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 report is intended for use within the AIDS Institute and the reporting medical organization and is not intended for outside dissemination.

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 2023

QI Profile Completion Date:
April 2024

Latest Revision Date:
April 2024

Program Name: Albany Medical Center

Clinic Information

Type of Clinic	Clinic Name	Address	City	Zip
Hospital	DM/HIV - Clara Barton	1 Clara Barton Drive	Albany	12208
Hospital	DM/ID - Hackett Blvd	25 Hackett Blvd	Albany	12208
Hospital	DP/SCCAYA	22 New Scotland Ave	Albany	12208
Hospital	DM – Washington Ave	178 Washington Avenue	Albany	12203
Hospital	DM/MPG - Latham	1019 New Loudon Road	Latham	12047
	Multi-Specialty Clifton Park	453 Route 146	Clifton Park	12065
	Multi-Specialty Amsterdam	375 Golf Course Road	Amsterdam	12010

Important Contacts

HIV Medical Director	Alexandra Abrams-Downey	Abramsa2@amce.edu	(518) 262-4043
HIV Program Administrator	Gina Sleeper	sleeperg@amc.edu	
Lead QI Contact	Sabine Needham	NeedhaS@amc.edu	(518) 262-4676
Contract Manager	Romel Wilson	Romel.wilson@health.ny.gov	
NY Links Coach	Daniel Belanger	Daniel.belanger@health.ny.gov	(212) 417-5131

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 2017-2022

Figure 1. Newly Diagnosed Viral Load Suppression Rates at Organizational Level from 2017-2022

Newly Diagnosed Viral Load Suppression Rate from 2018-2022
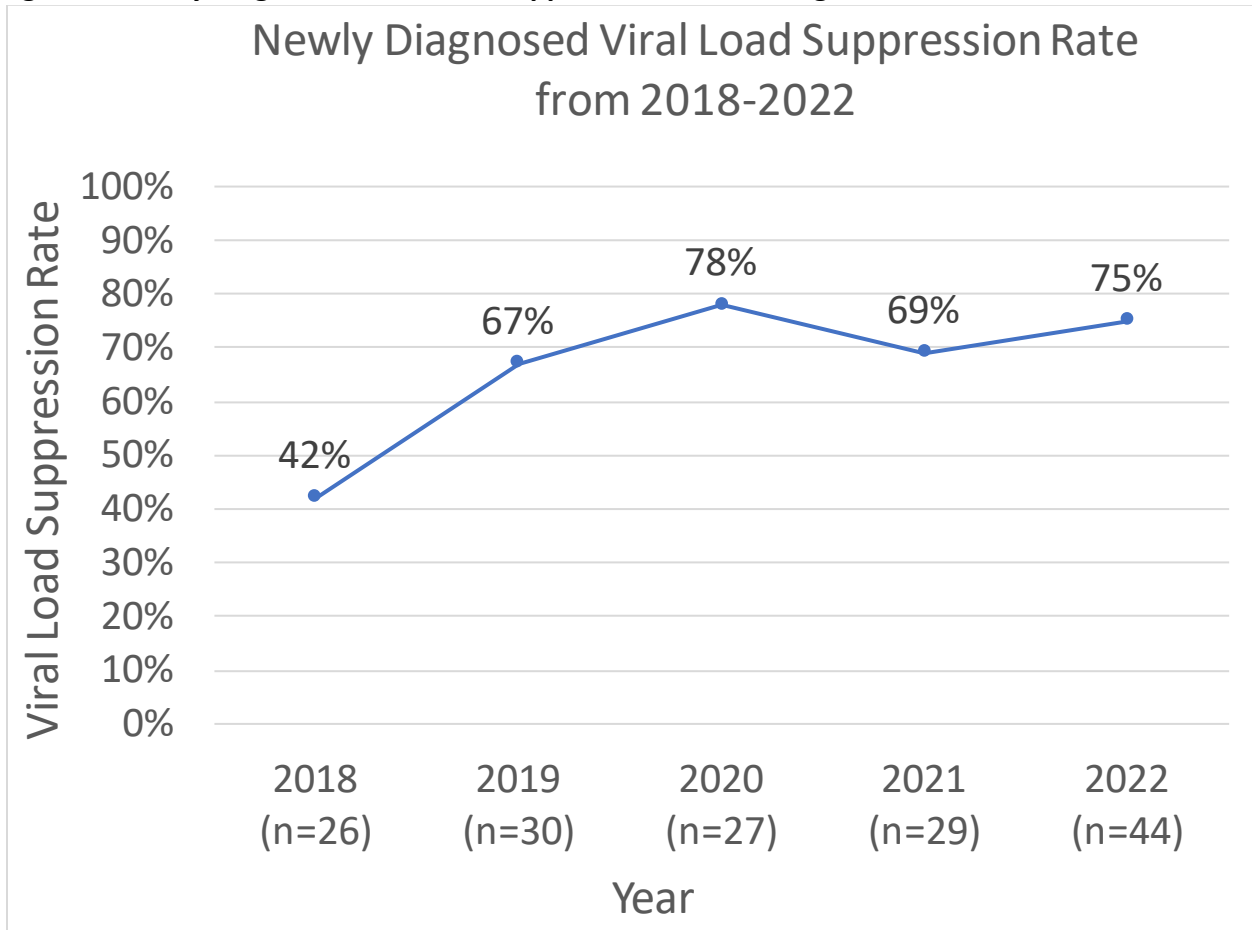
Note: Data from 2017 has been redacted due to small number of applicable patients (fewer than 10).

