NEW YORK STATE | Department of Health | Medicaid Redesign Team

# HIV/AIDS

## Clinical Advisory Group

Meeting Date: October 1

October 2015

# Content

Tentative Meeting Schedule and Agenda

A. Recap of Last Meeting
B. ACO Model Overview
C. Introduction of Business Case
D. AIDS Institute – The New York State HIV Quality of Care Program
E. Outcome Measures

# A. Recap of last meeting

# Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will likely consist of the following:

**Meeting 1**

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- Contracting Chronic Care: the Different Options
- Examples of VBP
- Introduction to Outcome Measures
- Introduction to Ending the Epidemic

**Meeting 2**

- Recap of Last Meeting
- Use of PACs for HIV/AIDS
- ACO Model Overview
- Introduction to Business Case
- AIDS Institute – The New York State HIV Quality of Care Program
- Discussion of Interventions
- Outcome Measures

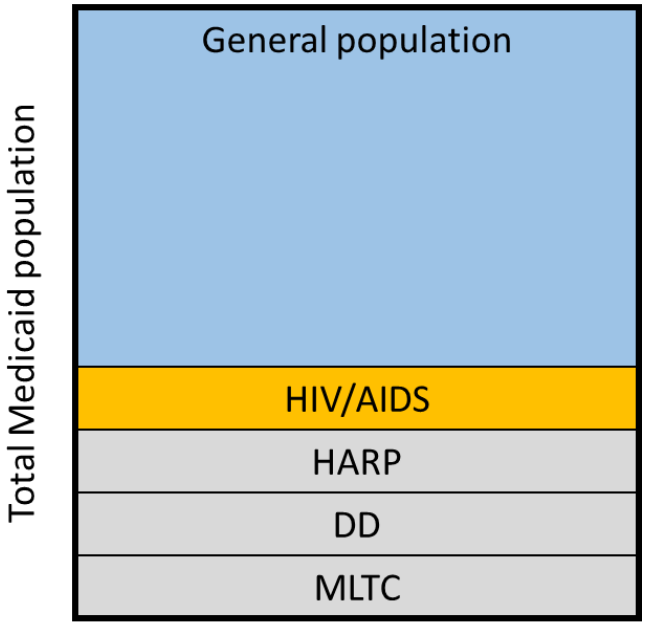
**Meeting 3**

- HIV/AIDS Outcome Measures
- Wrap-up of Discussion of Interventions
- Wrap-up of open questions

# Recap of last meeting

## HIV/AIDS population

- Four subpopulations are carved out of the total Medicaid populations
- HIV/AIDS is one of those subpopulations




## Value Based Payment (VBP)

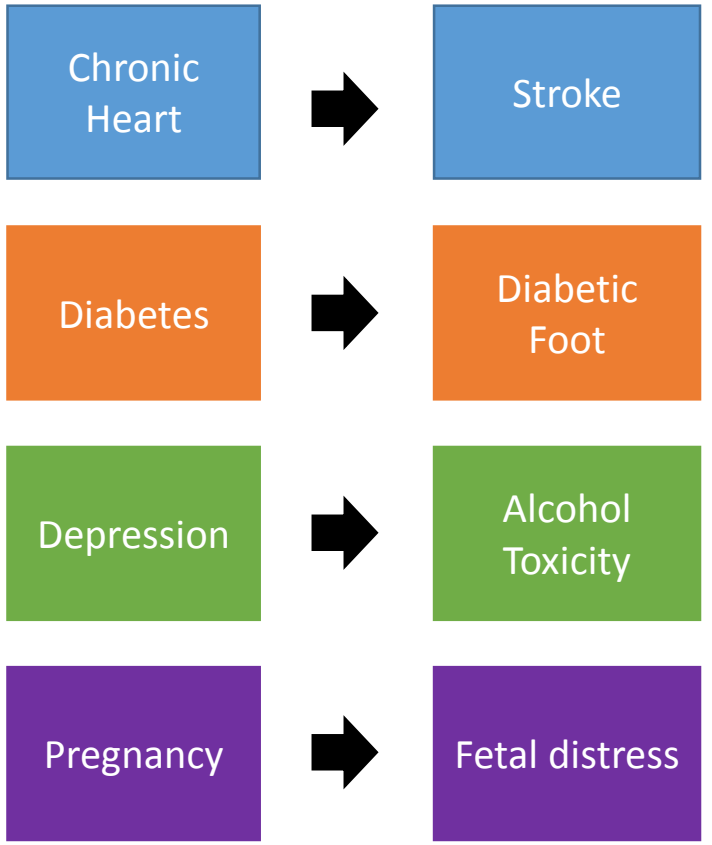
- Reward value instead of volume
- Different levels of VBP: variation in risk-sharing for the provider
- Provider groups will be responsible for total cost of all HIV/AIDS patients attributed (MCO attributes patients to provider group)
- Challenge for provider group: lowering total costs PMPY by
  - 1) finding where the 'waste' in the system is and
  - 2) improving outcomes of care
  - 3) investing smartly

# Great example of reducing costs by improving quality: focus on Potentially Avoidable Complications (PACs)

**Recap from last time**

- Care for a specific condition may be divided into 'typical' care or 'potentially avoidable complications'
- PACs can stem from poor care coordination, failure to implement evidence-based best practices or medical errors
- Not all PACs may be prevented, but avoiding PACs creates opportunities to achieve savings.
- Only events that are generally considered to be (potentially) avoidable by the caregivers that manage and co-manage the patient are labeled as 'PACs'

Examples of PACs



# PACs and the HIV/AIDS Population

- 'PACs' is a concept that is rapidly getting traction
- Key is reliance on readily available data
- Suggestion: create suggested HIV/AIDS PACs with a small subgroup
- Present selection to CAG
- Test during Pilot phase

# Recap of last meeting

**EtE (main goals)**

- Identify patients with HIV who remain undiagnosed and link them to health care.
- Link and retain individuals diagnosed with HIV to healthcare and engage/retain them on anti-HIV therapy to maximize HIV suppression.
- Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk individuals to keep them HIV-negative.

