HIV Quality of Care QAC Meeting

55 Exchange Place

June 14, 2018, 12:00 p.m. – 5:00 p.m.

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
Introductory Remarks and Welcome	- QAC participants introduced themselves, and Dr. Kelly Ramsey, Susan Weigl, and Iris Arzu joined via phone. - Dr. Peter Gordon, QAC co-chair, introduced Dr. Charles Gonzalez as the new Medical Director for the AIDS Institute. - Dr. Gonzalez addressed the group, noting his background in advancing ARV therapy and his ADAP advisory role when drug-drug interaction guidance was put into place. He also discussed his structural approach to quality, highlighting how quality and safety intersect.	
CAC Update *Dana Diamond, CAC Co-Chair*	- Dana Diamond, CAC co-chair, provided an update from the previous day's CAC meeting. She brought up the new structure for consumer review of clinical guidelines wherein specific CAC members have signed up to review the guidelines for specific topics. - Ms. Diamond also brought up the CAC's commitment to subcommittees, and encouraged providers to commit to joint subcommittees. - She also discussed the QI activity Daniel Belanger, AIDS Institute, led with the group.	
Organizational HIV Treatment Cascades and Improvement Plans *Karen Mandel, Open Door* *Christine Kerr and Iris Arzu, HRHCare* *Ladan Ahmadi, Lenox Hill Hospital*	- Three organizations presented on their 2017 Organizational HIV Treatment Cascades and Improvement Plans. **Open Door** - Karen Mandel, Director of Care Coordination Programs at Open Door Family Medical Center, introduced Open Door as an organization and highlighted their 2017 submission. Open Door is a small organization with a small patient population. - Data was extracted from eCW to the Relevant Platform, which can customize reports. Chart review was also performed to verify accuracy. Excel was used to track newly diagnosed and new to care patients. - Open Door tracks Hispanic and non-Hispanic as ethnicity separate from race categories, owing to the racial diversity in the Hispanic community. - Issues with tracking open patients stemmed from a lack of documentation. For some, it was known that the patient was in care somewhere, but the provider may not have asked, or documented, where exactly they are receiving care. - Ms. Mandel also looked at the stories of each individual who was not suppressed in 2017 to address each individual's challenge. For such a small number of unsuppressed patients, generalizations did not explain adherence challenges. -In the future, quality improvement will focus on training medical providers in documenting care	

	information for HIV+ patients. They will also focus on reducing linkage time for newly diagnosed patients as they strive to meet the three-day linkage benchmark. - Julian Brown, CAC co-chair, asked why patient characteristics for open patients weren't captured. Ms. Mandel answered that because open patients have limited contact with Open Door they aren't able to capture all demographics, but they capture some. **Hudson River Healthcare** **-** Dr. Christine Kerr, QAC co-chair, and Iris Arzu, Data Analyst, discussed the 2017 cascade at Hudson River Healthcare. They are using a new technology called Spotfire to better track patients, especially after sites in Suffolk County began to be included in data reporting. - Spotfire is an analytics platform that connects to different databases and can import files. It is interactive and provides data visualization, which helps detect outliers and patterns in the patient population. It can generate cascades in real time and provide patient-level demographic data. - Staff had to develop new systems for identifying patients in care elsewhere, those who had been discharged, and new patients. - In the analysis of the cascade, HRH looked at different combinations of patient demographics to identify disparities. For example, they look at viral suppression geographically to target programs in areas with low VLS rates. - HRH is now bringing this data back to institutional leadership to advocate for more resources to remedy disparities. Each HRH site will also analyze their site-level data. **Lenox Hill** (joined by Daniel Spier to present) - Dr. Ladan Ahmadi and Daniel Spier, PA, from Lenox Hill reviewed their 2016 cascade goals, including better documentation of care, increased linkage for newly diagnosed patients, and expanding HIV care to their Greenwich Village site. - Since 2016, the electronic health record now generates alerts for all HIV+ patients admitted to the hospital, which are sent to the HIV care team. The emergency department now also follows up with the HIV team, there are open slots for HIV care, and there are two new providers close to the downtown Greenwich Village site. - Lenox Hill has made improvements in reducing the number of patients with an unknown status. To continue this, there will be provider education on documentation of HIV+ patients. - They also improved viral suppression rates, which were 91% at the end of 2017. Dr. Ladan expects this number to increase now that there is a new pharmacist who will work with patients individually. - Major disparities are found in the IDU and transgender populations, and linkage rates can still be improved. - Lenox Hill plans to improve viral suppression rates for newly diagnosed patients through intensive outreach and education. They are also planning on hiring an HIV counselor for the Greenwich Village site. - HIV testing has also been added to the standard electronic health record snapshots so that there is clear documentation of the last HIV test.	

