Quality Improvement Profile

The New York State Department of Health/AIDS Institute's HIV Quality of Care Program has compiled crucial information from your HIV quality improvement 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 quality management program's effectiveness and to make changes if needed. **We encourage sites to use the included data to focus on disparities in outcomes of patient groups to ensure equitable health and wellbeing for all patients.** 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 quality management program, please contact Dan Belanger at Daniel.Belanger@health.ny.gov.

Cascade Submission Date:
Review closed November 2024

QI Profile Completion Date:
February 2025

Latest Revision Date:
February 2025

Program Name: Sun River Health - Hudson Valley and LI*

**formerly known as HRH Care (2017) and HRH Care Community Health (2018 & 2019)*

Clinic Information

Type of Clinic*	Clinic Name	Address	City	Zip
CBO	Alamo Health Center at Goshen	888 Pulaski Highway	Goshen	10924
CBO	Elsie Owens Health Center at Coram	82 Middle Country Road	Coram	11727
CBO	Family Partnership Health Center at Poughkeepsie	29 North Hamilton Street	Poughkeepsie	12601
CBO	Health Center at Amenia	3360 Route 343	Amenia	12501
CBO	Health Center at Beacon	6 Henry Street	Beacon	12508
CBO	Health Center at Brentwood	1869 Brentwood Road	Brentwood	11717
CBO	Health Center at Dover Plains	3174 Route 22	Dover Plains	12522

CBO	Health Center at Greenport	327 Front Street	Greenport	11944
CBO	Health Center at Haverstraw	31 West Broad Street, 3rd floor	Haverstraw	10927
CBO	Health Center at Monticello	23 Lakewood Ave.	Monticello	12701
CBO	Health Center at Pine Plains	19 Pilch Drive	Pine Plains	12567
Hospital	Health Center at Riverhead	County Center, 300 Center Drive South	Riverhead	11901
CBO	Health Center at Spring Valley	2 Perlman Drive	Spring Valley	10977
CBO	HRHCare Health Center at Nyack	84 N. Highland Avenue	Nyack	10960
CBO	HRHCare Hudson	750 Union Street	Hudson	12534
CBO	HRHCare Huntington Health Center	55 Horizon Drive	Huntington	11743
CBO	HRHCare Kraus Family Health Center at Southampton	330 Meeting House Lane	Southampton	11968
CBO	HRHCare Marilyn Shellabarger Health Center at Shirley	550 Montauk Highway and Dorsett Place	Shirley	11967
CBO	HRHCare Martin Luther King Jr. Health Center at Wyandach	1556 Straight Path	Wyandanch	11798
CBO	HRHCare Maxine S. Postal Tri-Community Health Center	1080 Sunrise Highway	Amityville	11701
CBO	HRHCare New Paltz	1 Paradies Lane	New Paltz	12561
CBO	HRHCare Patchogue	365 East Main Street	Patchogue	11722
CBO	HRHCare Peekskill, The Jeannette J. Phillips Health Center	1037 Main Street	Peekskill	10566
CBO	HRHCare Valentine Lane Health Center at Yonkers	503 South Broadway, Suite 210	Yonkers	10705
CBO	HRHCare Yonkers, The Park Care Health Center	2 Park Avenue	Yonkers	10703
CBO	Wallkill Valley Health Center at Walden	75 Orange Avenue	Walden	12586

**CBO = Community Based Organization*

Important Contacts

HIV Medical Director	Aarthi Nagaraja	anagaraja@sunriver.org	Phone number not available
HIV Program Administrator	Aarthi Nagaraja	anagaraja@sunriver.org	Phone number not available
Lead QI Contact	Aldonza Milian	amilian@sunriver.org	(845) 709-4542
Contract Manager	Orane Henry	orane.henry@health.ny.gov	(212) 417-4663
NY Links Coach	Daniel Belanger	Daniel.belanger@health.ny.gov	(212) 417-5131

Regional Group/Learning Network Participation

Affiliation: New York Links
Participated in Group QI Project? N/A
Focus: N/A

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 (Previously Diagnosed Patients): 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. Only patients diagnosed by the participating organization, and not those referred by external providers or testing sites, are eligible for this indicator. 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.

Key Indicators

Figure 1. Newly Diagnosed Viral Load Suppression (within 91 days) Rates at Organizational Level from 2018 to 2023

