

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:
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QI Profile Completion Date:
February 2023

Last Revision Date:
October 27, 2023

Program Name: Northwell Health - CYAAPH

Clinic Information

Type of Clinic	Clinic Name	Address	City	Zip
Hospital	Center for Young Adults, Adolescent and Pediatric HIV (CYAAPH)	865 Northern Boulevard, Suite 101	Great Neck	11021

Important Contacts

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Regional Group/Learning Network Participation

Learning Network Affiliation: Adolescent Quality Learning Network (AQLN), New York Links

Participated in Group QI Project? Yes

Focus: Accessing Mental Health (2019), Sexual Health: Assessment, Receive Counseling, Testing and Treatment Indicators (2020 & 2021)

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.

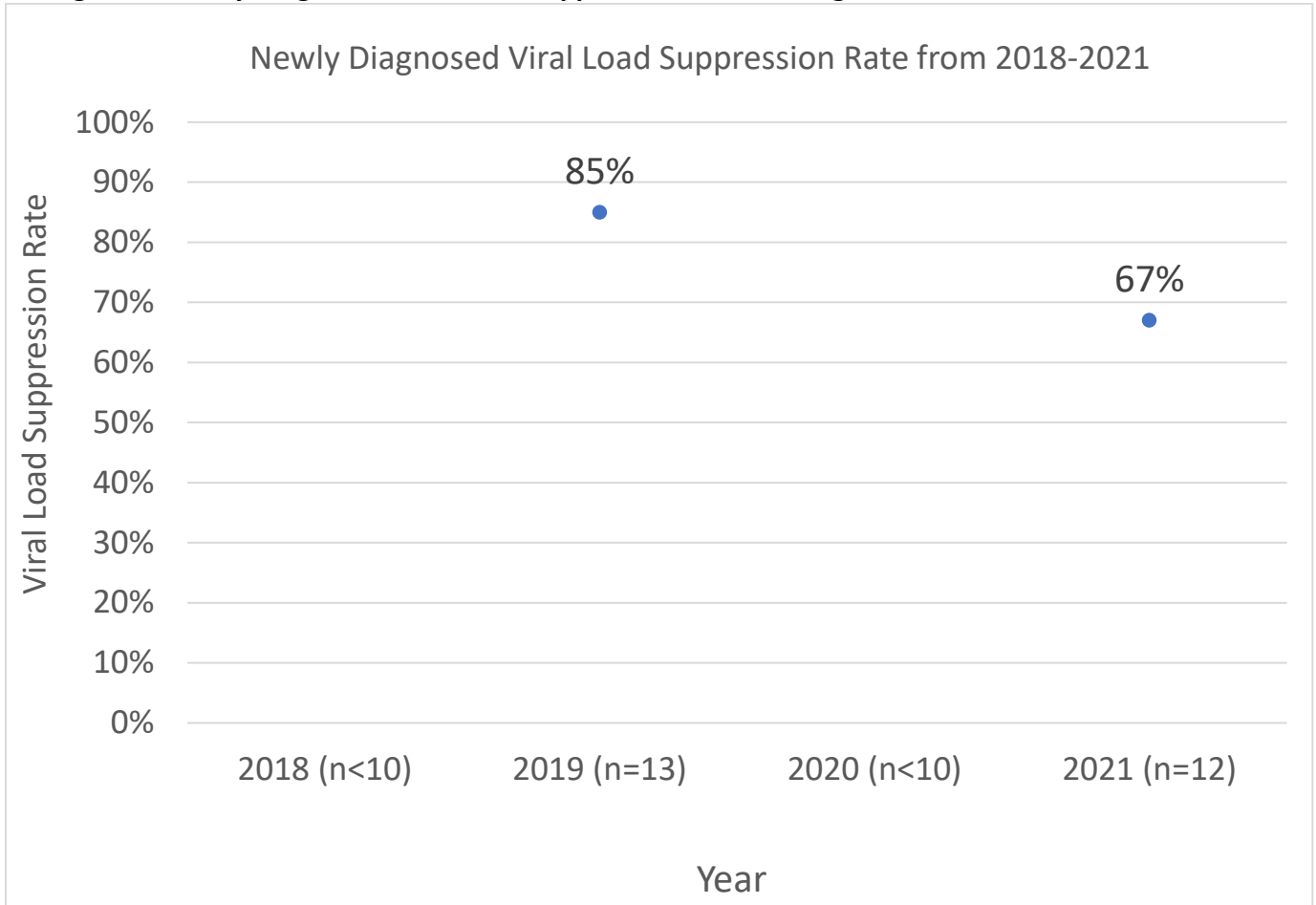
Suppressed within 91 Days (Newly Diagnosed Patients): A value of less than 200 copies/mL on any viral load test performed within 91 days of initial HIV diagnosis. Patients with no documented viral load test during this period are scored as unsuppressed.