**Opportunity Value Based Payment (VBP) incorporating EtE**

- DOH has embraced the opportunity to make the End of the Epidemic initiative part and parcel of the HIV/AIDS VBP initiative

# Are there Any Questions, Comments or Suggestions Based on the Content of the First Meeting?

**HIV/AIDS CAG Meeting 1 Agenda Items**

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- Contracting Chronic Care: the Different Options
- Examples of VBP
- Introduction to Outcome Measures
- Introduction to Ending the Epidemic

# B. Introduction to the ACO Model, Including EtE

# HIV/AIDS VBP Arrangement with ETE Included

Three prongs:

1. Putting all known HIV/AIDS patients on ARVs

2. Outreach to find as yet unknown HIV/AIDS patients

3. PrEP

Fully fits HIV/AIDS ACO model: People on ARV will cost less. Is thus essentially self-funding. (See business case).

Innovative, but fully fits HIV/AIDS ACO model: every new HIV/AIDS case added brings another PMPY in ('casefinding'). Is thus essentially self-funding. (See business case)

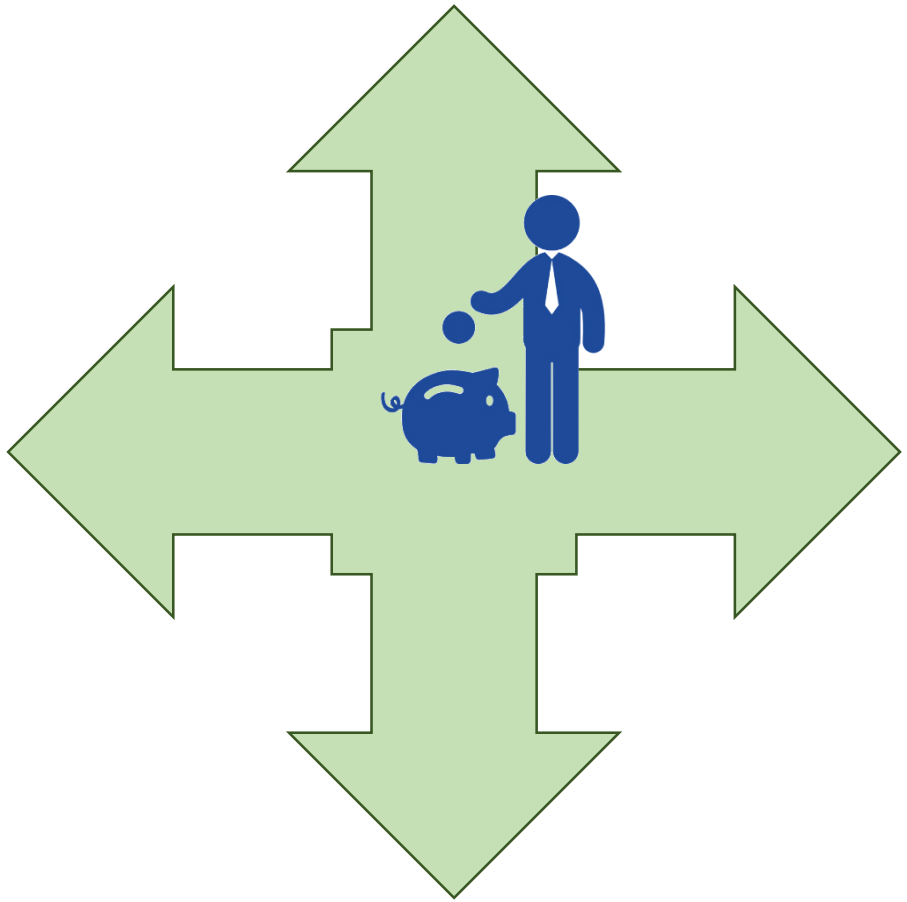
May not fit HIV/AIDS ACO model, because these individuals are not (and hopefully will never become) part of the HIV/AIDS subpopulation. Could remain FFS (volume is desirable). ACO could get additional reward for reaching quality targets.

This arrangement is limited to Medicaid-only beneficiaries (incl. those being enrolled during outreach etc). Other uninsured will still require additional funding from other sources. Duals & Medicare patients will hopefully soon be included as well.

