

HIV Quality of Care Advisory Committee Meeting
 55 W. 125th St., New York, NY
 Tuesday, September 19th, 2017, 12:00AM-5:00PM

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
Welcome and Introductions <i>Dr. Peter Gordon, Dr. Kelly Ramsey, Dr. Christine Kerr</i>	- The co-chairs welcomed everyone to the meeting and introductions were made.	-
Consumer Advisory Committee Updates <i>Dana Diamond and Julian Brown</i>	- Dana Diamond presented the agenda for the following day's CAC meeting	-
Beyond Satisfaction: Integrating Patient-Reported Experience and Outcomes into Quality Management and Improvement <i>Dr. Lisa Hirschhorn</i>	- Dr. Lisa Hirschhorn, an infectious disease clinician and QI expert, gave a presentation which addressed defining and measuring quality and how to move beyond measuring patient satisfaction to measure and improve patient experience. The following key points were made: <ul style="list-style-type: none"> • Technical quality, focusing on clinical outcomes, is an important component of care but doesn't always capture components of value to patient. There is a need to capture patients' longitudinal experience of care with metrics that matter to them. • Satisfaction measures aren't objective, and the most vulnerable populations tend to have lower expectations of health care, and so satisfaction can be met without high quality. Patient Reported Outcomes (PROs) and Patient Reported Experience Measures (PREMs) address experiential quality and measure the patient's experience in accessing or receiving their health care. • PROs are any report of the status of patient's health from patient without interpretation from anyone else. PREMs address measurable categories, such as waiting time, privacy, and empowerment. • In the US, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a popular and accessible measure, as are Press Ganey and World Health Survey. • The World Health Organization lists eight domains of Health Responsiveness: dignity, autonomy, confidentiality, communication, prompt attention, quality of basic amenities, access to social support, and choice of medical provider. • PREMs are usually measured through surveys, which can be broad or disease-specific. • More work needs to happen in quality of life measures in PREMs and PROs, and researchers need to understand how to best adapt and translate these measures to fit specific patient populations. • Using PREMs has been linked to better outcomes in diabetes experience, self-management, and efficiency in delivering care. They can also provide incentives to change and public accountability. • PREMs can be used to create improvement strategies at the practice and broader system levels. - Dr. Hirschhorn raised the following questions for considerations for the future of PREMs: How should PREMs and PROMS better drive improvement strategy and action? How can many	-

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<p>stakeholders work together? How to support response at individual and practice level? How do we balance expectations of care and technical quality when they are at odds? How can we more efficiently translate across different populations? How do we more effectively adjust interpretation for expectations and social desirability-driven answers? How can EMRs help drive response?</p> <ul style="list-style-type: none"> - A QAC member from MetroPlus asked how to deal with unreliable patient recollection in surveys. Dr. Hirschhorn responded that using patient reports for technical quality isn't a great measure but can be a useful indirect measure of communication. - Daniel Tietz asked if there are opportunities for qualitative responses. Dr. Hirschhorn suggested using focus groups to discuss improvement areas in addition to surveys. - Dr. Bruce Agins asked how consumer input can be most representative, and how that translates into improvement work. For example, how can we capture people who aren't returning or coming in? Dr. Hirschhorn responded that clinicians must become comfortable with "perfectly good enough" data. She suggested that embedding data in real time into EMR can increase sample size. - Dr. Peter Meacher noted that people who have best and worst experiences tend to complete surveys and asked about the optimal length of the survey. Dr. Hirschhorn responded that surveys should be short, the questions should be measurable but not too crude, and the surveys should be under 20 minutes with the most important questions at the beginning. - Dr. Kerr asked if each dimension of the visit should be captured separately, or in a single experience measure? Dr. Hirschhorn responded that PREMs can range from one extreme to another, or could encompass both specific aspects of the medical visit and the entire visit in a single survey. 	
<p>Organizational HIV Treatment Cascades: Engaging Open Caseload Patients <i>Callen Lorde, NYP/Weill Cornell</i></p>	<ul style="list-style-type: none"> - Providers from Callen-Lorde and New York- Presbyterian Hospital presented on the work they have been doing using the 2016 Organization HIV Treatment Cascades to identify patients living with HIV who have touched their clinical system but are not engaged in HIV care at their sites. - Dr. Peter Meacher presented on the 160 patients identified as "open" at Callen-Lorde. Callen-Lorde's focus was on documenting a patient's primary care provider (PCP) during a visit that accesses Callen-Lorde's services. Their goal was to get the information from 75% of patients who touch the system. The capacity to do this already existed in their EMR but had been used effectively. - If the patient does not have a primary care provider, Callen Lorde will engage with the patient and try and do intake on the same day. Additionally, Callen Lorde has an open access program which allowed patients to come in any day without an appointment. - Dr. Sam Merrick and Dr. Peter Gordon presented on the work at New York Presbyterian (NYP) to identify the 5,000 "open" patients found in the NYP system. - Dr. Merrick discussed the 800 "open" patients found at NYP East Campus, 83% of whom were classified as "in care". Open patients were from both the inpatient and outpatient units, with most of the patients touching the emergency room. Therefore, the focus on NYP East's project is ER treat and release. The ER navigators identify patients living with HIV who do not have a PCP and contact the HIV clinic or an outreach/linkage coordinator to assist the patient. Problems noted were navigators not always being in the ER and the need for IT solutions to set up an EMR alert. - Dr. Peter Gordon presented on the 794 "open" patients found at NYP West. Similarly, NYP West 	<p>-</p>