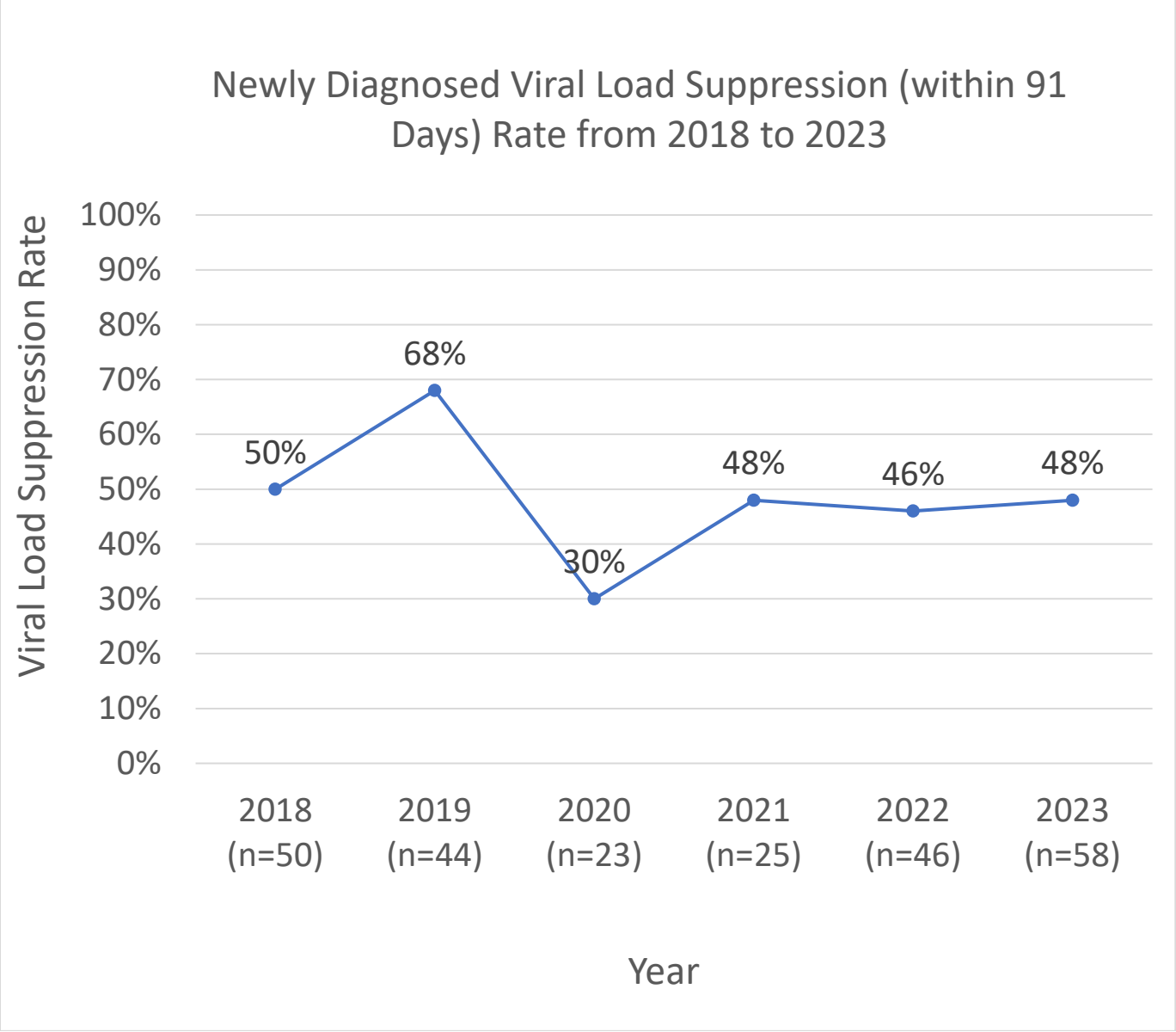


Figure 2: New to Care (Other than Newly Diagnosed) Viral Load Suppression Rates at Organizational Level from 2018 to 2023

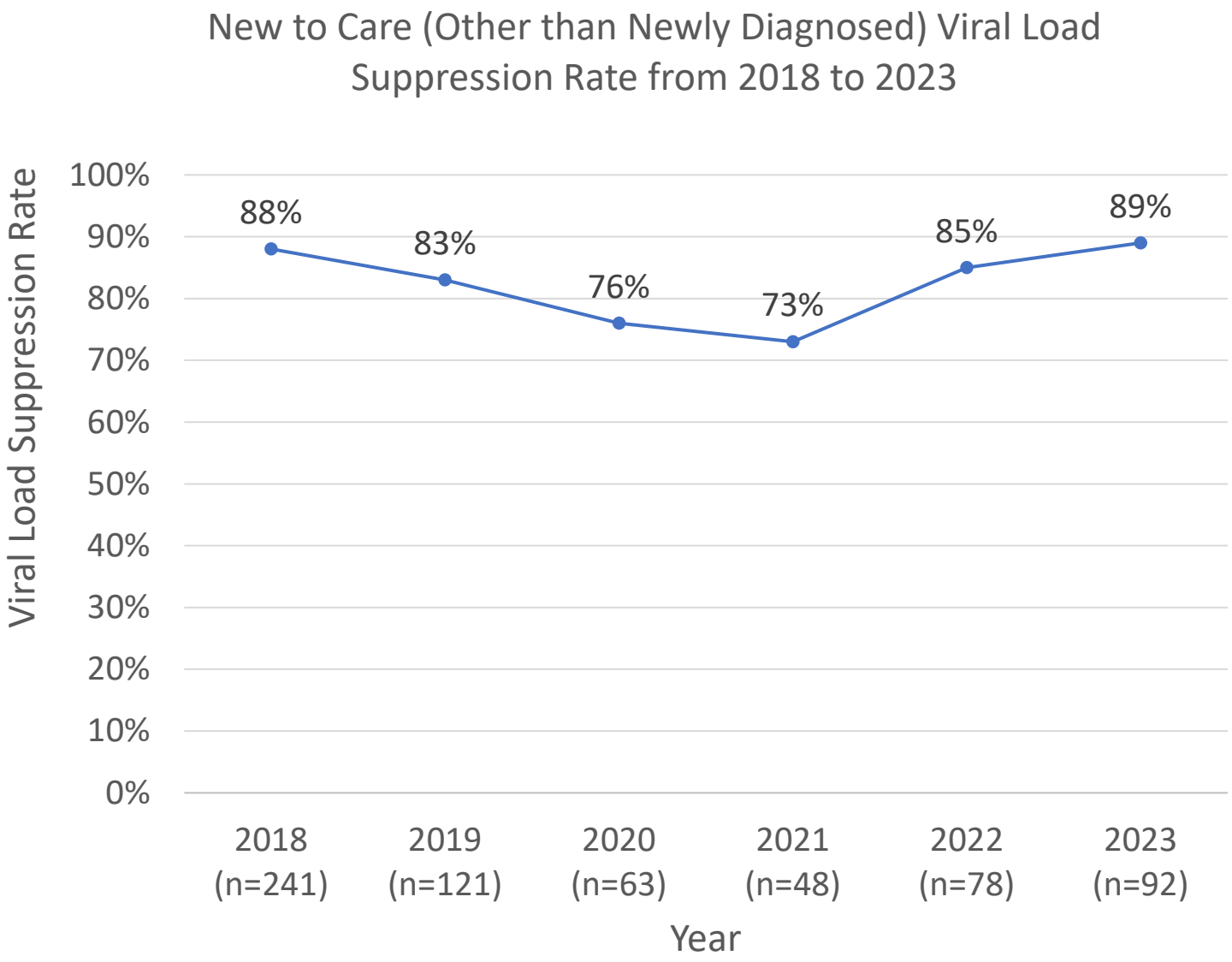


Figure 3: Established Active Viral Load Suppression Rates at Organizational Level from 2017 to 2023

