HIV Quality of Care Clinical Quality Advisory Committee Meeting

55 Exchange Place, New York, NY

June 13, 2019 1:00PM – 5:00PM

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS	RECOMMENDATIONS/FOLLOW-UP
Welcome and Announcements (Working Lunch) *Dr. Kelly Ramsey and Dr. Christine Kerr, QAC Co-Chairs*	- Dr. Christine Kerr and Dr. Kelly Ramsey, QAC co-chairs, welcomed the group and asked everyone to introduce themselves.	
CAC Update *Dana Diamond and Leanna Thornton, CAC Co-Chairs*	- Leanna Thornton, CAC co-chair, reported on the CAC meeting earlier in the day. The bylaws were passed without any new amendments. The CAC heard about CAB involvement in quality improvement from Callen Lorde's Boe Ramirez, staff stigma survey results and next steps from Courtney Ahmed, drug user health capacity building from Rob Curry, and consumer engagement in quality measurement from Dr. Thomas Concannon. The Young Adult Consumer Advisory Committee would be discussed at a later date. - Dana Diamond, CAC-co-chair, reiterated the importance of decreasing the amount of presentations per meeting to allow consumers time to voice their opinions. - Dr. Kerr added that June 5th was Long Term Survivors Day-- a reminder to pay attention to the aging population, and to be vigilant for those who haven't been represented. - Michele Lopez mentioned that Tulane University looks at aging in the perinatally infected youth and may be a good resource. - Dr. Kerr observed one thing echoed in the CAC meeting: some action must accompany the saying "we hear you." - Charles King shared that at Charles Gonzalez's request, he and a small group are looking at all-inclusive housing models for elder care. Those interested in joining should send him an email. - Michele Lopez remarked that she would have liked to have seen more clinicians attend the Long Term Survivors Day community event, and that she feels like there might be a break between on-the-ground workers and clinicians. Charles King expressed regret that he did not know of the event.	

Value-Based Payments and STI Measures
Dr. Doug Fish and Dr. Lindsay Cogan, NYSDOH
	- Dr. Doug Fish and Dr. Lindsay Cogan presented on value-based payment and STI measures in New York State for 2019. Through discussion, they hoped to obtain feedback about STI measures from clinicians.
	- The overall goal of value-based payment reform is to improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.
	- In April 2019, the DSRIP goal is to have at least 50% of total MCO expenditure in Level 1 VBP or above, and at least 15% of total payments contracted in Level 2 or higher. NYS is on target for these metrics.
	- 2019 Clinical Advisory Group (CAG) goals are to conduct annual review of the quality measure sets, identify and analyze clinical and care delivery gaps in current measure sets, and propose recommendations for 2020 VBP measure set.
	- According to the timeline for 2019, the first round of CAG meetings occurs in spring, and the second round in summer. The Measurement Year (MY) 2020 Quality Measure Sets will be published in the fall with feedback from committees like this one.
	- Among 53 VBP contracts examined by the NYS Office of Quality and Patient Safety, the majority used specific quality measures in shared savings calculations.
	- In current VBP quality measure use, most contracts do not include HIV related measures. NYS is now pivoting to make it a requirement to include a viral load measure (at least one measure of HIV/AIDS if involved with the contracts).
	- There is no threshold or number used. If someone with HIV or mental illness or substance use is included in the Total Cost of General Population (TCGP), the measure must be included in the domain.
	- AmidaCare's first contract lacked a HIV viral load measure because at the time they couldn't consistently do viral load tests for their patients. Managed care organizations (MCOs) get a bill for how many tests an organization does, but they won't get one for viral load if they don't know the viral load.
	- Dr. Fish and Dr. Cogan reminded the group that we are still very early in the VBP process. The benchmarks are intended to help guide the organizations in selecting measures.
	- Proposed VBP road map revisions include:
	  o Ensuring that if HIV-positive individuals are included in a TCGP arrangement, the measure selected from the HIV/AIDS measure set must be specific to HIV/AIDS.
	  o Strongly encouraging MCOs and providers that include individuals living with HIV/AIDS in their TCGP arrangement to select the "Viral Load Suppression" measure since it is a strong indication of health and well-being of PLWH.
	- Category 1 of the HIV/AIDS Measure Set include viral load suppression, screening for chlamydia, gonorrhea, and syphilis, and potentially Avoidable Complication (PAC) in patients with HIV/AIDS. One of these Category 1 measures must be chosen by the organization under the contract.	