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<p>focused their project on looking at patients who touched the ER. NYP West utilized New York City’s Care Status Report to identify the status of some patients. Of those whose statuses were identified through the CSR, a majority needed follow-up. NYP plans to use their REACH collaborative partners to engage their open caseload. NYP gave Healthix RHIO their open population list and will get a primary alert notification if one of those patient touches any location associated with Healthix. Alliance for Positive Change will also get a notification which will trigger outreach by a care coordinator.</p> <ul style="list-style-type: none"> - Additionally, Dr. Gordon mentioned a project at NYP West called the HASA Bottom-Up Alert Project that utilizes the RHIO in collaboration with HASA to identify open patients who are touching HASA services and not in HIV care. If a patient who is out of care touches HASA, NYP gets an alert notification. 	
<p>Stigma Reduction Initiative Early Adopters <i>Open Door, HRH Care, Mount Sinai, Housing Works</i></p>	<ul style="list-style-type: none"> - Four organizations presented on their stigma reduction survey implementation and result. <p>1. Housing Works; Alison Kliegman</p> <ul style="list-style-type: none"> - Ms. Kliegman discussed how at Housing Works they tailored the AI survey for their population, modifying some of the questions. Their goal was to have 175/600 staff complete it. Staff from all areas of the organization, including primary care, case management, health home, housing, harm reduction, HR, finance, IT, thrift store, coffee shop, book store were sent a Survey Monkey link from Charles King. They were given a one month period to respond. - For consumers, the survey was made shorter. It was piloted with a few consumers on a tablet to make sure it flowed well and made sense. Clients were able to complete the survey in the waiting room, at OASIS meeting and at Ault Day Healthcare community meetings. Everyone was surveyed, not just client living with HIV. - 298 staff/volunteers and 204 consumers, 65% of whom were HIV positive, completed the survey. - Feedback on the staff/volunteer survey was that it was long, taking an average of 13 minutes to complete. Housing Works intends to analyze where people dropped off. Other than that, feedback has been positive. - Among consumers, very few people refused the survey. It took on average 6 minutes to complete. - Housing works will form a short-term committee to address the findings of the survey. New people will be engaged in QI work. <p>2. Hudson River Healthcare; Dr. Christine Kerr</p> <ul style="list-style-type: none"> - There was support from leadership and the quality committee for implementing the survey. - A stigma champion was identified at each of the 11 HIV care sites which is where the survey was primarily administered, though it was given to staff at other clinics as well. - At first an in-person questionnaire at staff meetings was piloted, but it was too cumbersome to do the data processing of the hand-written surveys. There was also concerns about confidentiality, such as recognizable handwriting. Eventually used Survey Planet and emailed the link to staff at all sites. A pizza party was given for the site that contributed the most surveys. - A consumer survey was adapted from the provider survey. It was given out at case management visits and consumer advisory board meetings. There were also regional focus groups lead by a 	<p>-</p>

