Creating a Visual Representation of a Continuum of Care

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DISCLOSURES

• No conflicts to disclose
AGENDA

What is NYLinks?
The continuum of care and cascades
Benefits of cascades--Data Visualization
Cascade Elements
Examples of Cascades using New York State & NYLinks Cascades
Variations in Cascades--Other states and diseases, w/prevention
Organizational Cascades
Data and Improvement
How to build a cascade—How to develop and define measures—picking the beginning and the end
Using the Cascade to inform improvement
Final thoughts
Contact info
What is NYLinks?
NYLinks History

• A statewide initiative created through a HRSA Special Projects of National Significance grant
• One of six states funded through “Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative”
• Currently part of Governor Cuomo’s Ending the Epidemic Initiative
• NYLinks works to improve linkage to care, retention in care, and viral load suppression for PLWHA
• Focus on using data to drive improvement
Bridge systemic gaps between HIV related services and achieve better outcomes for PLWHA through improving systems for monitoring, recording, accessing, and sharing information about linkage to care, retention in care, and viral load suppression in New York State.
Linking QI with Public Health Outcomes
Continuum of Care
Delaware State Continuum of Care

Unengaged unsheltered homeless population

EMERGENCY SHELTER
(100 persons exited in 2013)
50 BEDS on HIC
100% on HMIS
2013 PIT: 30 persons
LOS < 30 days: 34%
LOS 1-2 months: 33%
LOS > 3 MONTHS: 33%

40% (40) unknown
10% (10) Temporarily with family and friends
1% (1) Other
1% (1) Exit to hospital/psychiatric

13% (5) Temporarily with family and friends
4% (2) Exit to hospital/psychiatric

70% exit into Homelessness

20% (10) unknown

40% exit into Homelessness

5% (5) Rental by client, no subsidy
10% (10) Permanently with family/friends
10% (10) Rental by client, with subsidy
5% (5) Exit to PSH

30% exit to PH

UNKNOW - PERMANENT HOUSING

UNKNOW - PERMANENT HOUSING

AFORDABLE HOUSING

PERMANENT SUPPORTIVE HOUSING
50 beds
2013 PIT: 50

RAPID RE-HOUSING
10 beds

SAFE HAVEN
10 beds

Unsheltered PIT: 10 persons
Temporary Destinations
Family/Friends Permanent
HIV Care Continuum

Unaware of HIV infection
Aware of HIV infection (not in care)
Receiving some medical care but not HIV care
Entered HIV care but lost to follow-up
Cyclical or intermittent user of HIV care
Fully engaged in HIV care

Adapted from
Eldred et al AIDS Patient Care STDs 2007;21(Suppl1):S1-S2
Cascades
CDC Cascade

MMWR December 2, 2011 / 60(47);1618-1623
Why A Cascade?
DATA VISUALIZATION

A way to present data in dynamic but simplistic visual formats such as interactive maps, infographics, cascades

A way to convey complex population temporal information to a wider public audience
QUALITY IMPROVEMENT

Data Drives Improvement

Quality Improvement efforts can be difficult to share because data can get in the way of comprehension

Comprehension breeds action
New York State Cascade of HIV Care, 2014

Persons Residing in NYS† at End of 2014 (6.7% NYC)

Estimated HIV Infected Persons: 123,000
92% of infected

Persons Living w/ Diagnosed HIV Infection: 113,000
74% of infected
81% of PLWDHI

Cases w/any HIV Care during the year*: 91,000
74% of infected
81% of PLWDHI

Cases w/continuous care during the year**: 77,000
62% of infected
68% of PLWDHI

Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 77,000
62% of infected
68% of PLWDHI
84% of cases w/any care

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
Thinking about Cascades
Considerations When Building a Cascade

- What is the purpose?
- Who is your target audience?
- Can you manage the analytic requirements?
- What data do you already have?
- How will you define your denominator?
  - E.g. number of active patients
  - Sub-populations
More Considerations for Building a Cascade

Data

- What data are available to you
  - Feasibility of data extraction from your system
  - Limitations of available data
- How will you define your measures
  - Will your results be comparable to those used by others? Is that important?
Things to Keep in Mind

Cascades progress from large to small usually with each subsequent measure a subset of the previous measure.

