

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 2023

QI Profile Completion Date:
April 2024

Last Revision Date:
April 2024

Program Name: New York-Presbyterian - East

Clinic Information

Type of Clinic	Clinic Name	Address	City	Zip
Hospital	Center for Special Studies: Judish Peabody Wellness Center: David Rogers Unit	119 West 24th Street	New York	10011
Hospital	Center for Special Studies: The Glenn Bernbaum Unit 525	525 East 68th Street	New York	10065

Important Contacts

<i>HIV Medical Director</i>	Samuel Merrick	stm2006@med.cornell.edu	(212) 746-4180
<i>HIV Program Administrator</i>	Samuel Merrick	stm2006@med.cornell.edu	(212) 746-4180
<i>Lead QI Contact</i>			
<i>Contract Manager</i>	N/A		
<i>QI/QM Coach – NYSDOH - Manhattan</i>	Susan Weigl	Susan.weigl@health.ny.gov	(929) 318-3318

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.

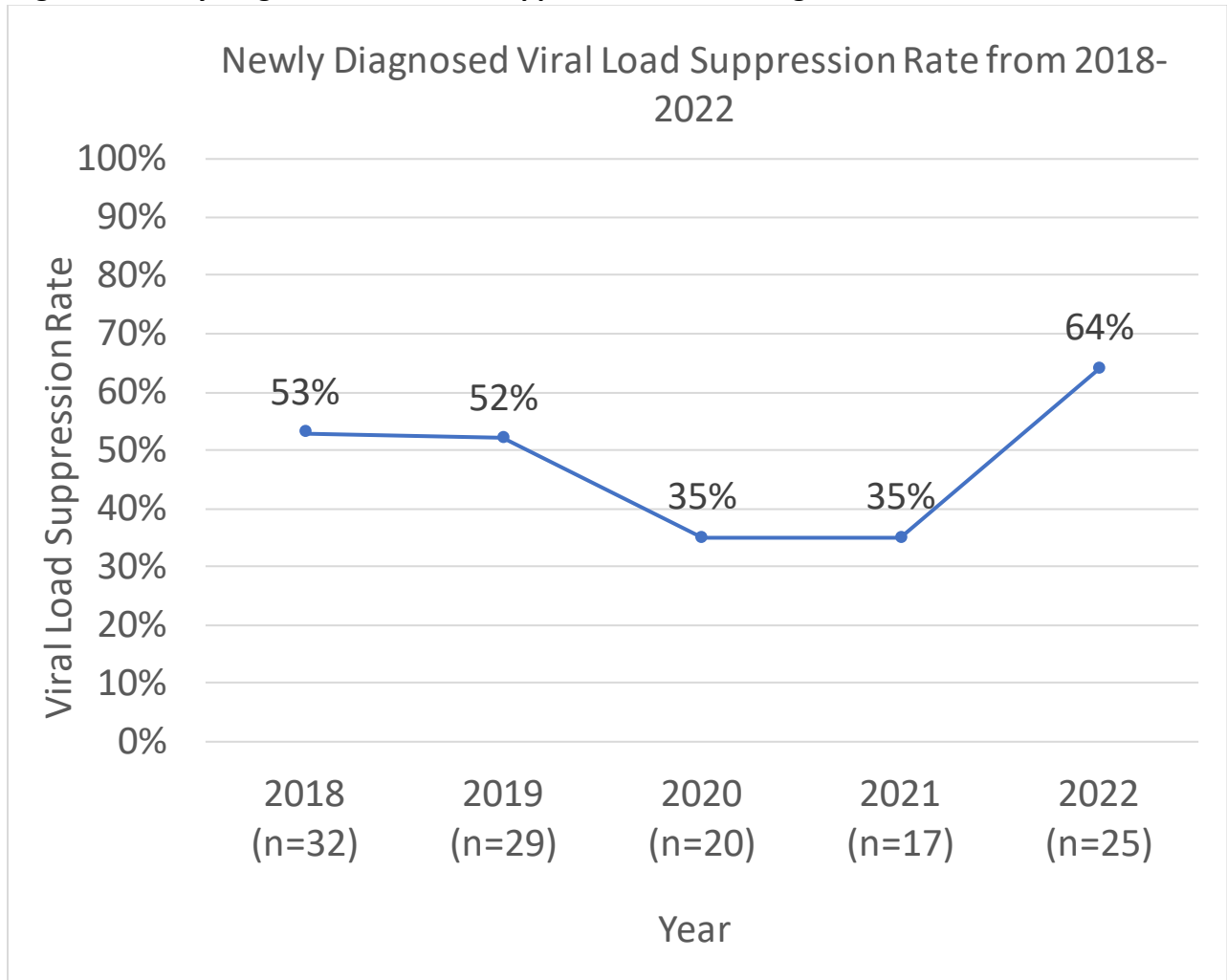
Suppressed within 91 Days (Newly Diagnosed Patients): A value of less than 200 copies/mL on any viral load test performed within 91 days of initial HIV diagnosis. Patients with no documented viral load test during this period are scored as unsuppressed.

