HIV Quality of Care Clinical Quality Advisory Committee Meeting

55 Exchange Place, New York, NY
September 12, 2019 | 9:00AM – 12:30PM

AGENDA ITEM/TOPIC	DISCUSSION/ACTION ITEMS
Welcome and Announcements *Dr. Kelly Ramsey and Dr. Christine Kerr, QAC Co-Chairs*	- Dr. Kelly Ramsey and Dr. Christine Kerr welcomed attendees.
CAC Update *Dana Diamond and Leanna Thornton, CAC Co-Chairs*	- Dana Diamond and Leanna Thornton recapped the CAC meeting earlier in the day: o Lailani Muniz reported on her experiences at the United States Conference on AIDS (USCA) on September 5-8. o Dr. Eugenia Siegler presented on empowering older adults living with HIV to manage their health. o Rob Curry presented on PrEP Aware Week resources, materials, and regional kick-off events taking place from Oct. 20-26. o The members gave general feedback on the four subcommittees, how the first planning calls went, and their preliminary goals. o There was brief discussion about a full day CAC meeting in December.
Introducing the QAC/CAC Subcommittees *Courtney Ahmed, AIDS Institute*	- Courtney Ahmed presented on the subcommittees' preliminary goals developed during their first planning calls. - Dr. Charles Gonzalez explained that the purpose of the subcommittees is to provide greater room for brainstorming and implementation outside of quarterly meetings. Discussion and work will take place prior to quarterly meetings and then be presented to the larger group so they can decide whether to implement the strategy or let the subcommittees pilot it first. - Michelle Lopez noted the need for a new quality indicator on aging with HIV. People living with HIV should have geriatric screenings around ages 50 to 55. She also noted the importance of care coordination and the need for all clinicians to communicate. - Stigma o Focusing on sharing best practices from experts, seeking youth and consumer input, and including additional populations like those aging with HIV, immigrants, and black and Latina women. o New CAC co-chair is Roland Marrero. - Tobacco o Focusing on marijuana and tobacco, understanding why people smoke and perceived benefits, utilizing surveys and/or focus groups, challenging e-cigarette use and vaping in light of CDC investigation, and developing patient-centered response tailored to individual's smoking rates. o Must spread the message that vaping is not a viable alternative to quitting. o One new member, Brandan Campbell.

	- HIV/HCV
	  o Focusing on eliminating HCV co-infection and mono-infection, working with agencies to develop cascades for HCV, improving tracking documentation, and increasing funding for linkage and retention.
	  o A challenge is thinking about how to improve on DOH efforts currently in place.
	  o How do we address stigma associated with reinfection?
	  o Two new members, Brandan Campbell and Sam Dien.
	- STIs
	  o Focusing on evaluating use of HPV vaccine in HIV care facilities, extragenital testing requirements, and promoting understanding of sexual health and safer sex techniques in light of U=U.
	  o One new member, Sam Dien.
	  o Dr. Margie Urban noted that the goals are preliminary since the STI subcommittee has not held their first planning call yet due to scheduling conflicts.
	  o Ms. Thornton suggested looking at the correlation between sex education in high schools and STI rates.
	  o Dr. Peter Gordon noted a pilot for PrEP in high schools and suggested looking at school-based healthcare clinics which do not have to follow Department of Education rules.
	  o Dr. Urban noted that nurses at school-based health clinics are considered educators.
	  ▪ School-based health nurse organizations have their own conferences, and the nurses may be willing to participate in surveys.
	  o Dr. Kerr also recommended urgent care for STIs.

Micro-Elimination Approach: Eliminating Hepatitis C in New York State *Shannon Mason, AIDS Institute*	- Shannon Mason shared the NYS Hepatitis C Elimination Task Force's micro-elimination approaches, which break down broader goals into smaller goals for individual population segments. - Data is relatively limited because the surveillance system for hepatitis C (HCV) is not as robust compared to that of HIV. - Trends have shifted toward a younger generation associated with injection drug use and the opioid epidemic. - USPSTF recently put out draft recommendations to expand testing to ages 18-79. Access to treatment is also expanding through Medicaid criteria, allowing general practitioners to provide care, not just HCV specialists. - The Task Force has received 5 million dollars to expand prevention, outreach, screening, care and treatment in NYS. - Goals include maintaining staffing, looking at linkage to care upon release, providing wraparound services to connect care, building provider capacity to respond to needs, and building more robust surveillance infrastructure in the coming year. - Co-location services enhance engagement and completion of treatment. The cure rate for people on treatment is 98%. - The Task Force currently supports rapid testing kits. Dry blood spot testing eliminates the second step which is difficult for patients to complete. - Priority populations include people who use drugs, currently or formerly incarcerated, baby boomers, unstably housed, and HCV/HIV co-infected individuals. - Priority settings include correctional facilities, harm reduction programs, drug/substance treatment programs, homeless shelters, primary and routine healthcare offices, community health providers, and FQHC. - NYC HCV elimination targets by 2030 include:

	○ 90% reduction in total viremic (RNA) prevalence, 80% reduction in new infections, 65% reduction in liver-related mortality, 90% diagnosis of viremic infections, and 80% of diagnosed patients initiated on treatment. - Task force recommendations include: ○ Testing all PLWH for HCV at baseline, screening high-risk populations for HCV at least annually, testing all pregnant individuals for HCV, and treating all persons chronically infected with HCV. - Comments: ○ Dr. Gordon reported that his hospital lowered the testing age to under 18 and saw their testing for HCV go up by 1600%. 'Nudge' reports are sent out monthly to providers. ○ Stigma is a significant barrier to treatment, particularly for active drug users and the unstably housed. Providers do not have enough knowledge to overcome these barriers. ○ Stigma is only part of the problem; a different model of care and enhanced coordination is needed. ○ Ms. Lopez suggested utilizing certified peers. ○ Dr. Gordon suggested piloting a program with a field-based team. The same approach for HIV – setting up notifications when a person touches the system – should be used for HCV to get those missing back into care.
Update on Value Based Payment and STI Measures *Dr. Doug Fish, NYSDOH*	- Dr. Doug Fish, NYSDOH, provided an update on value-based payment and STI measures. - Two major changes were made to HIV/AIDS VBP arrangement based on providers' feedback at the June QAC meeting: ○ STI screening measure switched from pay for performance to pay for reporting. ○ This leaves one choice for HIV pay-for-performance measure: VLS - Change in numerator for STI screening measure: ○ HIV+ MSM and/or transgender patients who had one or more genital, rectal, AND pharyngeal screenings (3-site testing) ○ For HIV+ men and women, numerator compliance is still genital screen only - Ms. Lopez and Katrina Balovlenkov stated that women who don't fall into the targeted population should still be asked if they need 3-site testing. - Joe Pirone expressed concerns that under pay for performance, services will be cut from people or be incomplete. Dr. Timothy Kanter also expressed concerns that the concept encourages providers to choose healthier patients. ○ Dr. Fish explained that individual needs will be decided by the patient and doctor and that the payment reform creates opportunity for quality improvement. Following the guidelines improves care, which then creates savings in the healthcare system. The dollars are then shared with the provider to improve services. ○ Dr. Gordon stated that currently, there's no incentive for hospitals to care for people out of care. VBP changes that so that money is made when the population is healthy. Providers take a hit when the patient is out of care. - A member commented that it is hard to determine transgender categories based on EMR. - Eunice Casey asked if STI screening measures can apply to the general population, not just HIV. - Dr. Gonzalez asked if HPV vaccination could be a measure for the general population. - Ms. Lopez stated that aging is a measure that consumers want to see.