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<p>stigma champion and 2 CAB members.</p> <ul style="list-style-type: none"> - Consumers will be part of the stigma reduction task force that will be formed. - 260 surveys have been completed - The following feedback was provided by staff survey participants at HRHCare <ul style="list-style-type: none"> •The state should have provided an online survey from the start •Some people thought the language was too complicated •The questions in section about transgender patients were found to be confusing •Some commented “we already know this”. -The following feedback was provided by consumer survey participants <ul style="list-style-type: none"> •Services for patients who are hearing impaired should be evaluated •Conducting the survey face-to-face would have been preferable - Many consumers were uncomfortable with the results from the “Opinions about People living with HIV” section and felt the staff would have answered questions differently if they were HIV positive. This has motivated some consumers to want to share their storied in staff as a way to contribute to stigma reduction. - Based on the staff survey findings it was determined that education is needed around HIV and childbearing. <p>3. Open Door; Karen Mandel</p> <ul style="list-style-type: none"> - Open Door will administer the survey primarily at the two sites where the HIV medical experts are located. The survey will be administered to the medical team, nutrition, call center, lab and any one that patients might encounter. Survey monkey will be used and results will be aggregated by site and by job function. - The survey will be adapted for consumers and translated into Spanish. It will be administered on iPads in exam rooms and during quarterly case management visits. Results will be aggregated by site, gender identify and sexual orientation. The results will be discussed with the monthly support groups. - Some challenges in the planning process have been figuring out the best system to administer the survey, getting approval for a paid Survey Monkey account and finding time for the marketing department to translate they survey into Spanish <p>4. Mount Sinai; Amy Newton</p> <ul style="list-style-type: none"> - The staff survey was administered to 300 staff (medical providers, nurses, behavioral health staff, social work staff, administrators, front desk) across 5 Manhattan HIV clinics. It was aggregated in Survey Monkey and extracted to Excel and R for further analysis. - Informal discussions about stigma were had with the CABS at each practice, and a brief survey, adapted from the staff survey, was administered in coordination with the leaders of each CAB. - The staff survey was completed in August with 200 respondents. So far 19 consumer surveys have been collected; one CAB still needs to meet. -Initial findings show gaps in stigma training for healthcare workers, the need for written policies and 	

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<p>procedures around stigma and discrimination and some negative opinions about people living with HIV that require education. Negative opinions about people with a mental health diagnosis were also found as was a need for more training around treating women with HIV.</p>	
<p>Louisiana State Department of Health HIV Quality Program <i>Dr. Deborah Wendell and Dr. DeAnn Gruber</i></p>	<ul style="list-style-type: none"> - Dr. DeAnn Gruber provided an overview of the Louisiana HIV Clinical Quality Group, emphasizing that as a Part B recipient, LA is committed to pursuing quality improvement in HIV care. - Dr. Gruber reviewed the objectives of the LHCQG and discussed what an ideal CQI group looks like. She noted that the primary goals of the CQG is to collect and submit data for performance measures. - The power of sharing QI project results at meetings was discussed. Dr. Gruber shared an overview of the Out of Care Initiative, showing preliminary results of care status of queried medical records. She also provided an example of Tulane Medical Center’s VLS QI project, showing the results of a drill-down to identify clients that were unsuppressed. - Dr. Gruber provided an overview of Louisiana’s healthcare landscape, particularly Medicaid expansion in July 2016 and privatization of Louisiana’s public health network(LSU) - Dr. Gruber provided an overview of the Medicaid viral load suppression measure, based on HRSA HAB Performance Measure. Plans are penalized \$250,000 if VLS measure is not achieved. The target set by Managed Care Organizations was 54.3%. The new target will be 75% for new RFP. - In an overview of Medicaid match results from July 2016 to June 2017, it was shared that 95% of persons with an HIV claim matched in the Office of Public Health database. Of those that matched, 74% we virally suppressed. <p>LaPHIE</p> <ul style="list-style-type: none"> - LaPHIE is a bi-direction information exchange. The following criteria are applied to surveillance data: <ol style="list-style-type: none"> 1. people with no VL for nine months (out of care) 2. People who never received test results 3. HIV-exposed infants. Surveillance data filters into the LaPHIE server which runs reports nightly to identify people who meet these criteria. - On the other end, hospitals filter information on patient visits into the LaPHIE server. If there is a match between someone who meets the above criteria for needing follow-up and someone who registers at one of the public hospitals, the hospital receives an alert that that patient has additional information of public health need. Ideally, the patient can be engaged while they are still at the clinic. LaPHIE also provides prompts, tools and resources for the clinician and the clinician can enter in what they have done with the patient into the LaPHIE server. - LaPHIE was initially operating in eight public hospitals. With a 2011 SPNS linkage award, this system was scaled to the private sector. It launched in one private sector facility in August of 2015. Around this time, most of the public hospitals went private and LaPHIE is now only operating two of them that budgeted for it, despite efforts to promote its continuation. As the sites were transitioning from public to private, many sites did not stay in the program due to other priorities and issues with multiple EMRS. Now that the clinics might be more settled, the Department of Health will reach out again to see if they will rejoin. <p>STIs in Louisiana</p>	<p>-</p>

