# HIV Quality of Care QAC Meeting
55 Exchange Place
November 29, 2018 – 1:00 – 5:00 p.m.

| AGENDA ITEM/TOPIC | DISCUSSION/ACTION ITEMS | RECOMMENDATIONS/FOLLOW-UP |
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| **Welcome and Opening Announcements** | − Dr. Peter Gordon, QAC co-chair, welcomed the group and committee members introduced themselves.<br>− Johanne Morne, NYSDOH AIDS Institute director, welcomed everyone and recognized recent and upcoming events, including World AIDS Day and the Ending the Epidemic Summit, which showcased the work of the QAC, CAC, and community members, partners, and associates.<br>− The first meeting of the Hepatitis C task force was hosted thanks to the mobilization and advocacy of community leaders. Ms. Morne will share the final recommendations from the group in the next few months.<br>− In light of the recent passing of a former Young Adult Community Advisory Committee (YACAC) member, Ms. Morne asked the committee to take a moment of silence and recognition to remember the lives of those who have been lost. | - |
| **CAC Update**<br>*Dana Diamond and Leanna Thornton, CAC Co-Chairs* | − Dana Diamond, CAC co-chair, summarized the previous CAC meeting. The meeting covered Trillium Health's organizational treatment cascades, an Undetectable=Untransmittable (U=U) presentation, a presentation on hepatitis C and HIV co-infection, new education materials, and a project on using peers to address HIV and aging challenges.<br>− Leanna Thornton, the newly-appointed CAC co-chair, reminded the group of the issues faced by people perinatally infected with HIV, despite the prevention methods that currently exist. Three out of the four CAC/YACAC members who have died in the last four years were perinatally infected.<br>− Dr. Gordon asked if there are quality improvement projects or activities that the CAC could suggest that would shed light on understanding ways to address this, and Ms. Thornton addressed the lack of mental health support provided in the clinical setting. Questions should be asked routinely about mental health and referral to mental health specialists.<br>− Another consumer testified to his struggles with mental health, stating that he has often thought about suicide. He urged providers to step out of their comfort zone and discuss mental health challenges with consumers.<br>− Dr. Gordon commented that this discussion brings to light providers' lack of a systematic approach to assessing mental health programs, which should be discussed by the QAC.<br>− Dr. Kelly Ramsey, QAC co-chair, suggested reaching out to colleagues who work with | - Ms. Diamond addressed the challenges of holding both the CAC and QAC meetings in a single day and recommended shortening the consumer agenda to reflect only the topics that are most important so that consumers have enough time to respond and share their feedback. |

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| | − different diseases, but whose populations also struggle with mental health.<br>− A provider recommended routine annual check-ups for mental health in the HIV care setting. However, lack of resources and a sustainable model for this approach present challenges.<br>− Dr. Charles Gonzalez, AIDS Institute Medical Director, commented on the success of measuring HIV care and prevention in terms of viral load suppression, but noted that HIV care is not just about viral load suppression and should include supportive and mental health services. | |
| **Ending the Epidemic Metrics**<br>*Dr. James Tesoriero, AIDS Institute* | − Dr. James Tesoriero, AIDS Institute, presented the seven supplemental Ending the Epidemic (ETE) metrics that have been added to the nine core metrics released last year, which are instrumental for ending the epidemic. The same process was used in developing both the core and supplemental metrics. The group met a few times to achieve a consensus on the measures.<br><br>**Supplemental Metrics**<br>− Stigma Measure<br>    − Medical Monitoring Project, a surveillance system supported by the CDC to learn more about the experiences and needs of PLWH, was used as a model for the measure.<br>    − In NYS, the measure is based on results of ten questions looking at four dimensions of stigma: personalized stigma, disclosure concerns, negative self-image, and perceived public attitudes about people with HIV.<br>    − Goal: By 2020, reduce the median score of question responses by 25%.<br>    − The measure test will be distributed to a random representative sample of PLWH.<br>− HIV-Related Deaths<br>    − The data source for measuring HIV-related deaths is the annual IPRO record review conducted on a representative sample of deaths among PLWH occurring in NYS, and results of the reviews will indicate the number of deaths due to HIV/AIDS.<br>    − Goal: By the end of 2020, reduce the number of deaths due to HIV to zero.<br>    − Deaths due to HIV/AIDS will be measured by the presence of opportunistic infections.<br>− Newly Diagnosed HIV<br>    − The percentage of persons newly diagnosed with HIV infection who had a suppressed viral load after test within 91 days of the date of HIV diagnosis constitute the measure.<br>    − Goal: By the end of 2020, increase percentage of newly diagnosed persons who reach viral load suppression within three months of diagnosis to 75%.<br>− Sustained Viral Load Suppression | |