	- Dr. Kerr asked if VBP contracts included any testing measure for HIV. Dr. Cogan responded with no, right now it is one of the gaps. - Category 2 of the HIV/AIDS Measure Set includes diabetes screening, Hepatitis C screening, housing status, linkage to HIV medical care, prescription of HIV antiretroviral therapy, sexual history taking, and substance abuse screening. Category 2 measures are not as ready for implementation as Category 1. - For the category 1 STI screening measure, HIV+ patients would be sorted via a decision tree, which recommends screening based on what group the patient is in. To meet compliance standards, "HIV+ MSM and/or transgender" patients should receive a "genital or rectal" screening. "HIV+ men and women" should receive a genital screening only. - Dr. Ramsey expressed her concern with the decision tree, noting that it assigns screening "based on what category you're in, not based on what you may actually be doing." - The group agreed that the OR statements should be replaced with AND. HIV+ MSM *and* transgender should receive genital *and* rectal *and* pharyngeal screening. The HIV+ men and women category should receive genital *and* rectal *and* pharyngeal screening. - A QAC member asked the question, how would they know who is high risk? Dr. Fish answered that that is based on extensive medical review, or the burden is on the provider. - Dr. Pete Gordon stated that if there must be a choice between STI screening or VLS, a managed care organization will always pick STI screening when VLS would be better. Therefore, VLS should be the mandatory category 1 measure, and STI screening should be the optional category 2 measure. - A consensus was reached to require the VLS measure to be included in VBP contracts involving HIV+ individuals and put the STI measure in category 2. Dr. Fish agreed to accommodate this by moving the STI measure to either P4R or category 2, either of which would have the same effect of preferring VLS as the only P4P measure to be chosen. - Michelle Lopez asked if they could capture a measure for the aging HIV population. Dr. Gonzalez stated that there is no frailty or aging measure because it gets defaulted to Medicare. Dr. Fish and Dr. Cogan responded that they are unsure but could consider developing one for the HIV population.	
2018 Cascade Presentation *Rebecca Green, Institute for Family Health*	- Rebecca Green, Regional Director of HIV Programs, and Dr. Robert Murayama, HIV Medical Director, presented on Institute for Family Health's HIV organizational treatment cascade. - Institute for Family Health is a federally qualified healthcare network of 31 full and part-time clinics in Manhattan, the Bronx, Brooklyn, and the Mid-Hudson region. Most patients are in the Downstate region. It is a Level 3 Patient Centered Medical Home. - The Institute's motto of HIV services is "No one fights alone in this family." It offers three unique family medicine-resided programs. Two have HIV primary care tracks, and in the second or third year, residents can become specialists in 24 months. Mentorship is offered to non-HIV specialists. - The Institute receives most of its funding from the city and state.	

	- The main sites for HIV care are Family Health Center of Harlem, Urban Horizons Family Health Center in the Bronx, and Institute for Family Health at 17th St. There are two new sites that also provide limited HIV services: Stevenson Family Health; Center and Family Health Center at Walton. - The Institute uses EMR (Epic) to pull their cascade data, specifically an internal HIV Registry and a secondary report that pulls data from other parts of the chart. - There are limitations to their methodology which include a lack of dedicated HIV QI program or staff, variability in staffing, high patient volume, lots of unknowns for race, and medically and psychosocially-complicated patients. - They have limited capacity to get data so there are a lot of chart reviews because not all data is clean. - Not all necessary data is in reportable EMR fields, and HIV reporting is not yet optimized. The Institute has received some funding to build a HIV dashboard, and the goal is to complete the dashboard in the next six months. - Staff is just beginning to analyze their HIV treatment cascade. They have done very well in terms of viral load testing and has resulted in an improvement in their viral load suppression rate. - Viral load suppression rate for newly diagnosed patients remains an area of concern. It was about the same for 2017 (51%) and 2018 (50%). - Most of IFH's patients are 45 years of age or older. - In 2018, the age group with the lowest viral load suppression rate (67%) was patients aged 20 to 24. This is a decrease from the age group's 2017 VLS rate of 80%. That year the age group with the lowest VLS rate of 73% was among patients between the ages of 30 and 39. - The Institute has a small cohort of transgender women, 12 patients. The viral load suppression rate has been the lowest for this gender group in 2018 (75%) and in 2017 (73%). The staff is committed to providing supportive services for their transgender women patients, including wrap-around services and a dedicated case manager. - The VLS rate is lower than average for unstably housed patients at 78% but is slightly higher than the 2017 VLS rate of 72%. - Dr. Murayama is IFH's new HIV Medical Director and is committed to quality. He works a lot with residents because they are more likely to see patients, as well as attending physicians who are not HIV specialists. - Staff is following up on Rapid Start and hoping to see better VLS for newly diagnosed patients in 2019 as a result. - In 2018, there was a lot of work with consumer involvement and building up CABs; however, it is difficult to measure how this shows up in VLS rates. For the first time, a patient participated in QI. There was also a lot of work around anti-stigma efforts. - A standing monthly case conference meeting is held at every site to make sure that numbers do not slip. The general CQI approach for 2019 is to set goals far in advance, embrace goals of QI, involve front line staff, and take a multi-disciplinary approach.	

