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 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 in November 2025**

Quality Improvement Profile Completion Date: **March 2026**

Latest Revision Date: **May 14, 2026**

Program Name: Northwell Health – Center for Young Adults, Adolescent and Pediatric HIV

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
Lead Quality Improvement Contact	Hope Zewou	hzewou@northwell.edu	(516) 622-5194
NY Links Coach	Febuary D'Auria	febuary.dauria@health.ny.gov	(631) 851-3625

Regional Group/Learning Network Participation

Learning Network Affiliation: New York Links
Participated in Group Quality Improvement 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 Antiretroviral Therapy: Documented prescription of one or more antiretroviral medications at any time during the review year.

Any Viral Load Test: Documentation of at least one viral load test at any time during the review year.

Viral Load Test within 91 Days (Newly Diagnosed Patients): Documentation of at least one viral load test performed within 91 days of initial HIV diagnosis.

Suppressed on Final Viral Load (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 antiretrovirals, 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 antiretroviral 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

Figure 1. Viral Load Suppression within 91 Days among Newly Diagnosed Patients: Organization Rate from 2018 to 2024

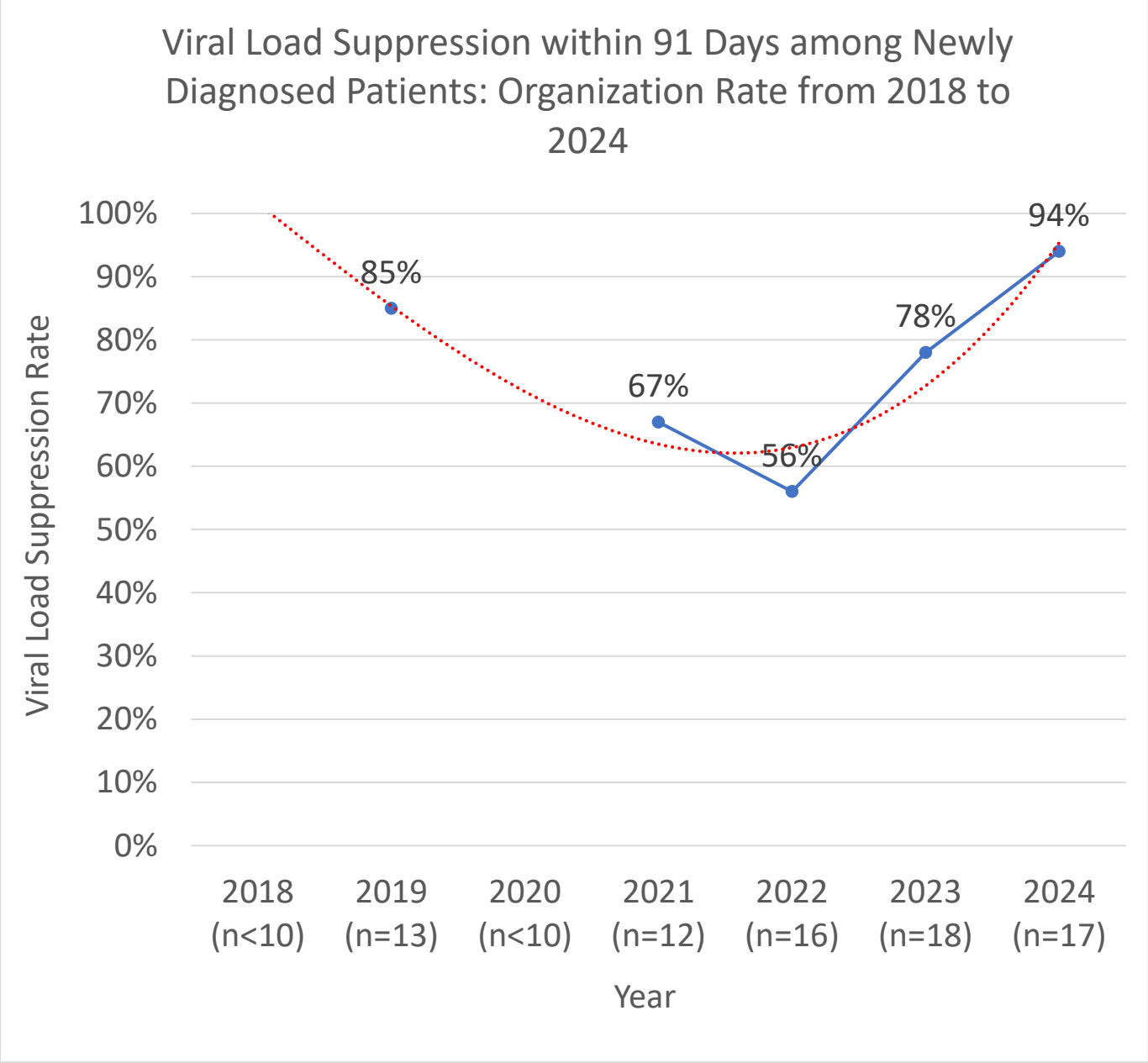
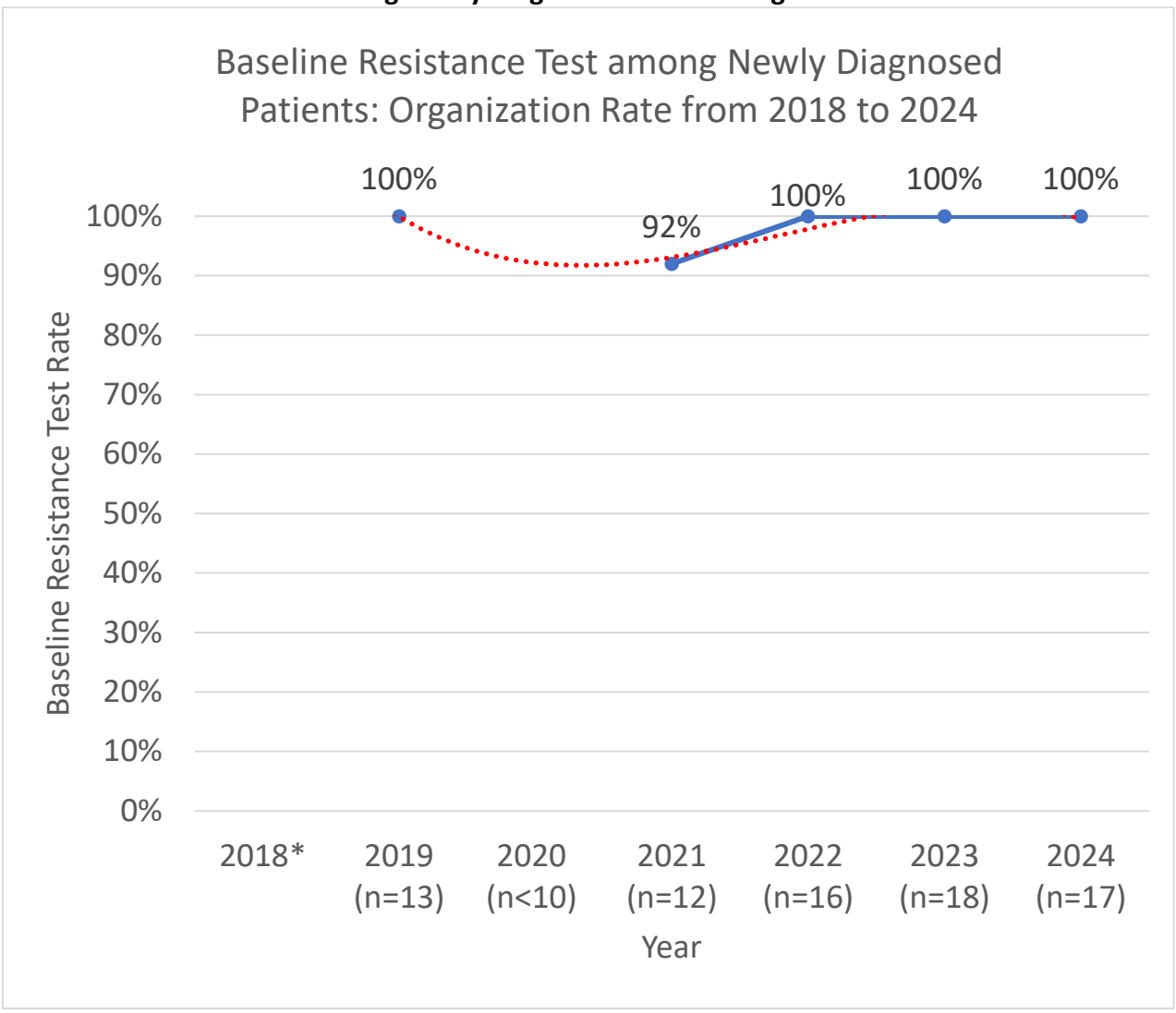


Figure 2. Baseline Resistance Test among Newly Diagnosed Patients: Organization Rate from 2018 to 2024



Note: Data for this indicator were not required for the review of care provided in 2018.

