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: 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

HIV Medical Director	David Rosenthal	drosenthal@northwell.edu	(516) 622-5070
HIV Program Administrator			
Lead QI Contact	Hope Zewou	hzewou@northwell.edu	(516) 622-5194
Contract Manager	N/A		
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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 2022

Figure 1. Newly Diagnosed Viral Load Suppression Rates at Organizational Level from 2017-2022
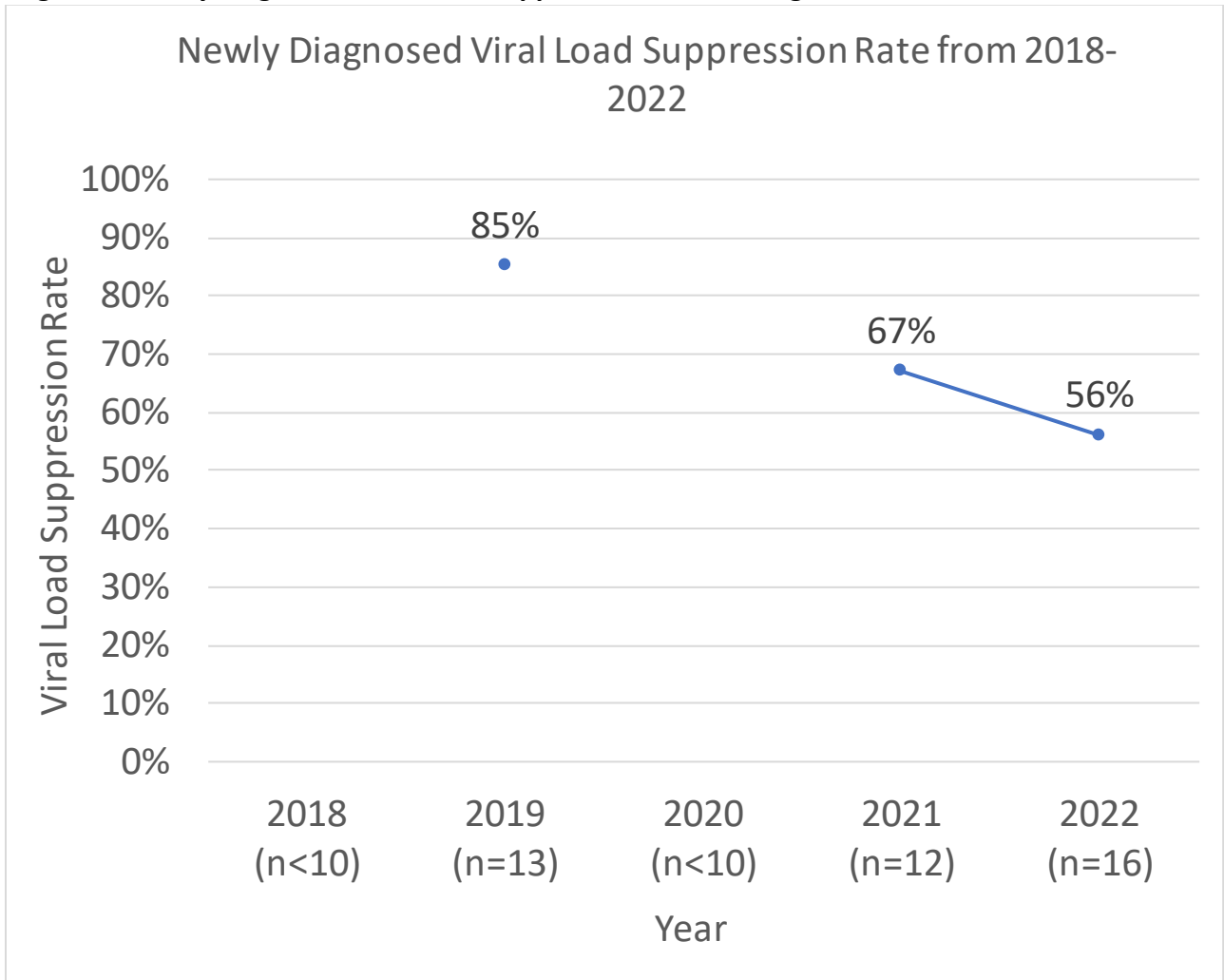
Newly Diagnosed Viral Load Suppression Rate from 2018-2022