	- The 2019 CQI projects that were determined before the cascade are analysis and revision of financial incentive program, analysis of new case finding workflow, expansion of Quick Start, stigma reduction through group intervention and PrEP for women. Following the cascade data, these CQI projects were added: an intervention targeting 20-24-year-old age cohort, drill-down of the newly diagnosed cohort to better understand barriers to suppression, continued efforts to strengthen housing referral network, and better care to transwomen patients (grant pending for supportive services). - All program managers are required to lead a QI project that aligns with top level goals. Front line staff are encouraged to participate. This year, there are two frontline staff committee members. A frontline staff member is interested in the low VLS rate of patients ages 20-24 and is working on a QI project. - In 2018, there were 771 prescriptions for PrEP, and this year IFH is hoping/expecting 25 percent more. They have 2 PrEP patient navigators and are working to educate and prescribe PrEP to more women. - The Institute is strengthening its housing referral network for low-income New Yorkers in general and people living with HIV. A grant co-locates a navigator with housing. Most peer navigators connect patients to housing. - A provider asked about specific interventions on PrEP for women. Ms. Green responded that they are reviewing their PrEP messaging and how pitching sex health/education to men affects women. They are also looking at patients already in their network and constantly monitoring the schedule to see who is coming in for sexual healthcare. She noted that they are still battling misperceptions among providers and competing interests. The Institute has built an algorithm that will launch in September. Dr. Murayama added that they target women who are coming for women's health services. There are a lot of misperceptions about who is at risk. - Dr. Kerr asked about targeting open patients. Ms. Green responded that they are noting HIV positive patients who are visiting and patients who are in care elsewhere but visit for another purpose. A lot of viral load tests are also run even though they are open patients. IFH has a very good social support system that is mandated to see every HIV positive person who visits clinic. - Dan Belanger asked about IFH's goals before the cascade and if the cascade data was helpful. Ms. Green responded that their top-level goals are the same because they were decided before receiving the cascade data. They are working to create a culture of encouraging staff and asking about staff's interests. They are honoring the interests of people doing the work and align with the goals.	
QAC Subcommittee Updates: Stigma and Tobacco *Dr. Kelly Ramsey*	**Discussion on Tobacco Subcommittee** - Dr. Ramsey opened the discussion by noting that she and Dr. Gonzalez discussed reinvigorating subcommittees for stigma and tobacco. Dr. Ramsey noted that the tobacco campaign had clumsy indicators and hopes that the tobacco subcommittee will reframe the tobacco campaign	