	- After the presentations, QAC attendees asked questions of the presenters. - Katrina Balovlenkov, CAC member, asked how consumers are being involved in the cascade process, particularly IDU. - Dr. Ladan responded that Lenox Hill has a very small number of IDU and transgender patients. She wondered if the hospital's location had any relationship to the small number of patients identified as IDUs. Lenox Hill does have a CAB, but is often poorly attended. Additionally, Dr. Ladan mentioned that Lenox Hills currently has HIV-track residents who help with documenting and consulting with open HIV+ patients. - Dr. Kerr responded that HRHCare has had a strong peer response to the cascade process. Peers at HRHCare are running data reports and are involved in the data reporting process, which is very accessible. - Dr. Gordon brought up the role that organizational quality programs play in ETE, and how quality teams help locate resources to address issues at the site leve. - Charles King, QAC member, brought up AIDS Institute Director Johanne Morne's December letter urging the inclusion of non-clinical service providers in the cascade process. He reminded the group that they can help to facilitate the inclusion of non-clinical service providers in routine quality work, as they can reach people that clinical providers often cannot. - Mr. Belanger also mentioned that this year, the AIDS Institute will conduct quarterly check-ins on the progress of organizations' quality improvement plan based on their 2017 cascades.	
PREMs Subcommittee Update *Freda Coren, AIDS Institute*	- Freda Coren, AIDS Institute, presented on the draft scope of work for the PREMs subcommittee, created after the December Joint CAC/QAC meeting discussions. - Objectives include using PREMs in quality improvement, identifying ways to engage hard-to-reach patients, and standardizing an approach to measuring patient experience. - Thus far, only three QAC members have signed up to participate in the subcommittee. There has been more interest in the subcommittee in the CAC. - Dr. Gordon urged QAC members to join the subcommittee and underscored the importance of PREMs in the healthcare setting. He said that PREMs could be incorporated into cascade work and used in the improvement process.	- Contact Freda Coren, freda.coren@health.ny.gov, if your organization is utilizing PREMs or CAHPS at the organization level or in quality improvement, or if you'd like to join the subcommittee.
Mortality Review Update *Leah Hollander and Charles Gonzalez, AIDS Institute*	- Leah Hollander, AIDS Institute, gave an overview of the mortality review. A mortality subcommittee was created to revise the CoDe tool, and the adapted tool was presented at the September QAC meeting and the revised tool was presented at March meeting. We now have a comprehensive tool that is ready for use. - The AIDS Institute will conduct a review of administrative data sets to identify the number of AIDS-related deaths in 2017. - The mortality review tool is currently on hold and will be re-invigorated when new staff are hired.	- Sites that are interested in independently piloting an unofficial version of the CoDe mortality review tool may contact Freda Coren at freda.coren@health.ny.gov.

	- Dr. Gonzalez discussed sentinel events, the need for validated data sets, and the use of the established and clear definition of an AIDS death. Since there are currently no hard numbers, the AIDS Institute will be compiling different data streams in order to validate findings. The CoDe tool has allowed us to add certain elements outside of the traditionally ascribed causes of death, such as housing status. The tool will also inform on comorbidities. - Dr. Gordon mentioned that his organization does not measure mortality in a systematic way, but residents in the program want to use it to examine mortalities in the past year. This tool captures a lot of nuance that the original tool did not. - Dr. Peter Meacher, QAC member, mentioned that there are many lessons to learn by examining the causes of death for his organization's patient population. They will use the tool to identify areas that need attention. - Dr. Eunice Casey, QAC member, wondered if sites should pilot the use of the tool independently, as opposed to an organized review. Dr. Gordon responded that without an organized review, the HIV provider community won't really know what they are missing when HIV+ patients die. - Mr. King brought up the importance of capturing nuance and detail in a mortality review, so that we can better direct resources into the correct programs and make actionable improvements.	
Quality Improvement Plans to Decrease Stigma *Rebekah Glushefski, IFH*	- Rebekah Glushefski, Retention and Adherence Program Director, presented on Institute for Family Health's (IFH) quality improvement plans to reduce stigma. - In the integrated service program COMPASS, questions on stigma were added to the annual patient satisfaction survey, completed by 77 people. Peer educators were also interviewed about stigma at IFH. - IFH received 166 responses to the AIDS Institute's stigma survey tool across six sites and many staff disciplines. - The team developed reports of survey results to share with CABs and administrative leadership. After the surveys were reviewed, a stigma reduction task force with patient and staff membership was created. The task force developed a multi-point stigma reduction action plan and will provide additional education and training for patients and staff. - The stigma reduction action plan incorporates U=U messaging into various points of care, including staff education and a message on U=U from the CEO. - The team is developing U=U trainings and presentations for staff across all sites. Messaging includes posters with images from real patients and real staff (messaging is geared towards all patients, regardless of HIV status), a feature on the home page of the IHF website, and educational materials. - They are also distributing U=U "ambassador buttons" for those who are knowledgeable about U=U and can discuss with others. - One prominent theme in the consumer stigma survey was challenges and stigma around disclosure. This was taken back to the CAB, which wants to launch a group to promote disclosure training for care coordinators and patient navigators. Other efforts to reduce stigma in this area are under way.	