Figure 3. Viral Load Suppression at Last Test in Year among New to Care Patients (Other than Newly Diagnosed): Organization Rate from 2018 to 2024

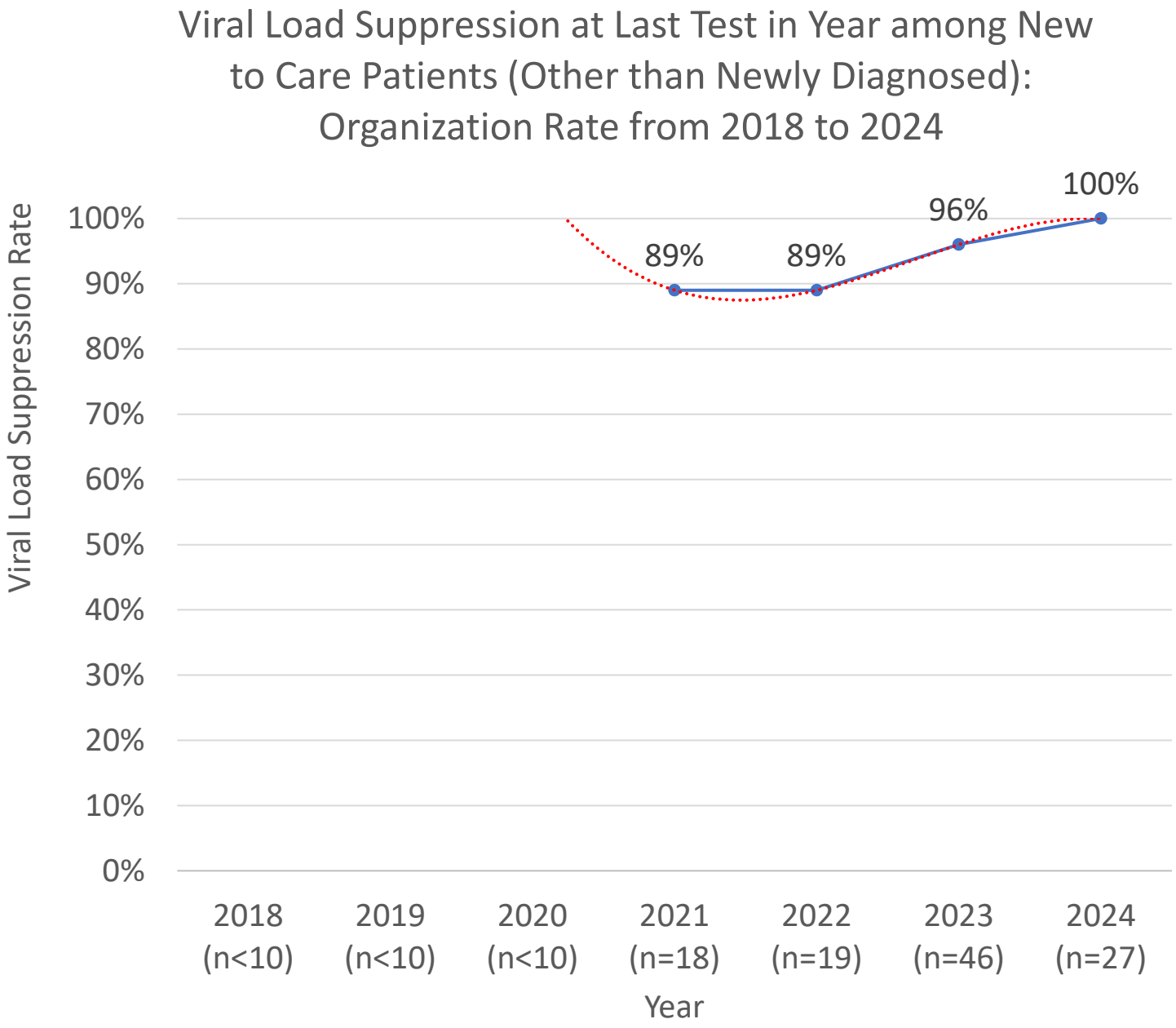


Figure 4. Viral Load Suppression at Last Test in Year among Patients Established in Care: Organization Rate from 2018 to 2024