and Dr. Barry Zingman	in a harm reduction framework. She invited QAC members to join the subcommittees by identifying their interest and offering suggestions. - Dr. Gonzalez noted that tobacco cessation is not binary and is difficult to measure on harm reduction. Harm reduction has not been tried with tobacco and they are not sure how it will work. EMRs makes it more difficult. Dr. Gonzalez also noted that harm reduction framework for tobacco does not fit the public health frame or the way indicators are usually created. - A member suggested including people who are working on tobacco now and may receive/formulate indicators that are more in line with harm reduction, a lot of work done in a general way and how they can help. - Guidelines for opioid use are available. 26 organizations submitted baseline data, and 16 submitted the first submission. - Dan Tietz noted that tobacco is difficult for consumers. He also commented that follow up can be difficult to keep checking in and capture quit attempts. Dr. Charles King recommended a staff member who is working on harm reduction for tobacco at Housing Works. - Dan Tietz commented that there is new research about overdosing on nicotine. - Dr. Gonzalez commented that individual subcommittees should identify what is best and most meaningful. He also noted that the wants those things to be active and stigma before U=U. - A QAC member noted that the focus has been on measurements instead of programs, and the focus needs to be on programs. Another member noted that the focus was on documentation but could not create it. Dr. Ramsey also noted that the focus is the outcome for patients. - Dan Belanger commented that the stigma survey can be used by providers/sites to create a plan to address stigma. - A QAC participant asked about the length of the tobacco pilot. Dr. Gonzalez responded that it was one year, and Dr. Ramsey noted it depended on where a person is in their tobacco use. She added that the EMR can follow this. - A QAC member noted that to do something meaningful, the entire state has to be committed. - Dr. Gonzalez commented that tobacco cessation should not be a one-year campaign. He supports a standing committee but can start with a subcommittee for now. - A member commented that providers can see the number of people on pharmacotherapy quarterly but not how many started each quarter. **Discussion on Stigma Subcommittee** - Dr. Zingman noted that the stigma effort started in 2016 and included consumers. The stigma reduction survey was administered at the end of 2016 and early 2017 to over 80 healthcare organizations in NYS. Sites were asked to do QI project based on the survey results, and the stigma subcommittee became inactive.	

	- Courtney Ahmed, Program Manager at the AIDS Institute, presented the stigma survey and its results. Stigma survey components included staff demographics and key populations. The wording of the survey questions was adapted from Health Policy Project's "Measuring HIV Stigma and Discrimination Among Health Facility Staff" by Dr. Laura Nyblade. Of the 80 health care organizations that received the survey, 50 completed the staff survey and submitted results which were qualitatively reviewed the QOC program. Quantitative results came from 12 of the 50 sites who submitted their results in raw data format. - Survey questions should be expanded based on consumer feedback. - Sites looked at results and created stigma reduction action plans. Many sites aimed to strengthen consumer involvement in stigma. - QAC members are encouraged to think about the kinds of programs that the stigma subcommittee can take on. - Dan Tietz commented that the difficulty with an online stigma survey administration is maintaining anonymity. - A CAC member commented that noon or late afternoon meetings will encourage more participation. - Dr. Zingman commented that consumers are really interested in stigma. The focus is on themselves (HIV) instead of hospital and makes it much more meaningful. - Dr. Gordon, who works at a larger organization, commented that it is beneficial to start internally and look at everyone because places will say that it is a one-day thing. - A QAC member commented that her organization was supposed to hold a stigma staff training but it was never held. After the survey results, her organization saw the significance. - A QAC member noted that her organization hosts a bimonthly table for patients and staff to meet and share information. Half of the participants know what PrEP is and some are not interested. The bimonthly schedule builds anticipation and increases awareness. Providers are reminded that they are a resource. - Dr. Zingman distributed the survey to his staff. - A QAC member asked if positive responses were tallied in addition to negative responses. Courtney responded that negative answers were tallied in order to achieve a quantifiable measure of stigma. The higher the number, the more stigma was evident. - Dr. Kerr asked if the AIDS Institute can create a Survey Monkey form for the stigma survey. Dr. Gonzalez responded that if the QAC wants it, then AI can create it. He also commented that system matters and some sites have already made the survey in Survey Monkey format. - Dr. Gordon asked about patients who leave against medical advice. Dr. Gonzalez and Ms. Ahmed responded that Ms. Ahmed will be working on the SPARCS data.	