# C. Introduction to the Business Case

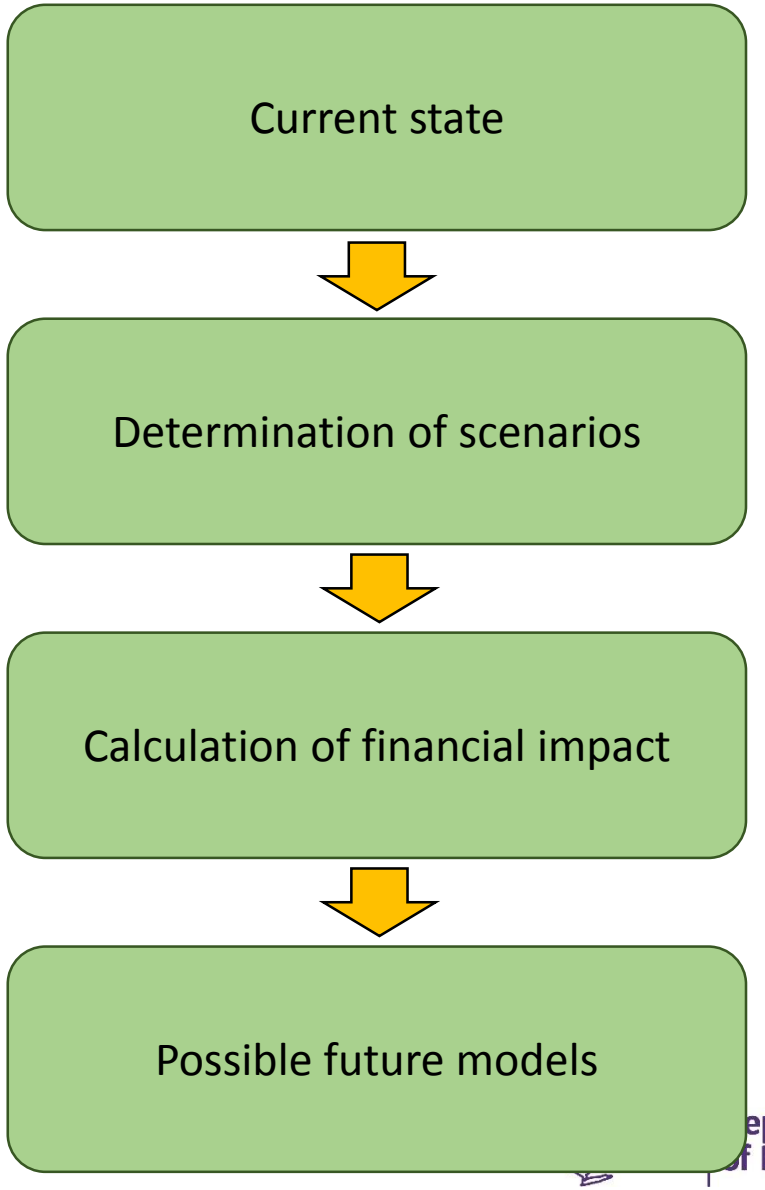
# Introduction to the Business Case

- The goal of the business case is to support decisions about investments by comparing (combinations of) interventions and their financial impact
  - Meeting the goals of EtE means fewer infections and lower healthcare costs
  - To reach these goals, interventions are needed
  - The effects of specific interventions will differ, as will the costs and investments needed



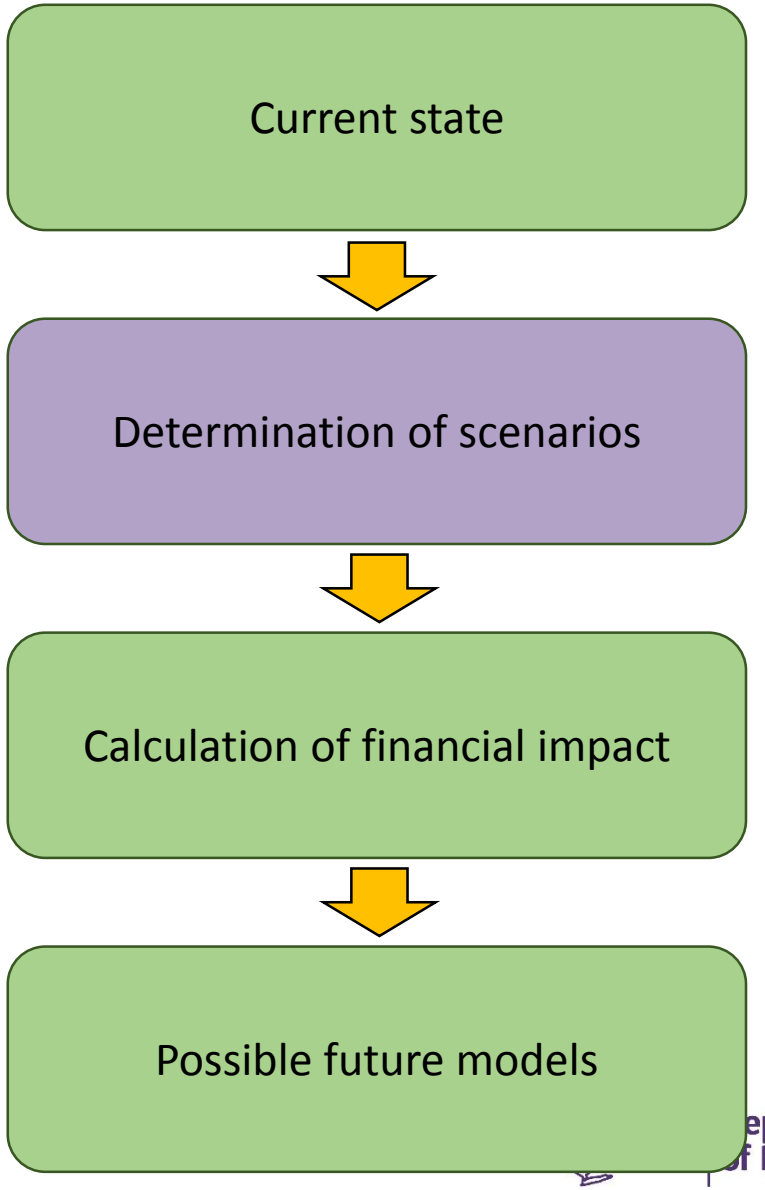
# Set Up of the Business Case

- Scenarios consist of (combinations of) interventions that will help reach the EtE goals
- Calculations will be based on research papers, input from the AIDS Institute, and founded assumptions
- In addition to the financial outcomes, possible future models and a current state description will be added



# Input for Building Scenarios

- Because of the extensive experience of this group in the HIV/AIDS field, we would like to use this opportunity to ask your input on suitable (combinations of) interventions
- First the AIDS Institute will present the New York State HIV Quality of Care Program
- Afterwards we will discuss the possible interventions to be included in the scenarios



# D. AIDS Institute – The New York State HIV Quality of Care Program

1. What interventions could help to identify patients who remain undiagnosed and link them to care?
2. What interventions would be useful to link and retain individuals diagnosed with HIV to anti-HIV therapy?
3. What interventions would help to facilitate access to PrEP and nPEP for high risk individuals?

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# The New York State HIV Quality of Care Program


