HIV Quality of Care Clinical Advisory Committee Meeting

Conference Rooms 4 A/B, 90 Church Street, New York, NY

Thursday, March 16, 2017, 12:00 PM – 5:00 PM

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
Welcome and Introductions *Dr. Peter Gordon*	- Dr. Peter Gordon welcomed meeting attendees and introductions were made.	
Consumer Advisory Committee Updates *Dana Diamond*	- Dana Diamond provided a brief summary of the March 15th meeting of the Consumer Advisory Committee. Key highlights included discussions of consumer involvement in regional ETE steering committees; updates on the tobacco cessation campaign, stigma survey, STI subcommittee, and NY Links; the launch of the AIDS-related mortality subcommittee; access to hepatitis C medications; and the Living Cascade.	
Mortality in HIV Infection: Monitoring Quality Outcomes *Dr. Steven Johnson*	- Dr. Steven Johnson began his presentation with a brief description of historical trends in HIV mortality, noting that mortality has steadily declined with the widespread availability of ART. Dr. Johnson also noted that while mortality has declined among PLHIV, it remains high compared to the general population. - Dr. Johnson presented the findings of several studies that have investigated HIV mortality, including the D:A:D (Data Collection on Adverse Events of Anti-HIV Drugs) Study, and the NA-ACCORD (North American AIDS Cohort Collaboration on Research and Design) Study. In summarizing these findings, Dr. Johnson noted several factors associated with mortality among PLHIV, including non-AIDS cancers, cardiovascular disease, HIV viremia copy-years, timing of ART initiation, and gender, racial, and geographic health disparities. - It was also noted that other comorbidities common among PLHIV—including tobacco use, substance use, mental health diagnoses, and HCV infection—are well-documented contributors to premature mortality among PLHIV, and may be modifiable. - Dr. Johnson then discussed the importance of monitoring HIV mortality at the clinic level, and described commonly used approaches to ascertaining causes of death among deceased clinic patients, including review of death records, medical record audits, and follow up with patients' families and other care providers. - A participant asked which approach is used by Dr. Johnson in his own clinic to ascertain cause of death. Dr. Johnson responded that his clinic uses medical record reviews and physician interviews.	
HIV-related vs. non-HIV-related deaths as categorized in HIV surveillance *Dr. James Tesoriero*	- Dr. James Tesoriero delivered a presentation on the use of NYSDOH surveillance data to differentiate HIV-related and non-HIV related mortality among PLHIV in New York State. - Dr. Tesoriero shared that analyses were based on NYSDOH data compiled through matches of NYS Vital Statistics, National Death Index, and the Social Security Death Master File.	

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	- Aggregated data from 2010-2014 found that 42% of deaths among PLWH were HIV-related. During this period, it was noted that there was a decline in the total number of deaths, driven by a 40% reduction in HIV-related deaths. - A significant finding was that 33% of all deaths (both HIV-related and non-HIV-related deaths) were among PWID, who account for only 13% of all HIV cases in New York State. - Noted limitations to the data included a lack of descriptive information on the contributing factors of mortality, lack of standardization in the cause of death coding on death certificates among providers, and the overall complexity of cause of death information. - Questions from participants focused on receiving notification of a patient's death sooner. Dr. Tesoriero noted that there is currently not a system in place for notification of providers, as there is often a one to two-year data lag. However, if providers have documented sources saying that the patient was under their care, information can be made available. - Dr. Bruce Agins noted that a mortality subcommittee is in the process of being formed. The goal of the subcommittee will be to examine what constitutes a preventable HIV-related death and what can be done clinically to monitor and prevent HIV-related deaths.	
Missed opportunities: adapting the HIV care continuum to reduce HIV-related deaths *Dr. Bisrat Abraham, Rebekkah Robbins*	- Rebekkah Robbins delivered a presentation on NYCDOHMH's HIV Mortality Reduction Continuum of Care, (HMRCC) a tool that was constructed to evaluate care patterns among PLHIV 15 months prior to death and identify possible areas of intervention to avoid premature mortality. - Ms. Robbins described the methodology for constructing the HMRCC, noting that data on HIV diagnoses, HIV-related laboratory tests, demographic characteristics, transmission risk, and circumstances of death were derived from the NYC HIV Surveillance Registry. - Key results from analyses of HMRCC data revealed poverty-related disparities in HIV-related mortality among several groups, with men, Latinos, and IDUs experiencing the most significant disparities. Results also showed that while rates of retention were high among PLHV who died between 2007 and 2013, rates of viral load suppression were low, indicating a need to develop innovative strategies to ensure that retained patients reap the full benefits of care engagement. - A participant asked whether HMRCC data are available for interpretation at the clinic level, as these data might be used to improve clinic-specific processes to promote VLS. Ms. Robbins responded that these data are not available, as provider data on lab tests are difficult to attribute to lab results submitted to NYCDOHMH. - A participant asked whether there were any trends in VLS over the 15-month analysis period. Ms. Robbins responded that rates of VLS worsened as the date of death approached. - A participant asked whether the magnitude of poverty's effect on mortality was surprising. Ms. Robbins responded that it was, indeed, surprising, as the safety net for PLHIV in NYC is viewed to be among the most comprehensive in the nation.	
Expanding HIV testing and finding	- Dr. Uriel Felsen delivered a presentation on the new strategies being implemented by Montefiore Health System to expand HIV testing coverage. As a prelude, Dr. Felsen shared national data from	-