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.

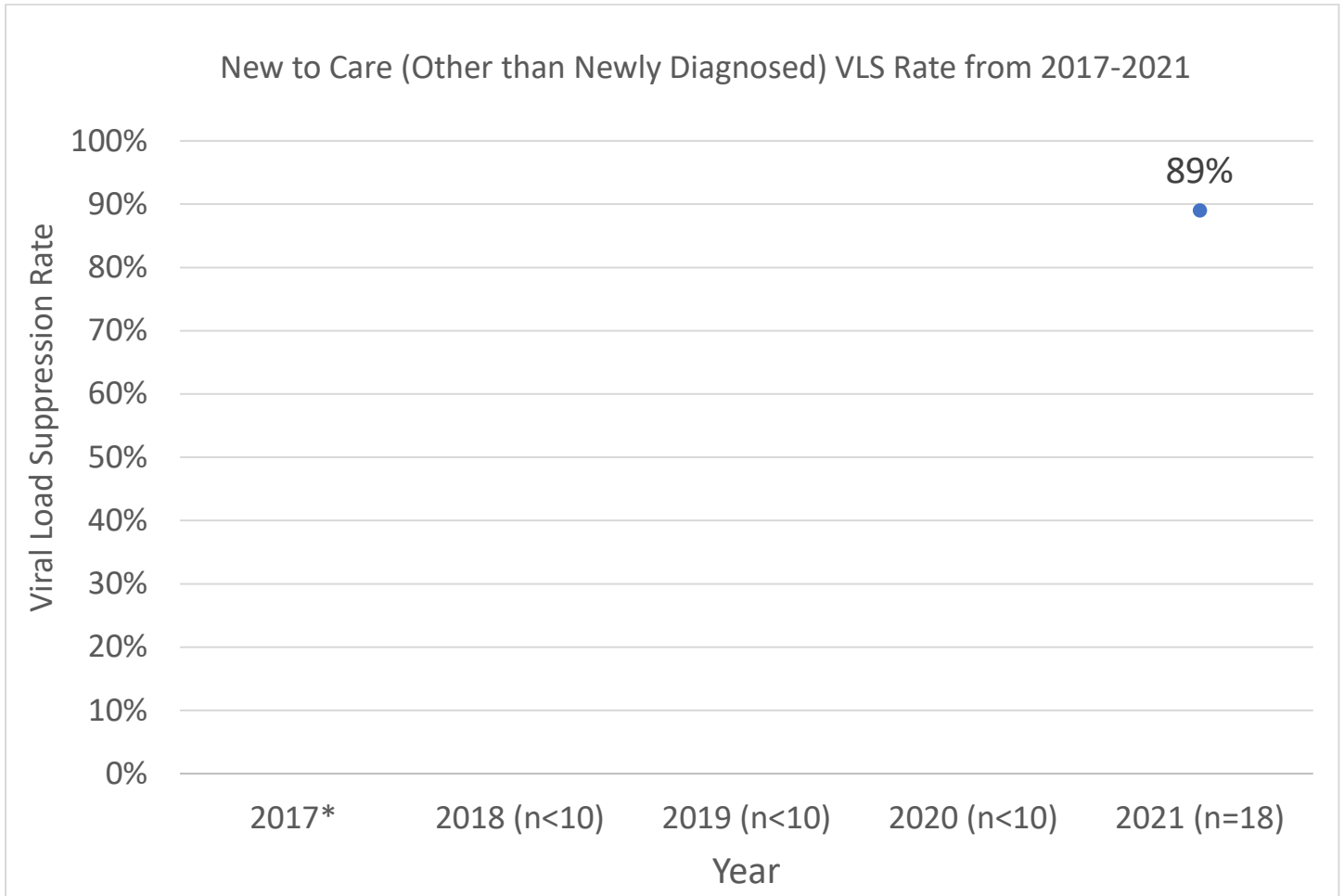
Key Indicators from 2017 to 2021

Figure 1. Newly Diagnosed Viral Load Suppression