Figure 2: New to Care (Other than Newly Diagnosed) Viral Load Suppression Rates at Organizational Level from 2017-2022
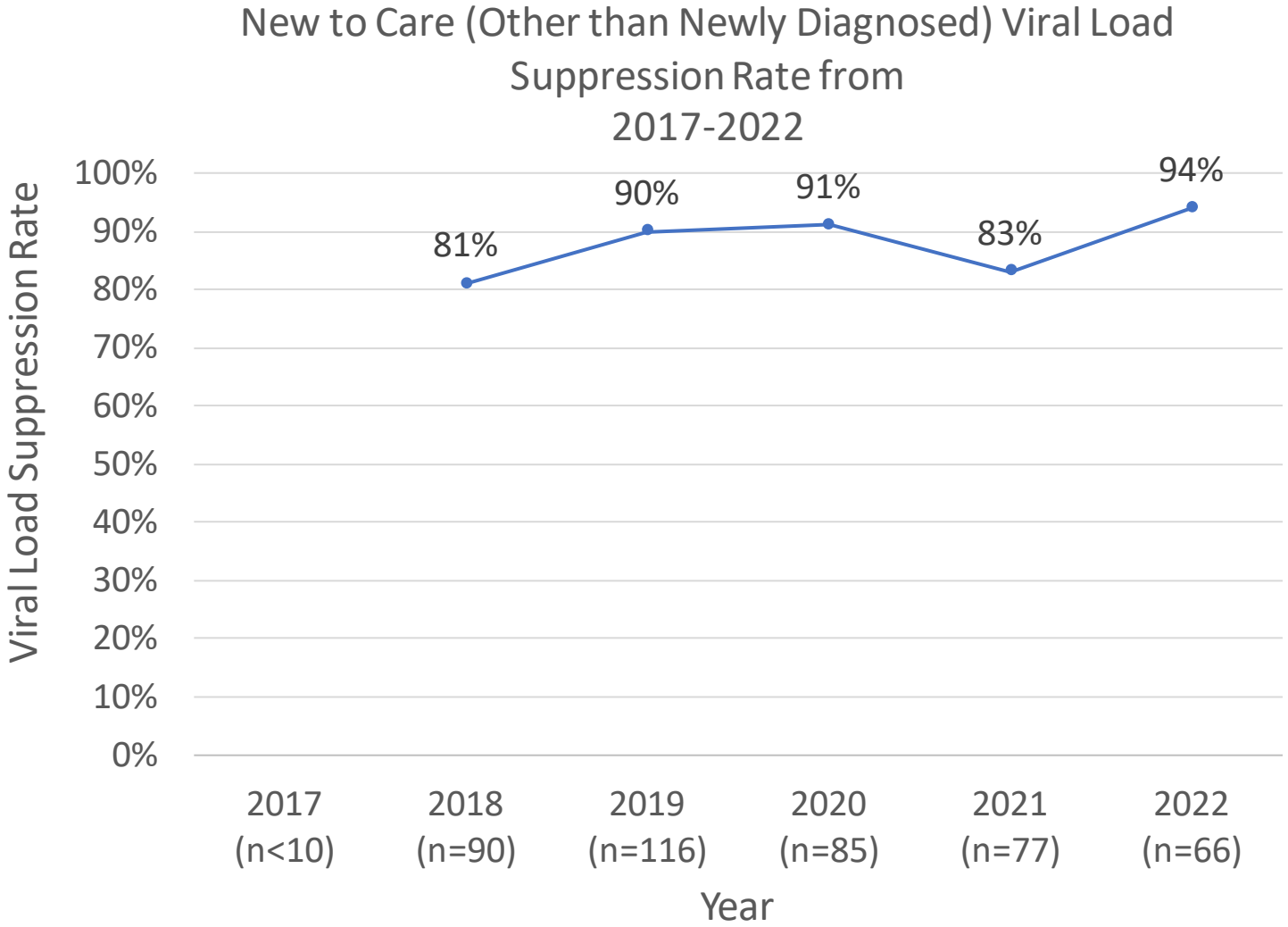
New to Care (Other than Newly Diagnosed) Viral Load Suppression Rate from 2017-2022