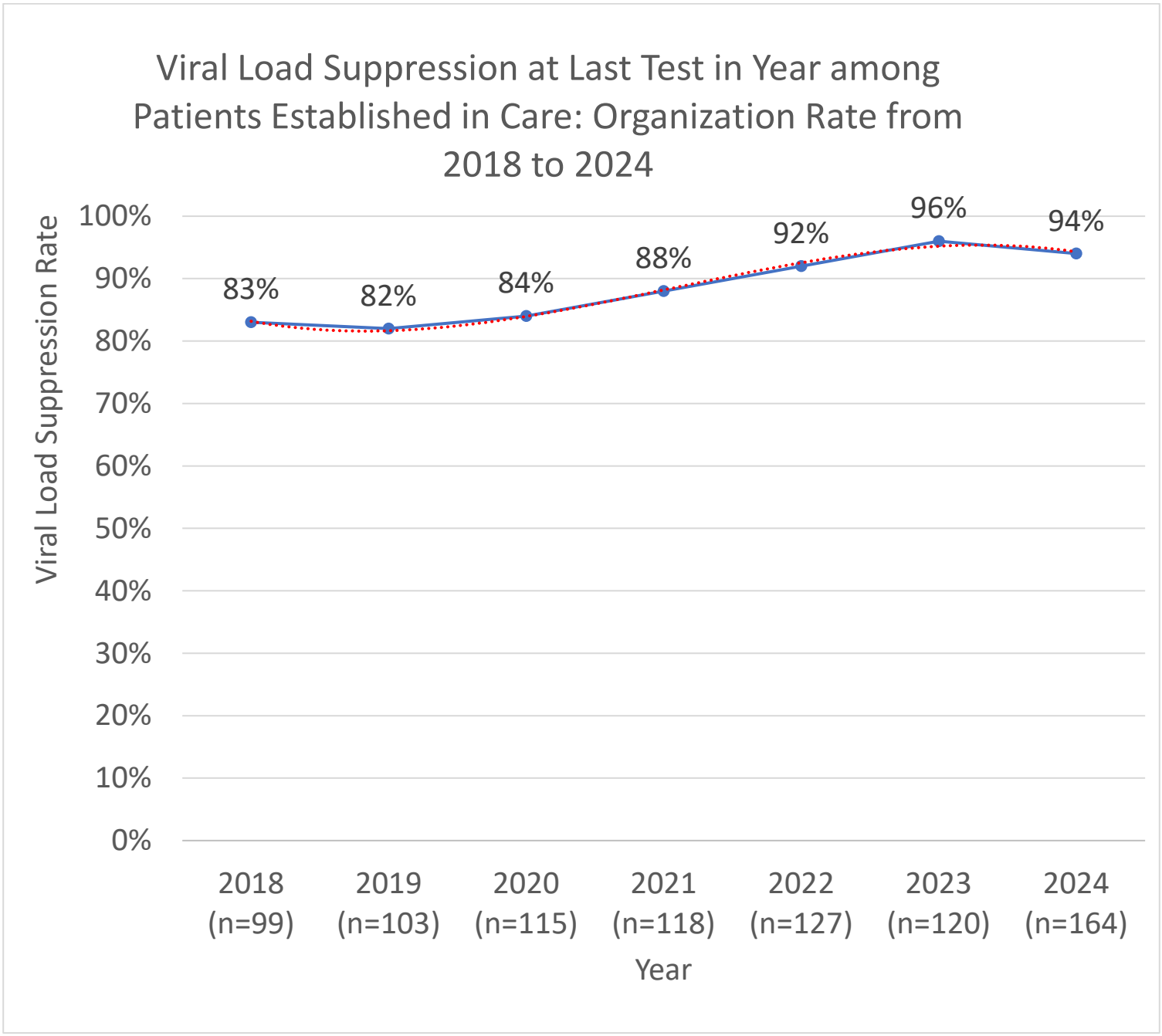


Figure 5. 2024 Established Active Viral Load Suppression Rates by Age at Organizational Level

