 goal for this indicator: 89%
Description: Increasing Viral Load Suppression Rates Among New to Care Patients through Interdisciplinary Case Conferencing Due to the COVID-19 pandemic, JPAFHC Ryan White support staff have been operating remotely for a large part of 2021. The team has not been able to meet with new patients in person or get to know their barriers very well. We have seen the most success engaging patients with treatment adherence issues utilizing a team approach, where the entire care team is on the same page with the plan of care and support.

We plan to implement a monthly Unsuppressed Viral Load Case Conference with the Ryan White support staff, treatment adherence nursing staff as well as medical providers. Monthly, our QI/Data Specialist will generate a list of unsuppressed patients at JPAFHC (with a viral load of <200). For those patients not currently engaged in high level intervention and/or are unfamiliar to the team, the team will meet to "present" the patient. Through chart review and/or knowledge of the patient, a team member will attempt to identify the patient's medical and psychosocial profile. The team will then work together to identify interventions that would work for the patient based on best-practice and the teams' varied experience working with patients of similar background/barriers.

The patient will then be assigned to a team member for follow up to support the implementation of the intervention with that patient. Though designed to support our new to care patients, this intervention will have the added benefit of targeting and supporting all patients who are virally unsuppressed to create individualized care plans based on a team approach. Assigned patient follow up will be closely tracked with outreach expected to be conducted within a week of the case conference. Once patient is engaged in the intervention, VL testing will be conducted within 2-3 months to assess how well the intervention is supporting the patient. If patient is still unsuppressed, they will be looped back into the case conferencing process.

Consumer Involvement

Due to continuing challenges with the COVID-19 pandemic as well as staff changes and vacancies, we have been unable to fully engage consumers in the review and formulation of our quality improvement project. There is a plan to establish a community advisory board. We are currently seeking technical assistance through our HRSA Part C funders to create and implement a sound plan in this regard.

Coach's Feedback and Updates on Cascade QI Plan

The program increased the viral suppression for their established patients. The program provided a good analysis of viral suppression performance among various patient subgroups. The data analysis supported their QI project selection. It is recommended that the program engage consumers in the process of developing the quality improvement plan. The program should also make efforts to get consumer feedback on its QI plan through patient surveys, focus groups, and/or including consumers on its QI project team.