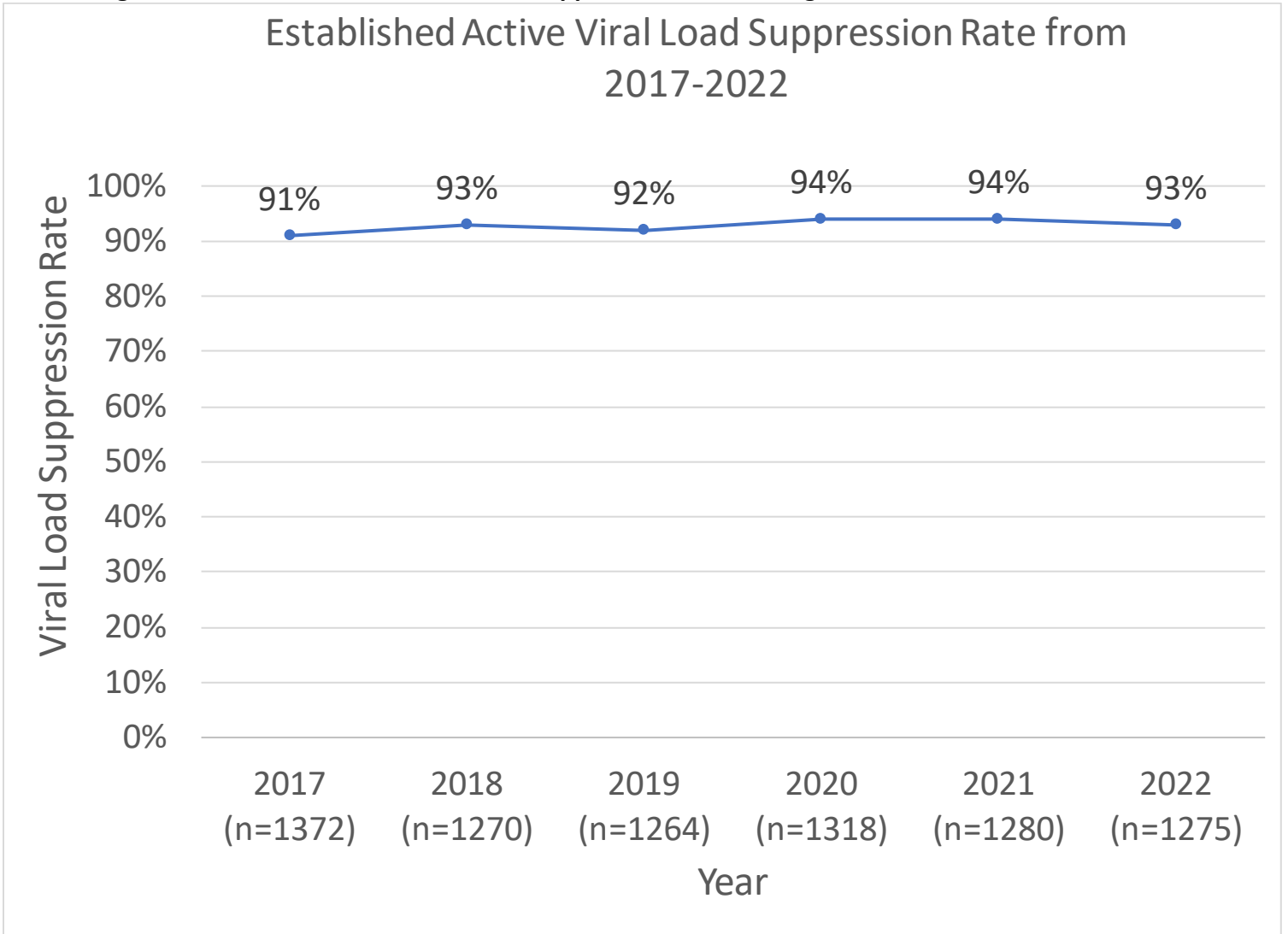**Figure 3: Established Active Viral Load Suppression Rates at Organizational Level from 2017-2022**

Established Active Viral Load Suppression Rate from 2017-2022

Figure 4. Time to Linkage Rates

Albany Medical Center
2022 Linkage Rates by Time Interval (n=15)

Legend:
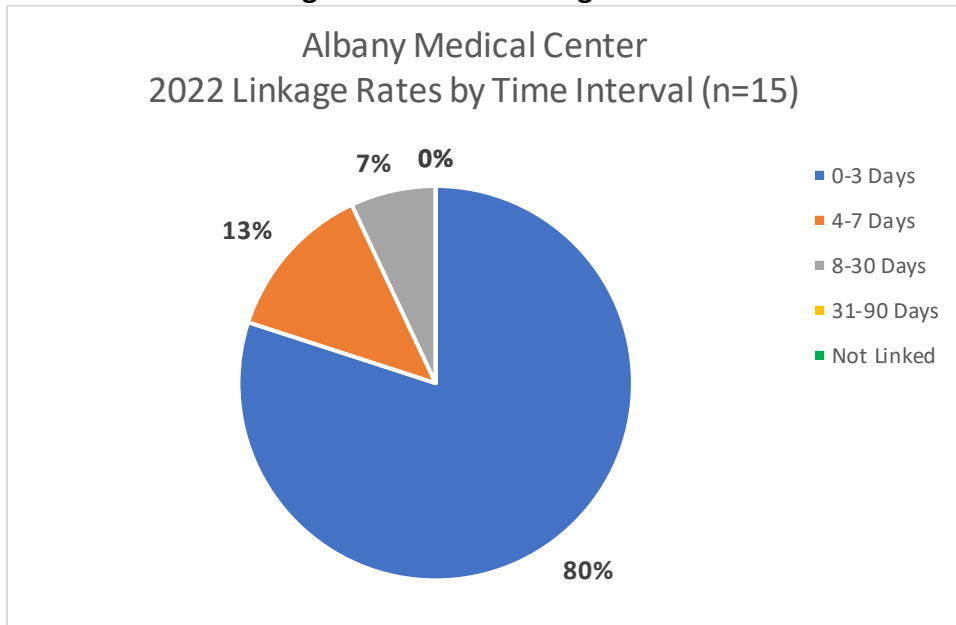- 0-3 Days
- 4-7 Days
- 8-30 Days
- 31-90 Days
- Not Linked

Figure 5. 2022 Established Active Viral Load Suppression Rates by Age at Organizational Level

2022 Established Active Viral Load Suppression Rates by Age at Organization Level

Viral Load Suppression Rate by Age:

Age	Rate
0-12 (n<10)	
13-19 (n<10)	
20-24 (n=16)	75%
25-29 (n=47)	91%
30-39 (n=141)	87%
40-49 (n=180)	91%
50-59 (n=427)	95%
60+ (n=460)	95%