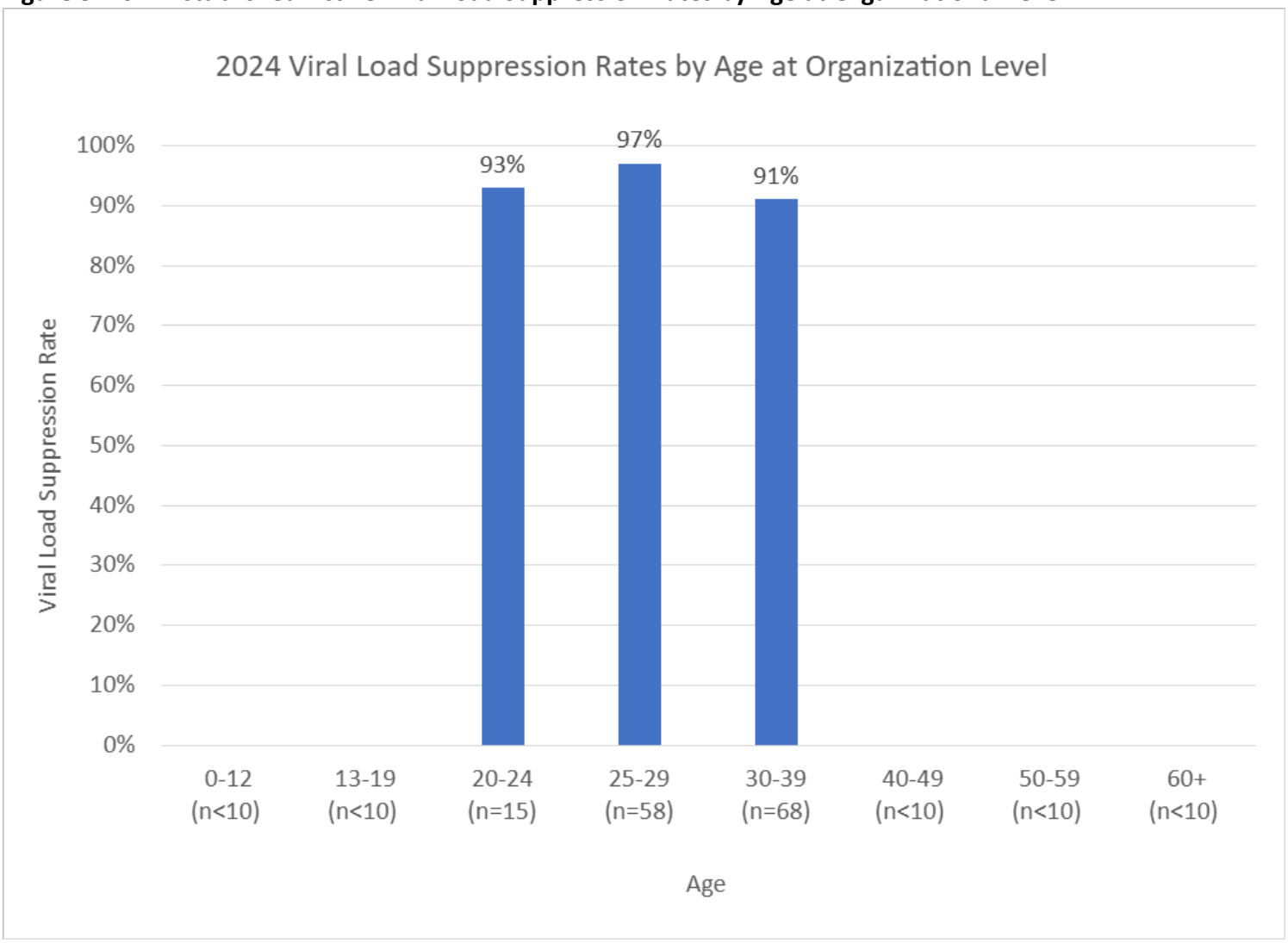
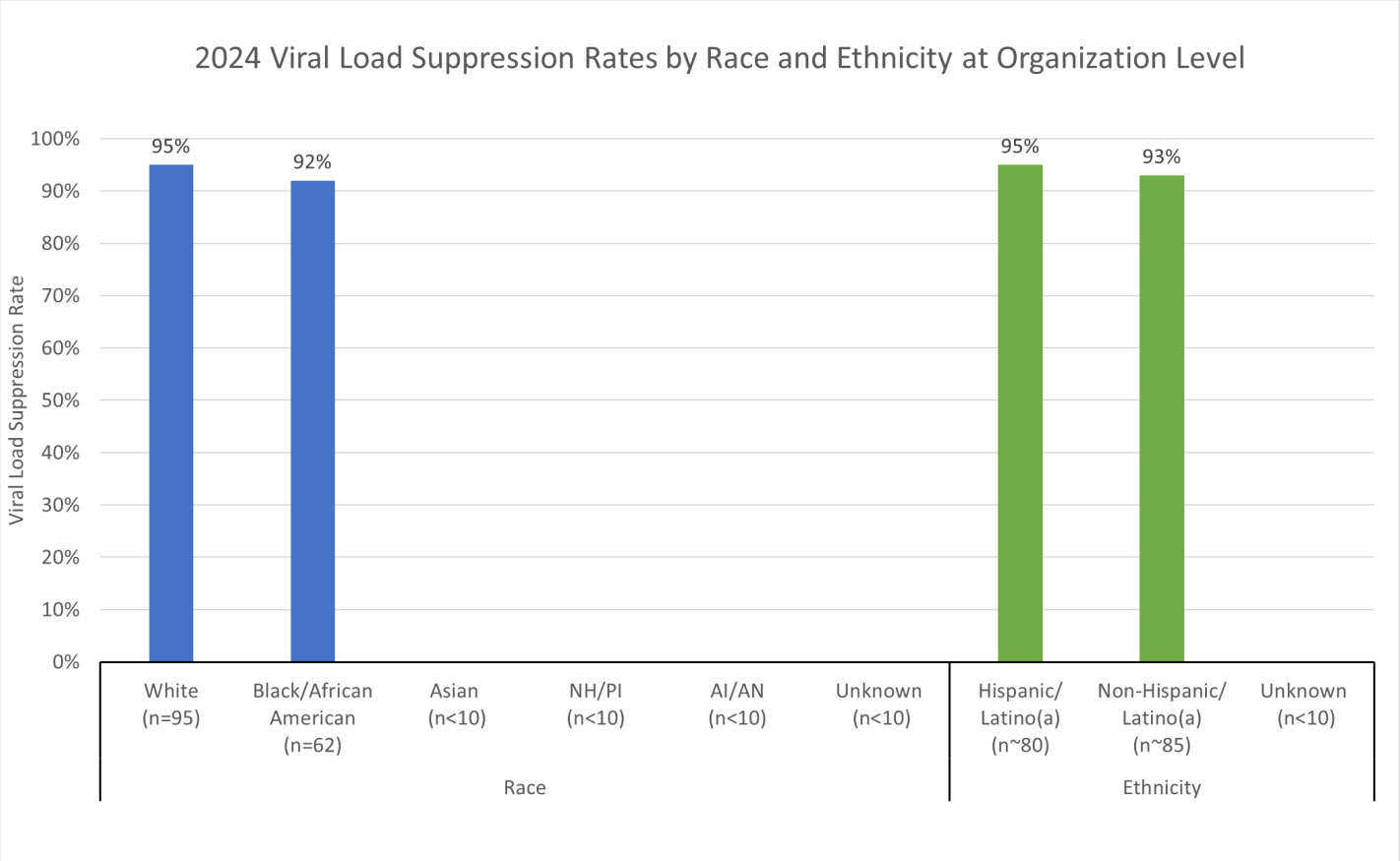