	- The Institute is also building up well-trained cohort of medical providers, and there is a residency program at two sites, including specialty electives for the COMPASS program. - In the future they will work on interventions, but now are looking at what to do moving forward, including: more care in screening for stigmatizing beliefs in job hiring, and incorporating stigma reduction and HIV 101 into new hire orientation. - In response to a question about how the site is measuring change, Ms. Glushefski responded that training attendees complete pre- and post-training assessments. They will also measure changes in patient satisfaction surveys. The CAB will also assess the survey and help refine it for future use. In the future, the staff survey will also be re-distributed so they can measure change over time. - In response to a question about securing institutional leadership, Ms. Glushefski said that staff slowly started rolling out the U=U buttons. COMPASS program staff approached leadership and the communications team with a clear message about how U=U fits with IFH's general mission. They're also building relationships across departments. - Ms. Glushefski spoke more about the "boot camp" training for new COMPASS staff which covers case management needs, health literacy and education, HIV basics, adherence interventions, and psychosocial needs of patients. - The message of stigma reduction is being spread throughout the organization, even outside of the HIV program.	
Value-Based Payments Update *Doug Fish and Lindsay Cogan, NYSDOH*	- Dr. Doug Fish and Lindsay Cogan, PhD, discussed Value-Based Payments (VBP) and the QAC's advisory role. - Currently, Drs. Fish and Cogan are working to align the two HIV VBP quality measure advisory groups. They hope to bridge their Quality Advisory Group (QAG) with the QAC. - VBP arrangements apply only to Medicaid, and only affect managed care organizations (MCOs). Adopting VBP is a gradual process, and healthcare organizations can determine if they want to participate. The Level 1 VBP arrangement carries no financial risks for providers. - The Delivery System Reform Incentive Payment Program (DSRIP) has several VPB objectives, including reading providers across the state for a broader implementation for VBP. As a payment system, VPB has bi-partisan support from the federal government. - One of the main DSRIP goals is to reduce avoidable hospital use (emergency and inpatient) by 25% over 5+ years of DSRIP. To achieve this goal, the state and providers must remove communication silos, develop integrated care delivery systems, enhance community and primary care, and enhance behavioral and mental health care. objectives. - A VPB arrangement compares actual end-of-year payments spent to target budgets jointly set by the provider and MCO at the beginning of the year. Yearly savings can be utilized for programming and quality improvement. The underlying fee-for-service payment structure remains in VBP Levels 1 and 2. - Level 1 entails a 50/50 split of savings between provider organization and MCO contractor. There is no financial risk for exceeding the target budget in this level.	

	- Level 2 entails rewards for willingness to accept financial risk; organizations and MCOs retain 90% of savings if there is surplus; otherwise the amount spent over budget needs to be returned to the state. - Providers and MCOs mutually decide which quality measures they aim to meet, and payment is based on meeting these measures. - One QAC member commented that VBP offers no incentive to recruit the most high-risk patients who would cost the most. This could de-incentivize organizations from opening doors to certain populations if they are looking to move to a higher arrangement level and cut spending. - Dr. Fish responded that the VBP incentive aims to align the provider with the patient correctly. Accordingly, different kinds of organizations may choose different arrangements. For example, they could choose between a total cost of care arrangement or an HIV-specific arrangement. - In Level 3, the highest level, providers are given money prospectively and monthly, and will not get more. MCOs are less relevant to this arrangement, and are not involved in payments. For example, an MCO would no longer have to give prior authorization for an HCV drug or ART because they no longer control how the money is spent. - Services may be reimbursed as fee-for-servic0e, as they are now, or per member per month. - VBP also measures quality outcomes at the end of the year. - Goals by April 2020: 80-90% of total MCO expenditure will be in Level 1 or above; at least 35% of total payments contracted will be in Level 2 or higher. - Goals by April 2019: at least 50% of total MCO expenditure will be in Level 1 or above; at least of 15% total payments will be in Level 2 or higher. - 2018 VBP Clinical Advisory Committee goals: conduct an annual review of quality measure sets; identify and analyze clinical and care delivery gaps in current measure sets; and propose recommendations for 2019. - In Febuary 2017, the VBP workgroup approved 76 unique quality measures. There are ten HIV-specific measures. In 2017, only one of these HIV measures is supportable, but there are not currently any pilot arrangements with HIV-specific organizations. - Quality measurement is a way to keep organizations accountable for the care they provide. Efficiency should not be sacrificed for quality in the VBP system. - This year, VBP quality measures will be focused and refined, as will reporting and measurement processes. Ideally, electronic digital data will be collected at the point of care. Measures will ideally be aligned with other groups' measurements, such as the AIDS Institute's quality measures. - VBP will seek to collect meaningful measures. Meaningful measures are high-impact, meaningful to patients, minimize provider burden, and outcome-based. The Meaningful Measures Framework also seeks to address measure needs for population-based payment through alternative payment models, and align the measures across programs and/or payers. - Current VBP measures will also be consolidated, and process-driven measures will be removed in favor of outcome-based measures. - Dr. Cogan posed questions about the consolidation and alignment of HIV VBP measures to the	