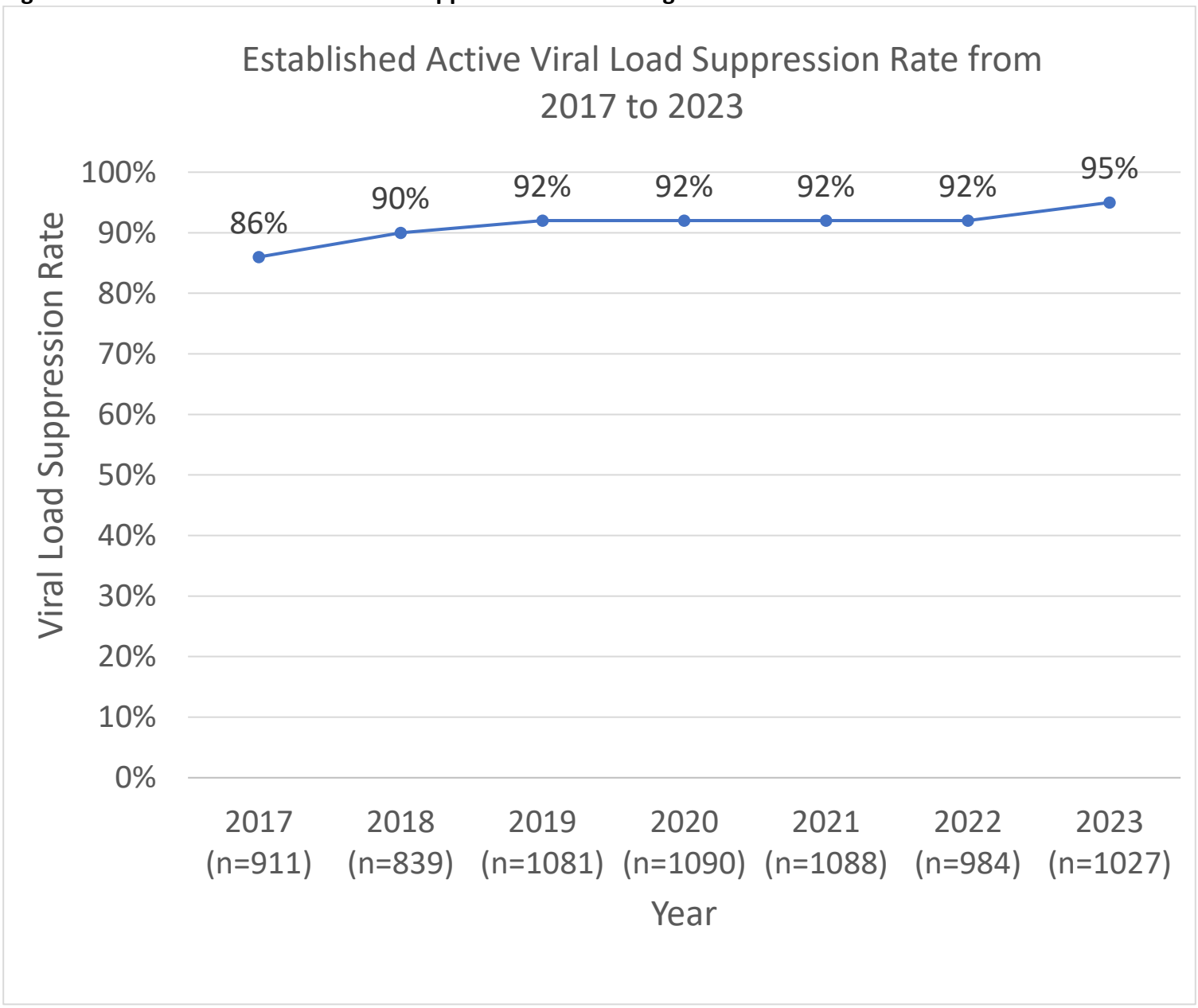


Figure 4. Time to Linkage Rates

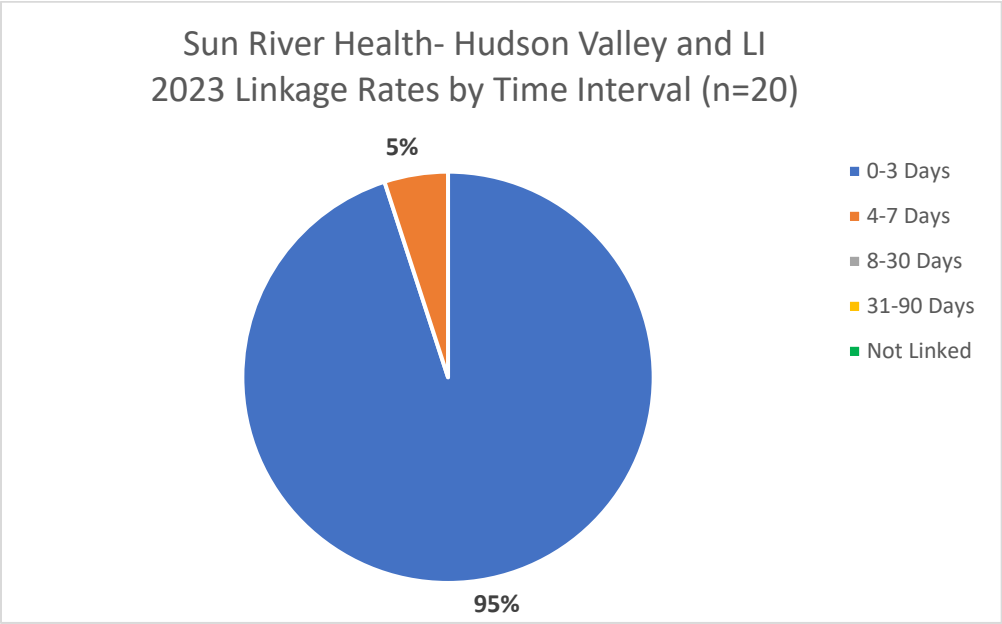


Figure 5. 2023 Established Active Viral Load Suppression Rates by Age at Organizational Level