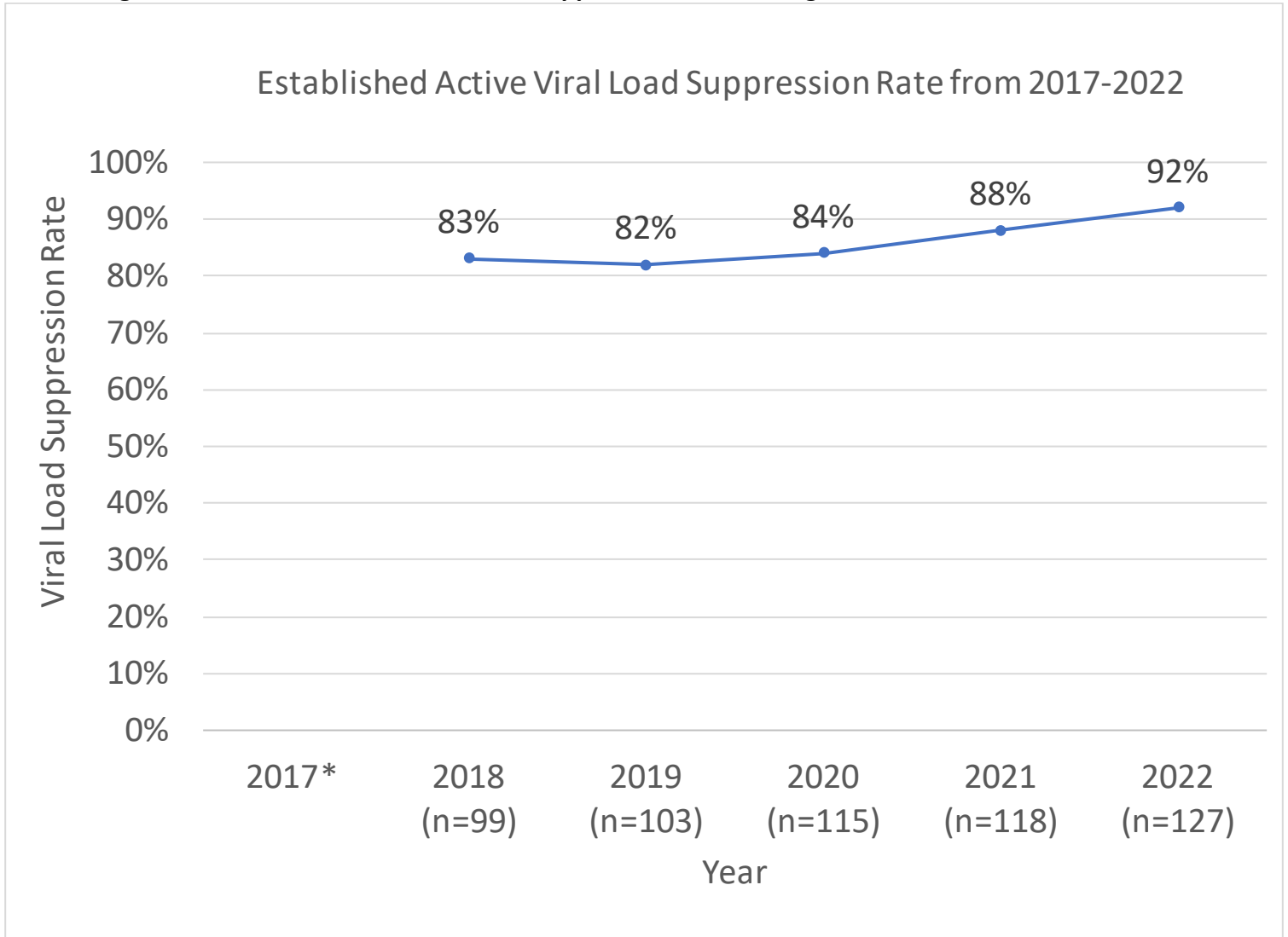**Note:** Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017.