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<ul style="list-style-type: none"> - Louisiana has very high STI rates, ranked nationally in 2015 first for primary, secondary and congenital syphilis and gonorrhea and second for Chlamydia, though they did see a decrease in 2016 - Syphilis rates are particularly high among black men, in metropolitan areas, and in the far north west of the state. Congenital syphilis is the Commissioner’s project. - Successes in STI reduction include more available syphilis testing at CBOs, treatment being provided more rapidly, extragenital testing increasing in public health clinics, lab validated testing in 12 clinics that cover all nine regions of the state. Through these efforts, 228 cases were identified that would have been missed. Additionally, there was an increase from two to 13 PrEP clinics, a task force was established in each region of the state, and a congenital syphilis care review was conducted to identify areas for improvement and increase awareness among providers. <p>Questions</p> <ul style="list-style-type: none"> - Dr. Steven Kritz asked how people with substance use problems who are not virally suppressed had been impacted by the public to private transition. Dr. Gruber explained that lack of funding for behavioral health services made it hard to access those services in a timely fashion. She noted that they are trying to contract with CBOs using Ryan White resources knowing that other resources might not be available. She also noted that more attention is being given now to the opioid epidemic. A needle exchange bill was just passed in Louisiana which will allow more opportunity to provide services to people who use drugs, including comprehensive testing and referral to treatment. - Dr. Kelly Ramsey asked whether the high rates of syphilis in Shreveport were due to sex work or drug use. Dr. Gruber replied that casinos have recently opened in Shreveport, which is 25 miles from the Texas border. A lot of people come from Texas and other parts of the state. There has been an increase in commercial sex work and drug use. 	
<p>New York State’s Health Care Transformation: The Path to Medicaid Payment Reform Through Value-Based Payment Programs <i>Dr. Douglas Fish</i></p>	<ul style="list-style-type: none"> - Dr. Doug Fish gave a presentation on Value Based Payments, joined by Ira Feldman and Frank Laufer. He started by noting that even if the ACA is repealed, DSRIP and VBP will continue - A summary of Medicaid Payment Reform efforts in NYS was provided. It was explained that DSRIP was built on CMS and EtE goals which include, attempting to remove silos in medical care; increasing access to primary care; enhancing communication between primary care and community based organizations (CBOs); integrating behavioral health and primary care; and reducing avoidable hospitalizations. DSRIP will last for five years and act as the bridge from fee-for-service to performance-based reimbursement. VBP is the sustainable part of DSRIP. - NYS is currently at 38% VBP, but trying to get to 80-90% by 2020. The state is on target to meet the 2019 goal. It needs to reach the goals to qualify for the total amount of DSRIP dollars from the federal government. - Dr. Fish explained the differences in the different VBP levels: <ul style="list-style-type: none"> • Levels 1 and 2 payments are determined at the end of a period by comparing actual costs against a target budget (which is based on the past 1-3 years and growth trends). If VBP contractors come up under that target budget, they are eligible to share in some of the savings. 	