**CAG**

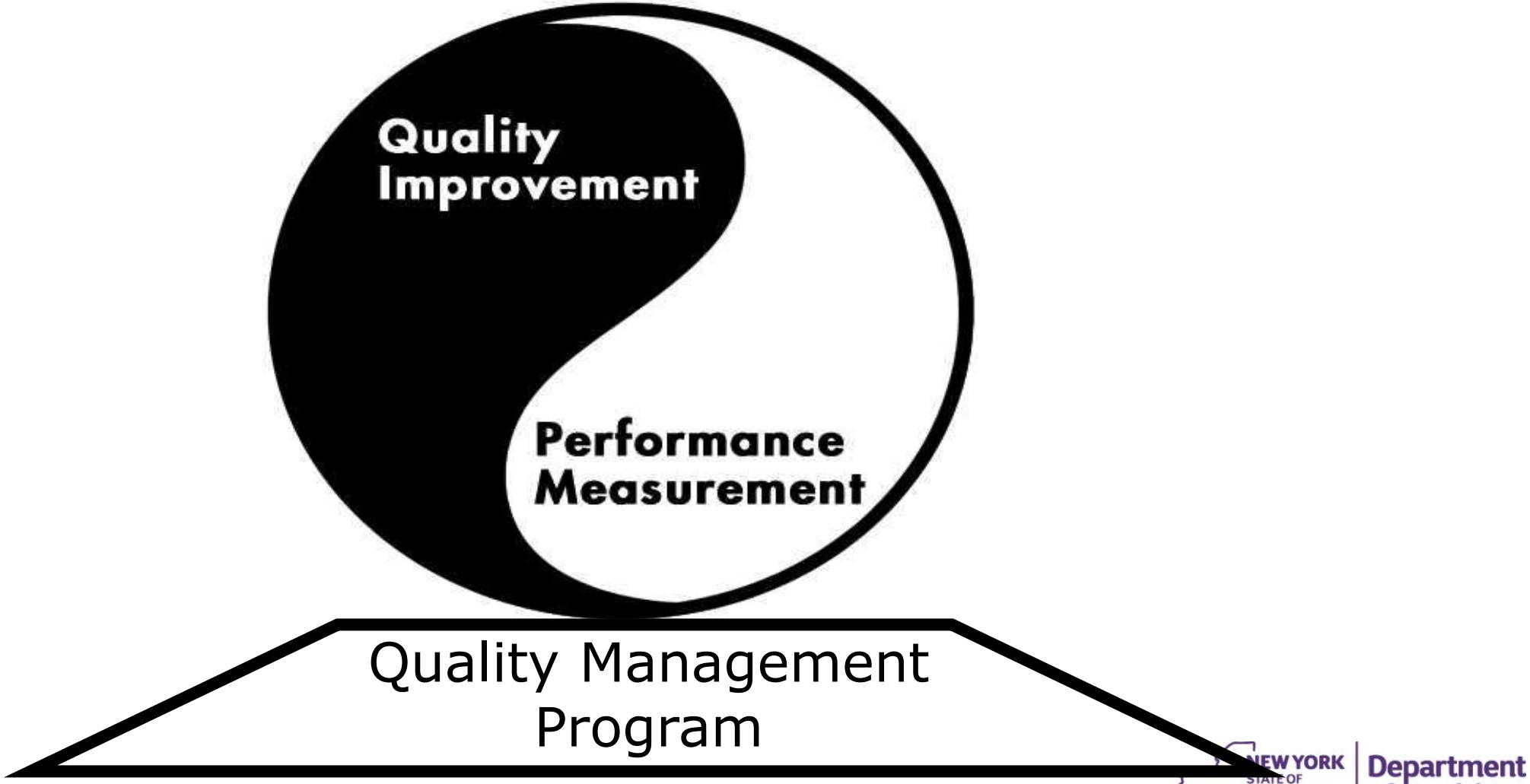
**KPMG**

**Bruce D. Agins, MD MPH**

**Medical Director, AIDS Institute**


**October 1, 2015**

# A Little Philosophy: Our Approach



# Performance Measurement

•Indicators are prioritized and developed by the provider and consumer advisory committees and then formally defined with specifications by AI staff.

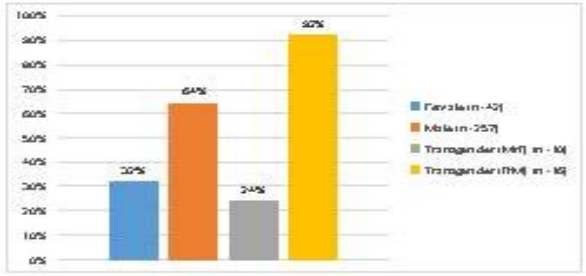
•Data are uploaded into eHIVQUAL, a web-based platform. Automatic reports can be generated at facility level to assess performance and define areas for improvement. Over 180 facilities currently submit data.

•Individual agencies are programming their EMRs to upload data directly.

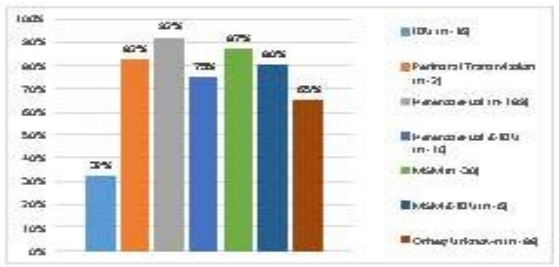
•A contract with Azara, aligned with work of CHCANYS, has resulted in programming of the CPCI to automatically produce reports and uploading of eHQ reports from EMRs for all participating providers.