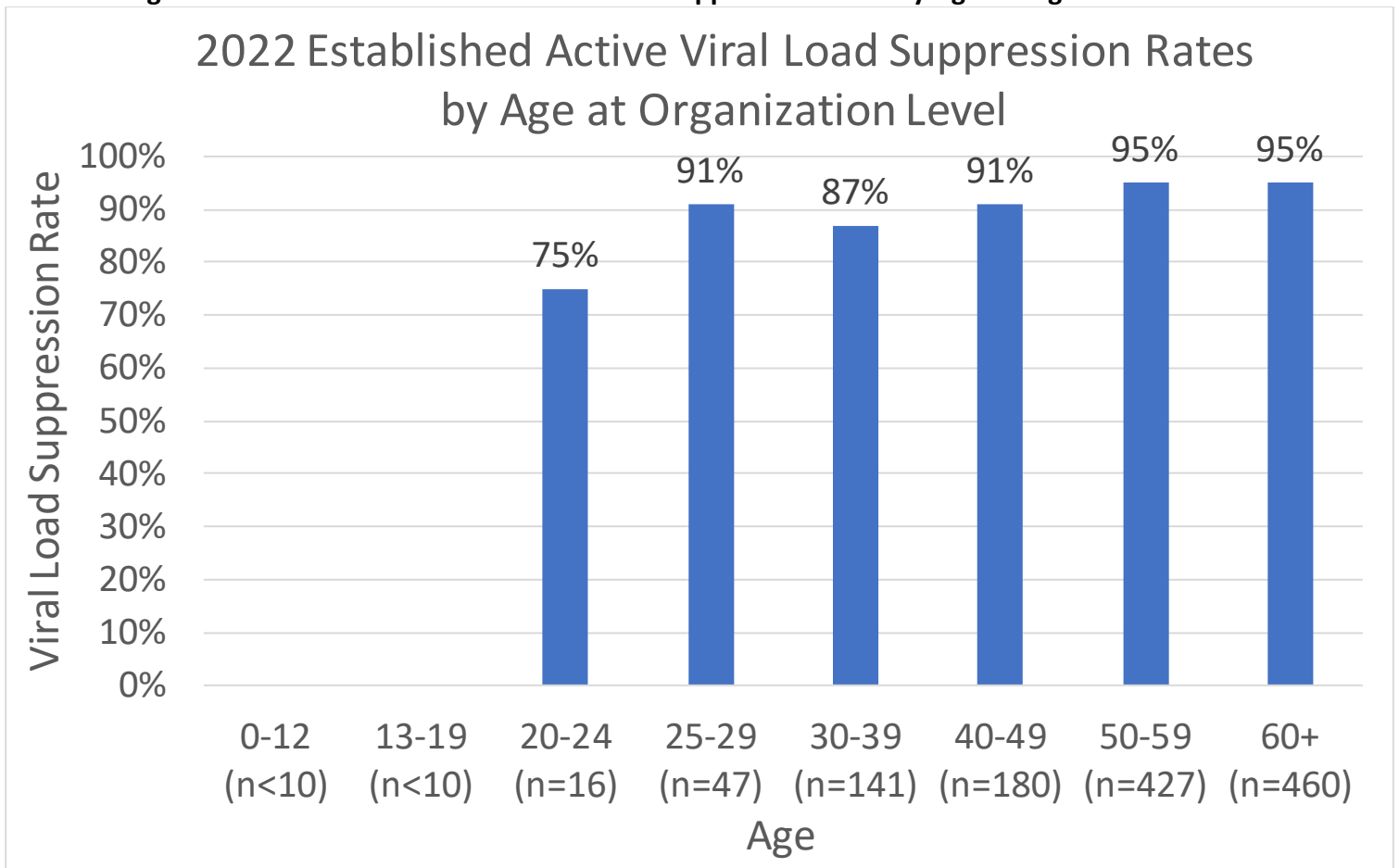**Figure 6. 2022 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organizational Level**
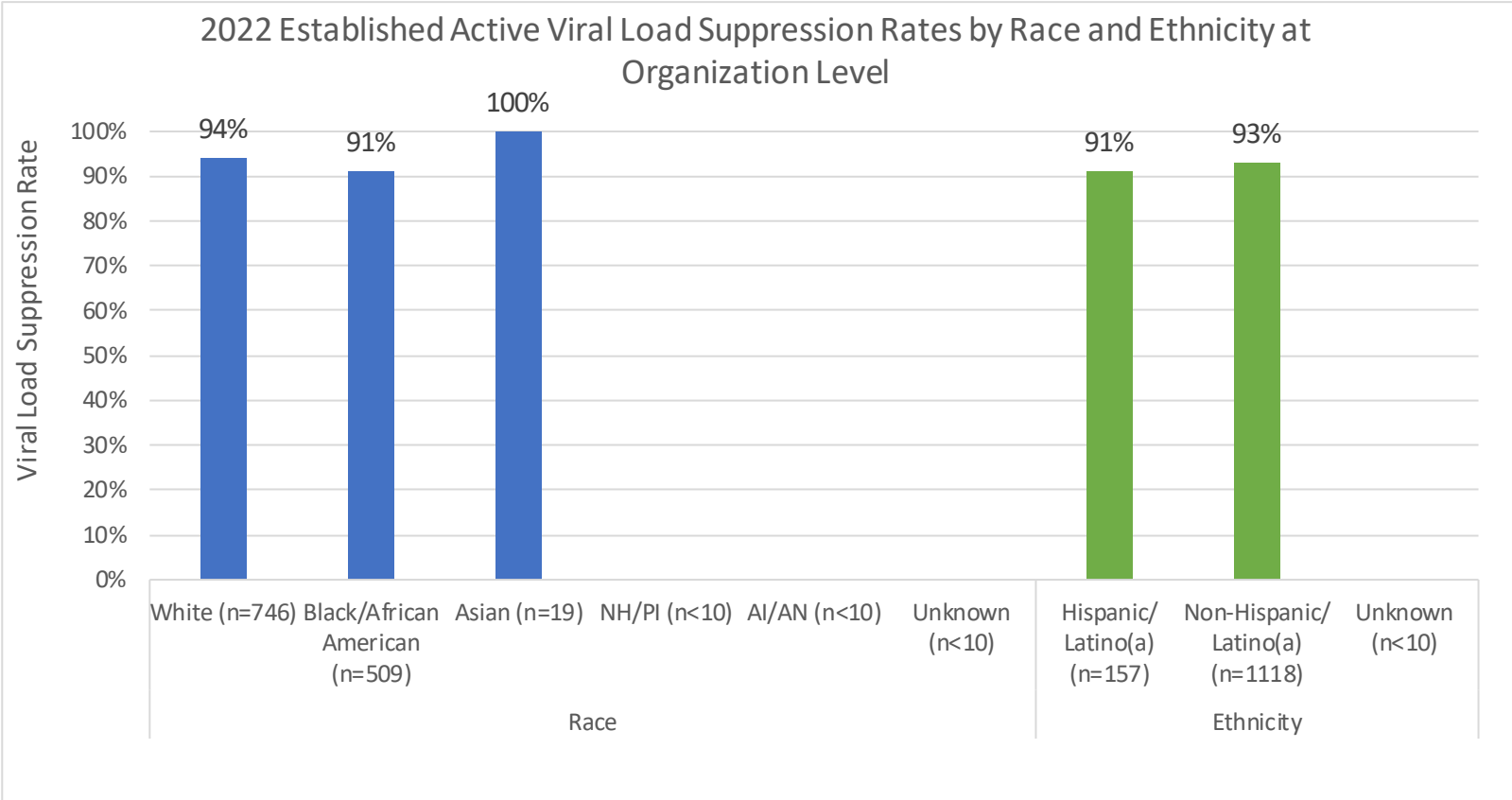