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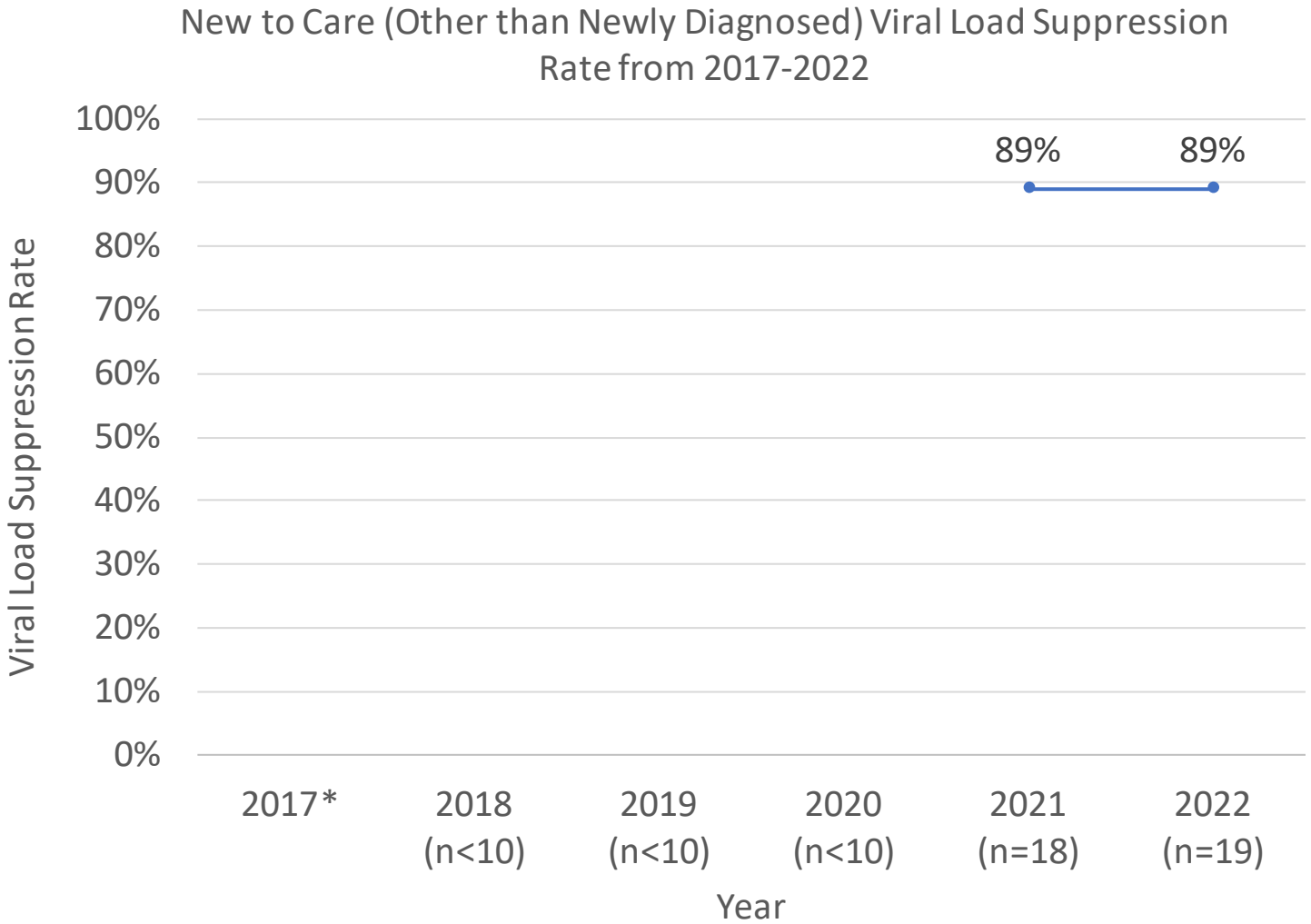
*Did not receive usable data for Northwell Health-CYAAPH in the review of care provided in 2017.