Cascade within Cascade progression can be measured against the largest measure.

In order for cascades to be comparable all measures must be equitable.

Everything should be defined and labeled.

When possible use both % and number.
AS WE LOOK AT CASCADES...

- Consider the choices that were made in terms of structure and data
- Think about what is missing and what you might do different
- Note aspects you might wish to borrow
- Contemplate the cascade as a tool and how it could be used to inform improvement
- Think about the ways you could use a cascade in your facility, your documents, your staff meetings, your marketing.
Cascades of New York
HIV CASCADES...

- Show the “number of individuals living with HIV infection who are impacted by each point Along the Continuum”
- Are a visual tool of HIV care and outcome at a point in time
- Assess key parameters of care for persons living with HIV infection
- Identify gaps in care
- Prompt discussion on steps to improve HIV care outcomes
New York State Cascade of HIV Care, 2014

Persons Residing in NYS† at End of 2014 (6.7% NYC)

- Estimated HIV Infected Persons: 123,000
- Persons Living w/ Diagnosed HIV Infection: 113,000 (92% of infected)
- Cases w/any HIV Care during the year*: 91,000 (74% of infected, 81% of PLWDHI)
- Cases w/continuous care during the year**: 77,000 (62% of infected, 68% of PLWDHI)
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 77,000 (62% of infected, 68% of PLWDHI, 84% of cases w/any care)

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
New York State Cascades of HIV Care

2013 versus 2014

+ Estimated HIV-Infected Persons†: 129,000 (2013) vs 123,000 (2014)
+ Persons Living w/Diagnosed HIV Infection‡‡: 112,000 (2013) vs 113,000 (2014)
+ Cases w/any HIV Care During the Year*: 87,000 (2013) vs 91,000 (2014)
+ Cases w/continuous Care During the Year**: 76,000 (2013) vs 77,000 (2014)
+ Virally Suppressed***: 63% of PLWDBHI (2013) vs 68% of PLWDBHI (2014)

† Estimation methods differ between years
‡‡ Based on most recent address, regardless of where diagnosed
* Any VL or CD4 test during the year; ** ≥2 tests, ≥3 months apart
*** Viral load undetectable or ≤200/ml at test closest to end-of-year
Cascade of HIV Care: Lower Hudson Ryan White Region
Persons Residing in the Lower Hudson Ryan White Region†, at End of 2014 (excludes prisoner cases)

- Estimated HIV Infected Persons: 4,100
- Persons Living w/ Diagnosed HIV Infection: 3,600 (87% of infected)
- Cases w/any HIV Care during the year*: 2,900 (70% of infected, 80% of PLWDHI)
- Cases w/continuous care during the year**: 2,300 (56% of infected, 65% of PLWDHI)
- Virally suppressed (n.d. or ≤200/ml) at test closest to end-of-year: 2,500 (61% of infected, 71% of PLWDHI, 88% of cases w/any care)

* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart
† Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.
Cascade of HIV Care among Men who Have Sex with Men

Persons Residing in NYS† at End of 2014

- Estimated HIV Infected Persons‡: 54,900
- Persons Living w/ Diagnosed HIV Infection: 47,200
- Cases w/any HIV Care during the year*: 38,300 (81% of PLWDHI)
- Cases w/continuous care during the year**: 31,600 (67% of PLWDHI)
- Virally suppressed at test closest to end-of-year***: 33,200 (70% of PLWDHI; 87% of cases w/any care)

‡ Includes cases with MSM and MSM/IDU HIV transmission risk
§ 14.1% are infected and unaware; based on CDC estimates
* Any VL or CD4 test during the year
** At least 2 tests, at least 3 months apart
*** Non-detectable viral load or viral load ≤200/ml
NYLinks Cascades
HIV Care Cascade: Newly Diagnosed by NYLinks Upper Manhattan Provider, 2010-2012