Rates at Organizational Level from 2018-2021



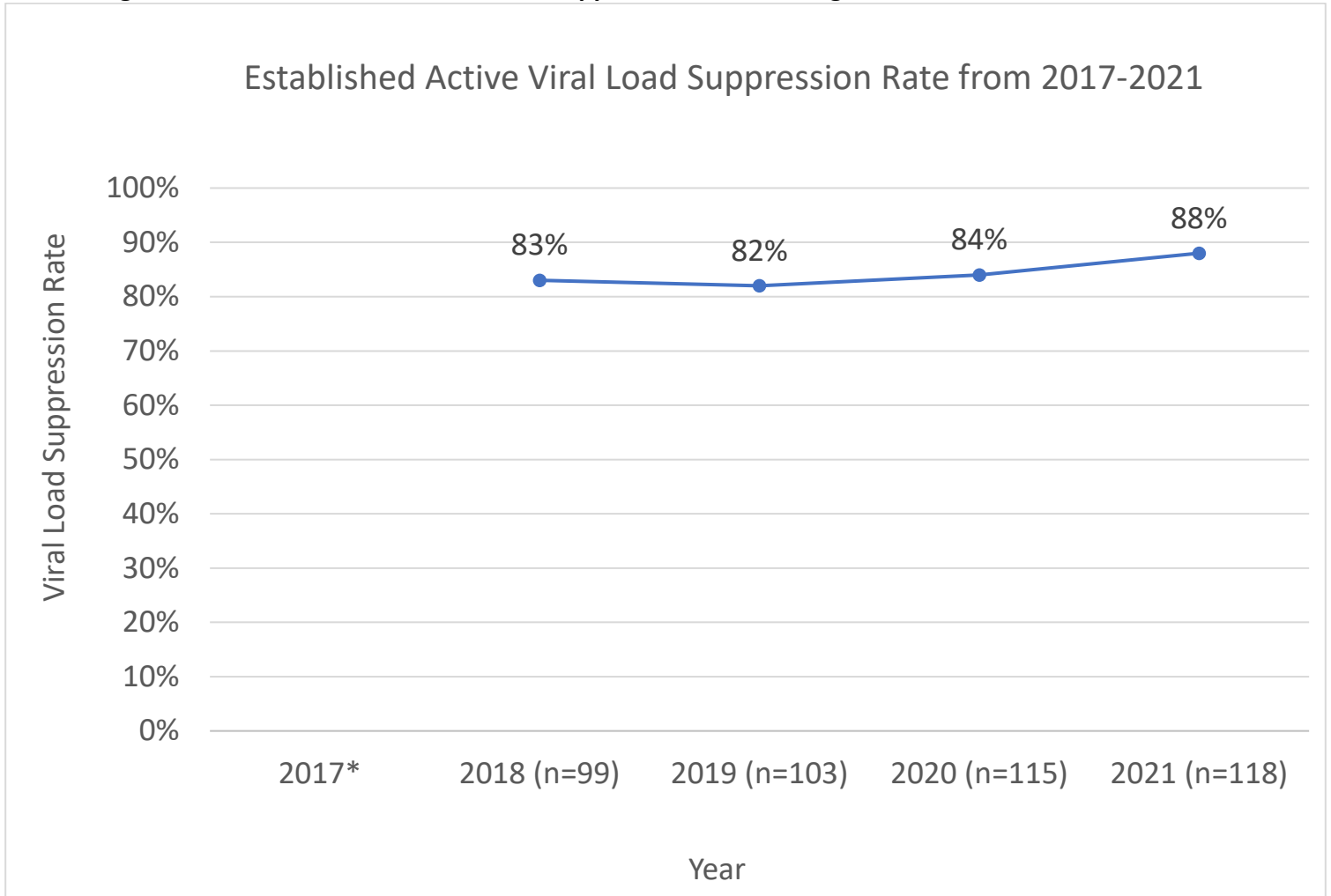
Note: *Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017, 2018, and 2020.