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

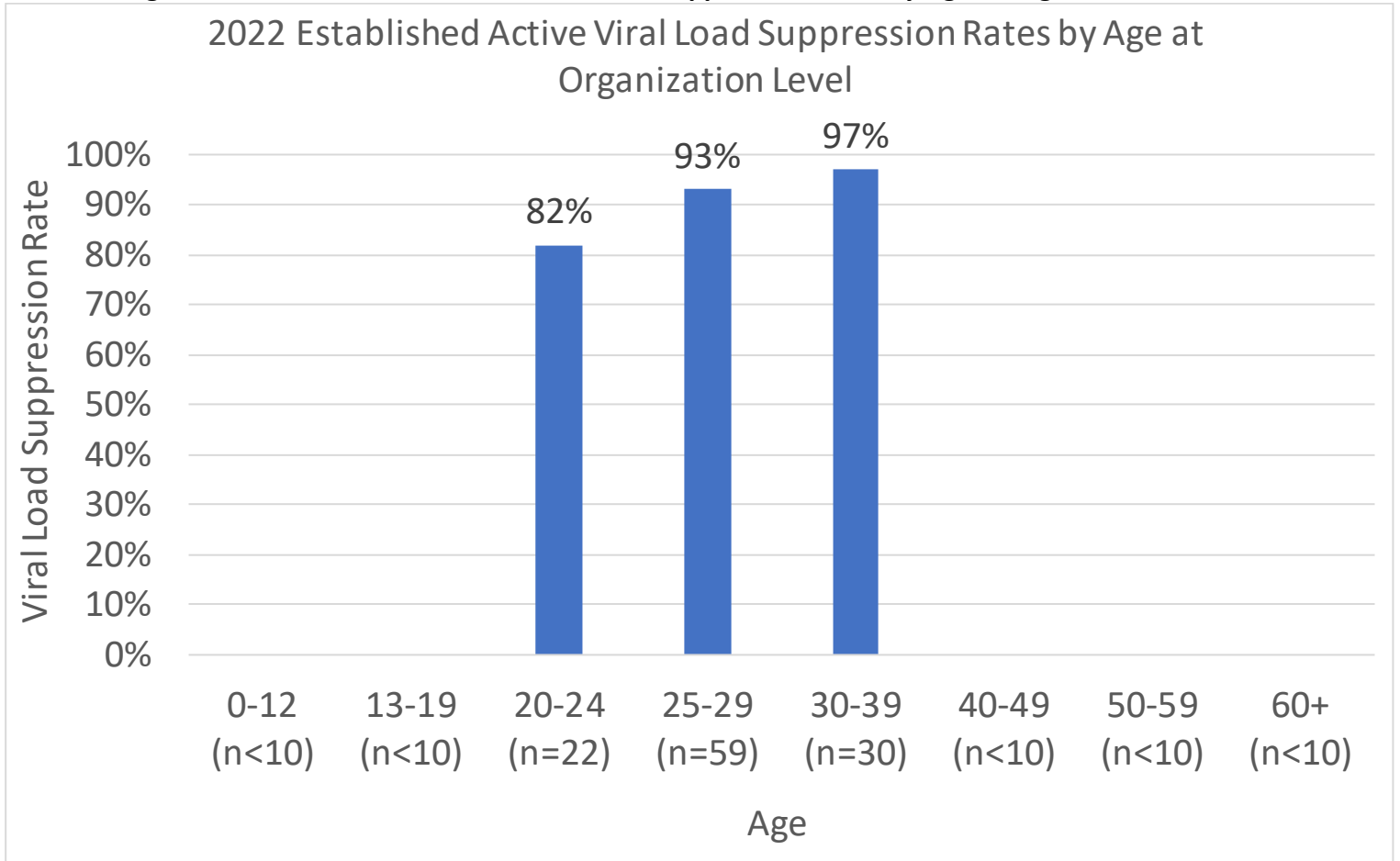Established Active Viral Load Suppression Rate from 2017-2022