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 2022

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



Note: Among newly diagnosed patients in 2017, the final VL suppression rate was reported as 82% (n=62).

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

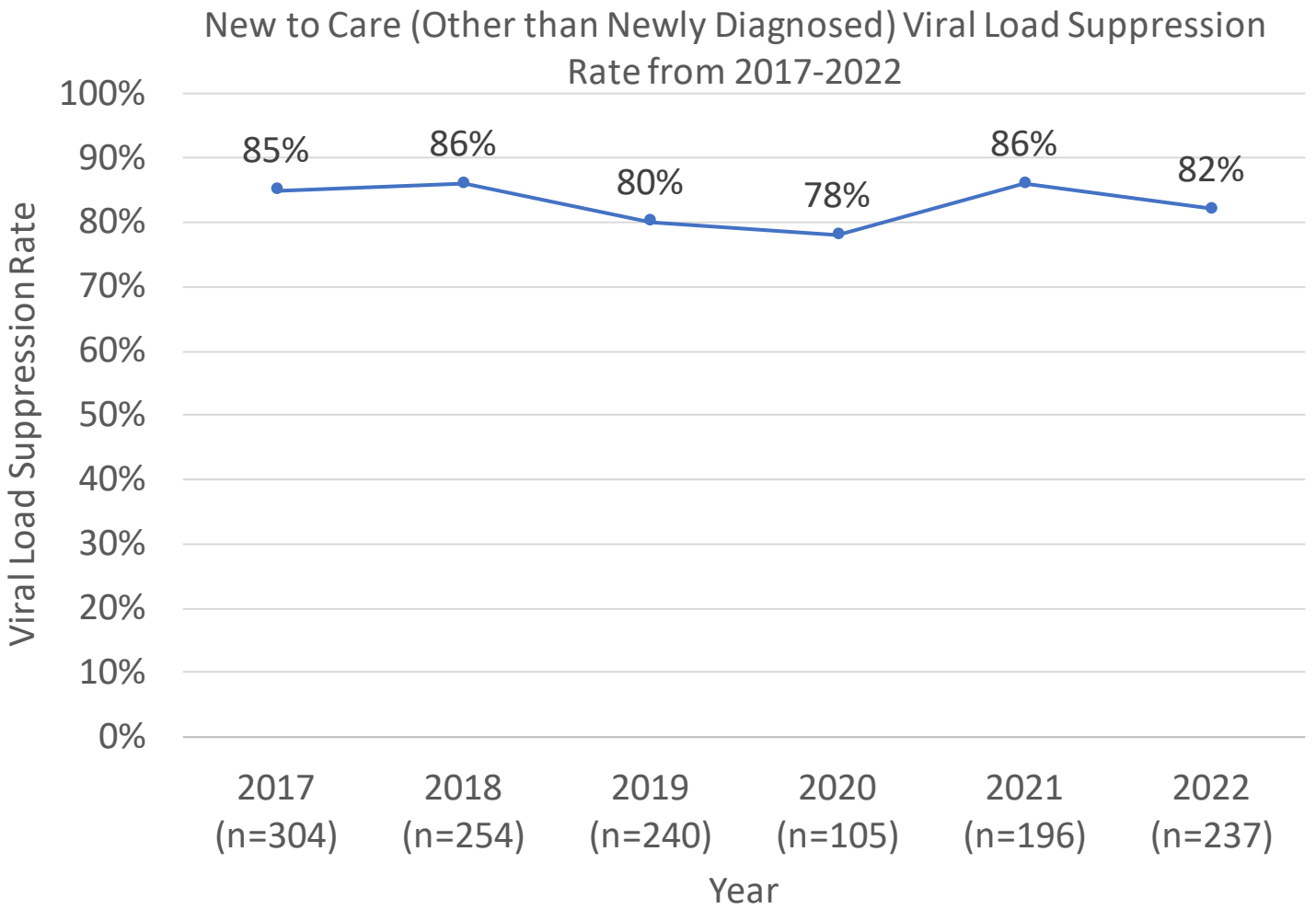


Figure 3: Established Active Viral Load Suppression Rates at Organizational Level from 2017-2022