2022 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organization Level

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

Table 1: Indicator Scores at Organization Level for 2017-2022

Patient Group	Indicator	2017 Org. Score	2017 State Median	2018 Org. Score	2018 State Median	2019 Org. Score	2019 State Median	2020 Org. Score	2020 State Median	2021 Org. Score	2021 State Median	2022 Org. Score	2022 State Median
Newly Diagnosed	3-day Linkage to Care	33% (n=15)	65%	-- (n<10)*	41%	-- (n<10)*	52%	75% (n=12)	55%	43% (n=14)	61%	80% (n=15)	53%
	On ARV Therapy	-- (n<10)*	91%	96% (n=26)	96%	100% (n=30)	100%	100% (n=27)	100%	100% (n=29)	100%	100% (n=44)	100%
	VL Test within 91 Days	**	**	100% (n=26)	93%	93% (n=30)	95%	100% (n=27)	95%	97% (n=29)	92%	98% (n=44)	96%
	Suppressed Final VL	-- (n<10)	65%	**	**	**	**	**	**	**	**	**	**
	Suppressed within 91 Days	**	**	42% (n=26)	45%	67% (n=30)	50%	78% (n=27)	46%	69% (n=29)	50%	75% (n=44)	50%
	Baseline Resistance Test	**	**	**	**	90% (n=29)	74%	96% (n=27)	80%	96% (n=26)	82%	86% (n=43)	80%
Other New to Care	On ARV Therapy	-- (n<10)*	96%	99% (n=90)	97%	100% (n=116)	100%	96% (n=85)	100%	97% (n=77)	100%	98% (n=66)	100%
	Any VL Test	-- (n<10)*	97%	100% (n=90)	99%	99% (n=116)	98%	100% (n=85)	100%	99% (n=77)	100%	98% (n=66)	98%
	Suppressed Final VL	-- (n<10)*	70%	81% (n=90)	74%	90% (n=116)	78%	91% (n=85)	77%	83% (n=77)	69%	94% (n=66)	78%
Established Active	On ARV Therapy	99% (n=1372)	99%	100% (n=1270)	99%	100% (n=1264)	99%	99% (n=1318)	93%	99% (n=1280)	99%	100% (n=1275)	100%
	Any VL Test	99% (n=1372)	99%	100% (n=1270)	99%	99% (n=1264)	99%	98% (n=1318)	97%	98% (n=1280)	98%	98% (n=1275)	98%
	Suppressed Final VL	91% (n=1372)	88%	93% (n=1270)	88%	92% (n=1264)	89%	94% (n=1318)	87%	94% (n=1280)	88%	93% (n=1275)	89%
Open Previously Diagnosed (Active & Inactive)	On ARV Therapy	97% (n=1507)	92%	92% (n=1539)	95%	95% (n=1514)	96%	94% (n=1494)	96%	96% (n=1452)	97%	95% (n=1469)	97%
	Any VL Test	94% (n=1507)	92%	87% (n=1539)	93%	86% (n=1514)	93%	89% (n=1494)	90%	88% (n=1452)	94%	87% (n=1469)	93%
	Suppressed Final VL	85% (n=1507)	80%	79% (n=1539)	80%	79% (n=1514)	83%	84% (n=1494)	77%	84% (n=1452)	79%	83% (n=1469)	83%

* 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 2022

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*	--	16	75%	47	91%	141	87%	180	91%	427	95%	460	95%

GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Gender X		Unknown Gender			
n	%	n	%	n	%	n	%	n	%	n	%	n	%		
830	93%	435	93%	<10*	--	<10*	--	<10*	--	<10*	--	<10*	--		

RACE															
White		Black/African American		Asian		Native Hawaiian/PI		American Indian/ AN		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%				
746	94%	509	91%	19	100%	<10*	--	<10*	--	<10*	--				

ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
157	91%	1118	93%	<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	%
135	94%	595	93%	504	93%	<10*	--	17	94%	25	80%	<10*	--	12	100%

HOUSING STATUS															
Stable Housing		Unstably Housed		Temporarily Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
1147	94%	20	75%	101	86%	<10*	--								

INSURANCE TYPE															
ADAP		Dual Eligible		Medicaid		Medicare		Private Insurance		Veteran's Admin		Other		No Insurance	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
242	98%	250	95%	424	89%	96	93%	255	94%	<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 2017-2022

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	DHIVM	**	**	**	**	99% (n=1338)	99% (n=1338)	91% (n=1338)
	PID/SCCAYA	**	**	**	**	97% (n=34)	100% (n=34)	88% (n=34)
2018	DHIVM	**	99% (n=90)	100% (n=90)	81% (n=90)	100% (n=1239)	100% (n=1239)	93% (n=1239)
	PID/SCCAYA	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	97% (n=29)	100% (n=29)	86% (n=29)
	DM/ID	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	DM/Washington Ave	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
2019	DHIVM	89% (n=28)	100% (n=115)	99% (n=115)	90% (n=115)	100% (n=1238)	99% (n=1238)	92% (n=1238)
	PID/SCCAYA	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	96% (n=26)	100% (n=26)	88% (n=26)
	DM/ID	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
2020	Department of Medicine/HIV - Clara Barton	96% (n=27)	96% (n=83)	100% (n=83)	92% (n=83)	99% (n=1295)	98% (n=1295)	94% (n=1295)
	Department of Medicine/Infectious Diseases - Hackett Blvd	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Department of Pediatrics: Specialized Care Center for Adolescents and Young Adults	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=21)	100% (n=21)	86% (n=21)
2021	Department of Medicine/HIV - Clara Barton	**	**	**	**	99% (n=1261)	98% (n=1261)	94% (n=1261)
	Department of Medicine/Infectious Diseases - Hackett Blvd	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Department of Pediatrics: Specialized Care Center for Adolescents and Young Adults	**	**	**	**	100% (n=17)	100% (n=17)	88% (n=17)
2022	Department of Medicine/HIV - Washington	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Department of Medicine/HIV - Clara Barton	**	**	**	**	100% (n=1260)	98% (n=1260)	93% (n=1260)
	Department of Medicine/Infectious Diseases - Hackett Blvd	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Department of Medicine/HIV - Latham	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Department of Pediatrics: Specialized Care Center for Adolescents and Young Adults	**	**	**	**	92% (n=13)	100% (n=13)	69% (n=13)
	Multi-Specialty Clifton Park	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*

Program Summary: Albany Medical Center

	Multi-Specialty Amsterdam	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (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 2023 (Self-reported based on 2022 results)

Methodology

Information for the Albany Medical Center (AMC) HIV Treatment Cascade(s) was generated using Soarian, our inpatient (IP) electronic health record (EHR); Allscripts, our outpatient (OP) EHR; and the AIDS Institute Reporting System (AIRS), our AIDS Program database used for patients served by the Division of HIV Medicine (DHIVM) and the Specialized Care Center for Adolescents and Young Adults (SCCAYA). We used internal documents, patient records, HIXNY, and public information on people in county jails or the prison system to supplement information from these reports. We chose Soarian because it contains demographic, insurance, lab reports, and provider notes for all IP and Emergency Department (ED) patients served at Albany Medical Center. Allscripts provides similar information for patients receiving ambulatory care. AIRS contains information needed to complete all data elements of the cascade for patients served by the Division of HIV Medicine and Specialized Care Center for Adolescents and Young Adults, and it represented the entire active caseload except for a few patients seen by the Division of Infectious Disease.

We began with separate reports from each of the above systems. For Soarian, we requested a list of all patients with an HIV diagnosis who received services at the hospital or Emergency Department, including labs, imaging, surgery, and procedures. For patients on this list, we received name, medical record number (MRN), date of birth (DOB), date of death, race, ethnicity, primary language, sex or gender, address, insurance, date/result of last 2022 viral load (VL), discharge disposition, and service location. We requested a list of all patients with HIV screening and HIV antibody tests. This list provided the above information and date/result of any HIV screening or antibody tests. An analyst from the Albany Medical Center Medical IS Team provided the Soarian reports. For Allscripts, we requested the above information on patients served anywhere in the outpatient setting. The Faculty Practice Applications Specialist provided this information. For AIRS, the Division of HIV Medicine Senior Applications Specialist (SAS) generated a list of all HIV-positive patients who attended medical visits at the Division of HIV Medicine and Specialized Care Center for Adolescents and Young Adults programs in 2022. This included information on nearly all the cascade data elements. The report also included AIRS intake date, date of the last HIV provider visit during 1/1/20 - 12/31/21, and date of last viral load measurement during 1/1/20-12/31/21, allowing us to identify patients returning to care after a 2-year lapse and previously diagnosed patients transferring services to our program.