2018 Cascade Presentation *Melissa Napierkowski, SUNY Upstate Medical University*	- Melissa Napierkowski of the Immune Health Services at SUNY Upstate Medical University presented the 2018 organizational treatment cascade for Immune Health Services (IHS) and the Pediatric Infectious Disease department. - Immune Health Services is the only designated AIDS center in central NY and serves a 13-county radius. In 2016, IHS became a level 3 certified Primary Care Medical Home (PCMH). About 75 percent of IHS patients receive primary care from IHS. PrEP, LGBT, and RAP grants are provided through AIDS Institute. - IHS provides the following services: PrEP, primary care for partners of people living with HIV, primary care to members of the LGBTQ community, Hepatitis C mono-infection treatment, mental behavioral health, substance use services, anal dysplasia program and adherence support. - Mental/behavioral healthcare is available on site. - Pediatric Infectious Disease & Immunology provide HIV primary care to children and adolescents. - If a patient is diagnosed with HIV in the hospital, then s/he is seen the same day. If diagnosed outside, then an appointment is set up. - Pediatrics reviewed all patients 24 and younger. Adult HIV reviewed all patients 25 and older. If there is not adequate documentation, a patient may be missed. - Their patient population is primarily 30 years of age or older. 11 percent of their patients are 29 years or less. A majority of patients are cisgender male, followed by cisgender female. A minority of patients are transgender female and other trans, non-binary, or gender fluid. Most of SUNY Upstate's patients are white. 89 percent of their patients are non-Hispanic. - SUNY Upstate is doing better with newly diagnosed but still working on it. Rapid initiation started later in 2018 so they are hopeful that the VLS rate will be higher later on. One patient left against medical advice due to lack of insurance. Staff was able to find him and take care of insurance for him. - Younger age groups, women and transwomen have lower suppression rates. White patients have higher suppression rates. The Hispanic patient population has a comparatively low viral load suppression rate compared to non-Hispanic. Perinatal transmission has the lowest viral load suppression rate out of all risk groups. - Spanish speaking patients were assessed for pharmacy satisfaction and given the option to switch to a Spanish speaking provider. 5 of 15 patients switched to the Upstate pharmacy due to errors with medication, possibly due to language barrier. - The Joint Quality Project between IHS and Pediatric Infectious Disease is in response to lower VLS rates among 20-29 year-olds. All patients in the age group were asked for consent to send personalized text messages between regular clinic visits from August 1, 2019 to January 31, 2020. Patients without a scheduled follow up will be contacted to make an appointment. All 20-29 year-old patients with an unsuppressed VL in 2018 will be reassessed for participation in	

	enhanced services. Virologic suppression will be reassessed in the 2019 HIVQUAL Cascade. The goal is a 5 percent improvement in virologic suppression. - The Pediatric Infectious Disease quality project addresses lower VLS for <20-year old's perinatally infected with HIV. The goal is to improve VLS by 5 percent. Peer support will be offered to all patients. VL suppression rates will be monitored quarterly. - A CAC member asked how pediatric providers speak to the patients under 19 years old. She shared her experience of raising a perinatally-infected daughter, who disclosed her status in school and was shunned the next day. She also asked how staff is working with the parents and child on how to navigate this. Ms. Napierkowski responded that it is very individual to each family. She noted that they take the education of parents and children very seriously and encourage age-appropriate education for everybody. - A CAC member commented that providers should not solely focus on the aspect of getting patients under 19 years old into treatment, but also focus on their processing. She added they need a lot of support and should be met where they are at. - Dan Belanger asked if the intervention for Spanish speakers come out of the cascade review. Ms. Napierkowski responded yes. She commented that being able to see where the disparities are has been very helpful for their clinic. Upstate Medical University has behavioral health specialists and social workers on site.	
NYCDOHMH HIV/HCV Dashboard *Dr. Ann Winters and Nirah Johnson, NYCDOH*	- Nirah Johnson, NYCDOHMH Bureau of HIV Care and Treatment, gave an update on Project SUCCEED: A Data to Care Approach to Hepatitis C Elimination in PLWH in New York City. It is a HRSA-funded project which began in 2014 with the goal of eliminating hepatitis C in NYC. It was enabled by NYC's robust surveillance system for HIV and HCV, an important first goal to establish. - The care continuum does not look as good for Hep C as it does for HIV. Three interventions were implemented: provider training, clinical practice facilitation, and outreach and linkage to care via telephone. Project SUCCEED looked at people technically classified in HIV care but not HCV care. - 4,200 people living with HIV are currently HCV RNA positive. The majority of patients were in care for HIV sometime during the year and many were virally suppressed. Project SUCCEED worked with their surveillance teams to develop care status dashboards for HCV and HIV treatment initiation. These were very well received among those who received them. Project SUCCEED offered the same healthcare providers a list of their HIV and Hep C RNA positive patients. These didn't exactly correlate, however, which Ms. Johnson noted was interesting. It turns out people were lost to care that they previously thought were in care. - 20% of patients were cited as lost to care by the providers. For 16.7%, the provider said they would do outreach. 9.2% were deemed unqualified for treatment, possibly due to comorbidities. Ms. Johnson noted that it also might be because providers are choosing not to treat people who use drugs. - Project SUCCEED asked the top 15 sites with the highest numbers of patients not yet treated for HCV. Many providers were surprised by what they found. Their electronic health records system	