Figure 2: New to Care (Other than Newly Diagnosed) Viral Load Suppression Rates at Organizational Level from 2017-2021



*Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017.

Figure 3: Established Active Viral Load Suppression Rates at Organizational Level from 2017-2021



*Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017.

Figure 4. 2021 Viral Load Suppression Rates by Age at Organizational Level

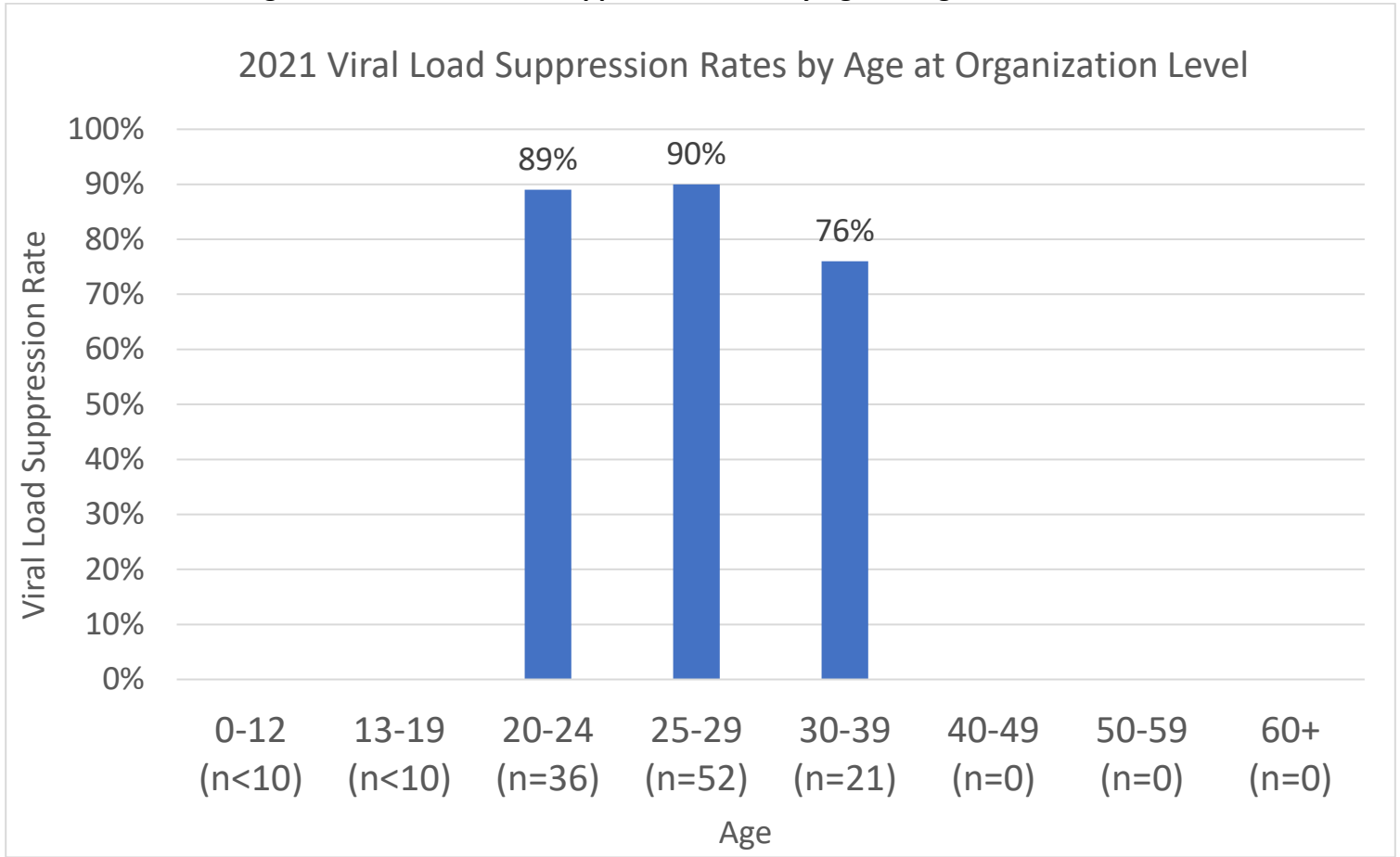
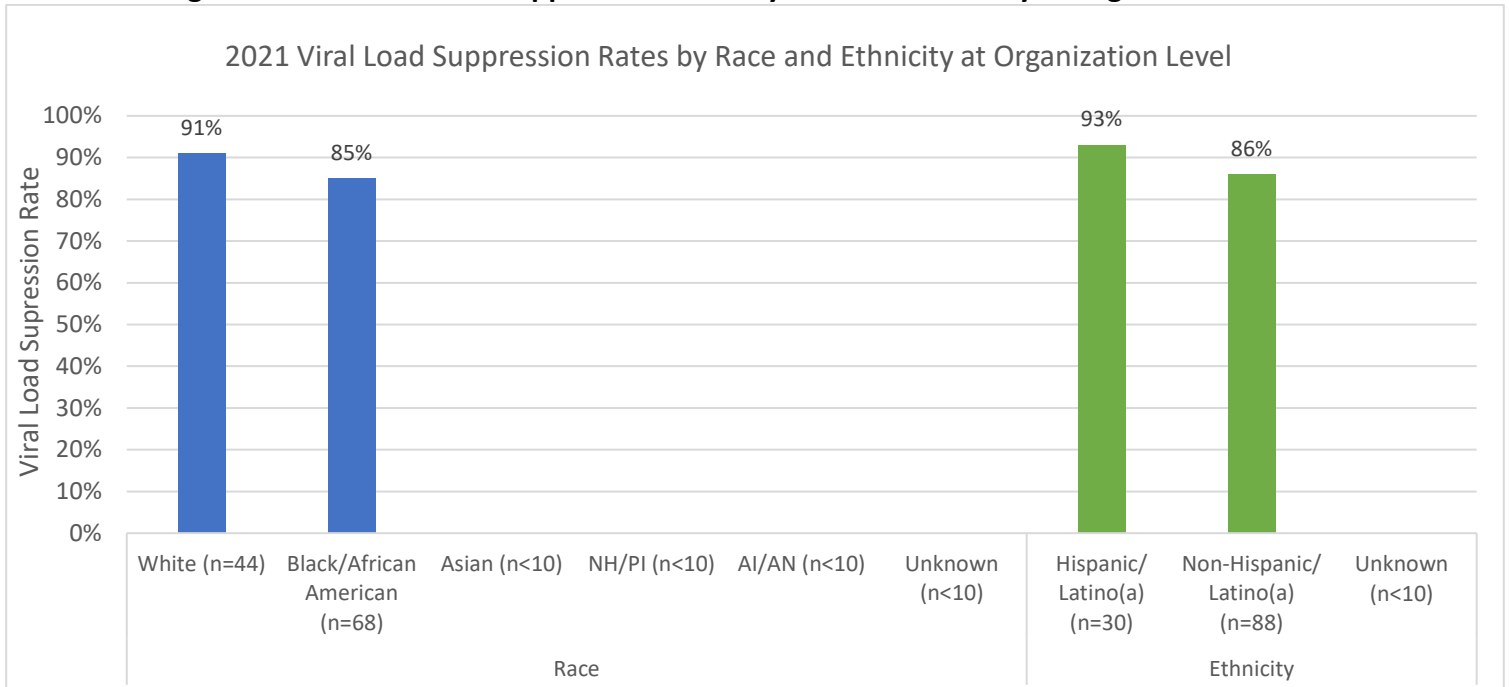