We modified each spreadsheet from the above reports to match the AIDS Institute cascade template. The Division of HIV Medicine SAS merged the files. She removed duplicates using Excel® functions. However, this did not remove all duplicates. Some patients in Soarian and AIRS have MRNs with six digits while Allscripts requires at least seven digits (patients with 6 digits in Soarian or AIRS are modified with a leading zero in Allscripts). Duplicates that weren't identified using the feature were removed manually, when identified, or removed later using the template feature. The SAS and Quality Manager (QM) reviewed IP and outpatient Electronic Health records to verify HIV status and capture information not provided in the electronic health record reports. Data elements most frequently extracted from manual chart review included sex at birth/gender, HIV exposure risk, housing status, evidence of incarceration/ relocation/ external HIV provider, HIV diagnosis and enrollment status, service lines for patients meeting "other" enrollment status, antiretroviral status, and viral load information. The quality manager reviewed records for newly diagnosed patients manually to capture all cascade data elements and verify data provided in the reports. We used information provided in the reports to clarify some data elements. We filtered patient addresses and payers to identify county jails/ prisons, homeless shelters, transitional housing, etc. We used the prison look up website to clarify the year-end incarceration status.

In addition to the above reports, we received reports on all patients outlining the service lines used by the patients. This information was then manually added to the master spreadsheet for patients with "other" enrollment status. Several patients were missing this information and we looked manually in Allscripts to identify outpatient appointments, procedures, and documentation of IP or emergency department admissions. Other enrollment statuses were determined as follows:

Deceased: This information was provided in the reports from each system (Soarian, Allscripts, AIRS). In addition, all deceased patients are clearly highlighted as such when initially opening the patient record.

Incarcerated: In addition to filtering county jail and prison address or payer information provided in the EHR reports, we noted documentation indicating incarceration when reviewing patient records and then documented this on our spreadsheets.

Relocated outside NYS: This status was based on documentation in the EHR. For patients with AIRS closure/relocation status, we verified in the patient record to assure the patient moved out of state.

In HIV care with external provider: We gave this enrollment designation when progress notes identified the HIV provider, we found outside notes from the office providing HIV care, when provider notes were copied to a known HIV provider, or if we were able to establish this in HIXNY.

Data elements for newly diagnosed patients: As suggested in the AIDS Institute handout on patient-level data elements, the date of the confirmatory test (usually the HIV 1 / 2 Antibody Differential Assay) provided in the Soarian and Allscripts were verified by manual record review and used as the date of diagnosis for internally diagnosed patients. Most externally diagnosed patients did not have clear documentation of the date of the confirmatory test sample and this information was often based on patient report.

Prior to pasting the spreadsheet to the template, the quality manager used the Excel® filter feature to review each column and make sure our responses aligned with those noted in the cascade data elements document provided by the AIDS Institute. We filtered for blanks to assure completeness. We referred to the AIDS Institute data element instructions to help determine when to use "NA" vs "UK" vs leaving the cell blank. The quality manager copied and pasted the data to the cascade template and ran reports to identify errors, warnings, and duplicates. Most errors, warnings, and duplicates were easily corrected. Some warnings were not resolved, and the quality manager provided comments to explain. Items requiring comments related to:
  • DOB for one patient who over 90 years.
  • Unknown status for housing and HIV risk exposure. Even with our active patients, there were some patients for whom we could not determine risk or housing status.
  • Sex assigned at Birth. For most open, inactive patients, we were unable to verify this information. Please see the data limitations section below.
  • First viral load suppression date for newly diagnosed. We served one external newly diagnosed patient whose initial viral load was detectable at a value under 100 copies, so he met the definition of viral load suppression before he ever started antiretrovirals.

The quality manager, with guidance from the Division of HIV Medicine Medical Director, was primarily responsible for analyzing the results. Results were shared with the quality team, and we brainstormed on interventions for

improvement. The quality manager also shared data on the Peds ID/Specialized Care Center for Adolescents and Young Adults patients with the Specialized Care Center for Adolescents and Young Adults Program Coordinator and Medical Director. Their feedback is included in the Key Findings, Analysis and Improvement section. Limitations of data sources. External records scanned to the electronic health records are not retrieved via electronic reports, antiretroviral (ARV) information for IP and emergency department patients is not easily retrievable electronically, reports from Allscripts included antiretroviral information for old antiretroviral orders, electronic health record reports several patients who were HIV negative and/or did not have documentation of services in 2022, electronic health record reports did not include information on race or ethnic sub-groups, and information on HIV risk or housing was not available electronically on inactive patients. Issues like these required us to manually verify or capture some data elements via manual chart review. We continue to struggle with "sex at birth" and "current gender" data elements. Data within our grant-funded programs are specific on both of these elements. But these data elements are often not distinguished in our electronic health record and this impacts the accuracy or completeness of these elements in our open inactive patients.

Key Findings

We utilized the reports provided control panel worksheet and the scored data worksheet in the template to help us analyze the data. The following provides a comparison of our HIV treatment cascade performance in 2021 compared to the current review period.