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

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

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

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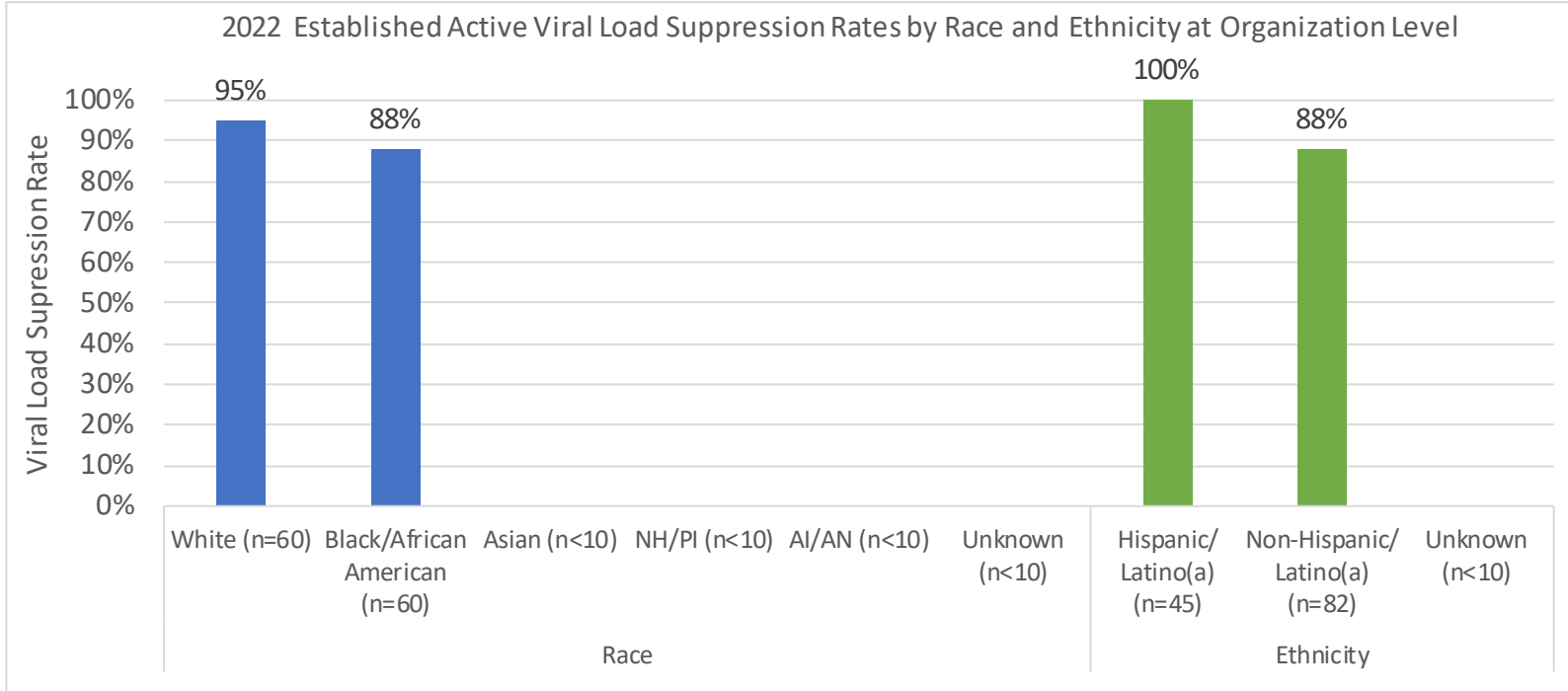
2022 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organization Level