Figure 5. 2021 Viral Load Suppression Rates by Race and Ethnicity at Organizational Level



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

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE HIV QUALITY OF CARE PROGRAM

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	--	65%	-- (n<10)*	41%	-- (n<10)*	52%	-- (n<10)*	55%	-- (n<10)*	61%
	On ARV Therapy	--	91%	-- (n<10)*	96%	100% (n=13)	100%	-- (n<10)*	100%	92% (n=12)	100%
	VL Test within 91 Days	**	**	-- (n<10)*	93%	100% (n=13)	95%	-- (n<10)*	95%	92% (n=12)	92%
	Suppressed Final VL	--	65%	**	**	**	**	**	**	**	**
	Suppressed within 91 Days	**	**	-- (n<10)*	45%	85% (n=13)	50%	-- (n<10)*	46%	67% (n=12)	50%
	Baseline Resistance Test	**	**	**	**	100% (n=13)	74%	-- (n<10)*	80%	92% (n=12)	82%
Other New to Care	On ARV Therapy	--	96%	-- (n<10)*	97%	-- (n<10)*	100%	-- (n<10)*	100%	100% (n=18)	100%
	Any VL Test	--	97%	-- (n<10)*	99%	-- (n<10)*	98%	-- (n<10)*	100%	100% (n=18)	100%
	Suppressed Final VL	--	70%	-- (n<10)*	74%	-- (n<10)*	78%	-- (n<10)*	77%	89% (n=18)	69%
Established Active	On ARV Therapy	--	99%	99% (n=99)	99%	99% (n=103)	99%	100% (n=115)	93%	100% (n=118)	99%
	Any VL Test	--	99%	100% (n=99)	99%	98% (n=103)	99%	100% (n=115)	97%	100% (n=118)	98%
	Suppressed Final VL	--	88%	83% (n=99)	88%	82% (n=103)	89%	84% (n=115)	87%	88% (n=118)	88%
Open Previously Diagnosed (Active & Inactive)	On ARV Therapy	--	92%	99% (n=99)	95%	99% (n=103)	96%	100% (n=115)	96%	100% (n=118)	97%
	Any VL Test	--	92%	100% (n=99)	93%	98% (n=103)	93%	100% (n=115)	90%	100% (n=118)	94%
	Suppressed Final VL	--	80%	83% (n=99)	80%	82% (n=103)	83%	84% (n=115)	77%	88% (n=118)	79%

Note: Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017.

* 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*	--	36	89%	52	90%	21	76%	<10*	--	<10*	--	<10*	--
GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Unknown Gender					
n	%	n	%	n	%	n	%	n	%	n	%		%		%
69	91%	46	83%	<10*	--	<10*	--	<10*	--	<10*	--				
RACE															
White		Black/African American		Asian		Native Hawaiian/PI		American Indian/ AN		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%		%		%
44	91%	68	85%	<10*	--	<10*	--	<10*	--	<10*	--				
ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%		%		%		%		%		%
30	93%	88	86%	<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	%
<10*	--	21	76%	50	94%	<10*	--	<10*	--	49	88%	<10*	--	<10*	--
HOUSING STATUS															
Stable Housing		Unstably Housed		Temporarily Housed		Unknown Housing									
n	%	n	%	n	%	n	%		%		%		%		%
111	89%	<10*	--	<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	%
<10*	--	<10*	--	64	83%	<10*	--	43	95%	<10*	--	<10*	--	<10*	--
Unknown															
n	%		%		%		%		%		%		%		%
<10*	--														