	was not capturing what they thought it was. Providers found that they were missing opportunities to systematically screen people. To avoid this, Ms. Johnson encourages multi-disciplinary teams to work together. - 30% of 641 patients were reached through telephone. The majority accepted some service, but also indicated they were already in care but needed advocacy for Hep C treatment. 22% are now RNA negative. Project SUCCEED plans to continue telephone outreach to patients. - 32.9% are now RNA negative, a.k.a. cured, because of Project SUCCEED. But who are the 50% who are RNA positive or indeterminate? Ms. Johnson thinks that some may have actually been cured, but she is very curious to conduct the analysis. - Ms. Johnson encouraged providers to take a look at their screening practices particularly for those at elevated risk for Hep C. She reminded the group that the last time Project SUCCEED presented, they released a health alert about acute Hep C in MSM. - Ms. Johnson said she would be happy to support the CAC/QAC Hep C subcommittee. She recommended using a data-to-care approach and picking measurable indicators to track progress, stating that "this is an achievable goal in NYS." **Questions and Comments** - A QAC member asked how linkage is being defined, remarking that a patient could be bouncing to different providers, and that the data needs to be drilled down a little bit. Ms. Johnson responded that since they are viewing a cure as the goal, making sure patients are engaged in care is part of that. - Dr. Gordon asked if Project SUCCEED has been able to do a similar analysis on mono-infected patients. Ms. Johnson explained that they are set up to do that for Hep C, but they would have to narrow down to certain populations. They can look at the 50% RNA positive/intermediate population. - A QAC member commented that the insurance piece is a huge barrier. Not being able to have their medications approved and picked up is problematic for patients with Hep C. They don't have a reliable place to get their medication delivered. Patient themselves have to give authorization to have the meds delivered to the clinic. But they tend to lose the card with clinic information and don't have the clinic address. - Dr. Ramsey said that the HIV/HCV subcommittee will be a good opportunity for brainstorming. - Dr. King announced that a law signed by Gov. Cuomo prohibits insurance companies from using mail order pharmacies. - Dr. Gonzalez stated that the group should have an elimination target for dual-infection for a year, to get the ball rolling. He noted that when a patient's hep-C is treated, their diabetes gets better. - A QAC member commented that there would need to be some coordination with different groups to determine what they can pull together in order to close the gap.	

QAC Subcommittee Discussion: STIs and HIV/HCV *Dr. Christine Kerr, QAC Co-Chair*	- Dr. Kerr announced the revitalization of two additional subcommittees on HIV/HCV and STIs. Emails will be sent to the QAC and CAC members to recruit members for the subcommittees. **Background on HIV/HCV Co-Infection for HIV/HCV Subcommittee** - Ziyad McLean presented on HCV/HIV in New York State in order to provide a background for the HIV/HCV subcommittee. He explained how HCV-related morbidity and mortality are expected to rise for the next several years in New York. Baby boomers used to be the most at-risk, but now a younger population between the ages of 15-35 is showing the most newly reported cases. In particular, rates of co-infection in NYS are highest for people who inject drugs and live in non-urban areas. - Mr. McLean noted a large gap in treatment initiation, but also the success of treatment when it is completed by coinfected patients. Screening for HCV must be increased and integrated with HIV screening to enable early treatment, which would prevent transmission and lower the incidence of liver disease. - After Mr. McLean's presentation, Nirah Johnson presented on Project SUCCEED: A Data to Care Approach to Hepatitis C Elimination in PLWH in New York City. **Background on Sexually Transmitted Infections (STIs) for STI Subcommittee** - Ola Odedele gave an overview of the history of STI-related programs and next steps for the STI subcommittee. - Programs implemented by the Quality of Care program on STIs include an STI survey of facility and clinic-level STI information in 2010, a sexual activity screening, and piloted eHIVQUAL sexual activity indicators with the addition of extragenital testing indicators and sexual history taking. In 2010, the STI subcommittee was developed to address the STI survey and STI indicators. In 2015 and 2016, it drafted and revised the STI guidelines for HIV clinical providers. - According to the 2011 eHIVQUAL STI Data Review, the average percentage of patients at each clinic who had a sexual activity screening or discussion was 73%. An average of 82% received syphilis testing, an average of 48% received genital chlamydia testing, and an average of 50% received genital gonorrhea testing. - According to the 2011 eHIVQUAL Extragenital Indicators, 6% of eligible patients (67 out of 1031) were tested for pharyngeal chlamydia, and 9% of patients tested (6 out of 67) were found positive. 83% of patients were treated. - 9% of eligible patients (96 out of 1021) were tested for rectal chlamydia, and 13% of patients tested (12 out of 96) were found positive. All patients were treated. - 10% of eligible patients (99 out of 1031) were tested for pharyngeal gonorrhea, and 7% of patients tested (7 out of 99) were found positive. All patients were treated. - 10% of eligible patients (106 out of 1021) were tested for rectal gonorrhea, and 9% of patients tested (10 out of 106) were found positive. All patients were treated.	