1 As reported to the New York City HIV Surveillance Registry (NYC HSR) by June 30, 2014.
2 Timely linkage to care is defined as ≥1 CD4/VL reported to the NYC HSR 8-91 days post diagnosis.
3 Retention in care is defined as ≥1 CD4/VL test reported to the NYC HSR during each 4 month period in the 12 months immediately following diagnosis.
4 Suppressed viral load is defined as a patient's most recent viral load quantity reported to the NYC HSR within 6 or 12 months of diagnosis was ≤200 copies/mL.
Cascades From Other States
Clients moving through the care process

Cascade for U.S. and Tennessee

- TN's viral suppression rates are on par with U.S.
- TN's linkage & retention rates are likely artificially low due to incomplete VL & CD4 reporting in 2010, which should improve in 2011 and be fully corrected by 2012.
NC HIV Cascade, overall population
Diagnosed 2007-2010 and living through 2008-2011

- Estimated HIV-infected (diagnosed & undiagnosed)
  - 2008: 35,000
  - 2009: 35,000
  - 2010: 34,900
  - 2011: 36,500

- Cases diagnosed & reported
  - 2008: 21,128
  - 2009: 22,358
  - 2010: 23,427
  - 2011: 24,923

- At least 1 care visit
  - 2008: 7,531
  - 2009: 8,945
  - 2010: 9,789
  - 2011: 11,006

- 2 or more care visits 3 months apart
  - 2008: 5,134
  - 2009: 6,570
  - 2010: 7,061
  - 2011: 7,528

- Viral suppressed - Overall population (NHAS)
  - 2008: 4,712
  - 2009: 5,983
  - 2010: 6,922
  - 2011: 7,528

Communicable Disease Surveillance Unit
San Antonio, TX

**Treatment Cascade for San Antonio**

<table>
<thead>
<tr>
<th>Description</th>
<th>Estimate of HIV+ Individuals</th>
<th>HIV+ Individuals at end of 2011</th>
<th>Met Need in 2011</th>
<th>2 Visits or Labs 3 to 6 months Apart in 2011</th>
<th>Achieved Viral Suppression at end of 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate of HIV+ Individuals (Known + Unknown)</td>
<td>6,094</td>
<td>100%</td>
<td>4,991</td>
<td>82%</td>
<td>3,932</td>
</tr>
<tr>
<td>HIV+ Individuals at end of 2011</td>
<td>4,991</td>
<td>82%</td>
<td>3,932</td>
<td>65%</td>
<td>1,907</td>
</tr>
<tr>
<td>Met Need in 2011*</td>
<td>3,932</td>
<td>65%</td>
<td>1,907</td>
<td>31%</td>
<td>2,737</td>
</tr>
<tr>
<td>2 Visits or Labs 3 to 6 months Apart in 2011**</td>
<td>1,907</td>
<td>31%</td>
<td>2,737</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Achieved Viral Suppression at end of 2011**</td>
<td>2,737</td>
<td>45%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Unmet Need in Texas, 2011**

- Unmet Need: 1,059 (21%)
- Met Need**: 3,932 (79%)

** Linkage to Care among Newly Dx in Texas, 2011**

- Linked to Care in 3 months***: 224 (80%)
- Linked to Care in 4-12 months: 12 (4%)
- Not Linked: 45 (16%)

***No. of newly diagnosed individuals (diagnosed within the first 9 months of 2011) who were linked to medical care within 3 months of their HIV diagnosis.

** Estimated need from HAB, ELH, ABIES, ADAP, Medicaid, private payer data.

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**Population Treatment Cascade, 2011**

- 100% Retained in Care 2007-2011**: 2,349 (51%)
- In & Out of Care 2007-2011: 1,723 (37%)
- No Evidence of Care 2007-2011: 553 (12%)

*: Texas eHARS data as of July 2012

**: DSHS HIV Unmet Need Project, 2011 (incl. eHARS, ELH, ABIES, ADAP, Medicaid, private payer data)

***Texas Medical Monitoring Project, 2009

****Texas Electronic Lab Records, 2011

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**Table of Definitions**


- **HIV+ Individuals at end of 2011**: Number of HIV+ individuals (alive) residing in Texas at the end of the calendar year 2011.

- **Met Need in 2011**: Number of PLWH who had a met need (at least one medical visit, ART prescription, VL test, or CD4 test) in 2011.