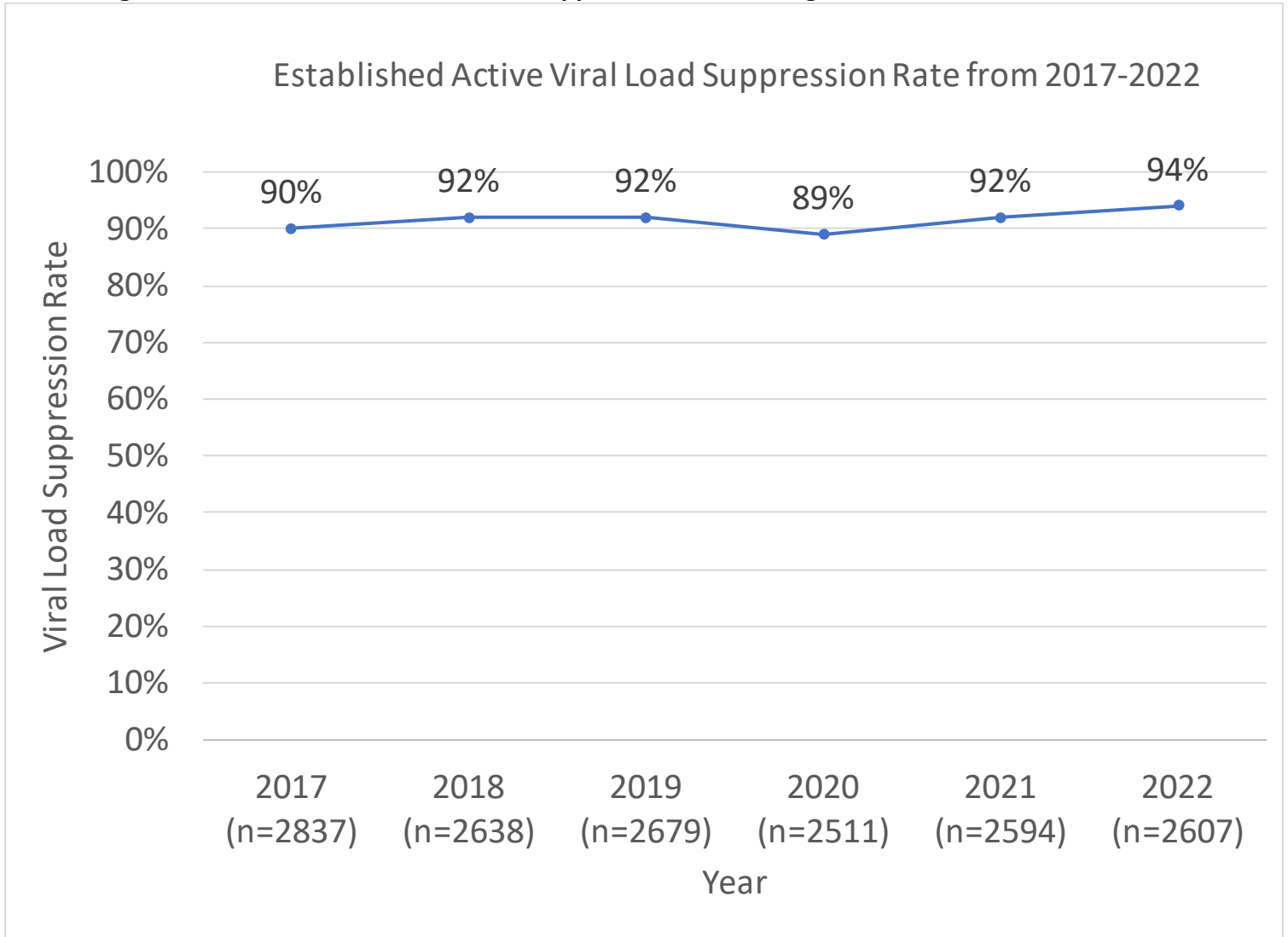


Figure 4. 2022 Established Active Viral Load Suppression Rates by Age at Organizational Level