Figure 6. 2024 Established Active Viral Load Suppression Rates by Race and Ethnicity at Organizational Level



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

Table 1: Indicator Rates at Organization Level for 2018 to 2024

Patient Group	Indicator	2018		2019		2020		2021		2022		2023		2024	
		Org. Rate	State Median	Org. Rate	State Median	Org. Rate	State Median	Org. Rate	State Median	Org. Rate	State Median	Org. Rate	State Median	Org. Rate	State Median
Newly Diagnosed	3-day Linkage to Care	-- (n<10)*	41%	-- (n<10)*	51%	-- (n<10)*	55%	-- (n<10)*	61%	-- (n<10)*	53%	62% (n=13)	63%	-- (n<10)*	53%
	On Antiretroviral Therapy	-- (n<10)*	96%	100% (n=13)	100%	-- (n<10)*	100%	92% (n=12)	100%	100% (n=16)	100%	100% (n=18)	100%	100% (n=17)	100%
	Viral Load Test within 91 Days	-- (n<10)*	93%	100% (n=13)	95%	-- (n<10)*	95%	92% (n=12)	92%	100% (n=16)	96%	100% (n=18)	95%	100% (n=17)	93%
	Suppressed within 91 Days	-- (n<10)*	45%	85% (n=13)	50%	-- (n<10)*	46%	67% (n=12)	50%	56% (n=16)	50%	78% (n=18)	50%	94% (n=17)	50%
	Baseline Resistance Test	**	**	100% (n=13)	74%	-- (n<10)*	80%	92% (n=12)	82%	100% (n=16)	79%	100% (n=18)	76%	100% (n=17)	83%
Other New to Care	On Antiretroviral Therapy	-- (n<10)*	97%	-- (n<10)*	100%	-- (n<10)*	100%	100% (n=18)	100%	100% (n=19)	100%	100% (n=46)	100%	100% (n=27)	100%
	Any Viral Load Test	-- (n<10)*	99%	-- (n<10)*	98%	-- (n<10)*	100%	100% (n=18)	100%	100% (n=19)	98%	100% (n=46)	98%	100% (n=27)	98%
	Suppressed Final Viral Load	-- (n<10)*	74%	-- (n<10)*	78%	-- (n<10)*	77%	89% (n=18)	69%	89% (n=19)	77%	96% (n=46)	80%	100% (n=27)	81%
Established Active	On Antiretroviral Therapy	99% (n=99)	99%	99% (n=103)	99%	100% (n=115)	99%	100% (n=118)	99%	100% (n=127)	100%	100% (n=120)	100%	100% (n=164)	100%
	Any Viral Load Test	100% (n=99)	99%	98% (n=103)	99%	100% (n=115)	97%	100% (n=118)	98%	100% (n=127)	98%	100% (n=120)	98%	100% (n=164)	98%
	Suppressed Final Viral Load	83% (n=99)	88%	82% (n=103)	89%	84% (n=115)	87%	88% (n=118)	88%	92% (n=127)	89%	96% (n=120)	91%	94% (n=164)	91%
Open Previously Diagnosed (Active & Inactive)	On Antiretroviral Therapy	99% (n=99)	95%	99% (n=103)	96%	100% (n=115)	96%	100% (n=118)	97%	100% (n=127)	97%	100% (n=120)	98%	100% (n=164)	98%
	Any Viral Load Test	100% (n=99)	93%	98% (n=103)	93%	100% (n=115)	90%	100% (n=118)	94%	100% (n=127)	93%	100% (n=120)	94%	100% (n=164)	93%
	Suppressed Final Viral Load	83% (n=99)	80%	82% (n=103)	83%	84% (n=115)	77%	88% (n=118)	79%	92% (n=127)	83%	96% (n=120)	83%	94% (n=164)	86%