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	--	65%	-- (n<10)*	41%	-- (n<10)*	52%	-- (n<10)*	55%	-- (n<10)*	61%	-- (n<10)*	53%
	On ARV Therapy	--	91%	-- (n<10)*	96%	100% (n=13)	100%	-- (n<10)*	100%	92% (n=12)	100%	100% (n=16)	100%
	VL Test within 91 Days	**	**	-- (n<10)*	93%	100% (n=13)	95%	-- (n<10)*	95%	92% (n=12)	92%	100% (n=16)	96%
	Suppressed Final VL	--	65%	**	**	**	**	**	**	**	**	**	**
	Suppressed within 91 Days	**	**	-- (n<10)*	45%	85% (n=13)	50%	-- (n<10)*	46%	67% (n=12)	50%	56% (n=16)	50%
	Baseline Resistance Test	**	**	**	**	100% (n=13)	74%	-- (n<10)*	80%	92% (n=12)	82%	100% (n=16)	80%
Other New to Care	On ARV Therapy	--	96%	-- (n<10)*	97%	-- (n<10)*	100%	-- (n<10)*	100%	100% (n=18)	100%	100% (n=19)	100%
	Any VL Test	--	97%	-- (n<10)*	99%	-- (n<10)*	98%	-- (n<10)*	100%	100% (n=18)	100%	100% (n=19)	98%
	Suppressed Final VL	--	70%	-- (n<10)*	74%	-- (n<10)*	78%	-- (n<10)*	77%	89% (n=18)	69%	89% (n=19)	78%
Established Active	On ARV Therapy	--	99%	99% (n=99)	99%	99% (n=103)	99%	100% (n=115)	93%	100% (n=118)	99%	100% (n=127)	100%
	Any VL Test	--	99%	100% (n=99)	99%	98% (n=103)	99%	100% (n=115)	97%	100% (n=118)	98%	100% (n=127)	98%
	Suppressed Final VL	--	88%	83% (n=99)	88%	82% (n=103)	89%	84% (n=115)	87%	88% (n=118)	88%	92% (n=127)	89%
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%	100% (n=127)	97%
	Any VL Test	--	92%	100% (n=99)	93%	98% (n=103)	93%	100% (n=115)	90%	100% (n=118)	94%	100% (n=127)	93%
	Suppressed Final VL	--	80%	83% (n=99)	80%	82% (n=103)	83%	84% (n=115)	77%	88% (n=118)	79%	92% (n=127)	83%

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 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*	--	22	82%	59	93%	30	97%	<10*	--	<10*	--	<10*	--

GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Gender X		Unknown Gender			
n	%	n	%	n	%	n	%	n	%	n	%	n	%		
80	96%	43	84%	<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	%				
60	95%	60	88%	<10*	--	<10*	--	<10*	--	<10*	--				

ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
45	100%	82	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	%
<10*	--	20	80%	66	98%	<10*	--	<10*	--	43	86%	<10*	--	<10*	--

HOUSING STATUS															
Stable Housing		Unstably Housed		Temporarily Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
123	92%	<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	%
22	95%	<10*	--	61	87%	<10*	--	42	98%	<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 2023 (Self-Reported based on 2022 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 was 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. CYAAPH utilizes the following data collection source (i.e. EMR. Redcap, AIRS, CareWare, etc) which may be similar to the adult program (CART) 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 AIDS Institute Reporting System. Furthermore, AIDS Institute Reporting System 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 some 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 2022 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 team at the Center for Young Adult, Adolescent Pediatric HIV is excited to report that we have achieved and surpassed our goal of viral load suppression rate in the 2022 Organizational Treatment Cascade. The goal was to reach 90% and we achieved 92% viral load suppression rate for active patients. The multidisciplinary team always strive to meet and surpass goals including the New York State objective of viral load suppression greater than 85% of people living with HIV/AIDS in continuous care (as recommended by the New York State AIDS Institute Clinical Guidelines). Moreover, the 2022 cascade shows a viral load suppression rate for CYAAPH open patients to be 92%, excluding those who were newly diagnosed and new to care. An increase of 4% from 88% in 2021. This is an unexpected finding because viral suppression remains a challenging task for many organizations throughout the state and the rest of the country. Although we have shown consecutive increase in viral load suppression rate throughout the past few years, the team would like to continuously support our patients to maintain undetectable viral load suppression rate as our main goal. CYAAPH implemented several processes to improve viral load suppression for our patients. As projected, those efforts seem to affect the viral load suppression rate for the 25-29 year old subgroup who increase from 90% in 2021 to 93% in 2022.