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| | <ul><li>The percentage of PLWH who were virally suppressed on all viral load tests in the previous two years, among those with at least two viral load tests in the previous two years constitutes the measure.</li><li>Goal: By 2020, increase percentage of PLWH with sustained viral load suppression to 75%.</li><li>This measure is related to the statewide U=U initiative.</li></ul><br>− Newly Diagnosed HIV: Persons Who Inject Drugs<ul><li>The number of persons newly diagnosed with HIV who have a history of injection drug use constitutes the measure, and includes persons newly diagnosed within the MSM and IDU risk group.</li><li>Goal: By 2020, reduce percentage of newly diagnosed persons with a history of injection drug use to 2.8%, which is equivalent to 42 new diagnoses with a history of injection drug use per year.</li></ul><br>− PrEP Utilization<ul><li>The number of individuals filling at least one prescription for Truvada (PrEP) within the calendar year constitutes the measure.</li><li>Goal: By 2020, increase number of individuals filling prescriptions for PrEP to 65,000.</li></ul><br>− PrEP Utilization: Medicaid<ul><li>The number of Medicaid recipients filing at least one prescription for Truvada within the calendar year constitutes the measure.</li><li>Goal: By 2020, increase number of Medicaid recipients filling prescriptions for PrEP to 30,000.</li></ul> | |
| **2018 Cascade Guidance**<br>*Daniel Belanger and Christopher Wells, AIDS Institute* | − Daniel Belanger and Christopher Wells, AIDS Institute, presented on the new guidelines for the 2018 Cascade Review, as well as the current process for reviewing the 2017 data and cascades.<br><br>**2017 Cascade Review**<br>− In 2017, 78 of 79 provider organizations submitted cascades, and 64 organizations passed validation checks for all the required cascades.<br>− Mr. Wells is performing further analysis to understand demographics subgroups variation, regional differences in outcomes, and "missed opportunities" among non-active patients.<br>− Mr. Wells and Mr. Belanger presented a preliminary report of the 2017 data; the results are based on data approved for analysis and are subject to revision. The review process must be examined to some degree, particularly the qualitative aspect, in the upcoming review cycle. Additionally, there is considerable variation between organizations and clinics. | |

- Newly Diagnosed/New to Care Patients
  - Externally diagnosed in 2017: 438 people were externally diagnosed and linked to care, with an average of 6.8 people externally diagnosed at each organization. The 90th percentile is 19.7 people.
  - Internally diagnosed in 2017: 1056 people were internally diagnosed, with an average of 16.5 people at each organization. The 90th percentile is 16.5 people at each organization.
  - Previously diagnosed: 6319 people were previously diagnosed but new to care at their organization in 2017, with an average of 98.7 people per organization. The 90th percentile is 218.1 people at each organization.
  - In all, the distribution of newly diagnosed patients is more uniform than that of previously diagnosed new-to-care patients.
- Newly Diagnosed Patients - Linkage
  - An average of 64% of newly diagnosed patients were linked within three days.
  - More than half of sites reviewed are set up with deliberate capability to link newly diagnosed patients within three days.
- Newly Diagnosed Patients - ART & VLS
  - An average of 83% of newly diagnosed patients were prescribed ART.
  - An average of 87% of newly diagnosed patients received a viral load test.
  - Average of 56% of newly diagnosed patients were virally suppressed.
- Open Patients - Patient Volume
  - All HIV+ patients (except newly diagnosed or new to clinic): 78,339 people.
  - Open patients (after exclusion for death, incarceration, or known to be in external care): 69,852 people.
  - Active patients enrolled in HIV ambulatory care: 53,272 people.
  - Average open-to-active ratio: 1.44:1
  - Due to data extraction challenges, there is considerable variation in the number of open patients and the number of patients excluded
- Open Patients - Benchmarks
  - An average of 86% of open patients were prescribed ART.
  - An average of 83% of open patients received a viral load test.
  - An average of 72% of open patients were virally suppressed.
- Active Patients - Patient Volume
  - There was an average of 323 active patients per clinic. The 90th percentile was 880 patients.
- Active patients - Benchmarks
  - An average of 97% of active patients have been prescribed ART.
  - An average of 95% of active patients have received a viral load test.