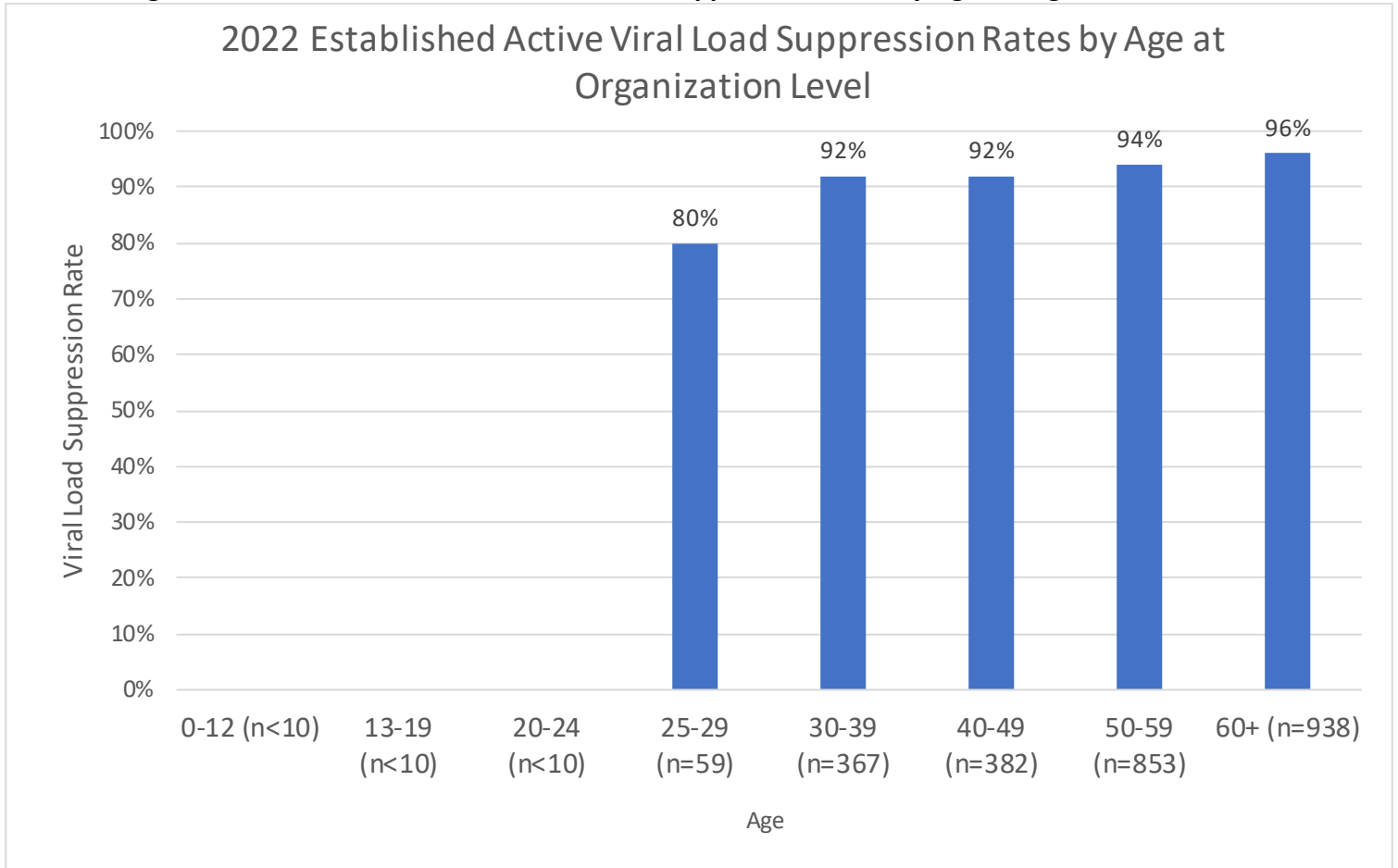
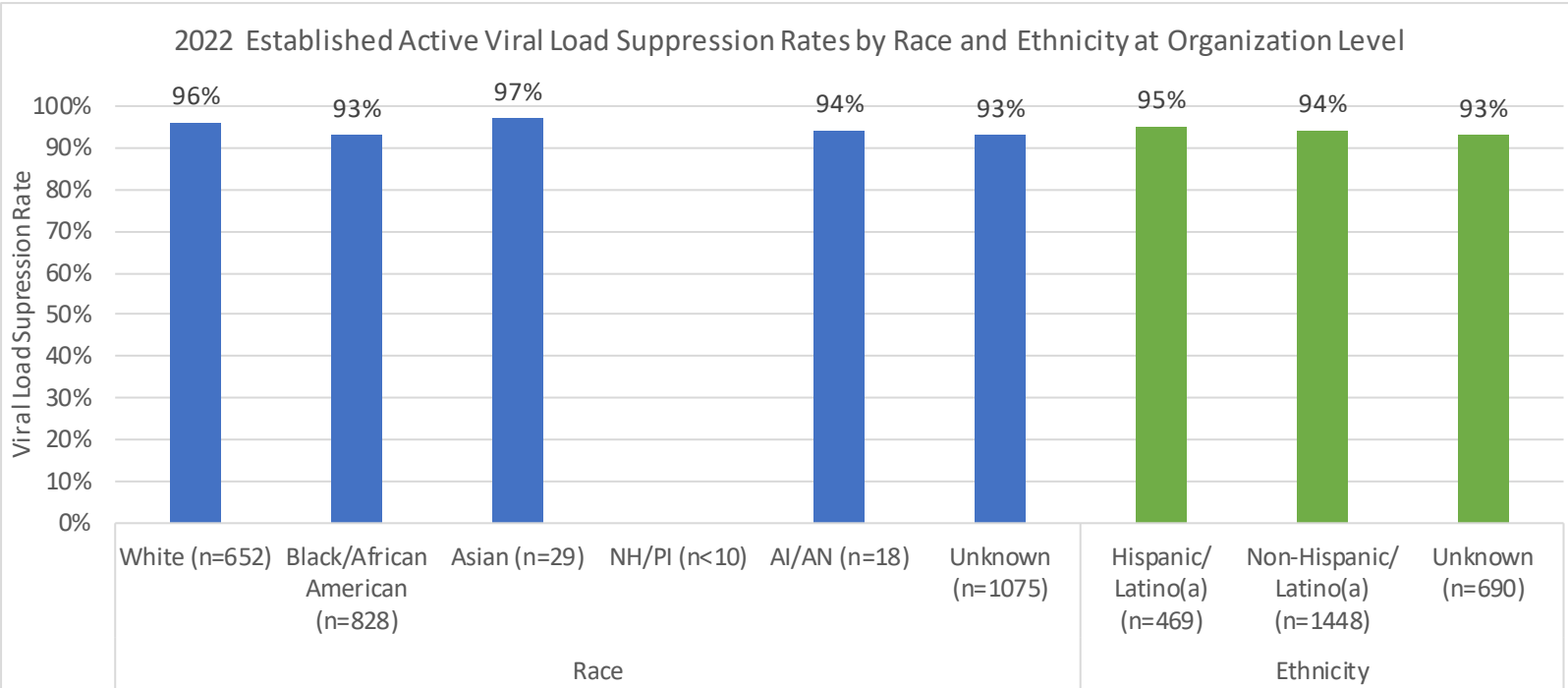