	group. Dr. Gordon encouraged the QAC to think about the measures that the QAC has previously held stewardship over, such as HIVQUAL. - A QAC member asked what would happen when several patients are consistently not meeting the measures, especially as this could result in adverse selection if organizations are not being reimbursed. Dr. Gordon responded that this might be a precedent for setting quality measures low, and not necessarily aligned with the QAC's higher standards. - Dr. Cogan also mentioned that the target budget should account for the possibility of intensive interventions and high-risk patients. - Dr. Casey brought up the concern that the QAC has generally pushed for quality measures to be more rigorous. If potentially costly patients are pushing HIV VBP quality measures lower than usual QAC standards, this is an issue that needs to be addressed. - Dr. Fish and Dr. Cogan responded that the VBP arrangement should reflect the organization's patient population. Furthermore, even if measures are consistent, the threshold to which organizations need to adhere could be adjusted (i.e. 70% VLS instead of 90%). - A QAC member brought up the concern that quality and quality improvement activities may suffer if clinics set artificially low measure thresholds. Dr. Cogan responded that pilot arrangements currently being tested have not set low bars, even though they are integrated primary care. They are hoping to make incremental goals with the understanding that they should strive for incremental improvement. - Dr. Meacher suggested two-tiered goals, accounting for social determinants and coexisting health issues. Goals for patients who have these co-conditions would be lower, which would incentive providers to engage those patients because they are an appropriate threshold, but it wouldn't penalize facilities that mostly deal with those patients. - Several meeting participants mentioned that newly diagnosed patients routinely bring down organization-wide VLS rates, which would impact VBP measures. - Dr. Joseph McGowan, QAC member, asked how VBP and DSRIP could be tied to Ending the Epidemic Initiatives within large institutions with relatively small HIV+ populations. Dr. Fish responded that if there is a Special Needs Plan that wants to bring together multiple providers on the same plan. However, for total care population arrangements, HIV patients would be excluded or added with a VLS measure. - Dr. Cogan discussed HIV specific measures, and added that they are looking for clinical feedback on three measures. She reminded the group that measures could be from administrative databases or other clinical measures. - Dr. Fish said that as of now, the only viable Level 1 measure is for VLS.	
Medical Scribes to Improve the Patient-Provider Relationship *Peter Meacher, Callen-Lorde*	- Dr. Peter Meacher, Medical Director at Callen-Lorde, presented on the use of medical scribes at Callen-Lorde. - Dr. Meacher explained physician's burdens entering data despite its importance. This has created some workforce morale issues at the organization, as charting entails hours of extra work and congest normal workflow. In primary care especially, EMRs contribute to burnout.	