2018 Organizational Treatment Cascades
Chris Wells, AIDS Institute
Jasmine Javier, Urban Health Plan
	- Chris Wells presented an overview of the 2018 organizational treatment cascade review, including preliminary data.
	  o Dan Belanger noted some sites have not yet submitted their cascades.
	  o Cascade review history
	  - HIV quality of care cascade review began in 2016 with eHIVQUAL.
	  - In 2017, there was an increased emphasis on treatment cascades and detailed reporting.
	  - In 2018, the review added patient-level information and QI planning.
	  o Key component: how data collected
	  o Review of 2018 data
	  - As of 8/7/2019, 74 of 79 requested submissions have been received.
	  - NYC Health + Hospitals submitted in a different format.
	  - 84 total organizations, including 225 clinics providing HIV-specific care and 94,382 patients.
	  o Duplicate patients are possible.
	  o Highlights
	  - Patients categorized as established active, open inactive, newly diagnosed and other new to care.
	  - Incarcerated, relocated, receiving ongoing external HIV care in NYS and deceased patients as of 12/31/18 were excluded.
	  - There was a significant number of unknown entries for patient characteristics
	  - There was a slight increase in viral load suppression rates for established active patients from 2017 to 2018.
	  - Dr. Gonzalez noted that rapid initiation of anti-retroviral treatment led to high 90-day linkage to care rates for newly diagnosed patients.
	  - Viral load suppression rates were lower for black/African-American and perinatally infected patients.
	  o They were also lower for unstably housed than stably housed patients.
	  - Of the 24,000 unique inactive patients, 6000 of them were identified as being in care elsewhere.
	  - There is a positive association between larger clinics and higher suppression rates, while there is a much weaker relationship between larger clinics and newly diagnosed and new to care patients.
	  o Therefore, having more patients does not necessarily help with viral suppression.
	- Jasmine Javier, HIV Coordinator, presented Urban Health Plan's 2018 HIV organizational treatment cascade.
	  o Highlights
	  - The Institute for The Advancement of Community Health (IACH) is Urban Health Plan's QI department.
	  o Trains staff in performance improvement
	  o Uses evidence-based QI models
	  - After drilling down their 3-day linkage to care rates, it was discovered that progress is impeded by inability to reach patients to give results.
	  o In other cases, patients do not come in as quickly as they said they will.
	  - Urban Health Plan (UHP) has four HIV primary care sites, but 2018 is the first year CitiCares was included in their cascade.

	o CitiCares was acquired in 2017, and staff calculated CitiCares's data on its own. o CitiCares increased from 57 percent in 2017 to 75 percent in 2018. o All staff was retained, and team-based care was implemented. o Viral load suppression increased or maintained 100 percent at all sites. o Harlem site is primary referral site for housing. - Successful strategies to achieve viral load suppression: o Motivational interview training for all staff o Partnered with Gilead to offer internal HIV training series o Team-based care o Drill down data to identify targeted interventions o Social workers see every HIV positive patient and unsuppressed patients are seen more frequently o Patient feedback helped start healthy cooking class in UHP's demonstration kitchen, "La Cocinita" o Patients are not interested in formal CABs so UHP must find innovative ways to involve consumers - Following the presentations, there was a discussion about the usefulness of the cascade review HIV indicators. o About half of the providers found the cascade useful for QI work, and the other half did not. Ms. Javier stated that the template is a good tool for reporting and presenting and allows them to take a deeper look at data that isn't normally looked at. Ms. Casey stated it is difficult for larger sites to use it for QI work and there is an opportunity cost of taking extra time to complete it. o The HIV cascade review is primarily designed to aid quality improvement and align the two processes of data reporting and QI work so that QI work is not retrospective. - The goal is for sites to look at their own data to develop quality plans to look at individual subpopulations. o Dr. Sam Merrick noted that the HIV cascade review and eHIVQUAL have pushed the quality of HIV care to meet the standards. o Members expressed a desire to continue discussion about the cascade review HIV indicators. The discussion will be placed on the QAC agenda for December.
Drug User Health at Hudson River Healthcare *Dr. Kelly Ramsey, Hudson River Healthcare*	- Dr. Ramsey did not present due to insufficient time.
Integrase Resistance Testing *Zhengyan Wang, PhD, NYSDOH*	- Dr. Zhengyan Wang, NYSDOH, presented on integrase resistance testing data and current trends. - With widespread use of integrase strand transfer inhibitors (INSTIs), concerns of transmitted integrase drug resistance and virologic failure are rising. It is important to utilize data to monitor integrase resistance. - Overall, clinician ordering of initial resistance testing lags current treatment guidelines. - It is required in NYS to obtain integrase (IN) testing at diagnosis, but 40% of newly-diagnosed patients do not get tested for resistance. A person with a later diagnosis has less chance of being IN-tested.

	- % of persons with initial IN test was lower in non-Hispanic blacks compared to non-Hispanic whites. - Among those who had initial IN testing, 24 showed resistance (0.7%). Resistance is low in NYS. - Data shows highest resistance to the 2 drugs EVG and RAL. Most prevalent mutations are E157Q, L74M/I, T97A, G163R/K, H51Y. - Resistance takes 4-5 years to appear in the population. - Immediately following diagnosis, it is crucial for clinicians to order resistance testing in general, and IN testing in particular, to make an informed treatment decision.
Working Lunch and Closing Remarks *Dr. Kelly Ramsey and Dr. Christine Kerr, QAC Co-Chairs*	