Figure 5. 2022 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organizational Level



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 2017-2022

Patient Group	Indicator	2017		2018		2019		2020		2021		2022	
		Org. Score	State Median	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	82% (n=17)	65%	59% (n=17)	41%	71% (n=14)	52%	-- (n<10)*	55%	-- (n<10)*	61%	-- (n<10)*	53%
	On ARV Therapy	97% (n=62)	91%	84% (n=32)	96%	97% (n=29)	100%	95% (n=20)	100%	100% (n=17)	100%	100% (n=25)	100%
	VL Test within 91 Days	**	**	75% (n=32)	93%	97% (n=29)	95%	95% (n=20)	95%	94% (n=17)	92%	96% (n=25)	96%
	Suppressed Final VL	82% (n=62)	65%	**	**	**	**	**	**	**	**	**	**
	Suppressed within 91 Days	**	**	53% (n=32)	45%	52% (n=29)	50%	35% (n=20)	46%	35% (n=17)	50%	64% (n=25)	50%
	Baseline Resistance Test	**	**	**	**	76% (n=29)	74%	55% (n=20)	80%	88% (n=17)	82%	96% (n=25)	80%
Other New to Care	On ARV Therapy	98% (n=304)	96%	99% (n=254)	97%	100% (n=240)	100%	98% (n=105)	100%	99% (n=196)	100%	100% (n=237)	100%
	Any VL Test	98% (n=304)	97%	100% (n=254)	99%	99% (n=240)	98%	89% (n=105)	100%	98% (n=196)	100%	100% (n=237)	98%
	Suppressed Final VL	85% (n=304)	70%	86% (n=254)	74%	80% (n=240)	78%	78% (n=105)	77%	86% (n=196)	69%	82% (n=237)	78%
Established Active	On ARV Therapy	99% (n=2837)	99%	99% (n=2638)	99%	99% (n=2679)	99%	100% (n=2511)	93%	99% (n=2594)	99%	100% (n=2607)	100%
	Any VL Test	100% (n=2837)	99%	100% (n=2638)	99%	100% (n=2679)	99%	95% (n=2511)	97%	99% (n=2594)	98%	100% (n=2607)	98%
	Suppressed Final VL	90% (n=2837)	88%	92% (n=2638)	88%	92% (n=2679)	89%	89% (n=2511)	87%	92% (n=2594)	88%	94% (n=2607)	89%
Open Previously Diagnosed (Active & Inactive)	On ARV Therapy	89% (n=3237)	92%	95% (n=3451)	95%	92% (n=3326)	96%	96% (n=3648)	96%	96% (n=3715)	97%	98% (n=4091)	97%
	Any VL Test	88% (n=3237)	92%	89% (n=3451)	93%	90% (n=3326)	93%	81% (n=3648)	90%	70% (n=3715)	94%	84% (n=4091)	93%
	Suppressed Final VL	79% (n=3237)	80%	80% (n=3451)	80%	83% (n=3326)	83%	75% (n=3648)	77%	65% (n=3715)	79%	76% (n=4091)	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*	--	<10*	--	59	80%	367	92%	382	92%	853	94%	938	96%
GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Gender X		Unknown Gender			
n	%	n	%	n	%	n	%	n	%	n	%	n	%		
1955	94%	602	93%	<10*	--	23	91%	25	92%	<10*	--	<10*	--		
RACE															
White		Black/African American		Asian		Native Hawaiian/PI		American Indian/ AN		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%				
652	96%	828	93%	29	97%	<10*	--	18	94%	1075	93%				
ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
469	95%	1448	94%	690	93%										
RISK FACTOR															
IDU Risk		Heterosexual Risk		MSM		Hemophilia or Coagulation		Blood Transfusion		Perinatal		Other Risk		Unknown	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
214	95%	778	93%	1604	94%	10	100%	27	100%	70	80%	14	100%	16	94%
HOUSING STATUS															
Stable Housing		Unstably Housed		Temporarily Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
766	93%	11	82%	<10*	--	1830	94%								
INSURANCE TYPE															
ADAP		Dual Eligible		Medicaid		Medicare		Private Insurance		Veteran's Admin		Other		No Insurance	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
290	96%	659	94%	991	91%	159	97%	508	97%	<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	NYP-East Campus	**	**	**	**	99% (n=177)	100% (n=177)	90% (n=177)
2018	Center for Special Studies: Jewish Peabody Wellness Center: David Rogers Unit	**	99% (n=113)	100% (n=113)	88% (n=113)	99% (n=1317)	100% (n=1317)	93% (n=1317)
	Center for Special Studies: The Glenn Bernbaum Unit 525	**	99% (n=134)	100% (n=134)	84% (n=134)	99% (n=1292)	100% (n=1292)	91% (n=1292)
2019	Center for Special Studies: Jewish Peabody Wellness Center: David Rogers Unit	76% (n=17)	100% (n=141)	99% (n=141)	82% (n=141)	99% (n=1342)	100% (n=1342)	92% (n=1342)