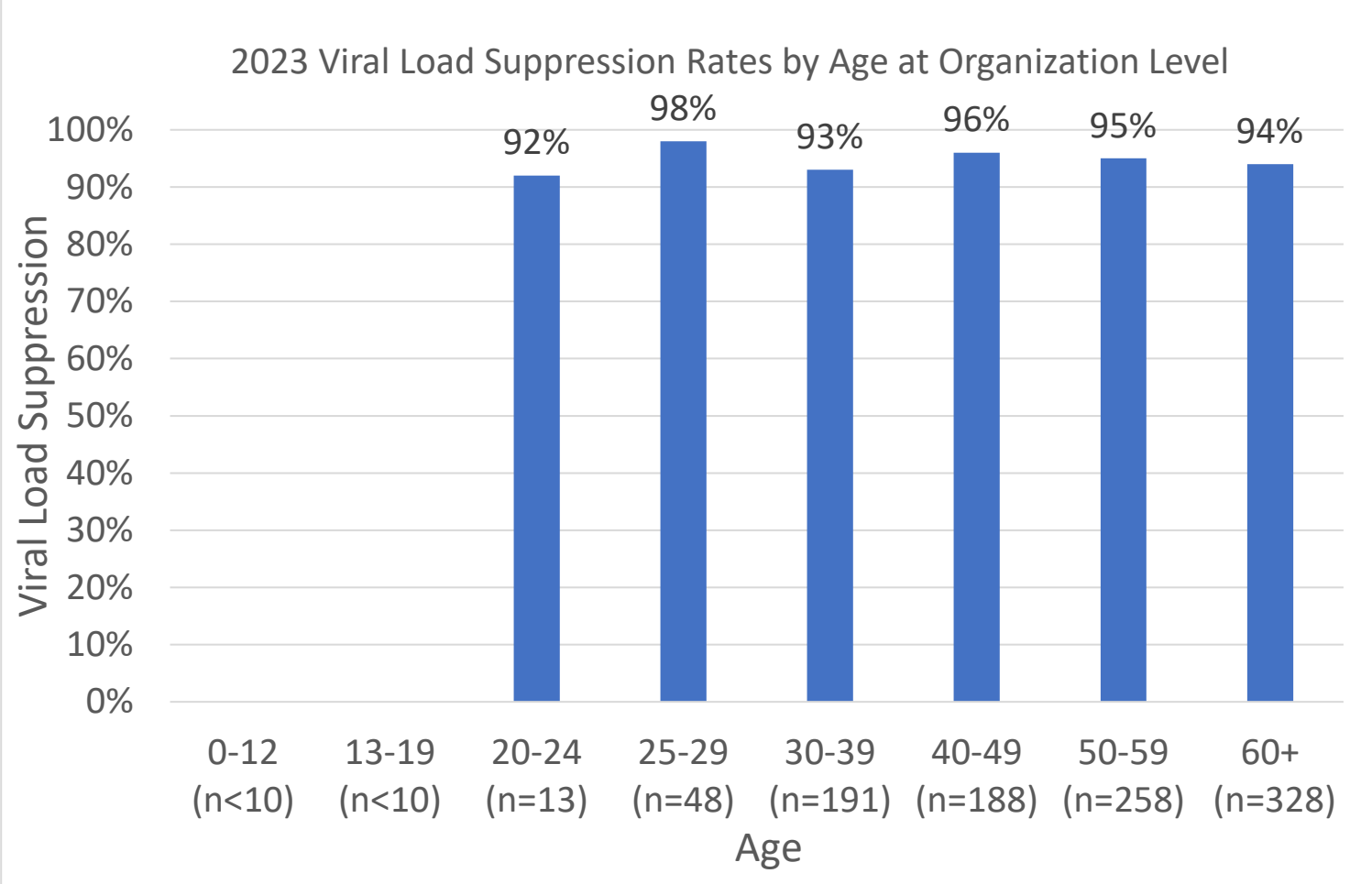
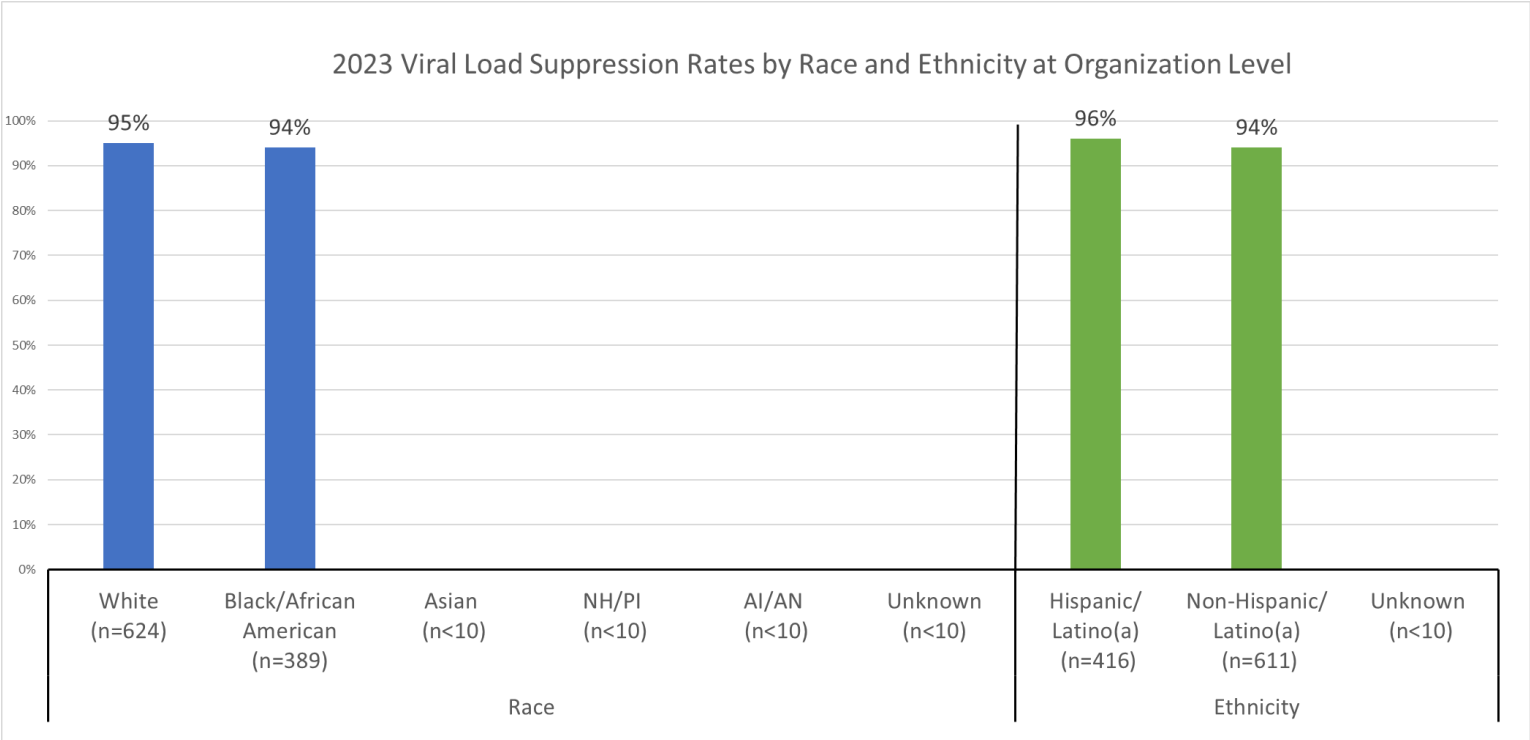


Figure 6. 2023 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organizational Level



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

Table 1: Indicator Scores at Organization Level for 2017 to 2023

Patient Group	Indicator	2017		2018		2019		2020		2021		2022		2023	
		Org. Score	State Median	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	**	**	29% (n=38)	41%	42% (n=24)	51%	40% (n=10)	55%	-- (n<10)*	61%	53% (n=15)	53%	95% (n=20)	63%
	On ARV Therapy	**	**	84% (n=50)	96%	98% (n=44)	100%	87% (n=23)	100%	100% (n=25)	100%	91% (n=46)	100%	98% (n=58)	100%
	VL Test within 91 Days	**	**	88% (n=50)	93%	91% (n=44)	95%	74% (n=23)	95%	92% (n=25)	92%	85% (n=46)	96%	86% (n=58)	95%
	Suppressed within 91 Days	**	**	50% (n=50)	45%	68% (n=44)	50%	30% (n=23)	46%	48% (n=25)	50%	46% (n=46)	50%	48% (n=58)	50%
	Baseline Resistance Test	**	**	**	**	82% (n=44)	74%	83% (n=23)	80%	68% (n=25)	82%	59% (n=46)	79%	60% (n=58)	76%
Other New to Care	On ARV Therapy	**	**	94% (n=241)	97%	93% (n=121)	100%	90% (n=63)	100%	100% (n=48)	100%	88% (n=78)	100%	100% (n=92)	100%
	Any VL Test	**	**	96% (n=241)	99%	94% (n=121)	98%	86% (n=63)	100%	88% (n=48)	100%	96% (n=78)	98%	97% (n=92)	98%
	Suppressed Final VL	**	**	88% (n=241)	74%	83% (n=121)	78%	76% (n=63)	77%	73% (n=48)	69%	85% (n=78)	77%	89% (n=92)	80%
Established Active	On ARV Therapy	93% (n=911)	99%	96% (n=839)	99%	98% (n=1081)	99%	100% (n=1090)	99%	100% (n=1088)	99%	100% (n=984)	100%	100% (n=1027)	100%
	Any VL Test	100% (n=911)	99%	97% (n=839)	99%	98% (n=1081)	99%	97% (n=1090)	97%	98% (n=1088)	98%	98% (n=984)	98%	99% (n=1027)	98%
	Suppressed Final VL	86% (n=911)	88%	90% (n=839)	88%	92% (n=1081)	89%	92% (n=1090)	87%	92% (n=1088)	88%	92% (n=984)	89%	95% (n=1027)	91%
Open Previously Diagnosed (Active & Inactive)	On ARV Therapy	87% (n=981)	92%	95% (n=912)	95%	92% (n=1164)	96%	91% (n=1201)	96%	97% (n=1165)	97%	93% (n=1170)	97%	97% (n=1194)	98%
	Any VL Test	93% (n=981)	92%	92% (n=912)	93%	91% (n=1164)	93%	89% (n=1201)	90%	95% (n=1165)	94%	92% (n=1170)	93%	95% (n=1194)	94%
	Suppressed Final VL	80% (n=981)	80%	84% (n=912)	80%	86% (n=1164)	83%	84% (n=1201)	77%	88% (n=1165)	79%	85% (n=1170)	83%	90% (n=1194)	83%