- An average of 81% of active patients were virally suppressed.

**2018 Cascade Review**
- In 2018, there will be a single cascade submission process combining patient-level information with the analysis and quality improvement (QI) planning.
- The submission will be broken into two parts:
  1. Patient-Level Data Excel Template
     - Data fields matched to Ryan White requirements
     - Additional fields for methodology, key findings, QI plans, and updates
     - Built-in features include:
       - data validation
       - cascade chart generation
       - export of non-confidential content for use in-house and within networks
  2. Submission through NYS Health Commerce System (HCS)
     - File routed to secure data server
     - Automated feedback via email
     - Final approval after review by quality coach and medical director

**Questions and Comments**
- A provider questioned the new guidance's stipulation for clinics to provide patient level data, given that the state already has this data from surveillance. Dr. Gonzalez clarified that clinics will only be responsible for providing information they already have, including names, date of birth, and other fields that match Ryan White requirements for funding. The state will utilize the patient level data to identify individuals who are out of care, without the risk of duplication across organizations.
- Another provider was concerned that they wouldn't be able to provide the same level of information for every patient and asked if the data will be invalidated if the information isn't fully complete. Dr. Gonzalez responded that providers will not be penalized for lacking information, and that it will be normal to have some fields empty. The purpose of the new guidance is to alleviate the burden on providers.
- Mr. Wells said that it is the AIDS Institute's intention to keep this guidance for the next three years at least, and added that it may be challenging at first, but it will get easier over time.
- Mr. Belanger provided the timeline for the 2018 Cascade Review.
  - December 2018 and Jan 2019: Health Commerce System registration, pilot testing, distribution of data template, and formal announcement of 2018 guidance.
  - February and March 2019: organizations complete and submit data template and initial QI plan, coaches begin review of submissions.

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| | − Spring 2019: organizations begin implementing QI projects. | |
| **Value-Based Payments HIV Measures**<br>*Dr. Douglas Fish and Dr. Lindsay Cogan, NYSDOH* | − Dr. Doug Fish and Dr. Lindsay Cogan, New York State Department of Health, discussed the Value-Based Payment (VBP) annual review, in which each measure set is reviewed and approved by the VBP workgroup. Recommendations were presented in September 2018.<br>− Drs. Fish and Cogan clarified the distinction between Pay for Performance measures and Pay for Reporting measures. All VBP measures are classified as Category 1 or Category 2.<br>− Category 1 measures are standardized measures that have already been used by providers and contractors. They must be utilized and reported in all arrangements. These measures can be either Pay for Performance of Pay for Reporting.<br>− Pay for Performance measures allow for shared savings between the provider organization and the contractor. Pay for Reporting measures, however, will not result in shared savings, as they are often Category 2 measures, which need further validation or experience to advance to Category 1.<br>− Category 2 measures are Pay for Reporting and are not required to be reported to share in savings but may be used in VBP pilot arrangements.<br>− In 2019, a measure prioritization process will begin. This entails choosing the best measure or process measure for a given chronic condition, and will focus on efficient measurement, a core set of measures to reduce administrative burden on providers, selecting measures from clinical data rather than claims data, and aligning quality measures across stakeholder communities and state and federal programs.<br>− Various advisory groups engage in a consensus-based approach for selecting and prioritizing measures for a given chronic condition.<br>− For HIV VBP arrangements, viral load suppression has been discussed as the priority measure. For the VBP arrangement, viral load suppression is defined as having under 200 copies per milliliter of blood at the last test.<br>− Advisory groups are currently reviewing the most effective strategy for reporting quality measures that minimize the reporting requirements for provider organizations. Thus, providers would report measures to the managed care plan, which in turn will report the data from all its VBP arrangements to the NYS Department of Health, rather than having the provider organization submit data directly to the state.<br>− Currently, the VBP HIV advisory group is working on a measure of potentially avoidable complications, which are costs that are avoidable or attributed to a given condition.<br>− It was clarified that each provider and managed care organization determines its own baseline for a given metric.<br>− QAC members brought up concerns that high-risk patients would be disincentivized, that different populations would have different quality standards, and that providers themselves are not in communication with managed care organizations on an | |