	Center for Special Studies: The Glenn Bernbaum Unit 525	75% (n=12)	99% (n=99)	100% (n=99)	79% (n=99)	99% (n=1337)	100% (n=1337)	93% (n=1337)
2020	Center for Special Studies: Jewish Peabody Wellness Center: David Rogers Unit	69% (n=13)	98% (n=50)	86% (n=50)	76% (n=50)	100% (n=1252)	94% (n=1252)	88% (n=1252)
	Center for Special Studies: The Glenn Bernbaum Unit 525	-- (n<10)*	98% (n=55)	91% (n=55)	80% (n=55)	100% (n=1259)	95% (n=1259)	89% (n=1259)
2021	Center for Special Studies: Jewish Peabody Wellness Center: David Rogers Unit	**	**	**	**	100% (n=1278)	100% (n=1278)	92% (n=1278)
	Center for Special Studies: The Glenn Bernbaum Unit 525	**	**	**	**	99% (n=1316)	100% (n=1316)	93% (n=1316)
2022	Center for Special Studies: Jewish Peabody Wellness Center: David Rogers Unit	**	**	**	**	100% (n=1324)	100% (n=1324)	94% (n=1324)
	Center for Special Studies: The Glenn Bernbaum Unit 525	**	**	**	**	100% (n=1283)	100% (n=1283)	94% (n=1283)

* 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

To identify the 2022 organizational caseload of people living with HIV (PLWH) at NYP-Weill Cornell Medical Center we used monthly reports generated from the Epic database that have been designed specifically for our program to track all CSS patients seen during a rolling trailing 12-month period. These have demographics (when provided by the patient), HIV risk, date of diagnosis, antiretroviral therapy use, and a number of other quality indicators. We use a modified version of that report to search for all patients seen at Cornell or LMH who were NOT identified as CSS patients. Finally, provider notes available through the electronic medical record (EPIC for outpatient and inpatient) were used to obtain data through chart reviews.

New York Presbyterian patients were included in the 2022 New York Presbyterian people living with HIV caseload if they met the following criteria:

- 1.) HIV diagnosis: patients were considered as HIV positive if they had corresponding ICD 9 or ICD10 diagnostic codes recorded in NYP's billing and registration system (Eagle) or electronic medical record (EMR). Patients were also included if they had any positive HIV confirmatory test result, any HIV genotype test, or both an HIV viral load and CD4 test.
- 2.) Received any service in the review year: All HIV positive patients identified were filtered to those with any visit registration or laboratory test (of any type) at New York Presbyterian in 2022. We have an automated report that accurately identifies all patients seen at CSS which includes date of diagnosis and whether the patient has had a previous visit at the program. This allows us to identify those newly diagnosed in 2022 and track overall enrollment status. We maintain a list of all patients who die during the calendar year. Other enrollment status categories were determined by chart review (e.g. incarcerated, relocated, external care, etc.); however, due to resource limitations this list may be incomplete. All patients with unknown status who were undetectable were considered to be on antiretrovirals. Service line was determined by either locations of visits obtained during the above data retrieval or supplemented by chart review. Patients with a date of diagnosis in 2022 had a chart review to determine where the diagnosis was made and how many days to linkage with CSS. A significant number of patients included in the open caseload may be in care elsewhere or come here only for specialty care and thus they do not get HIV labs done at their visits. Chart review often identified patients who were treated and released from the respective emergency rooms as "HIV+ on antiretroviral therapy with undetectable viral load;" however, in the absence of confirmatory records, they were not categorized as in care elsewhere.