# RETENTION DASHBOARD

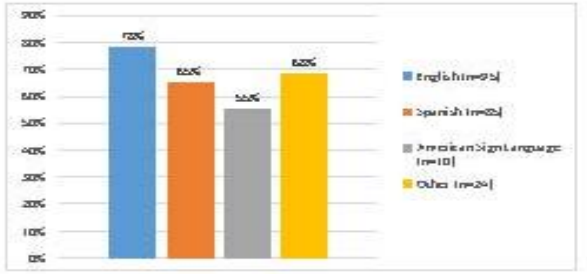
**Retention by Gender**



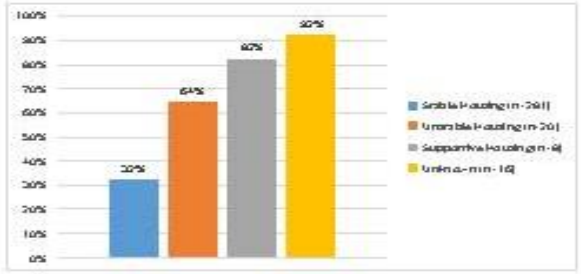
**Retention by Risk Factor**



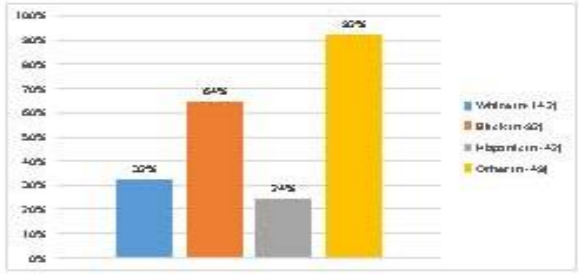
**Retention by Language**



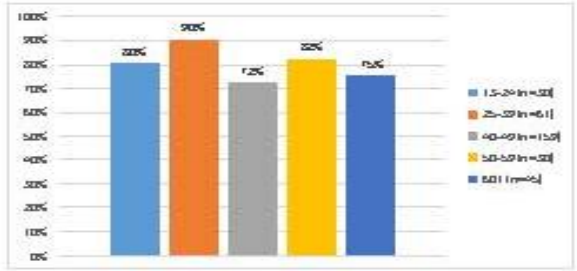
**Retention by Housing Status**



**Retention by Race**



**Retention by Age**



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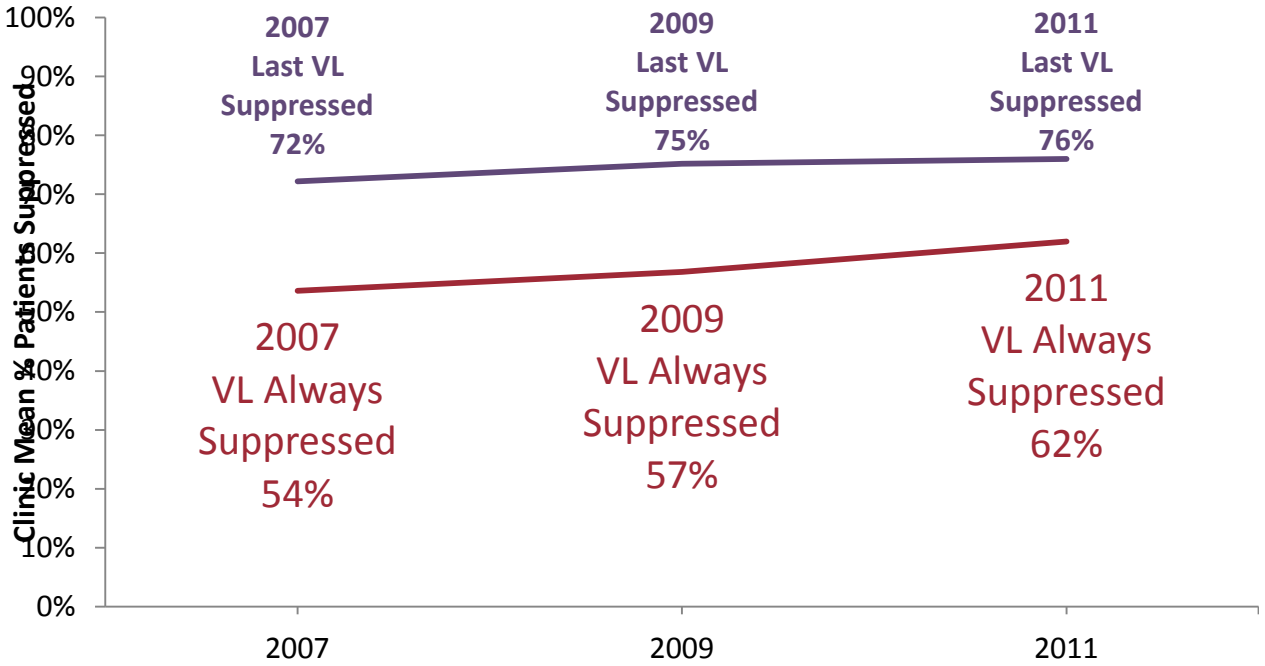
# Reports: Viral Load Suppression

## Last Viral Load Suppressed

| Clinics | Eligible Patients | Clinic Mean |
|---|---|---|
| 179 | 8089 | 76% |




| Program Name | 2007 | 2009 | 2011 |
|---|---|---|---|
| All NYS Reporting Clinics | 7773 | 8885 | 8804 |
| Addiction Research and Treatment Corporation - Bushwick | 14 | 10 | 10 |
| Addiction Research and Treatment Corporation - East New York | 22 | 21 | 16 |
| Addiction Research and Treatment Corporation - Fort Greene | 26 | 29 | 28 |
| Addiction Research and Treatment Corporation - Highbridge | 9 | 14 | 12 |
| Addiction Research and Treatment Corporation - Kaleidoscope | 15 | 14 | 10 |
| Addiction Research and Treatment Corporation - Starting Point | 29 | 25 | 28 |
| Addiction Research and Treatment Corporation - Third Horizon | 8 | 9 | 9 |
| AIDS Care | | 82 | 91 |
| AIDS Community Services of Western New York - Evergreen | 80 | 76 | 82 |
| Albany Medical College - AIDS Treatment Center | 100 | 97 | 101 |
| Albany Medical College - Mid-Hudson Care Center | 58 | 56 | 59 |
| All Med M&R of New York - 3rd Avenue Site | 22 | 67 | 58 |
| Ambulatory Surgery Center of Brooklyn | 77 | 60 | 60 |
| Anthony L. Jordan HC | 19 | 41 | 70 |
| Arnot Ogden Medical Center - Ivy Clinic | 63 | 61 | 68 |
| Asian and Pacific Islander Coalition on HIV/AIDS Primary Care | 30 | 47 | 70 |
| Bedford Stuyvesant Family HC - Main Site | 28 | 55 | 58 |
| Betances HC | 42 | 37 | 40 |

# eHIVQUAL 2014: ETE Indicators

# 2014 Performance Report Measures

- **Viral Load Suppression**
  - Suppressed at Last VL of Review Period
- **ART and Baseline Resistance Testing**
  - Prescribed Antiretroviral Therapy
  - Baseline Resistance Test
- **Retention**
  - Visit Frequency (12 months) (all patients)
  - Visit Frequency (24 months)
  - New Patient Visit Frequency

# STIs

- **Sexually Transmitted Infections: Gonorrhea and Chlamydia**
  - Genital Gonorrhea and Chlamydia Testing
  - Rectal Gonorrhea & Chlamydia Testing Among MSM and MtF Transgender Patients
  - Pharyngeal Gonorrhea Testing Among MSM and MtF Transgender Patients
  - Gonorrhea Treatment
  - Chlamydia Treatment

# Smoking Cessation Campaign

- **Tobacco Use Screening and Cessation Counseling**
  - Tobacco Use Screening
  - Tobacco Cessation Counseling