Similar result is also noted for the 30-39 year old subgroup who also saw an increase from 76% to 97% in 2022. Furthermore, consistent improvement is detected when the data is disaggregated with gender, ethnicity, risk factors and housing status. The female subgroup increased from 83% to 84%. The black subgroup population viral load suppression rate trend has been great for the past three years, from 76% in 2019 to 82% in 2020, to 85% in 2021, to 88% in 2022. This is a great improvement trend considering the disparities that this specific population face in healthcare. The Hispanic subgroup also maintained the momentum with an increase from 79% to 93% in 2021, and to 100% in 2022. Although the data shows many improvements across subgroups, we still have certain population groups that need improvement. The team will strategize to identify evidence-based interventions for our adolescents and young adult patients whose viral load suppression fail below the average rate. The 13-19 subgroup declined from 100% to 80% in 2022 and the 20-24 subgroup also declined from 89% to 82% in 2022. The perinatal subgroup has been doing well for the past couple years but experience some challenges in 2022. The viral rate falls from 88% in 2021 to 86% in 2022 but still fall in within the average viral rate recommended by the state.

Moving forward, we continually aim to improve our overall viral suppression rate metric by increasing it by 1% to reach 93% in 2023. We also want to maintain the objective of increasing the viral load suppression rate for patients within 13-19 and 20-24 age group. The data shows a gap in viral load suppression between patients who identify as black 88% and white 95%. We will maintain the same efforts and strategies to be consistent in the reduction of the population with unstable and temporary housing. With our small population with unstable housing who had 50% viral load suppression rate in 2021, increased in 2022 to 100%. The team will continue to prioritize our patients and their needs whether it's medical treatment, housing, or transportation. The most common contributing factors to low and declining of viral load consist of low health literacy, mental health issues, and socio-economic factors.

We also would like to streamline our procedures with our partners to reduce the gap in the linkage of new patients who are seeking care with our center. The quality improvement team will continue to implement evidence based behavioral interventions (EBIs) to address the challenges restraining our patients. In addition to the evidence based behavioral interventions, with a continuous assistance with housing for patients who are eligible, we project to reducing the disparity in viral load suppression rate for patients with different racial background. We foresee our viral load suppression to improve by December 2023 for the patients who are not virally suppressed.

QI Projects

QI Project #1
Indicator : Viral load suppression among established active patients
2022 rate for this indicator : 92%
Overall 2023 goal for this indicator : 93%
Description : CYAAPH continually aim to improve our overall viral suppression rate metric by increasing it by 1% to reach 93% by December 31, 2023. Our Quality Improvement team are currently working together by reviewing charts and identified eligible patients for implementation of a multidisciplinary approach to increase virally load suppression rate. This includes psychologist, who continue to implement evidence based behavioral interventions (EBIs) to patient with mental health priority. In addition to the evidence based behavioral interventions, and a continuous assistance with housing for the eligible patients. The team is also doing quarterly chart audit to identify any patients who may fall under any deliverables so they can be address immediately. The medical case managers are also doing enhance 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 plan to continue this practice to leverage retention in care and medication adherence. We foresee our viral load suppression to improve by December 2023 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.

Program Summary: Northwell Health - CYAAPH

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. 90% of the patients who completed the survey indicated that our staff listen to their needs, concerns, and value their participation in their medical care. All participants indicated that our care team works in collaboration with them to achieve their personal health plan goals. 90% of consumers noted that they have smooth appointments with personable staff who clearly explain everything. Participants indicated that they are comfortable and happy with the care they receive at the clinic. As an improvement, 37% of participants suggest that the team should provide a better after care plan for in between visits. The information gathered from the surveys are being implemented to meet our patients where they are. The following is a statement provided by a consumer, expressing her sentiments for the team. "They make me feel like I'm important like I am family and that I am not the only one fighting! They let me know that I can depend on them, and they support everything I do! Medically and personally!" The team will strive to create many more great experience for our consumers.

Coach's Feedback and Updates on Cascade QI Plan

Several improvements over the last few years, despite the decrease within in 13-19-year-old and 20-24- year-old populations recently. Overall, the submission and stated quality improvement project suffices for the organization. During my annual site visit they mentioned they are working on increasing consumer involvement/feedback utilizing digital surveys. In addition, they will be providing internal quality improvement training with staff. Staff will then review their program data and select quality improvement projects for their individual programs.