Race and ethnicity is dependent on patients being willing to self-identify their race and ethnicity during registration and being elicited by the Front Desk staff to provide this information. The operational workflow makes it challenging for consistent data collection of these data during registration. In addition, the categories requested for the review do not align with the categories available to us in our Electronic Medical Record. The main limitations are related to standard issues with any database (incorrect or missing information) as well as the time and resources necessary to do chart review. Dr. Merrick was responsible for entering the data into Excel. Dr. Smith entered the Quality information. The data will be reviewed and analyzed with the Quality and Consumer committees.

Key Findings

The significant gaps in care revealed during our review are as follows:

- 1) The rate of viral suppression for all (Open) patients with HIV at our organization was 76% during 2022, which is less than the New York State ETE goal of 85%.

Program Summary: New York-Presbyterian - East

- 2) For newly diagnosed patients at our organization, the rate of viral suppression within 90 days of diagnosis during 2022 was 64%, which is less than the New York State ETE goal of 75%.
- 3) For subgroups of people living with HIV, those aged 20-24 and 25-29 had lower rates of viral suppression (75% and 80% respectively) during 2022 than all other older age groups (92-96%).
- 4) Only 80% of patients whose risk category for HIV was perinatal were virally suppressed by the end of 2022. This is significantly less than the other categories (93->100%).
- 5) The rate of viral suppression for those with unstable housing (82%) was significantly lower than those with stable permanent housing (93%) for 2022. However, over 70% of patients were in the unknown housing category, which limited our ability to determine the extent of the gap if it exists.

There were some significant changes between the 2021 and 2022 cascade results. There were significant increases in the percentages of all (Open) patients who had viral load testing (70->84%) and viral load suppression (65->76%) between 2021 and 2022. The percentages for viral load suppression (86->82%) decreased slightly for other patients new to care. In subgroup analyses, there were improvements in the percentage of patients who identified as transgender women who were virally suppressed (83->89%). There were also declines in the viral suppression rates for people aged 20-24 (86->75%) and 25-29 (91->80%) between 2021 and 2022, although the number of patients in these categories is small at 8 and 59 respectively. The quality improvement interventions that were tested during 2022 included enhanced contact and follow-up services for newly diagnosed patients provided by Social Work, Health Home, and Registration staff. This supplemented our automated appointment reminder systems.

Barriers that we faced in implementing the quality improvement interventions included staffing challenges. As we noted last year, in many ways the pandemic continued to affect our staffing as the impact on people's individual lives contributed to their life choices. Turnover in our nursing staff prevented us from being able to restart our Primary Nursing program, which provides one-on-one contact and teaching to improve patient knowledge and adherence support. We also had staff turnover in our Health Home program; this limited our support and follow-up services. To address this, we focused on recruitment rather than modifying the improvement plan. We did achieve our goal of increasing the viral suppression rate for newly diagnosed patients to >60% in 2022. We did not increase the viral suppression rate for new-to-care patients to 90%; it in fact fell slightly from 86->82%. This group of patients includes those who may have been out of care for a variety of reasons, and depending on the timing of their first visit, there may not have been time to re-suppress. This could be an area for further investigation in the quality project below. We were able to decrease the number of outpatients identified as unknown race from 1108 to 1075 and unknown ethnicity from 818 to 690 between 2021 and 2022.

QI Projects

QI Project #1

Indicator: Viral load suppression among newly diagnosed patients

2022 rate for this indicator: 64%

Overall 2023 goal for this indicator: 75%

Description:

Quality improvement Project #1 Goal 1: 75% of outpatients newly diagnosed with HIV at New York Presbyterian/East Campus in 2023 will have a viral load <200 copies/ml within 91 days of diagnosis.