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

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

Table 2: Viral Load Suppression by Established Active Patient Demographic Group at Organization Level for 2023

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*	--	13	92%	48	98%	191	93%	188	96%	258	95%	328	94%

GENDER															
Cis Male		Cis Female		Trans Male		Trans Female		Other Gender		Gender X		Unknown Gender			
n	%	n	%	n	%	n	%	n	%	n	%	n	%		
642	94%	372	95%	<10*	--	10	100%	<10*	--	<10*	--	<10*	--		

RACE															
White		Black/African American		Asian		Native Hawaiian/PI		American Indian/ AN		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%				
624	95%	389	94%	<10*	--	<10*	--	<10*	--	<10*	--				

ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
416	96%	611	94%	<10*	--										

RISK FACTOR															
MSM		IDU Risk		Heterosexual Risk		Hemophilia or Coagulation		Blood Transfusion		Perinatal		Other Risk		Unknown	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
354	95%	52	94%	625	94%	<10*	--	16	100%	15	100%	10	60%	<10*	--

HOUSING STATUS															
Stable Housing		Temporarily Housed		Unstably Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
972	95%	13	92%	42	76%	<10*	--								

INSURANCE TYPE															
ADAP		Dual Eligible		Medicaid		Medicare		Private Insurance		Veteran's Admin		Other		No Insurance	
n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
188	96%	150	95%	339	93%	83	92%	228	97%	<10*	--	<10*	--	35	89%
Unknown															
n	%														
<10*	--														

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

Table 3: Indicator Scores at Clinic Level for 2017 to 2023

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	75 Washington	**	**	**	**	92% (n=145)	100% (n=145)	88% (n=145)
	Beacon	**	**	**	**	97% (n=109)	100% (n=109)	88% (n=109)
	Brentwood	**	**	**	**	89% (n=177)	100% (n=177)	82% (n=177)
	Elsie Owens (Coram)	**	**	**	**	88% (n=16)	100% (n=16)	81% (n=16)
	Shirley	**	**	**	**	98% (n=56)	100% (n=56)	82% (n=56)
	MLK/Wyandanch	**	**	**	**	93% (n=100)	100% (n=100)	85% (n=100)
	Amityville	**	**	**	**	97% (n=64)	100% (n=64)	75% (n=64)
	Monticello	**	**	**	**	93% (n=101)	100% (n=101)	92% (n=101)
	Patchogue	**	**	**	**	90% (n=52)	100% (n=52)	79% (n=52)
	Peekskill	**	**	**	**	97% (n=69)	100% (n=69)	91% (n=69)
	Riverhead	**	**	**	**	100% (n=22)	100% (n=22)	95% (n=22)
2018	Elsie Owens Health Center at Coram	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=11)	100% (n=11)	73% (n=11)
	Family Partnership Health Center at Poughkeepsie	**	98% (n=50)	100% (n=50)	98% (n=50)	96% (n=101)	93% (n=101)	90% (n=101)
	HRHCare Marilyn Shellabarger Health Center at Shirley	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	96% (n=49)	98% (n=49)	88% (n=49)
	HRHCare Martin Luther King Jr. Health Center at Wyandach	**	80% (n=10)	90% (n=10)	80% (n=10)	96% (n=107)	100% (n=107)	88% (n=107)
	HRHCare Maxine S. Postal Tri-Community Health Center	**	70% (n=10)	100% (n=10)	70% (n=10)	100% (n=60)	100% (n=60)	90% (n=60)
	HRHCare Patchogue	**	100% (n=18)	94% (n=18)	78% (n=18)	100% (n=52)	98% (n=52)	92% (n=52)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	96% (n=69)	97% (n=69)	88% (n=69)
	Health Center at Beacon	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	95% (n=102)	100% (n=102)	93% (n=102)
	Health Center at Brentwood	**	88% (n=16)	94% (n=16)	69% (n=16)	98% (n=166)	96% (n=166)	89% (n=166)
	Health Center at Monticello	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	94% (n=95)	98% (n=95)	89% (n=95)
	Health Center at Riverhead	**	-- (n<10)*	-- (n<10)*	-- (n<10)*	95% (n=20)	100% (n=20)	95% (n=20)
	Health Center at Spring Valley	**	94% (n=103)	95% (n=103)	87% (n=103)	-- (n<10)*	-- (n<10)*	-- (n<10)*

2019	Elsie Owens Health Center at Coram	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=21)	100% (n=21)	100% (n=21)
	Family Partnership Health Center at Poughkeepsie	-- (n<10)*	100% (n=12)	100% (n=12)	92% (n=12)	97% (n=155)	97% (n=155)	93% (n=155)
	HRHCare Hudson	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Marilyn Shellabarger Health Center at Shirley	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=56)	98% (n=56)	95% (n=56)
	HRHCare Martin Luther King Jr. Health Center at Wyandach	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	95% (n=118)	99% (n=118)	86% (n=118)
	HRHCare Maxine S. Postal Tri-Community Health Center	-- (n<10)*	69% (n=13)	100% (n=13)	85% (n=13)	100% (n=62)	100% (n=62)	95% (n=62)
	HRHCare Patchogue	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	97% (n=67)	97% (n=67)	90% (n=67)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	97% (n=63)	95% (n=63)	90% (n=63)
	HRHCare Yonkers, The Park Care Health Center	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Beacon	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	97% (n=104)	100% (n=104)	96% (n=104)
	Health Center at Brentwood	-- (n<10)*	92% (n=13)	92% (n=13)	92% (n=13)	100% (n=179)	97% (n=179)	91% (n=179)
	Health Center at Dover Plains	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Greenport	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Monticello	-- (n<10)*	89% (n=28)	100% (n=28)	96% (n=28)	97% (n=102)	96% (n=102)	92% (n=102)
	Health Center at Riverhead	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	93% (n=30)	97% (n=30)	97% (n=30)
	Health Center at Spring Valley	-- (n<10)*	100% (n=18)	94% (n=18)	72% (n=18)	97% (n=118)	98% (n=118)	92% (n=118)
2020	Elsie Owens Health Center at Coram	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=33)	100% (n=33)	97% (n=33)
	Family Partnership Health Center at Poughkeepsie	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	99% (n=157)	97% (n=157)	93% (n=157)
	HRHCare Hudson	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Huntington Health Center	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Marilyn Shellabarger Health Center at Shirley	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=55)	98% (n=55)	94% (n=55)
	HRHCare Martin Luther King Jr. Health Center at Wyandach	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	99% (n=106)	100% (n=106)	95% (n=106)
	HRHCare Maxine S. Postal Tri-Community Health Center	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=68)	100% (n=68)	96% (n=68)
	HRHCare Patchogue	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	99% (n=67)	100% (n=67)	94% (n=67)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=68)	97% (n=68)	94% (n=68)
	Health Center at Amenia	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Beacon	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	99% (n=102)	97% (n=102)	91% (n=102)