- **2 Visits or Labs 3 to 6 months Apart**: Number and percent of PLWH who had at least 2 visits or labs in 12 months, at least 3 to 6 months apart.

- **On ART (Estimated)**: Estimated number of PLWH who were on ART in 2011, from MMP.

- **Achieved Viral Suppression**: Number of PLWH who achieved viral suppression (VL test ≤ 200 copies/mL) at last lab visit of 2011.
National-level cross-sectional cascade, Thailand, 2015

- PLHIV: 433,635
- Diagnosed with HIV: 402,695
- In HIV care: 381,072
- On ART: 284,434
- VL Test: 256,540
- VL suppression: 244,214
- VL Undetect: 231,064

-7% -5% -25% -10% -5% -5%
Cascades of Other Disease States
The HCV Continuum of Care in Australia

- HCV antibody diagnosed
- HCV RNA diagnosed
- HCV assessed
- Liver disease assessed
- Treatment
- Cure

85%
50-70%
25-50%
15-30%
10-15%
5-10%

Cascade of Care for U.S. Adults With Diabetes

In 2012, an estimated 28.4 million adults had diabetes in the United States.

Abbreviations: ABC, combined control of A1C, blood pressure, and LDL cholesterol; BP, blood pressure.

The New HIV Neutral Continuum of Care (Theoretical)

HIV CARE AND PREVENTION ARE THE SAME = GETTING TO HIV NEUTRAL
Organization Cascades
Treatment cascade comparison of Mt Sinai, NYC, & USA

Quality Indicator #1 is Viral Load Suppression
- To increase the total percentage of HIV+ patients on ART
- To increase the total percentage of HIV+ patients with a controlled and/or undetectable HIV Viral Load
### Evergreen Medical Group (EMG)
#### HIV Positive Patients in Care

**June 2014**

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active HIV+ Enrolled In Care</td>
<td>97%</td>
</tr>
<tr>
<td>Continuous Care (Visit in the past 6 months)</td>
<td>96%</td>
</tr>
<tr>
<td>Prescribed ART</td>
<td>87%</td>
</tr>
<tr>
<td>Virally Suppressed &lt;200/ml</td>
<td>&lt;20/ml</td>
</tr>
</tbody>
</table>

**Comparisons**
- EMG Continuous Care percentage is 97% compared to US 37% and NYS 56%
- EMG Prescribed ART percentage is 96% compared to US 33%
- EMG Virally Suppressed percentage (<200/ml) is 87% compared to US 25% and NYS 51%
- Of those virally suppressed – 87% have lab results reflecting <20/ml
Iris House HIV Care Continuum, Jan-Dec 2013

- **HIV-diagnosed**: 154 (100%)
- **Engaged in Care**: 149 (97% of diagnosed)
- **Retained in Care in 2013**: 122 (79% of diagnosed)
- **Prescribed ART by PCP**: 146 (95% of diagnosed)
- **VL Suppressed**: 115 (75% of diagnosed)

**Client’s chart has proof of HIV status**

**Client’s chart holds record of current HIV medical care provider in 2013**

**At least 2 lab tests in 2013, at least 6 months apart**

**Client’s chart holds documentation of prescribed HIV medication in 2013**

**Most recent VL in 2013 was ≤200 copies/mL**
NYP Institutional Care Cascade

**Inclusion Criteria:** seen at NYP from 7/19/2014-7/19/2016 (24 months), ever diagnosed HIV+

- NYP HIV+ caseload in past 24 months: 5377 (100%)
- Engaged last 12 months: 2679 (50%)
- Retained last 12 months: 2015 (37%)
- Retained last 24 months: 1538 (29%)
- On ART in last 12 months: 2675 (50%)
- Suppressed <200: 2462 (46%)
## Measure Definitions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Time Period</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+ Caseload*</td>
<td>Prior 24 months</td>
<td>Any HIV confirmatory test positive or ICD9 &amp; ICD10 codes c/w HIV infection in either billing or EMR</td>
</tr>
<tr>
<td>Engaged in Care†</td>
<td>Prior 12 months</td>
<td>HIV+ with primary care visit</td>
</tr>
<tr>
<td>Retained in Care†</td>
<td>Prior 12 months</td>
<td>HIV+ with primary visit in each 6 month period</td>
</tr>
<tr>
<td>Retained in Care†</td>
<td>Prior 24 months</td>
<td>HIV+ with primary visit in each 6 month period</td>
</tr>
<tr>
<td>Prescribed ART†</td>
<td>Prior 12 months</td>
<td>HIV+ with any record of ARV in EMR</td>
</tr>
<tr>
<td>Virally Suppressed†</td>
<td>Prior 12 months</td>
<td>HIV+ and most recent viral load test drawn in the past year &lt;200 copies/ml</td>
</tr>
</tbody>
</table>