	- Currently the percentage of sexually active women aged 16-24 on Medicaid who are tested for chlamydia hovers around 72% in NYC and 60% in upstate NY. This is significantly below the recommended 100%. - According to 2017 NYSDOH STI Bureau updates, the majority of new early syphilis cases are not tested for HIV within 30 days of syphilis diagnosis (62%). - Possible next steps for the STI subcommittee include increasing public engagement and education about STI prevention, educating HIV and non-HIV providers about taking sexual history, and increasing 3-site testing for all sexually active patients. **Questions and Comments** - A QAC member commented that sexual activity screenings should be specified, noting that there is a difference between asking "are you having sex?" and "what kind of sex are you having?" - Dr. Gonzalez replied that the state is doing trainings for providers on how to ask these questions. A lot of these screenings take place in private practices, not clinics. Not much has been done since 2011. 3-site testing is a must; this was spoken of during the VBP discussion. - A QAC member agreed that now is a good time for an STI committee. 3-site testing was included in HIVQUAL several years ago and the results were poor. Dr. Gonzalez added that certain labs couldn't even do 3-site testing. Most people are only just now able to access the test. - Dr. Gonzalez recommended the committee to obtain solid data on STI rates and HPV vaccine rates. - A QAC member brought up the issue of EMR documentation, noting that the models she has seen are very poor. Information must be captured in a standard way. How do we connect PrEP to this? How are we tracking STIs so we can better connect people to PrEP? - Dr. Gonzalez acknowledged that PrEP and STIs are not mutually exclusive, and said we have to revisit how people are trained in this intrinsic part of life which many were excluded from. It's always been "use your condoms" and don't talk about this. That has to change. - Dan Tietz commented that additional data needs to be captured if you are offering medication for STIs. - Dr. Kerr asked if there was any messaging such as "ask your doctor about STI protection" incorporated as a routine part of care. - Charles emphasized the importance of treating sex as a healthy activity and its intrinsic connection to stigma work and HIV care. - Dr. Kerr spoke of the need to bring this message into the larger world, not just the HIV community. PrEP initiation must also be disseminated as well. Dr. Gonzalez asked for the STI subcommittee to work on this within the frame of their control, on an ongoing basis. - A QAC member remarked that at her facility, emergency room doctors were asking for a clear way to connect patients who are STI positive to stronger care. She was surprised that ER doctors were asking for this. - Dr. Kerr remarked that the message is diffusing much more slowly than she expected.	

	- Another QOC member offered her opinion: The world has really changed from the consumer and clinician perspective. EDs were very resistant 7-8 years ago. Starting with the smaller HIV subpopulation is helping transform the system as a whole in a more doable way. - Dr. Gonzalez reminded the group that the big 3 STIs (syphilis, chlamydia, and gonorrhea) are largely asymptomatic. For years they've done symptomatic treatment, but in this day and age, screening is more important than ever.	
Closing Remarks *Dr. Kelly Ramsey and Dr. Christine Kerr, QAC Co-Chairs*		