	Health Center at Brentwood	-- (n<10)*	80% (n=10)	60% (n=10)	50% (n=10)	100% (n=171)	91% (n=171)	86% (n=171)
	Health Center at Haverstraw	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Monticello	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=123)	98% (n=123)	93% (n=123)
	Health Center at Riverhead	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=26)	96% (n=26)	85% (n=26)
	Health Center at Spring Valley	-- (n<10)*	-- (n<10)*	-- (n<10)*	-- (n<10)*	100% (n=113)	97% (n=113)	92% (n=113)
2021	Alamo Health Center at Goshen	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Elsie Owens Health Center at Coram	**	**	**	**	100% (n=33)	97% (n=33)	85% (n=33)
	Family Partner Health Center at Poughkeepsie	**	**	**	**	100% (n=154)	99% (n=154)	95% (n=154)
	Health Center at Amenia	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Beacon	**	**	**	**	100% (n=103)	100% (n=103)	94% (n=103)
	Health Center at Brentwood	**	**	**	**	100% (n=182)	95% (n=182)	88% (n=182)
	Health Center at Haverstraw	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Monticello	**	**	**	**	100% (n=116)	99% (n=116)	93% (n=116)
	Health Center at Riverhead	**	**	**	**	100% (n=23)	100% (n=23)	96% (n=23)
	Health Center at Spring Valley	**	**	**	**	100% (n=107)	100% (n=107)	95% (n=107)
	HRHCare Huntington Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Marilyn Shellabarger Health Center at Shirley	**	**	**	**	100% (n=60)	98% (n=60)	93% (n=60)
	HRHCare MLK Health Center at Wyandach	**	**	**	**	100% (n=114)	100% (n=114)	87% (n=114)
	HRHCare Maxine S. Postal Tri-Community Health Center	**	**	**	**	100% (n=60)	95% (n=60)	90% (n=60)
	HRHCare Patchogue	**	**	**	**	100% (n=68)	100% (n=68)	90% (n=68)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	**	**	**	**	100% (n=59)	98% (n=59)	95% (n=59)
	HRHCare Valentine Lane Health Center at Yonkers	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Yonkers, the Park Care Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Wallkill Valley Health Center at Walden	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
2022	Alamo Health Center at Goshen	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Elsie Owens Health Center at Coram	**	**	**	**	100% (n=28)	93% (n=28)	86% (n=28)
	Family Partner Health Center at Poughkeepsie	**	**	**	**	100% (n=138)	100% (n=138)	96% (n=138)

	Health Center at Amenia	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Beacon	**	**	**	**	100% (n=96)	100% (n=96)	98% (n=96)
	Health Center at Brentwood	**	**	**	**	100% (n=177)	97% (n=177)	89% (n=177)
	Health Center at Dover Plains	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Greenport	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Haverstraw	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Monticello	**	**	**	**	100% (n=103)	100% (n=103)	99% (n=103)
	Health Center at Pine Plains	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Riverhead	**	**	**	**	100% (n=23)	96% (n=23)	83% (n=23)
	Health Center at Spring Valley	**	**	**	**	100% (n=98)	100% (n=98)	94% (n=98)
	HRHCare Center at Nyack	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Center Hudson	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Huntington Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Kraus Family Health Center at Southampton	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Marilyn Shellabarger Health Center at Shirley	**	**	**	**	100% (n=54)	93% (n=54)	87% (n=54)
	HRHCare MLK Health Center at Wyandach	**	**	**	**	99% (n=101)	100% (n=101)	93% (n=101)
	HRHCare Maxine S. Postal Tri-Community Health Center	**	**	**	**	100% (n=45)	98% (n=45)	80% (n=45)
	HRHCare New Paltz	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Patchogue	**	**	**	**	97% (n=73)	96% (n=73)	88% (n=73)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	**	**	**	**	100% (n=48)	100% (n=48)	92% (n=48)
	HRHCare Valentine Lane Health Center at Yonkers	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Yonkers, the Park Care Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Wallkill Valley Health Center at Walden	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
2023	Alamo Health Center at Goshen	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Elsie Owens Health Center at Coram	**	**	**	**	100% (n=26)	92% (n=26)	88% (n=26)
	Family Partner Health Center at Poughkeepsie	**	**	**	**	100% (n=134)	100% (n=134)	99% (n=134)
	Health Center at Amenia	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*

	Health Center at Beacon	**	**	**	**	100% (n=96)	100% (n=96)	99% (n=96)
	Health Center at Brentwood	**	**	**	**	100% (n=193)	98% (n=193)	85% (n=193)
	Health Center at Dover Plains	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Greenport	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Haverstraw	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Monticello	**	**	**	**	100% (n=108)	100% (n=108)	99% (n=108)
	Health Center at Pine Plains	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Health Center at Riverhead	**	**	**	**	100% (n=30)	100% (n=30)	99% (n=30)
	Health Center at Spring Valley	**	**	**	**	100% (n=97)	100% (n=97)	100% (n=97)
	HRHCare Center at Nyack	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Center Hudson	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Huntington Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Kraus Family Health Center at Southampton	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Marilyn Shellabarger Health Center at Shirley	**	**	**	**	100% (n=59)	98% (n=59)	88% (n=59)
	HRHCare MLK Health Center at Wyandach	**	**	**	**	99% (n=112)	99% (n=112)	81% (n=112)
	HRHCare Maxine S. Postal Tri-Community Health Center	**	**	**	**	100% (n=44)	98% (n=44)	95% (n=44)
	HRHCare New Paltz	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Patchogue	**	**	**	**	100% (n=76)	99% (n=76)	93% (n=76)
	HRHCare Peekskill, The Jeannette J. Phillips Health Center	**	**	**	**	100% (n=51)	100% (n=51)	98% (n=51)
	HRHCare Valentine Lane Health Center at Yonkers	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	HRHCare Yonkers, the Park Care Health Center	**	**	**	**	-- (n<10)*	-- (n<10)*	-- (n<10)*
	Wallkill Valley Health Center at Walden	**	**	**	**	-- (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 or were not scored at this level.**

Quality Improvement Interventions for 2024

Self-Reported based on 2023 results

Methodology

Several data sources were utilized to create Sun River Health's 2023 Organizational Cascade. Based on the information requested in the Organizational Cascade Guidelines, we created a data report in an Excel spreadsheet format from Cognos, a report writing program. This information was then reviewed and verified with information in each patient's electronic medical record, eClinical Works. The structured data fields created over the past several years following our Organizational Treatment Cascade submissions have made data collection much more automated. Duplicate patient names were eliminated. Limitations to the data collection tool were identified and addressed. Errors were evaluated through manual chart review; the data team met biweekly to share updates and problem-solve until submission.