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the undiagnosed: challenges, insights and successes *Dr. Uriel Felsen*	2009 showing that undiagnosed HIV-infected individuals were responsible for approximately 30% of onward transmissions, which underscores the importance of HIV testing in achieving epidemic control. - Dr. Felsen stated that only 5% of emergency department patients ages 21-64 were tested for HIV at Montefiore Health System sites between 2011 and 2013. In 2013, a new routine testing strategy was developed, with an emphasis on opt-in offering of testing, lab-based (rather than point-of-care) testing, and follow-up of results by non-ED staff. Results showed that while the testing strategy yielded new diagnoses at a rate of 33 patients per 100,000, the prevalence of undiagnosed HIV was 250 patients per 100,000, suggesting that many undiagnosed patients were missed by the routine testing strategy. - In response to this gap, a new testing strategy using EMR support was developed to target inpatients without documentation of an HIV test, and inpatients for whom HIV infection is a documented diagnostic consideration. Results of a pre-post investigation found that the EMR-supported strategy led to increased testing rates among those with and without prior testing, and a nearly 3.5-fold increase in the likelihood of making a new diagnosis by screening.	
What is managed care's role in HIV control? Some lessons from an EtE pilot *Dr. Jay Dobkin and Dr. Bill LaRock*	- Drs. Jay Dobkin and Bill LaRock delivered a presentation on Visiting Nurse Service of New York (VNSNY)'s High Priority Project, an EtE pilot aimed to promote viral load suppression among VNSNY members. - As part of the Project, Dr. Dobkin explained that VNSNY used pharmacy and lab data to stratify HIV-positive members as either (1) lost to follow up; (2) marginally engaged; or (3) engaged. Then, members received a tailored bundle of interventions depending on their level of engagement. - Dr. LaRock discussed the peer-based outreach strategies being used by VNSNY, highlighting that the importance of care integration in identifying root causes of loss to follow up and devising strategies to ensure that members remain engaged. - Dr. Dobkin resumed the presentation by discussing the importance of viral load trends—rather than single data points—for ascertaining whether an elevated viral load is indication of a brief or prolonged lapse in adherence. Dr. Dobkin also discussed the High Priority Project's Provider Case Conferences and the incentives that are given to providers to furnish lab and PCP visit data and participate in case conferences. - Dr. Dobkin concluded the presentation by describing the Project's next steps, including the prospect of involving health homes, and the need to explore and implement multiple adherence interventions.	-
Expanded mortality surveillance: identifying modifiable factors	- Dr. Sandy Schwartz presented on expanded HIV mortality surveillance efforts being undertaken by the San Francisco Department of Public Health (SFDPH), with the aims of assessing the limitations of death certificate data, standardizing classification of underlying and contributory causes of death, and identifying modifiable factors associated with mortality among PLHIV. - Dr. Schwartz reviewed the sources of data currently used by SFDPH to ascertain cause of death,	- The original CoDe tool can be accessed at:

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and validation of mortality data sets *Dr. Sandy Schwartz*	including local vital statistics, annual computer matches with California social security death file, annual computer matches with National Death Index (NDI), Vital Record Business Intelligence System (VRBIS), death certificate data linked to HIV/AIDS case registry, and causes of death obtained from NDI and VRBIS. - Dr. Schwartz described the biases and limitations of death certificate data in assigning causes of death, and introduced a proposed protocol for adapting the Coding Cause of Death (CoDe) tool to standardize assignment of contributory causes of death among PLHIV. In the adapted tool, fields were added to assess factors such as poly-substance use, compliance with medical care, history of incarceration, history of suicide attempt or ideation, and receipt of hospice care, among others. - The presentation ended with a discussion of next steps for refining the proposed protocol, including further pilot testing and form revision.	www.chip.kd/Tools-standards/CoDe/Documents
Pharmacy Subcommittee Update *Maggie Brown*	- Maggie Brown delivered an update on pharmacy subcommittee activities. Ms. Brown shared that the subcommittee reconvened in January 2017 to discuss implementation strategies that had been accepted by the AIDS Advisory Council, and specifically how consumers would be engaged in realizing these strategies. - A participant asked whether the subcommittee is addressing medication diversion. Ms. Brown responded that one of the focus areas of the implementation strategies document is medication diversion, and the issue of the medication buybacks (i.e., pharmacies offering cash in exchange for unfilled prescriptions) in particular.	-
Tobacco Cessation Improvement Campaign Update *Dr. Kelly Ramsey, Dan Tietz, Kelly Hancock*	- Kelly Hancock delivered an update on the tobacco cessation improvement campaign. Ms. Hancock shared that the campaign's website will be launched April 1, 2017, and will allow providers to enroll in the campaign and submit quarterly indicator data. Ms. Hancock also shared that the website will feature provider and consumer tobacco cessation toolkits, and monthly webinars for consumers engaged in the campaign. - Ms. Hancock announced that an initial webinar to introduce the campaign, website, and database, and review the campaign guidance document will be held in mid-April.	
Stigma Subcommittee Update *Kelly Hancock*	- Kelly Hancock provided an update on stigma subcommittee activities, indicating that the stigma survey guidance document is nearly ready for dissemination. - Ms. Hancock shared that the survey will be implemented in three phases: (1) a planning period in which facilities discuss how the survey will be administered; (2) an implementation period in which the survey is administered and consumer input is solicited; and (3) an action period in which the results of the survey are analyzed and a stigma reduction plan is drafted by facilities.	

For further information on this meeting, please contact Leah Hollander at leah.hollander@health.ny.gov.