	- Callen-Lorde captures a lot of data, particularly around gender and sexuality which is challenging to enter into the EMR. Additionally, patients feel that providers are not present when they are entering data into the computer. - Dr. Meacher cited a study which found that nearly one hour of a provider's administrative work was saved with a scribe. - Goals of scribe program at Callen-Lorde include increased provider satisfaction, improved patient experience, and improved access for care, in addition to standardized documentation, routine documentation, improved coding and billing, cost-neutral, exposure of next generation of medical staff to LGBT health, and recruitment of future staff. - To make the program cost-neutral, providers see one extra patient per hour, which has been successful and potentially even cost effective. - Concerns include space in the exam room, patients' receptiveness, and costs. - Callen-Lorde piloted the scribe program with existing Callen-Lorde staff. Recently, the scribe pilot has expanded with hires from the company Scribe America. Callen-Lorde has hired enough staff to cover three full-time providers. - Providers who choose to use a scribe generally have trouble with documentation and were found in a survey to be unsatisfied with the current documentation system. - Callen-Lorde is going to expand to another phase by end of 2018 and by mid-2019, in which all providers who want a scribe will have one (approximately ⅔ of Callen-Lorde providers). - Pre- and post-scribe program physician surveys found that physicians who used scribes were as satisfied as those who did not. The initial group of doctors who volunteered to use scribes found charting difficult, but, after eight months with a scribe, their attitudes changed. - Callen-Lorde patients were also surveyed before and after their physician began using a scribe, and most thought their experience was the same or better. - Generally, the rooming nurse asks patients to consent to having a scribe in the room, and patients are generally comfortable with the scribes. - Cycle time has remained unaffected by scribes, with the same number of patients seen per session by providers. Now, providers using scribes see an extra 1.5 patients per session, and chart notes are 80-90% complete after a given session. - Over course of discussion, the scribe will prepare to print or send patient education information that is specific to patient in the room. - Dr. Rona Vail, QAC member, who uses a scribe at Callen-Lorde, said that having a scribe allowed her to spend more time with patients and develop a better relationship. Notes are generally more thorough and are helpful for provider follow-up. Patients also become comfortable with the scribe over time, as the scribe is always paired with the same physician. - The question of possible chart mistakes was raised, and Dr. Meacher said that no chart is finalized until the provider signs it. Scribes cannot prescribe or update immunizations. At end of the visit, the provider reviews chart and may edit or add information and then signs the chart to make official. - Scribes are well-trained through Scribe America, and are also given additional training by Callen-	

	Lorde staff. Before beginning, they also shadow a provider for one week. - Physical exams remain private, and there have been some multilingual scribes paired with multilingual providers.	
HIV and Smoking Cessation *Ali Kliegman, Housing Works* *Scott McIntosh, University of Rochester*	- Dr. Vaty Poitevien, Housing Works Medical Director, presented on smoking cessation efforts at the organization. - Dr. Poitevien explained that prior to this initiative, smoking and cessation screening was inadequate. Using a harm reduction framework, the program focuses on getting patients on the path to cessation. - The goal was to enroll 30 HIV primary care patients in the integrated smoking cessation pilot program. They developed a smoking cessation toolkit, including advocating the use of e-cigarettes as nicotine replacement therapy. - E-cigarettes were "prescribed" based on the quantity of combustible cigarettes patients usually smoke. The brand of e-cigarette prescribed has no flavoring, has clearly documented ingredients, are low temperature and disposable, and are filled with the appropriate amount of nicotine for one day. - Housing Works is considering marketing the campaign in a similar way to the Undetectables campaign. - The pilot had a huge rush of participants. Housing Works staff still need education about tobacco dependency. - Housing Works also created categories in their EMR for tobacco cessation consultation and follow-up. - The pilot was paid for by a one-year Robin Hood grant. Enrolled patients participate in the 90-day program with scheduled nicotine decreases. They plan to track all enrollees for up to four months, and they plan to scale up the program in the fall. - This pilot project will be conducted as a study, with formal evaluation. Dr. Gordon suggested incorporating a control group and follow-up at six months and one year. - Combination therapy and Bupropion prescriptions are also utilized in the program. - The difference in cost between e-cigarettes and combustible cigarettes was also discussed.	
Tobacco Subcommittee Update *Kelly Hancock, AIDS Institute*	- Kelly Hancock, AIDS Institute, reviewed tobacco cessation measures and addressed provider concerns about the measures themselves. The quit measures were most challenging. - Screening measures look at patients screened at their last visit, whereas counseling measures looked at all patients with a primary care visit. Submitting data on two different patient cohorts presented a major challenge. - There is not consensus on whether the lack of continuity between the cohorts matters. One QAC member said that having two cohorts makes data collection twice as difficult. - Dr. Vail suggested screening non-smokers annually and counseling smokers every three months. - QAC members expressed the desire to focus more on pharmacotherapy prescriptions. - QAC members also shared the difficulties of collecting and extracting these data in EMRs.	

	- It was also brought up that quit attempts should be captured, but could be less specific than the current measures. - Dr. Vail asked why harm reduction strategies such as vaping are not included in the data collection. Dr. Gordon and Dr. Gonzalez reminded the QAC that the NYSDOH does not endorse vaping.	
Closing Remarks	- Mr. King announced that there will be a summit on how the U=U message is being integrated globally. The summit will take place the day before the International AIDS Conference.	