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| | administrative level. Providers were concerned that those negotiating and setting arrangements with managed care organizations have little knowledge of the clinic itself.<br>– Dr. Fish reminded QAC members that there is no financial risk for the provider at Level 1 arrangements, and that the goal of VBP is to improve population health and care coordination with the additional revenue stream from a VBP arrangement.<br>– The QAC came to the consensus that viral load suppression is the best central, Category 1 measure for HIV VBP arrangements.<br>– The group returned to the discussion of a measure for sexually transmitted infections (STIs) from the previous QAC meeting in September. At the September meeting, QAC members were concerned that the measure is for single site STI testing rather than multi-site STI testing, which is the standard of care for HIV providers.<br>– The current 2019 measures are adopted from HIV Special Needs Plans (SNPs) quality and process measures. They include: one syphilis screening during the measurement year and one urine/cervical/urethral test for chlamydia and gonorrhea during the measurement year.<br>– After discussion, the QAC came to the consensus that the current measure will remain unchanged this year, although there is room for improvement. They would like to initiate a process to develop, test, and implement the measures for 2020, such that they would specify non-genital, multi-site testing in addition to genital screening.<br>– Drs. Fish and Cogan will work with the AIDS Institute to develop more comprehensive STI measures in the next six to nine months. Feedback and recommendations can be sent to vbp@health.ny.gov or matthew.reuter@health.ny.gov. | |
| **Value-Based Payments and SNPs**<br>*Eli Camhi and Dr. Jay Dobkin, CUMC* | – Dr. Jay Dobkin and Eli Camhi, QAC members, from the Select Health SNP discussed Select Health's experience with VBP arrangements.<br>– They explained that most New York State Medicaid funding will go through the VBP channel, as over 80% of Medicaid dollars will be in VBP by 2020, a total of over $50 billion. Most HIV care is paid for by Medicaid. In the VBP model, patient outcomes should improve, patients will make fewer visits, and fee-for-service clinic revenue will decline as shared savings increase.<br>– HIV disease is a unique scenario for VBP, as it is an expensive chronic condition whose two cost drivers, avoidable emergency visits and hospital admissions and inappropriate or ineffective anti-retroviral therapy utilization, are sensitive to primary care provider action and quality of care.<br>– Dr. Dobkin and Mr. Camhi explained the process for calculating the total cost of care. All expenses in the patient experience, including drugs, are used to determine a three-year weighted average of the cost of care. This weighted average is then compared to the actual total cost of a cohort of patients for one year. If the actual cost of care at the year's end is less than the three-year weighted average, the provider organization and | |

the managed care organization can share the savings.

- VBP contracts are negotiated at the institutional level, and those negotiating may not grasp the nuance of care and the care experience. However, all patient costs would still be calculated. For example, if in the past three years there were many patients receiving treatment for hepatitis C, these higher costs would be included in the average cost. If during the arrangement year, however, there are fewer hepatitis C patients, the total cost of care would be lower, and the organization can share the money saved during the year.
- Additionally, VBP arrangements begin on January 1 of a given year. Thus, only the patients who are enrolled at the beginning of the year will be measured in that year's arrangement, and any patients added during the rest of the year will be added to the next year's cycle.
- Quality and performance are also a component of the VBP arrangement. Budget negotiations include adjustments for efficiency, quality, and risk. Patient risk is added to the initial budget calculation. However, if an organization underperforms on their quality metrics, they will receive a lower percentage of the shared savings.
- There are also allowable exceptions to the VBP arrangement, the costs of which are not included in the VBP target budget. High cost drugs, for instance, are an allowable exemption. The cost of these drugs is not included in the total cost of care, allowing providers to prescribe the medication they think is best. However, because high cost drugs and transplants are not included in the target budget, providers will also not share in any savings related to the exemptions.
- The VBP arrangement process also leaves room for leakage, which is the cost of care out of the provider and managed care organizations' control, such as hospitalization.
- For now, fee-for-service will continue. VBP supplements fee-for-service revenue, with a bonus for performance, which organizations will receive six to nine months after the end of the measurement year. VBP does not affect the revenue of an organization in real time.
- Dr. Dobkin and Mr. Camhi stressed that Level 1 arrangements carry no risk to the provider, only the possibility of shared savings. If the cost of care does increase in a Level 1 arrangement, there is not penalty. However, Level 2 and Level 3 arrangements carry some risk to the provider, but also increase the shared savings.
- Because seeing patients less frequently is a better health outcome, VBP is better than the old fee-for-service model, which would penalize providers for seeing patients less. With VBP, providers will share in savings as health outcomes improve and patients are seen less frequently.
- VBP works best at a large scale with over 1,000 patients. Managed care organizations should work with larger practices first and encourage smaller practices to merge or link their contracts to benefit from VBP.