Universe of patients = seen at NYP in past 24 months and ever diagnosed HIV+
All lab and visit data is NYP only

*NYP
†NYS DOH
**NYP HIV Clinic Care Cascade**

**Inclusion Criteria**: seen at NYP from 7/19/2014-7/19/2016 (24 months), ever diagnosed HIV+, most recent ambulatory visit at an NYP HIV clinic

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**Click to Filter:**

- **Last NYP Contact**
  - Ambulatory Clinic
  - Emergency Department
  - Inpatient

- **Primary Care Site**
  - HIV Clinic
  - Other Clinic

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<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic HIV+ caseload in past 24 months</td>
<td>3004</td>
<td>100%</td>
</tr>
<tr>
<td>engaged last 12 months</td>
<td>2546</td>
<td>85%</td>
</tr>
<tr>
<td>retained last 12 months</td>
<td>1934</td>
<td>64%</td>
</tr>
<tr>
<td>retained last 24 months</td>
<td>1474</td>
<td>49%</td>
</tr>
<tr>
<td>on ART in last 12 months</td>
<td>1970</td>
<td>66%</td>
</tr>
<tr>
<td>suppressed &lt;200</td>
<td>2130</td>
<td>71%</td>
</tr>
</tbody>
</table>
Cascade Design

• NYP HIV screening rate: 19% (105,772 patients ever screened out of 569,165 total patients seen in prior 24 months)

• Institutional cascade universe of patients: seen at NYP in past 24 months and ever diagnosed HIV+ (N=5,377)

• Housed in Tableau, with capability to view data graphically and create individualized visualizations

• Ability to click to drill down to table data for individual patients, with fields including:
  • Demographics
  • Location/date and provider at last NYP visit
  • Primary care data (if applicable)
  • Recent ED & Inpatient Utilization
  • Viral load and CD4 Data
Hudson Valley Cascade 2015
Hudson River Healthcare

On ART
- Atrium (158): 93.4%
- Beacon (102): 94.3%
- Peekskill (68): 94.1%
- Monticello (92): 95.1%
- Overall (793): 94.1%

Continuous Care
- Atrium (158): 86.1%
- Beacon (102): 88.2%
- Peekskill (68): 89.1%
- Monticello (92): 89.1%
- Overall (793): 88.7%

VL<200
- Atrium (158): 85.5%
- Beacon (102): 87.0%
- Peekskill (68): 88.2%
- Monticello (92): 88.2%
- Overall (793): 91.2%

>/>= 1 visit in 12m
- Atrium (158): 96.2%
- Beacon (102): 94.1%
- Peekskill (68): 94.1%
- Monticello (92): 97.1%
- Overall (793): 97.1%

>/>= 1 CD4 or VL
- Atrium (158): 97.8%
- Beacon (102): 97.1%
- Peekskill (68): 97.8%
- Monticello (92): 97.5%
- Overall (793): 97.5%

Continuous Care
- Atrium (158): 91.2%
- Beacon (102): 91.2%
- Peekskill (68): 91.2%
- Monticello (92): 91.2%
- Overall (793): 91.2%
How to Build a Cascade
Construct the Cascade

1. Descriptive title
2. Clearly label the measures presented
3. Clearly define the measures presented
4. Show counts of persons at each bar
5. Show percent of persons in each bar (denominator)
6. Clearly label the axis

HIV care, among Persons with One or More Visits in 2013: Fictitious Data from Agency A