Program Summary: New York-Presbyterian - East

Action Steps:

- 1) The Quality Improvement Committee chair will conduct ongoing chart reviews of the patients who were newly diagnosed in 2023 and their viral suppression to determine the reasons that they were not suppressed at the same rate as other patients. This review will include looking at any subpopulations that these patients belong to and any differences between those who were suppressed and those who were not.
- 2) Enhanced follow-up services will be provided by CSS Social Work and Health Home outreach staff for all newly diagnosed patients. These will include telephone calls, secure messages via Epic My Chart and/or letters, and home visits when necessary to remind patients of their follow-up appointments and for patients who miss their follow-up visits for office visits and lab visits to reschedule the appointments. These patients will also be screened for assignment to our Primary Nursing program for telephone calls and Epic My Chart messages to provide enhanced education and adherence services.
- 3) Data will be collected by the Quality Improvement Committee chair on a quarterly basis regarding the status of newly diagnosed patients and viral suppression. This data will be reported to the committee to promote discussion on how viral suppression can be improved.
- 4) The plan and data collected will be reported to our Community Advisory Committee and to patient teams for feedback and ideas.
- 5) We will work with the committee to determine how best to communicate data on a regular basis to both patients and staff.

QI Project #2

Indicator: Viral load suppression among new-to-care patients

2022 rate for this indicator: 82%

Overall 2023 goal for this indicator: 90%

Description: QI Project #2 Goal 2: 90% of outpatients with HIV who are new-to-care at New York Presbyterian/East Campus in 2023 will have a viral load <200 copies/ml by the end of 2023.

Action Steps:

- 1) The Quality Improvement Committee chair will conduct ongoing chart reviews of the patients who were new to CSS in 2023 and their viral suppression to determine the reasons that they were not suppressed at the same rate as other patients. This review will include looking at any subpopulations that these patients belong to and any differences between those who were suppressed and those who were not.
- 2) Enhanced follow-up services will be provided by CSS Social Work and Health Home outreach staff for all new-to-care patients. These will include telephone calls, secure messages via Epic My Chart and/or letters, and home visits when necessary to remind patients of their follow-up appointments and for patients who miss their follow-up visits for office visits and lab visits to reschedule the appointments. These patients will also be screened for assignment to our Primary Nursing program for telephone calls and Epic My Chart messages to provide enhanced education and adherence services.
- 3) Data will be collected by the Quality Improvement Committee chair on a quarterly basis regarding the status of new-to-care patients and viral suppression. This data will be reported to the committee to promote discussion on how viral suppression can be improved.
- 4) The plan and data collected will be reported to our Community Advisory Committee and to patient teams for feedback and ideas.
- 5) We will work with the committee to determine how best to communicate data on a regular basis to both patients and staff.

Consumer Involvement

Quality Improvement Committee This committee is composed of the CSS Medical Director, Associate Medical Director (who serves as chair), and representatives from Nursing, Medicine, Psychiatry, Gyn, Social Work, Nutrition, Registration, Health Home, and Administration within CSS. The committee reviews data and the plan on an ongoing basis and can make changes as needed. Consumer Involvement The CSS Consumer Advisory Committee suspended its meetings during 2022, so the data could not be submitted for review prior to the submission of this data. We are in the process of trying to reconstitute the committee. Once this is done, the data and quality improvement interventions will be presented to the committee for discussion and input. The interventions will be modified as needed based on the committee input. Updates will be provided to the committee on a quarterly basis. As mentioned in the quality improvement goals, data will be provided to consumers and staff via posting at our care sites, along with making flyers available with graphics on one side and more detailed methodology on the reverse.

Coach's Feedback and Updates on Cascade QI Plan

New York Presbyterian East has significantly high viral load suppression and other indicator rates among its established patient population. The team has appropriately identified variation in outcomes for key populations and noted where decreases in viral load suppression from 2021 to 2022. The team did achieve one of their quality improvement goals in 2022 of increasing the viral load suppression rate of newly diagnosed patients to greater than 60%. Like other programs - staff turnover impacted the team's ability to implement the full quality improvement project plan. The project plan as proposed makes sense in terms of targeting the new to care and newly diagnosed population, as well as testing the strategy that was planned for in 2022. It is not uncommon to see that consumer advisory committees are struggling to re-invigorate their groups and work, post COVID. The quality improvement coach will raise this common challenge with the AIDS Institute quality management Program staff, including the Director of Consumer Affairs to identify potential resources and/or support that might be offered.

Some suggestions: consider a few easy measures to understand if the intervention as proposed is feasibly implemented and/or whether (or which) of the intensive engagement strategies are having a positive effect (E.g. number of newly diagnosed/new to care patients linked to Health Home and/or nurse support; number of successful calls and or contacts with patients; and length of time from diagnosis or first visit to connection with these supportive services. In future the team may also want to consider variation in outcomes based on race and income. Please reach out to quality improvement Coach Susan Weigl (sweigl@yahoo.com) for any additional information and/or technical assistance, Coaching and/or training of staff.

Attached below is a potential resource – the Appointment Reminders protocols and tools developed from one of HRSA Special Projects of National Significance.

<https://newyorklinks.z13.web.core.windows.net/Interventions>