*** 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 2024

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*	--	15	93%	58	97%	68	91%	<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	%		
108	96%	40	88%	<10*	--	15	93%	<10*	--	<10*	--	<10*	--		

RACE															
White		Black/African American		Asian		Native Hawaiian / Pacific Islander		American Indian / Alaskan Native		Unknown Race					
n	%	n	%	n	%	n	%	n	%	n	%				
95	95%	62	92%	<10*	--	<10*	--	<10*	--	<10*	--				

ETHNICITY															
Hispanic, Latino, Latina		Non-Hispanic, Latino, Latina		Unknown Ethnicity											
n	%	n	%	n	%										
~80	95%	~85	93%	<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	%
105	96%	<10*	--	22	86%	<10*	--	<10*	--	39	92%	<10*	--	<10*	--

HOUSING STATUS															
Stable Housing		Temporarily Housed		Unstably Housed		Unknown Housing									
n	%	n	%	n	%	n	%								
151	93%	<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	%
54	94%	<10*	--	67	91%	<10*	--	39	97%	<10*	--	<10*	--	<10*	--
Unknown															
n	%														
<10*	--														

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

Quality Improvement Interventions for 2025

Self-reported[1] based on 2024 results

Methodology

Information about all persons living with HIV were extracted from the Appointment Management System, Soarian Financials, Allscripts (AEHR), AIDS Institute Reporting System (AIRS) and internal medical case management data source (excel). The data sources mentioned above were also utilized to obtain data patient enrollment and diagnosed status. Limitations exist in combining data from all the sources to obtain one clean, analyzable dataset. Center for Young Adult and Adolescent Pediatric HIV utilizes the following data collection source (i.e. electronic medical record, Redcap, AIDS Institute Reporting System, Excel, CareWare, etc). 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 who have changed names which are reflected 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 Center for Young Adult and Adolescent Pediatric HIV patients, thus allowing for extraction of appointments, labs, and medication information for the cascade. The sources also inform on information such as housing, insurance, and risk category for the disaggregation of the active caseload. In addition to a traditional way of communicating with each patient (i.e., phone call, voicemail message) we use technology which includes texting, instant messaging, and IPAD/tablets to follow-up with patients and build opportunities to maintain engagement. Often this works, but for some cases, the patients are still not engaged, despite efforts made to date. The Data Analyst was responsible for extracting and entering data into the template. The Medical Director and Grant Manager ensured complete accuracy of the 2024 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 data shows that the team at the Center for Young Adult, Adolescent Pediatric HIV reports a viral load suppression rate of 94% in 2024. Last year, the quality team decided to improve the newly diagnosed patients' viral load suppression rate to 85% from 78%. We are happy that data shows an increase to 94% in 2024. We also used evidence-based models such as the Plan-Do-Study-Act cycle to improve 3-day linkage to care from 62% to 89% in 2024. Another milestone improvement in 2024 was the increase in viral load suppression rate for the 13-19 age group from 60% to 75% in 2024. We will continue to monitor this group to achieve a higher viral load suppression rate of 85% or higher by the end of December 2025. The female subgroup shows a decrease in viral suppression rate from 90% to 88%. The team has set up a quality improvement plan to increase to 90% or above

[1] Text in square brackets represents minor edits by the Quality of Care Program to remove details about small groups of patients.

by the end of December 2025. Similar quality improvement efforts will focus on the heterosexual subgroup to increase viral load suppression from 86% to 90% by the end of December 2025.

Our medical management team did a phenomenal job ensuring that patients without stable housing remain virally suppressed at 100%. The team is eager to improve the overall viral load suppression rate from 94% to 96% by the end of December 2025. Moving forward, we continually aim to improve our overall viral suppression rate. We also want to maintain the objective of increasing the viral load suppression rate for patients within 13-19 age group. 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 suppression 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 continuous assistance with housing for patients who are eligible, we project to reducing the disparity in viral load suppression for patients with different racial background. We foresee our viral load suppression to improve by December 2025 for the patients who are not virally suppressed.