- 76% of in care
- 73% of in care
- 71% of in care

1. HIV positive clients with at least one clinic visit in 2013
2. HIV positive clients with at least 2 visits, at least 3 months apart
3. HIV viral load of <200/mL (detectable or non-detectable) at last test during the measurement year
Describing Your “Cascade”

- State results in the context of:
  - Definitions used
  - Denominator(s)

E.g., of 790 persons who were in care in 2013, 600 (76%) were retained in care (i.e., ≥2 visits, ≥3 months apart)

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HIV care, among Persons with One or More Visits in 2013: Fictitious Data from Agency A

- 790 HIV positive clients with at least one clinic visit in 2013
- 600 HIV positive clients with at least 2 visits, at least 3 months apart
- 580 HIV viral load of <200/mL (detectable or non-detectable) at last test during the measurement year
- 568 71% of in care

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1HIV positive clients with at least one clinic visit in 2013
2HIV positive clients with at least 2 visits, at least 3 months apart
3HIV viral load of <200/mL (detectable or non-detectable) at last test during the measurement year
Remember - Direct Comparisons with Other Jurisdictions’ Results may be Misleading

Percent of all People with HIV

- Retained in Care: 40% (National Estimate: 76%)
- Prescribed ART: 50% (National Estimate: 71%)
- Virally Suppressed: 30% (National Estimate: 71%)

Remember - Direct Comparisons with Other Jurisdictions’ Results may be Misleading
Cascade Steps

Pick your Cascade Coverage
Pick your Beginning and End points
Pick your mid points
Collect your data
Does your data make sense?
Choose your Cascade Style
Build your Cascade
Label, Label, Label
Pick a process that allows you to swap out data to update your cascade
Utilizing Cascades to Inform Improvement
Using Robust Quality Improvement at the Facility Level Through Cascades

- Reliably measuring the magnitude of a problem
- Identifying the root causes of the problem and measuring the importance of each cause
- Finding solutions for the most important causes
- Proving the effectiveness of those solutions
- Deploying programs to ensure sustained improvements over time
Setting Goals Based on HIV Care Outcomes

Internal Goals
- Address the greatest gaps
- Target specific outcome e.g., viral suppression
  - “All persons who are prescribed ART are virally suppressed”

External Targets
- Achieve specific targets such as the NHAS goals

HIV Care, among Persons with One or More Visits in 2013: Fictitious Data from Agency A

- 790 clients with at least one clinic visit in 2013
- 600 clients with at least 2 visits, at least 3 months apart
- 580 clients with viral load of <200/mL (detectable or non-detectable) at last test during the measurement year
- 568 clients with viral load of <200/mL (detectable or non-detectable) at last test during the measurement year

1HIV positive clients with at least one clinic visit in 2013
2HIV positive clients with at least 2 visits, at least 3 months apart
3HIV viral load of <200/mL (detectable or non-detectable) at last test during the measurement year
Understand what your gaps mean

Figure 1 – Example of an HIV cascade of prevention and care for B.C.6
Example of cascade analysis (1):
Too many people are not aware of their HIV status

Cascade of HIV diagnosis to care, China, 2012

Example

**ECMC**

**Measure 2A: Global Retention**

85%

How do we track Progress?