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

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

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

Methodology

Data extraction methods for Center for Young Adults, Adolescent and Pediatric HIV (CYAAPH) have remained the same for the past several years. Information about all HIV+ individuals were extracted from the Appointment Management System, Soarian Financials, Allscripts (AEHR), AIDS Institute Reporting System (AIRS) and internal medical case management data source (excel). The above data source was also utilized to obtain data patient enrollment and diagnosed status. Limitations exist in combining data from all the sources in order to obtain one clean, analyzable dataset. CART and CYAAPH use similar systems to collect data (i.e. EMR. Redcap, AIRS, CareWare, etc.) as we are under one health system. There is always room for errors when utilizing different data sources. We seek to minimize this risk by carefully cross-referencing patients, and centralizing data based on unique identifiers. The use of quarterly improvement meetings to discuss programming and data efforts supports each program's work for improvement.

Since data is extracted from separate systems, there are sometimes differences in patient identifiers. For example, there may be patients with two last names in Allscripts, but not in AIRS. Furthermore, AIRS data entry is manual and does not automatically pull patient identifiers from the electronic health records, thus allowing for misspelling of names or mistakes in date of birth. Data was exported into excel and cross validated based on sorting of identifiers. Patients from each data set who cannot be linked are then compared using approximate matching methods which compares in exact textual data, assigns similarity, and allows for joining data from multiple data sets into one. The data sources were chosen as these are the sources that contain information on all CYAAPH patients, thus allowing for extraction of appointment, viral load, and medication data for the cascades. The sources also inform on information such as housing, insurance and risk category for the disaggregation of the active caseload.

For those patients that are non-active, CYAAPH makes several attempts to reengage them in care. In addition to a traditional way of communicating with each patient (i.e. phone call, VM message, we use technology which includes: texting, instant messaging, IPAD/tablets to follow- patients and build opportunities for reengagement). Often this works, but for cases, the patients are still not engaged, despite efforts made to date.

The data entry staff and Data Analyst were responsible for extracting and entering data into the template. The Medical Director and Grant Manager ensured complete accuracy of the 2021 cascade data. The results were analyzed by the Data Analyst and the Medical Director. The quality committee team held meetings to analyze and discuss the outcome of the cascade. We shared data through secured emails amongst the team and utilized all graphic display available from the template during the analysis process.

Key Findings

The Center for Young Adult, Adolescent Pediatric HIV always strive to meet and surpass goals including the New York State objective of viral load suppression greater than 85% of PLWHA in continuous care (as recommended by the NYS AIDS Institute Clinical Guidelines). The 2021 cascade shows an overall VL Suppression rate for CYAAPH active patients of 88%, excluding those who were newly diagnosed and new to care. An increase of 4% from 84% in 2020, which surpassed the goal of 87% set in 2020. This is an unexpected finding because the COVID-19 pandemic is still affecting organizational operation in 2021. However, increase in viral load suppression remains one of our main goals regardless of the circumstances. CYAAPH implemented several processes to improve viral load

suppression. As projected, those efforts seem to affect the viral load suppression rate for the 13–19-year-old subgroup with an increase 17%, 83% from 2020 to 100% in 2021. 20–24-year-old subgroup also saw an increase from 82% to 89% in 2021. VL suppressing has remained consistently above average for the 25–29-year-old subgroup at 90%. Furthermore, consistent improvement is detected when the data is disaggregated with gender, ethnicity, risk factors and housing status. The female subgroup increased from 74% to 83%. Consistent improvement is noted in the Black subgroup for the past two years, from 76% in 2019 to 82% in 2020, to 85% in 2021. The Hispanic subgroup increased from 79% to 93%, and the perinatal subgroup from 77% to 88% and those who maintain stable housing from 85% to 89% in 2021.