The tables created by the Cascade spreadsheet were also compared to our 2023 Cascade created in Spotfire, a secure software product that allows for drill down to detect outliers, find patterns, and understand data by visually exploring the database. The data sources utilized in this project were chosen based on accuracy, reliability, and availability. Cognos and Spotfire are used to generate the monthly and quarterly quality improvement reports reviewed by the Genesis teams and Sun River Health's agency-wide Genesis Quality Management, and Improvement Clinical Quality Council. The Genesis Data Coordinator was responsible for extracting the data, running the Cognos report, and entering the data into the Cascade template. The Data Coordinator, Data Specialist, and data team members conducted a chart review. The Medical Director of HIV & Hepatitis C and the Assistant Vice President of Grant Funded Clinical Services reviewed all data for completeness and accuracy. Weekly meetings were held to review data and processes. The team participated in the Department of Health Cascade webinars.

Key Findings

Upon comparing the 2023 Organizational Treatment Cascade data to 2022 for Hudson Valley and Long Island, the program continues to provide quality care, with antiretroviral therapy among established active patients being at 100%, viral load testing at 99%, a 1% increase from 2022, and suppression at 95%, a 3% increased from 2022.We did have 43 new individuals added to the cascade. Our established patients went up to 1027 individuals from 984 individuals in 2022.

Our rise in denominator was spread amongst most sites, but the largest increase was in Brentwood and Martin Luther King Jr. Health center. Overall, we had 92 new-to-care individuals, with 100% antiretroviral therapy, an increase of 12% from 2022. Viral load testing was 97%, an increase of 1%. Viral load suppression was 89%, an increase of 4% since 2022. In addition, we had an increase in the denominator, with 92 new-to-care individuals in 2023, while 2022 had 78 new-to-care individuals.

We had 58 newly diagnosed individuals in 2023, while in 2022, we had 46 individuals. Antiretroviral therapy was 98%, increased by 7% from 2022. Viral load testing was 86% increased by 3% from 2022. Viral load suppression

was 48%, increased by 2% from 2022. 3-day internal linkage was 95% increased by 42%, 7-day linkage was 100%, which increased by 20%. 30-day linkage was 100% similar to 2022. Viral load resistance testing for new to care was 60% increased by 1% from 2022. Suppression within 91 days of newly diagnosed in the first 9-month period was 54%, a 1% decrease from last year. Ever suppressed during the review period went up by 7% since 2022.

Overall, Sun River continues to see many new diagnoses and new-to-care individuals in 2023, and it has been a steady increase since last year. Those who are new-to-care and newly diagnosed continue to bring new challenges, including social determinants of health barriers, housing instability, mental health, substance use, and stigma associated with seeking care, whether it's structural or internalized. We employed a patient-centered approach and trained our staff in the language of caring, motivational interviewing techniques, harm reduction, rapid start, and frequent outreach techniques. We employed linking all those new-to-care, newly diagnosed, to intensive case management services to make some of our improvements in our testing and suppression numbers. This is reflected in 92 new individuals compared to the 58 newly diagnosed individuals, where viral load suppression is higher in new-to-care at 89% compared to 48% in those newly diagnosed.

We employed Rapid Start universally and hybrid models of care, and at home lab draws for both sets of these populations. We were a part of Health Resources and Services Administration and Center for Quality Improvement and Innovation's Impact Now learning collaborative, from January 2023 to June 2024. As part of this project, we engaged new-to-care, newly diagnosed, and viremic individuals into a Retention and Adherence Program and general case management program. We compared the Ryan White Services Report data that Center for Quality Improvement and Innovation provided during this project. We were able to retain and intensify case management support, use data driven drilldowns, and rapid start to suppress 265 individuals within our system, and they contributed to 6% of overall viral load suppression rates. In this subgroup, we showed that 85 individuals obtained a rapid start before picking up their prescriptions. Part of Rapid Start dispensation is documentation in the electronic medical record so that it can be captured. This was happening inconsistently, although meds were being given on-site. Rapid start is available at all Genesis sites and integrated into primary care. Subdividing our large population by identifying at-risk and vulnerable helped us achieve our overarching goal of retention and suppression. Staff meetings, case conferences, grand rounds, and Quarterly genesis quality meetings provided education about this project and its interventions.

All the above interventions were crucial to improve care for vulnerable populations, especially those re-engaging or with new diagnoses. Viral load suppression by demographics is as follows:

- Overall, viral load suppression by age groups is strong, including young adolescents and adults.
    - 20-24 age group stayed at 92%.
    - 25-29 age group was 95%, increased by 3%.
    - 30-39 age group was 93%, which increased by 4%.
    - 40-49 age group was 96%, which increased by 4%.
    - 50-59 age group was 95%, which increased by 1%.
    - 60 and older age group was 94%, increased by 2%.
- Viral load suppression by gender:
    - Among males was 94% increased by 2%.
    - Among females was 95%, increased by 3%.

    - Among transgender men and transgender women was 100% which we have 13 individuals, it's the first time we saw this high number.
        - We do have providers who provide gender affirming hormones, and we augment use via telemedicine and hybrid models.
- Viral load suppression by race and ethnicity:
    - Among whites was 95%, increasing by 2%.
    - Among African Americans was 94%, increasing by 3%.
    - Among Hispanics was 96%, increasing by 4%.
    - Among non-Hispanics was 94%, increasing by 2%.
- Viral load suppression by risk factor:
    - Among men who have sex with men population was 95%, increasing by 2%.
    - Among people who inject drugs was 94% and increasing by 3%.
        - We have integrated our harm reduction and medication assisted treatment services and will discuss this at case conferences.
    - Among perinatally diagnosed population was 100%, a 12% increase, a significant threshold to reach.
- Viral load suppression by housing status:
    - Among populations who have stable housing was 95%, which has increased by 2% since 2022.
    - Among populations who have temporary housing was 92% and increased by 13%.
    - Among populations who have unstable housing was lowest at 75% and decreased by 10%.

We used our hybrid models to engage those with housing instability and used at-home lab draws if we felt the temporary and unstable housing were safe environments. The linkage, prescription, retention, and viral load suppression rates reflect integration within our program throughout our wide geography and regions. However, the ultimate low viral load suppression rates in those unstably housed are felt to be due to social determinants of health barriers. We did experience some provider, nursing, and case management staff turnover and shortages, but we tried to circumvent this the best we could. We had hired two new providers in 2022, one for Hudson Valley and one for Long Island regions to replace providers, who transitioned, and we ensured that their expertise was utilized optimally with telemedicine.