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| **Hepatitis C and HIV Coinfection in NYS**<br>*Ziyad McLean, AIDS Institute* | − Ziyad McLean, AIDS Institute, gave a presentation on hepatitis C and HIV coinfection in New York State.<br>− The hepatitis C mortality rate has been increasing throughout NYS and has now surpassed the mortality rate of 59 other infectious diseases combined.<br>− Although the hepatitis C epidemic is growing, effective medications and treatments are available.<br>− Using the AIDS Institute Reporting System (AIRS), it was found that fewer than 30% of people co-infected with hepatitis C and HIV in NYS have started treatment. However, 95% of people who have started and completed treatment were cured of hepatitis C.<br>− Although direct-acting antivirals (DAAs) have proven effective in curing hepatitis C, access to these medications needs to be improved throughout NYS.<br>− In 2008 it was discovered that the "baby boomer" population was greatly affected by hepatitis C. However, in recent years younger populations, especially woman, are now becoming more heavily impacted by the epidemic. This younger shift in the hepatitis C epidemic may be associated with the opioid epidemic.<br>− Currently, Western New York has the most newly reported cases of hepatitis C, while the Hudson Valley region has seen a decrease in the number of newly reported cases. | |
| **Hepatitis C and HIV Coinfection**<br>*Dr. Ann Winters and Nirah Johnson, NYCDOHMH* | − Dr. Ann Winters and Nirah Johnson, New York City Department of Health and Mental Hygiene (NYCDOHMH), presented on Project SUCCEED. Project SUCCEED was developed in efforts to eliminate hepatitis C in people living with HIV in NYC.<br><br>**Background Information**<br>− Dr. Winters provided background information on hepatitis C (HCV) and HIV co-infection. People living with HIV/HCV are known to experience rapid progression of liver fibrosis and cirrhosis. About 16% of people living with HIV in NYC have been co-infected with HCV. However, direct antivirals have shown to be successful in curing patients of HCV.<br>− HIV and HCV are both reportable diseases in the NYC surveillance registries and are primarily reported through electronic medical records (EMR). The information provided for HIV and HCV varies in the NYC surveillance registry.<br>− All HIV diagnosis, viral load, CD4 count, HIV genotype test results, and demographic data are made available for HIV reporting.<br>− HCV positive antibody, positive and negative RNA, and genotype test results are reported. Negative antibody tests and HCV rapid test results are not reported. In addition, minimal demographic data is available in the HCV surveillance registry.<br>− In 2016, the NYCDOHMH received funding for Project SUCCCEED. Health department surveillance and other data was used to identify individuals co-infected in NYC. Around 4,200 individuals in NYC were found to be co-infected. Of these individuals, 84% were engaged in HIV care. | |

**Project SUCCEED Interventions**

− The first step assessed where the 4,200 individuals living with HIV and HCV were in care and identified target healthcare facilities with the highest burden of HIV and HCV.

− Of the 84% of co-infected individuals in HIV care, 56% were in care at the largest HIV care facilities in NYC. From there, dashboards were created for 47 of the largest HIV health care facilities. These clinics were offered surveillance-based lists of their own co-infected patients to promote HCV treatment.

− 23 facilities accepted a list of their co-infected patients (799 patients in total). Facilities were asked to review list and promote HCV treatment, and then return the list to the Health Department with patient status (i.e. HCV care status of each patient, treatment barriers).