Moving forward, we continually aim to improve our overall viral suppression rate metric by increasing it by 2% to reach 90% in 2022. We also want to maintain the objective of reducing the gap in viral load suppression between patients who identify as Black 85% and Hispanic 93%. The same efforts and strategies will be consistent with our small population with unstable housing who had 50% viral load suppression rate in 2021, a decrease from 60% in 2020. This group is often faced with a constant challenge of medication adherence and retention due to instability. Thus, medical treatment may not be at the highest priority. Housing continues to be an essential factor in viral load suppression. The most common contributing factors to low and declining of viral load consist of low health literacy, mental health issues, and socio-economic factors.

COVID-19 pandemic continues to worsen the challenges we already face. For example, we have a patient who transferred from another organization to our facility but due to unstable housing and a severe mental health condition, the patient was unable to return for care and treatment. Our case managers, with multiple attempts were unsuccessful tracking the patient down. This patient is missing resistance test and was not able to start treatment. We have 19 patients who have managed Medicaid plans. Those Medicaid numbers don't meet the criteria on this template, and therefore, the template is not accepting the numbers.

The center will continue to emphasize on the lessons learned and optimize the strategies that are working well with our patients to continue to improve on metric and patient care. The quality improvement team will continue to implement evidence based behavioral interventions (EBIs) to address the challenges restraining our patients. In addition to the EBIs, with a continuous assistance with housing for patients who are eligible, we project to reduce the disparity in viral load suppression for patients who are in unstable housing situation. We foresee our viral load suppression to improve by December 2022 for the patients who are not virally suppressed.

QI Projects

QI Project #1

Indicator: VL suppression among established active patients

2021 rate for this indicator: 88%

Overall 2022 goal for this indicator: 90%

Description: CYAAPH continually aims to improve our overall viral suppression rate metric by increasing it by 2% to reach 90% in 2022. Our Quality Improvement team are currently working together by reviewing charts and identifying eligible patients for implementation of a multidisciplinary approach to increase viral load suppression. This includes psychologist, who continues to implement evidence based behavioral interventions (EBIs) to patients with mental health priority. In addition to the EBIs, there is a continuous assistance with housing for the eligible patients. The team is also doing monthly chart audit to identify any patients who may fall under any deliverables so they can be addressed immediately. The medical case managers are also doing enhanced personal contact to reach patients prior to scheduled appointments, address any pressing needs in efforts to increase retention, and ultimately viral load suppression. Since telehealth services and lab fly have been integrated into patient care, we

Program Summary: Northwell Health - CYAAPH

plan to continue this practice to leverage retention in care and medication adherence. We foresee our viral load suppression to improve by December 2022 for patients who are not virally suppressed.

Consumer Involvement

The care team continue to include patients and their support system (family member, friends, peer, etc.) in the care process, and to provide additional support by attending appointments as well as advocate for consumers medications adherence. Pediatrics Caregivers of North Shore (PICONs)-parents and relatives of patients meet monthly to discuss relevant medical care, best practices, challenges, and concerns, that are also shared with our care team. A representative from the community advisory board also attends our quarterly quality meetings where quality improvement projects are discussed. In addition, CYAAPH also disseminate surveys to patients for input and recommendations. This year, we experience a low representation from consumers. Nevertheless, we value their input and participation. 88% of the patients who completed the survey indicated that our staff listen to their needs and concerns. All participants indicated that our care team works in collaboration with them to achieve their personal health plan goals. 88% of consumers noted that they have smooth appointments with personable staff who clearly explain everything. Regarding patient visits, they expressed the flexibility with making appointments as well as feeling comfortable with the team. As an improvement, the consumers suggest that the center offers more time and days for appointment availability. They are also interested in receiving information on new development on HIV. The information gathered from the survey are being implemented to meet our patients where they are.

Coach's Feedback and Updates on Cascade QI Plan

Robust methodology and QI projects are consistent with findings.