# Additional Measures from 2013 Performance Report

- **Sexually Transmitted Infections**
  - Syphilis Testing
  - Syphilis – Treatment for Positives
- **Sexual History Taking**
  - Sexual History Taking
  - Anal Sexual History Taking
  - Oral Sexual History Taking
  - Genital Sexual History Taking
- **Hepatitis C (HCV) Screening & Management**
  - Hepatitis C (HCV) Status
  - Hepatitis C (HCV) RNA Assay for Positives
  - Hepatitis C (HCV) Further Evaluation of RNA Positive Patients
  - Hepatitis C (HCV) Retest for Negatives, High Risk
- **Gynecology Care – Pap Test**
  - Gynecology Care – Pap Test
- **Mental Health Screening & Treatment**
  - Mental Health Screening
  - Mental Health – Referral for Treatment Made
  - Mental Health – Appointment Kept
- **Substance Use Screening & Abuse Treatment**
  - Substance Use Screening
  - Substance Abuse Treatment for Current Users
  - Substance Abuse Treatment for Past Users
- **PCP Prophylaxis**
  - PCP Prophylaxis
- **Mammography**
  - Mammography
- **Digital Rectal Exam**
  - Digital Rectal Exam
- **Anal Pap Test**
  - Anal Pap Test
- **Colon Cancer Screening & Follow-Up**
  - Colon Cancer Screening
  - Colon Cancer Screening Follow-Up
- **Diabetes Screening & Management**
  - Diabetic Control Among Diabetic Patients
  - Diabetes Screening
  - Diabetes Management – Serum Creatinine
  - Diabetes Management – Retinal Exam
- **Care Coordination – Patient Involvement**
  - Patient Involvement in Care Coordination Planning

# Health Data NY

Open.ny.gov | Health Data NY | Health.ny.gov | Developers | Help

## HIV Ambulatory Care Quality of Care Performance Results Map: 2011

Based on HIV Ambulatory Care Quality of Care Performance Results: Beginning 2011

This map displays the location and performance data for all participating clinics. The view defaults to a high-level map of the Eastern United States with the entire HIVQUAL data set

Manage | 2 More Views | Filter | Visualize | Export | Discuss | Embed | About

Find in this Dataset


| | Program Name | Address | City | ZIP | Year | Region | Indicator Name | Eligible Patients | Indicator Value | Quintile | Facility Type | Location |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 407 | Betances Health Center | 280 Henry St | New York | 10002 | 2011 | Manhattan | Health literacy screening | 46 | 80.4% | | Community Health Center | (40.7138936 |
| 408 | Betances Health Center | 280 Henry St | New York | 10002 | 2011 | Manhattan | General patient education | 46 | 93.5% | | Community Health Center | (40.7138936 |
| 409 | Betances Health Center | 280 Henry St | New York | 10002 | 2011 | Manhattan | Prevention education | 46 | 91.3% | | Community Health Center | (40.7138936 |
| 410 | Beth Israel Medical Center - Peter Krueger Clinic | 317 East 17th Street, Fierma | New York | 10003 | 2011 | Manhattan | Suppressed on last viral load | 91 | 87.9% | Second | Designated AIDS Center | (40.7339740 |
| 411 | Beth Israel Medical Center - Peter Krueger Clinic | 317 East 17th Street, Fierma | New York | 10003 | 2011 | Manhattan | Viral suppression (always) | 91 | 80.2% | First | Designated AIDS Center | (40.7339740 |

# Quality of Care Standards:

To guide providers in their establishment of sound quality management programs, the AIDS Institute has issued Quality of Care Program Standards that outline the expectations for HIV-specific quality programs.

# Quality of Care Standards: Infrastructure

**INFRASTRUCTURE:**

- Leadership
- Quality committee.
- Staff awareness with clearly defined roles in improvement activities.
- HIV quality management plan with a formal workplan.

# Quality of Care Standards:
# Measurement, Improvement, Staff Involvement

## PERFORMANCE MEASUREMENT

- Facility-defined  performance measures.
- Routine reporting with transparency of results throughout the agency.
- Information systems for tracking patients and monitoring quality of care.

## IMPROVEMENT ACTIVITIES

- Minimum of one annual improvement project.
- Improvement teams with cross-functional representation , including consumers.

## STAFF INVOLVEMENT

- Job expectations and descriptions require staff involvement in quality management activities.
- Staff participates in QI training opportunities.

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# Quality of Care Standards: Consumer Involvement

- Consumers are included in improvement activities and provide input into selection of improvement priorities

# Organizational Assessment

# OA Instrument and Process

- The scoring structure measures program performance in specific domains along the spectrum of improvement implementation.
- The OA is implemented in two ways:

    1) By an expert QI Coach

    2)As a self evaluation

- Leadership and staff should be involved in the assessment process to ensure that all key stakeholders have an opportunity to provide important information related to the scoring.

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# Specific Quality Areas Reviewed

- Quality Structure
- Quality Planning
- Quality Performance Measurement
- Quality Improvement Activities
- Staff Involvement
- Consumer Involvement
- Evaluation of Quality Program
- **Achieving Results**
- **Addressing the End of the Epidemic - New!**

# New OA Domain:  Ending the Epidemic

- Ultimate Goals (Scores 4-5)
  - Analysis of key sub-populations
  - Works with public health agencies and other large entities to determine if unretained patients are engaged elsewhere
  - Annual facility cascades that include testing and linkage rates within the institution, including EDs, inpatient units
  - Longitudinal cohorts to assess retention and suppression