− Provider education and training was offered to all facilities involved. This included HCV clinical provider training, HCV patient navigator training, HCV medication coverage training, and HCV basics for communities at risk. The HCV clinical provider training was developed in collaboration with the Empire Liver Foundation (ELF) and involved a 10 CME accredited live webinar training for new providers interested in learning to treat HCV. In addition, a half day observational preceptorship in a liver clinic was offered.

**Practice Transformation Model**

− Using surveillance data, the NYCDOHMH identified and recruited high burden facilities for Project SUCCEED.

− A full list of facilities with co-infected patients in need of HCV treatment was generated, and 15 facilities with highest number of patients not yet treated for HCV were selected for the Practice Transformation interventions. 10 of these facilities made formal commitments to receive the Practice Transformation interventions.

− The NYCDOHMH supported facilities to identify people living with HIV (PLWH) in need of HCV screening/treatment, train HIV clinical and non-clinical providers in HCV navigation, testing, care and treatment, and develop, implement and report on HCV service improvement plan.

**Practice Transformation Intervention**

− Facilities were asked to run a query to assess baseline, monitor progress and generate up to date list of patients in need of screening or treatment for HCV.

− Facilities were asked to create an improvement plan at baseline and submit interim progress report and final report with sustainability plan.

− Sites were provided with an electronic health record query tool. In addition, an introductory presentation and call were given to sites, as well as a brief needs assessment, three site visits, and training and technical assistance throughout the project.

- Many providers found the electronic health record query tool to be very helpful when looking at this specific data.
- In general, it was found that providers need to do a better job at screening their HIV-positive patients for HCV.

**HCV Services improvement Plans**
- Staff Support: Training and motivation; hire staff to fill service gaps (e.g. HCV testing); and clinical mentoring to promote treatment in PWUD (facilitated by a clinical expert).
- Enhanced Case Management: Use EHR query to update case lists of patients in need of screening and treatment; set up regular case conferences; develop community outreach capacity for return to care; and identify and utilize case finding tools to return lost to care patients.
- Improve Utilization of Existing Facility Resources: Support referral to HIV or HCV navigation; case management and care coordination programs available at the facility; leverage 340B to support HCV navigation staff; and utilize incentives and other priority resources to promote engagement in care
- System Changes: Develop and implement QI tools to monitor patient status/outcomes and provide feedback to staff; and improve EHR systems (alerts, order sets, auto ordering, patient panels).

**Interim Results**
- 10 facilities returned patient lists, with a total of 514 patients established in care. Of these patients, 21% were lost to care, 19% were said to be returned to care, 14% were not infected with HCV, 5% were currently in treatment, 5% were not treatment candidates, and 4% declined treatment.
- Clinical and non-clinical providers have utilized the training offered by the NYCDOHMH.
- Baseline HCV screening rates in PLWH were in the range of 57% to 100%, which was lower than expected.
- Approximately 900 co-infected patients were not in care at a high burden health care facility. These unengaged patients were assigned to NYCDOHMH staff for outreach and tele-navigation to promote HCV treatment. Of the 900 co-infected patients, 370 patients were assigned for outreach, 105 established contact, and 86 received navigation services.
- Out of the 4,200 PLWH who were HCV RNA positive in May 2017, 57% were RNA positive and 28% were RNA negative in October 2018.

**Remaining Challenges**
- HCV screening rates are much lower than expected. Healthcare facility leadership and providers must implement policies to screen all patients with HIV for HCV at intake into care.

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| | <ul><li>Providers may not treat patients for HCV who are co-infected if the patient is not on ART. Providers should consider short-term therapy for HCV if this is the case.</li><li>Providers may not treat patient if they are an active substance user. Providers should consider treating patients who are actively using drugs and/or alcohol. Providers comfortable with treating people who use drugs if needed should be referred, rather than withholding treatment.</li><li>Leadership at health care facilities should establish a centralized mechanism to ensure that all patients diagnosed with HIV and HCV are linked to care.</li><li>Currently there are limited resources for HCV surveillance and limited case finding resources. There is a need to enhance surveillance system capacity to enable receipt of negative HCV antibody test results.</li><li>The slogan for this initiative is "HIV Undetectable, HCV Cured!"</li></ul> | |