Quality Improvement Projects

Quality Improvement Project #1
Indicator: viral load suppression among established active patients
2024 rate for this indicator: 94%
Overall 2025 goal for this indicator: 96%
Description:
The Center for Young Adult and Adolescent Pediatric HIV continually aims to improve viral suppression rates for all unsuppressed patients and this year, we are focusing on improvement of viral suppression rates for patients who are in the 13-19 subgroup from 75% to 85%, the female subgroup population from 88% to 90%, and the heterosexual subgroup from 86% to 90%. Our quality improvement teams are currently working together by reviewing charts and identifying eligible patients for implementation of a multidisciplinary approach to increase viral load suppression. This includes a psychologist, who will continue to implement evidence-based behavioral interventions (EBIs) to patients with mental health priority. In addition to the evidence-based behavioral interventions, there is continuous assistance with housing for the eligible patients. The team is also doing quarterly chart audits to identify any patients who may fall under any deliverables so they can be addressed immediately. The medical case managers are also doing enhanced personal contact to reach patients prior to schedule appointments, address any pressing needs in efforts to increase retention, and ultimately viral load suppression. We'll continue to implement innovative strategies such as telehealth services and LabFly for patients who have opted for this option. We plan to continue this practice to leverage retention in care and medication adherence. We foresee our viral load suppression to improve by December 2025 for patients identified in 2025 who are not virally suppressed.

Consumer Involvement
Our patients' care teams continue to include patients and their support systems (family member, friends, peer, etc.) in the care process, and to provide additional support by attending appointments as well as advocating for consumer medication adherence. A representative from the community advisory board also attends our quarterly

quality meetings where quality improvement projects are discussed. In addition, the Center for Young Adult and Adolescent Pediatric HIV also disseminates surveys to patients for input and recommendations. We have a response rate of 12% in 2024 for our patient satisfaction rate. This is lower than 2023. We have already started implementing changes that could improve the response rate by separating the survey from the social determinants of health screening questionnaire to make it shorter. Within 12% of patients who completed the survey, 83% agreed that the staff listened to their concerns. 76% think the clinic hours work well with their schedules, and the program encourages questions from patients. 68% of respondents think that the clinic supports their health goals and are happy about the way the front desk staff treats them at their appointments. 96% of respondents found our staff to be friendly, 88% said it was easy to make appointments, 68% appreciated the cleanliness of the space and the staff taking the time to clearly explain things to them. For improvement of the clinic, 36% would like a shorter wait time, and 32% would like more availability with appointments. Additional suggestions to improve the clinic included “better phone service”, “registration process”, “bring back children section in waiting area” and “bring back favors snacks”. The information collected from the survey are taken into consideration to provide holistic care to our patients and to meet our patients where they are.

Coach’s Feedback and Updates on Cascade Quality Improvement Plan
Northwell Center for Young Adults, Adolescent and Pediatric HIV continues to be a top performer for their cohorts.

For Quality Improvement Project 1: Northwell’s multidisciplinary model describes psychology services delivering evidence-based behavioral interventions, housing support, medical case management outreach, and enhanced patient contact, is comprehensive and client-centered. The inclusion of quarterly chart audits to proactively identify clients who may fall out of care is a strong monitoring strategy. As Northwell continues implementation, the Coach suggests: 1) establishing clear criteria for identifying clients for multidisciplinary intervention to ensure consistency; 2) tracking process measures such as completed behavioral health referrals, housing referrals, telehealth utilization, and enhanced outreach contacts; 3) monitoring time from identification of unsuppressed status to intervention initiation and 4) conducting brief rapid-cycle reviews to assess whether strategies are yielding measurable improvements. In addition, clarifying how telehealth engagement correlates with suppression outcomes may further strengthen Northwell’s evaluation efforts.

Consumer Involvement: While a 12% response rate represents a decline from 2023, the Coach’s immediate recommendation is to shorten the survey by separating it from the social determinants of health screening and/or utilize other methods to disseminate the survey. In addition, other methods to strengthen client driven quality improvement efforts are: 1) selecting one or two survey identified priorities (e.g., wait time or phone service) for formal quality improvement cycles; 2) communicating back to clients what changes are being implemented based on their feedback (“You said, we did” messaging) and 3) setting a measurable goal to increase survey response rates in 2025 (e.g., 20%).

Appendix

Note: Results from 2017 have been moved to this appendix to make room for more recent data in the tables and charts within this profile. Of note, the data for 2017 were reported through a different process that did not include submission of patient-level data. Any interpretation of changes between 2017 and 2018 and subsequent years should be made with this discontinuity in the process in mind.

Appendix A-1
2017 Indicator Rates at Organization Level

Established Active			Open Previously Diagnosed (Active & Inactive)		
On Antiretroviral Therapy	Any Viral Load Test	Suppressed Final Viral Load	On Antiretroviral Therapy	Any Viral Load Test	Suppressed Final Viral Load
--	--	--	--	--	--

Note: Did not receive usable data for Northwell Health-Center for Young Adults, Adolescent and Pediatric HIV in the review of care provided in 2017.