# Regional Groups
# &
# Learning Networks

# Learning Networks

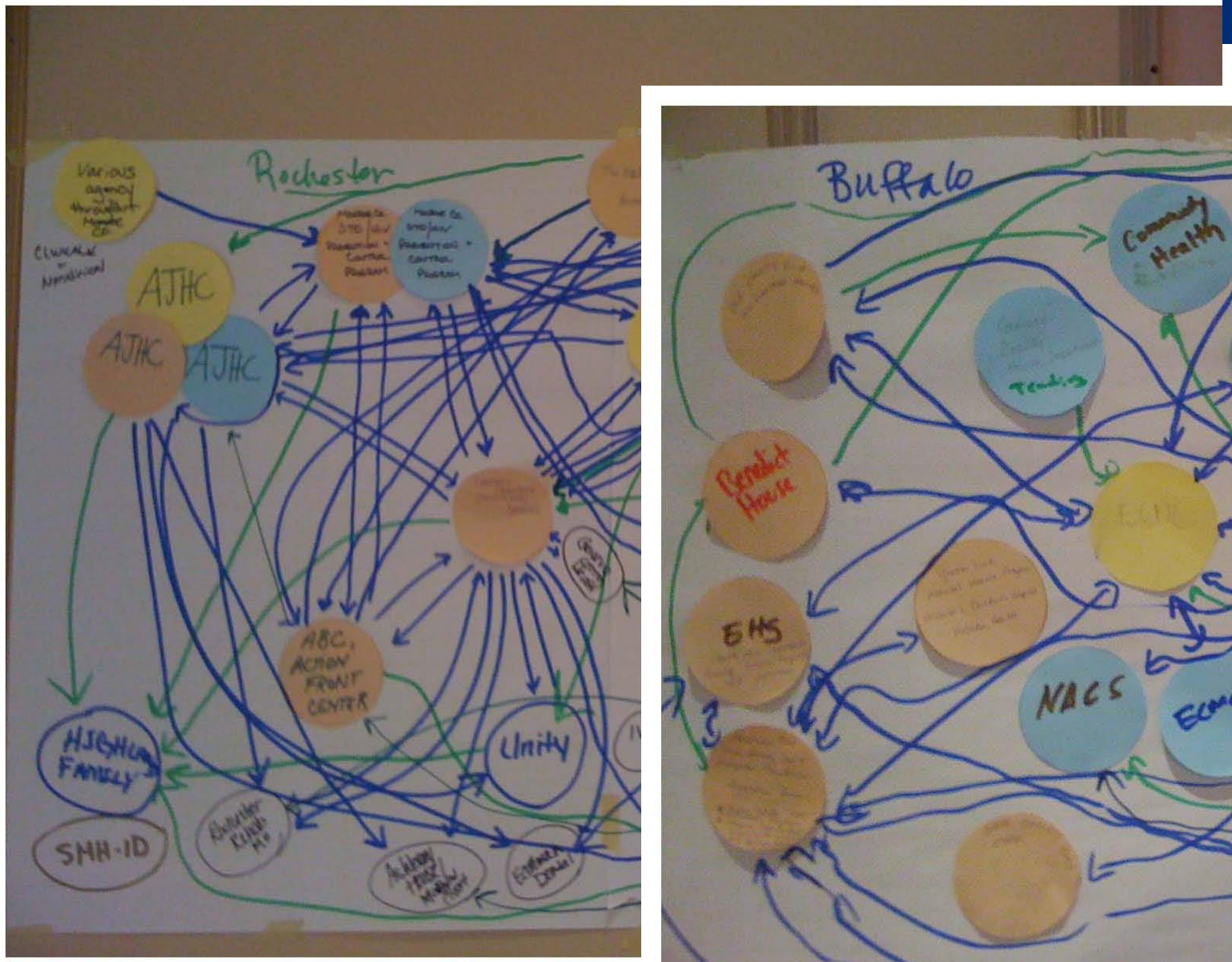
- Regional or provider affinity groups that join together and meet regularly to address quality, learn collaboratively, share successes and challenges in structured day-long or half-day meetings facilitated by an expert QI coach
- Supplemental training is integrated to advance QI and technical knowledge, e.g. interventions to improve retention or VLS

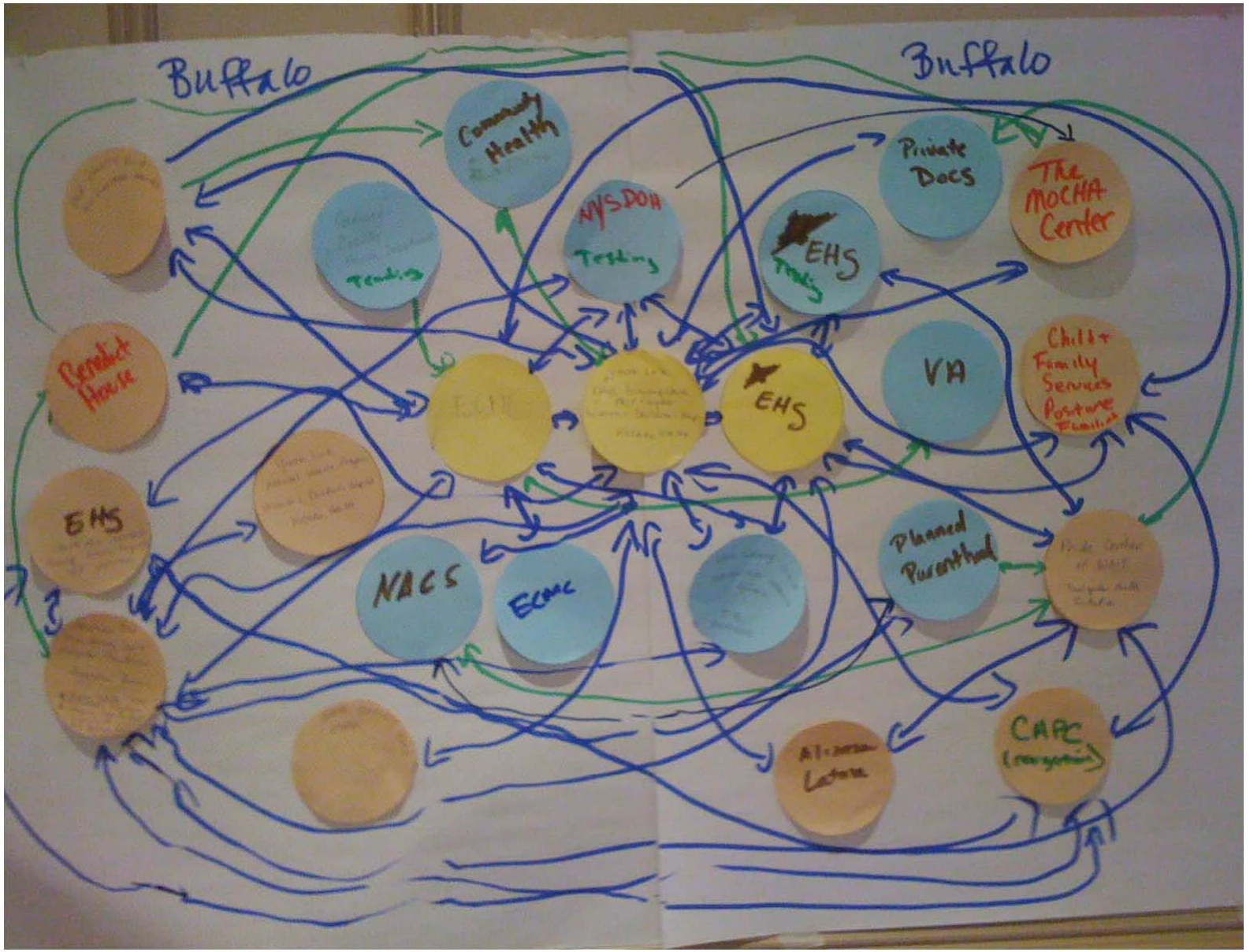
# Key Themes:
## *What does NYLinks Bring to the Table?*