• 3-day linkage to care: 43% in 2021 vs 80% in 2022
• 7- day linkage, including patients linked within 3 days: 72% in 2021 vs 93% in 2022
• Open Caseload viral load suppression: 84% in 2021 vs 83% in 2022
• Established Active viral load suppression: 94% in 2021 vs 93% in 2022
• Viral load suppression within 91 Days of New Diagnosis: 69% in 2021 vs 75% in 2022
• Viral load suppression in Other New Patients: 83% in 2021 vs 94% in 2022
• HIV Medicine viral load suppression: 94% in 2021 vs 93% in 2022
• Adult ID viral load suppression: 100% in 2021 vs 50% in 2022
• Pediatrics Infectious Disease (Peds ID)/Specialized Care Center for Adolescents and Young Adults viral load suppression: 88% in 2021 vs 69% in 2022

The data show significant improvement in our linkage of newly diagnosed patients at Albany Medical Center and significant improvement and viral suppression of newly diagnosed patients. These continue to be areas of major focus and priority in our programs. While we demonstrated improvement in the viral load suppression of other new to care patients, we were unable to actualize formal improvement plans in this population. The data show mild decreases in our suppression rates among open patients and established active patients. Our Peds ID/ Specialized Care Center for Adolescents and Young Adults and our Adult ID programs demonstrated lower performance. Both of these programs serve small numbers, resulting in significant rate fluctuations with changes in just one or two patients. Specialized Care Center for Adolescents and Young Adults provided significant reengagement efforts to patients, but most patients did not respond and are lost to follow up. One patient responded to efforts and achieved viral suppression in early 2023.

Linkage of Newly Diagnosed Patients (Internal) In review of the newly diagnosed patients who did not meet the linkage indicator, we note two patients were not linked within 3 days of diagnosis (date of diagnosis being defined as the date the confirmatory test sample was collected): #1: The confirmatory test result was completed by the lab on the day following the sample collection. Our office was notified on a Friday afternoon. We were unable to fit the patient in until the following Friday. The patient cancelled the appointment and was seen 3 days following the

cancellation. #2: The diagnosing primary care provider notified patient of diagnosis one day following blood draw. The patient contacted our office late that same afternoon (a Friday) and was scheduled for the following Wednesday. Contributing factors to linkage delay included lab processing time, reaching patient to deliver diagnosis, patient scheduling conflicts, scheduling requests received just before the weekend, and HIV Medicine provider capacity to see the patient.

Newly Diagnosed viral load suppression in 91 Days 75% of our newly diagnosed patients were virally suppressed within 91 days of diagnosis. Of the 11 that weren't suppressed:
- 6 were diagnosed in the last 3 months of the review period (3 in December, 2 November, 1 last week of October)
- 1 was an externally diagnosed patient and did not engage in HIV care
- 1 did not return for follow up/monitoring for viral load suppression, was lost to care, and may have relocated to another region of NYS. We tried multiple times to reach and locate the patient
- 3 patients missed multiple follow up appointments. 2 attained viral load suppression but this was not measured within the 91-day period. 1 patient did not achieve viral load suppression during the review period. Multiple reengagement efforts and reminders were provided to these patients.

When looking at race, ethnicity, and gender as individual categories, the data show several smaller disparities in care (for example, 94% in Non-Hispanic Whites compared to 91% in Non-Hispanic Blacks and 91% in Hispanics). Categories demonstrating more significant disparities are outlined below. Please note, all groups with viral load suppression rates under 85% represent 25 or fewer patients.
- Age 13-19 (67%)
- Age 20-24 (75%)
- Age 30-39 (87%)

When we further break this down to Black women aged 30-39, the disparity is more significant with viral load suppression dropping to 74%
- Unstable Housing (75%)
- Temporary Housing (86%)
- Perinatal Transmission (80%)
- Medicaid (89%)

QI Projects
QI Project #1
Indicator: Viral load suppression among newly diagnosed patients
2022 rate for this indicator: 5%
Overall 2023 goal for this indicator: 85%
Description:
1. Retention efforts
   a. Continue to schedule patients every month until the patient is virally suppressed.
   b. Obtain back up phone number (such as a friend) so we can reach the patient if their phone is not working.

      c. Evaluate intake process and ways to shorten initial appointment, obtain patient feedback via survey or focus group, consider implementing antiretroviral samples to prevent delays in antiretroviral initiation.

2. Consider implementing 1:1 portal training for patients who don't register or utilize the patient portal.
3. Offer flexible options including:
   a. Telemedicine appointments
   b. Lab visit w/o provider visit
   c. Lab visits with nurse or case management visit
   d. Lab visits at external labs
4. Continue monthly case management check in. Include review of next appointment during this contact. Continue reminder calls before appointments.

QI Project #2
Indicator: Viral load suppression among established active patients
2022 rate for this indicator: 93%
Overall 2023 goal for this indicator: 95%
Description: Focus on sub-categories:

1. Black women ages 30-39 with VL >200 copies or those demonstrating gaps in adherence:
   a. Assure all patients in this subgroup without viral load suppression are enrolled for case management services in Part D, FFHC, or Retention and Adherence Program.
   b. Review patient records to identify barriers.
   c. Schedule team case conference, including the patient, to focus on addressing barriers.
   d. Continue to enroll with pharmacy adherence services, if available.
2. Patients in the Specialty Care Center for Adolescents and Young Adults: Continue pre-existing intervention with intensified interactions for patients without viral load suppression:
   a. Increase patient contacts
   b. Adherence support

Consumer Involvement
We plan the following activities to assist us in our improvements. We will hire a new peer to fill the current vacancy. We are actively recruiting for this position. Once hired, and trained, the peer will participate in the quality improvement team and improvement activities, utilizing his/her own experiences and feedback from other consumers to drive suggestions. We plan to request attendees of our weekly women's group to participate in a focus group. This will include a review of our 2022 cascade, highlighting areas of strength and opportunities for improvement, and request consumer suggestions for improvement. We will print and laminate the cascade charts and post them in our lab waiting area for patients to view.

Coach's Feedback and Updates on Cascade QI Plan
The key findings are well explained. Quality improvement projects selected respond to data outcomes. There is a reasonable plan for involving consumers in the quality improvement process.