How is this process connected to QI?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned to clinic at the end of the reporting period, working with staff on past barriers</td>
<td>42</td>
</tr>
<tr>
<td>Unknown – can’t reach them due to changed contact information</td>
<td>18</td>
</tr>
<tr>
<td>Medically stable – feel well; doing well on treatment, generally state desire to come in as needed; counseled on continued need for monitoring</td>
<td>4</td>
</tr>
<tr>
<td>Employment – cite difficulties coming to appts due to work schedule</td>
<td>10</td>
</tr>
<tr>
<td>Disclosure/confidentiality issues – report difficulty coming to clinic due to concerns about who they will see and who will see them</td>
<td>3</td>
</tr>
<tr>
<td>Ongoing alcohol/substance use- Continued use creates barrier to attendance to medical and other obligations</td>
<td>12</td>
</tr>
<tr>
<td>Mental Health- Continued mental health issues create a barrier to attendance to medical and other obligations</td>
<td>8</td>
</tr>
<tr>
<td>Insurance instability Since resolved, created temporary issue</td>
<td>1</td>
</tr>
<tr>
<td>Disengaged/lack of buy-in</td>
<td>5</td>
</tr>
<tr>
<td>Staff has successfully contacted the patient but pt does not express understanding of importance medical follow up</td>
<td></td>
</tr>
<tr>
<td>Family obligations Cite obligations to family, generally care of young children and elderly patients</td>
<td>8</td>
</tr>
<tr>
<td>Hospitalized off site</td>
<td>1</td>
</tr>
<tr>
<td>Long admission to another local health facility</td>
<td></td>
</tr>
<tr>
<td>Incarcerated &lt;90 days</td>
<td>5</td>
</tr>
<tr>
<td>Not incarcerated long enough to meet exclusion criteria, but did miss appointments as result</td>
<td></td>
</tr>
<tr>
<td>Refuses treatment Patient expresses they do not wish to continue treatment/medical follow up</td>
<td>3</td>
</tr>
<tr>
<td>Dually located:</td>
<td>6</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
</tr>
<tr>
<td>Ongoing Utility/financial</td>
<td>1</td>
</tr>
<tr>
<td>Other medical issues</td>
<td>1</td>
</tr>
<tr>
<td>Plans to relocate/transfer</td>
<td>2</td>
</tr>
<tr>
<td>Housing instability</td>
<td>1</td>
</tr>
<tr>
<td>Reason</td>
<td>Number of Patients Total: 134</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Returned to clinic at the end of the reporting period, working with staff on past barriers</td>
<td>40</td>
</tr>
<tr>
<td>Unknown – can’t reach them due to changed contact information</td>
<td>18</td>
</tr>
<tr>
<td>Medically stable – feel well; doing well on treatment, generally state desire to come in as needed; counseled on continued need for monitoring</td>
<td>13</td>
</tr>
<tr>
<td>Employment – cite difficulties coming to appts due to work schedule</td>
<td>6</td>
</tr>
<tr>
<td>Disclosure/confidentiality issues – report difficulty coming to clinic due to concerns about who they will see and who will see them</td>
<td>1</td>
</tr>
<tr>
<td>Ongoing alcohol/substance use-Continued use creates barrier to attendance to medical and other obligations</td>
<td>14</td>
</tr>
<tr>
<td>Mental Health-Continued mental health issues create a barrier to attendance to medical and other obligations</td>
<td>8</td>
</tr>
<tr>
<td>Insurance instability</td>
<td>1</td>
</tr>
<tr>
<td>Since resolved, created temporary issue</td>
<td></td>
</tr>
<tr>
<td>Disengaged/lack of buy-in</td>
<td>13</td>
</tr>
<tr>
<td>Staff has successfully contacted the patient but pt does not express understanding of importance medical follow up</td>
<td></td>
</tr>
<tr>
<td>Family obligations</td>
<td>1</td>
</tr>
<tr>
<td>Cite obligations to family, generally care of young children and elderly patients</td>
<td></td>
</tr>
<tr>
<td>Hospitalized off site</td>
<td>0</td>
</tr>
<tr>
<td>Long admission to another local health facility</td>
<td></td>
</tr>
<tr>
<td>Incarcerated &lt;90 days</td>
<td>2</td>
</tr>
<tr>
<td>Not incarcerated long enough to meet exclusion criteria, but did miss appointments as result</td>
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</tr>
<tr>
<td>Refuses treatment</td>
<td>3</td>
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<tr>
<td>Patient expresses they do not wish to continue treatment/medical follow up</td>
<td></td>
</tr>
<tr>
<td>Dually located:</td>
<td>1</td>
</tr>
<tr>
<td>Transportation</td>
<td>1</td>
</tr>
<tr>
<td>Ongoing Utility/financial</td>
<td>1</td>
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<tr>
<td>Other medical issues</td>
<td>1</td>
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<tr>
<td>Plans to relocate/transfer</td>
<td>5</td>
</tr>
<tr>
<td>Housing instability</td>
<td>1</td>
</tr>
</tbody>
</table>
Final Thoughts About Cascades
The Aesthetics is up to You

Engagement in HIV care in Illinois – current, target, and NHAS goal
Contact Information

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