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<ul style="list-style-type: none"> • Level 1: no risk-sharing, less shared savings than Level 2 and 3 • Level 2: some risk-sharing – VBP contractors have to pay back some losses, but are eligible for more money back than Level 1 • Level 3: greatest risk-sharing, greatest potential for savings. Capitated payments, negotiated ahead of time. • Level 2 and 3 providers must include at least one social determinant of health in their measurement sets. To reach these targets, VBP contractors can do a number of things – provide food banks, air conditioners, etc. • Level 2 and 3 providers must also include at least one Tier 1 organization relating to housing, social services, food banks, or religious organizations. <ul style="list-style-type: none"> - There are numerous types of VBP arrangements, including Total Care for General Population (TCGP), Integrated Primary Care, Maternity Care, Health and Recovery Plans, HIV/AIDS, and Managed Long-Term Care Plans. - Quality measures used for VBP arrangements have been categorized and prioritized. Category 1 measures are ready to use now; there are two types of Category 1 – pay for performance and pay for reporting. Category 2 measures are clinically relevant, but have feasibility problems, and Category 3 measures have significant problems. All VBP arrangements must have at least one pay for performance measure. Most plans are using 4-10 measures. - Quality measures are specific to arrangement type. Many included in TCGP arrangement cross-over into the HIV/AIDS group as well. Five measures are specific to HIV/AIDS Arrangement in 2018. Two are pay for performance (STD screening and testing and viral load suppression). Three are pay for reporting (linkage to care, substance use screening, and avoidable complications). - Many of the measures are already being used elsewhere. They are trying to streamline measures and ask for similar/same measures to other state and federal agencies. - A VBP work group approves all measures. It is not anticipated that many significant changes will be made for next year. - Dr. Kelly Ramsey and other providers expressed concerns about the hepatitis and alcohol use disorder measures. Dr. Fish noted that it would be up to contractors to decide which measures to use. - Dr. Pete Gordon expressed concerns about aggregating data and using the data for quality improvement, if each plan chooses which measures to follow. Dr. Fish acknowledged uncertainty about what VBP would mean for quality management and noted that involvement of the QAC would be critical going forward. Dr. Fish requested that any providers interested in joining the clinical advisory group for HIV/AIDS VBP measures contact him. - Dr. Gordon noted that providers had expressed thoughts in the past and these recommendations were not adopted. - Anna Bezruki provided a brief summary of QAC member responses to the proposed alcohol and opioid use measures (collected via survey). The proposed alcohol use measure was the initiation of 	

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
	<p>pharmacotherapy upon a new episode of alcohol abuse or dependence, measuring the percentage of individuals who initiate pharmacotherapy with at least one prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence. The proposed opioid use measure was the initiation of pharmacotherapy upon a new episode of opioid dependence, measuring the percentage of individuals who initiate pharmacotherapy with at least one prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence. The majority of survey respondents were opposed to the two proposed measures and expressed a range of concerns in the survey, including patient readiness and evidence for the measures.</p>	
<p>Mortality Subcommittee Update <i>Dr. Pete Gordon and Leah Hollander</i></p>	<ul style="list-style-type: none"> - Leah Hollander provided an overview of the plans for the Mortality Review as well as the draft chart extraction tool for use in the review that had been modified from the Coding Causes of Death in HIV (CoDe) tool developed by the University of Copenhagen. - Dr. Steven Kritz brought up the situation of patients whose information may be split up between multiple providers. For example, they were receiving care at a substance use center, receiving HIV care at another institution and died in a third institutions hospital. With potentially three different organizations reviewing this patient, he wanted to know if there a way to identify and pull all these forms together. Dr. Bruce Agins responded that this is one of the issues that needs to be sorted out methodologically. We are hoping to coordinate different sources of data but there are a lot of kinks to work out. - Ali Kliegman ask whether the review will be part of eHIVQUAL and in what format it would be distributed. She expressed that it should not be on paper. She also wanted to know what we would be doing with this information. Ms. Hollander responded that hopefully the tool will be available as a fillable PDF. In regard to what the information will be used for, she noted that we will be asking organizations to analyze the causes of death and identify areas for improvement. - Chris Wells asked how much weight would be places on the summary of causes of death. Ms. Hollander noted that in the original CoDe protocol there is an external adjudication process for determining cause of death, but that the Mortality Committee had not yet discussed any external review process. She noted that more clear steps for determining cause of death during the internal review could be provided. Mr. Wells noted that a decision process would be useful. - Dr. Pete Gordon asked how the mortality review would dovetail with the ETE sentinel event work. Dr. Agins clarified that there is no plan for medical chart review for the sentinel event work. 	<ul style="list-style-type: none"> - Mortality sub-committee will meet to develop the methodology for the review, including the issue of bringing together data from decedents who received care at multiple organizations.
<p>Closing Remarks <i>Dr. Bruce Agins</i></p>	<ul style="list-style-type: none"> - Dr. Agins officially announced his retirement, delivered remarks and expressed his gratitude to the Committee for their voluntary commitment to improving care for PLWH in NYS - The QAC co-chairs each spoke of their experiences working with Dr. Agins and expressed their gratitude for the guidance he has provided. 	<p>-</p>

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