Viral load suppression for individual sites, ranged from 81% to 100%.

- Martin Luther King Jr. Health Center was 81%, dropped from last year by 12%, but this is the site that had many new-to-care and new diagnoses.
- Brentwood, the other site with the most new cases, went up to 95%, by 6% since last year.
- Other Long Island sites, such as:
    - Coram, had viral load suppression of 88%, which increased by 2% since 2022.
    - Riverhead stayed the same at 83%.
    - Shirley increased by 1%, to reach 88%.
    - Maxine increased by 14% and reached 95%. We had one of the new providers work closely at this site.
    - Patchogue increased by 6% and reached 93%.
- In the Hudson Valley:
    - Poughkeepsie's viral suppression increased by 3% to reach 99%.

- Beacon increased by 1% to reach 99%.
- Monticello stayed consistent at 99%.
- Spring Valley increased by 6% and reached 100%, with a new provider.
- Peekskill increased by 6% and reached 98% with the same new provider.

QI Projects

QI Project #1

Indicator: Viral load suppression among newly diagnosed patients
2023 rate for this indicator: 48%
Overall 2024 goal for this indicator: 80%
Description: Improve viral load suppression to 80% by December 2024 for individuals newly diagnosed with HIV. The goal will be implemented at all HIV sites in the Hudson Valley and Long Island. This is a new goal.

- Utilize Cognos New-to-Care report to ensure all newly diagnosed patients are referred to the Genesis Program.
- Assign a case manager to each newly diagnosed patient to support and assess and reduce barriers to medication adherence and care.
- Utilize Peer services for support and adherence education.
- Refer to the Retention and Adherence Program for intensive case management and adherence education.
- Explore the use of home draws even further and hybrid visits.
- Review data at the Annual Genesis Conference.
- Review Spotfire data on a quarterly basis during each site quality improvement meeting.
- Review Spotfire data at quarterly Quality Management Meetings and Consumer Advisory Board Meetings.
- Continue to look at social determinants of health, such as housing, transportation, substance use, mental health, food insecurity, and review regional resources to address these needs.

QI Project #2

Indicator: Viral load suppression among established active patients
2023 rate for this indicator: 95%
Overall 2024 goal for this indicator: 96%
Description:
Indicator: Viral load suppression among unstable housed
2023 rate for this indicator: 76%
Overall 2024 goal for this indicator: 80%

Improve viral load suppression to 80% by December 2024 individuals who are unstably housed. Goal will be implemented at all HIV sites in the Hudson Valley and Long Island. This goal is continued from last year.

- Generate a Spotfire list of unstably housed patients by site, including viral load, next Primary Care visit, case manager, and provider, to be automated for monthly distribution.
- Verify unknown housing data and enter in structured data.
- Update and distribute a housing directory/toolkit for each region.

- Assign each unstably housed patient a case manager to assess needs, reduce barriers, and improve housing for identified patients.
- Obtain HIPAA consent for all patients residing in transitional housing, Housing Opportunities for Persons With AIDS housing, or shelters for client-specific information sharing.
- Incorporate Consumers into outreach and engagement.
- Coordinate outreach efforts with the Community Engagement department to patients residing in shelters who are out of care to attempt to re-engage them.
- Continue to discuss housing in patient specific case conferences and address through care plans to reduce barriers to care.
- Continue to utilize Sun River Health adherence supports: Retention and Adherence Program services, Directly Observed Therapy, group attendance to reinforce antiretroviral adherence.
- Explore co-location of housing service provider or application sessions to expedite referral process.
- Review Driver Diagram and utilize Spotfire to review viral load suppression for unstably housed individuals quarterly during site quality improvement meetings, quality management meetings, Annual Genesis Conference
- Review viral load suppression for unstably housed individuals at Consumer Advisory Board Meeting.

QI Project #3

Indicator: Resistance testing among active newly diagnosed patients

2023 rate for this indicator: 60%

Overall 2024 goal for this indicator: 80%

Description: Improve viral load resistance testing to 80% by December 2024 for individuals newly diagnosed with HIV. The goal will be implemented at all HIV sites in the Hudson Valley and Long Island. This is a new goal.

- Utilize Cognos New to Care report to ensure all newly diagnosed patients are referred to the Genesis Program.
- Assign a case manager to each newly diagnosed patient to support, assess, and reduce barriers to medication adherence and care.
- During case conference, review if resistance testing has been ordered and resulted.
    - If it is test not performed, due to lab error, advise provider to re-order at next visit and notate that in electronic medical record.
- Utilize Peer services for support and adherence education.
- Explore the use of home draws even further.
- Review data at the Annual Genesis Conference.
- Review Spotfire data on a quarterly basis during each site quality improvement meeting.

Consumer Involvement

Quality improvement projects, as well as program survey results are discussed with the Hudson Valley and Long Island Consumer Advisory Committees on a quarterly basis to obtain feedback and recommendations. Consumers participate in the monthly quality improvement meetings, quarterly Consumer Advisory Board meetings, and Focus Groups routinely scheduled across sites. Progress on the Treatment Cascade goals is reviewed annually with staff and Consumer Advisory Board members at the Annual Genesis Conference which provides both information updates as well as education on quality improvement processes. Spotfire graphs are shared as well as the

Treatment Cascade and individual site cascades, special population data, and linkage to care data annually. Additionally, Consumers participate in Sun River Health Planetree Patient Advisory Committee across all regions providing feedback on new programs/materials, quality scores, and other patient feedback. They provide recommendations on programs, processes, communication strategies & marketing materials. Consumers participate in the Center for Quality Improvement and Innovation's Impact now Collaborate Liaison Affinity Group. The Affinity Group meet monthly from June 2022 to July 2023 and encouraged peer learning and exchanges while providing a safe space to voice concerns and share quality improvement resources. Consumers develop quality improvement skills while receiving guidance and support from content experts and their consumers. They supported the Center for Quality Improvement and Innovation mission "To promote the application of quality improvement methodologies and tools to measurably increase viral suppression rates for people with HIV served by Ryan White HIV/AIDS Program-funded providers that have the highest potential national impact." They are meaningfully engaged on quality improvement teams, they are actively involved decision-making processes, have access to performance data and results. Additionally, consumers participate in the completion of a Driver and Fishbone Diagram on improving viral load suppression. Progress will be shared with consumers throughout the year through focus groups, individual sessions, and viral load suppression displays in case manager's offices and treatment rooms.

Coach's Feedback and Updates on Cascade QI Plan

The methodology section details the data review process, the key findings section offers a thorough overview of changes in indicator results from 2022 to 2023. There is some variation in viral load suppression results for specific patient groups such as the unstably housed and some variation in overall results between clinic care sites. Consumer involvement occurs at quarterly costumer advisory meetings regionally. Consumer input is used to develop, asses and revise quality improvement efforts.