- Using public health information for quality improvement
- Segmenting the cascade for action
- Involving communities to improve “their cascades” through use of improvement methods
- Spreading proven strategies
- Consistently linking HIV process improvement to population outcomes

# NYLinks:  Current Status of Implementation

- Upper Manhattan
- Western NY (Rochester and Buffalo)
- Queens
- Staten Island
- Mid-Hudson
- Long Island- just launched
- Central NY/Southern Tier – November
- Integration with Bronx Knows ----  Knows-Links


Various agency
Rochester
AJHC
AJHC
AJHC
ABC, Action Front Center
Unity
SMH-ID


Buffalo
Buffalo
Community Health
NYSDOH
Testing
Private Docs
The MOCHA Center
EHS
Testing
Benedict House
EHS
VA
Child + Family Services
EHS
NACS
ECMC
Planned Parenthood
CAPC

# Brief Overview of NY Links Measures:

## Quarterly reporting (CUNY)

| Measure | Agency Type |
|---|---|
| Linkage | All Programs that conduct HIV testing |
| Retention | HIV Clinical Care |
| New Patient Retention | HIV Clinical Care |
| Clinical Engagement | Supportive Services, General Medical & Dental Programs* |
| Viral Load Suppression | All Sites |

*Including those co-located within HIV clinical care sites*

# Long Term Strategies

- **Use NYS surveillance data** to make cascade data accessible to frontline providers for QI efforts and to compare against facility level reports
- **Involve providers and consumers** in planning and implementation of regional processes to build regional networks that improve outcomes along the cascade
- **Enhance** understanding of how facility and local data affect regional and statewide cascade results
- **Strengthen** partnerships and peer learning
- **Integrate NYLinks into the Ending of the Epidemic Initiative** through creating sustainable community groups to focus on implementing strategies to achieve goals

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# Who Is Not Suppressed and What Are We Doing about It?

## NYS Quality of Care Program Low Performer Initiative and Quality Learning Networks

*Thanks to Dan Belanger and an incredible team of Program Coordinators and Assistants*

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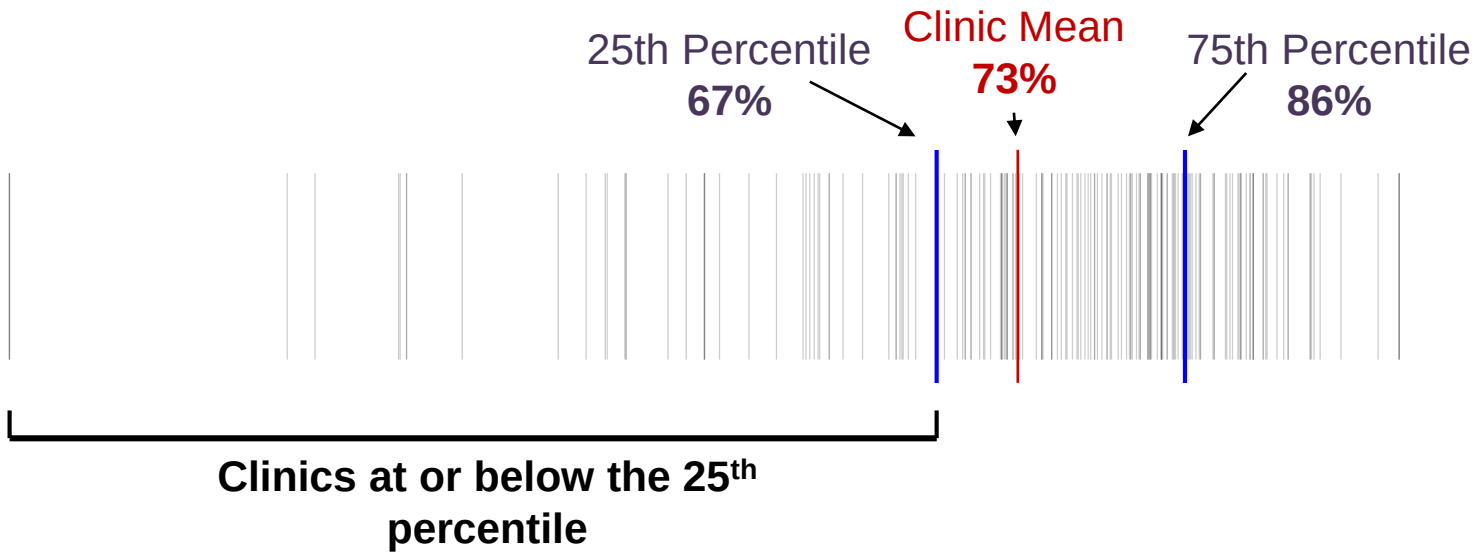
# Using Data to Drive Improvement: *Strategies*

- Focus on low performers
  - Lowest quartile performers targeted with letters requesting improvement plan for approval
  - Targeted coaching to improve performance
- Learning networks
- Sharing successes

# Viral Load Suppression Low Performer Initiative: 2013 eHIVQUAL

- Based on 2013 eHIVQUAL scores for Last Viral Load Suppressed




- **51 facilities across 25 organizations**
- **Targeted for intensive technical assistance and coaching**

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# Prioritization Tiers

## Tier 1: Non-Responsive/Resistant to Engagement & Lack Infrastructure for Quality

*Full scale "all-stops" approach to develop plans for each organization. Additional measures beyond normal technical assistance are needed.*

## Tier 2: Responsive/Engaged but Lack Infrastructure for Quality

*Prioritize these sites for technical assistance and follow-up.*

## Tier 3: Responsive/Engaged & Have Infrastructure/Capacity to Build Infrastructure for Quality

*These sites have been actively engaged in QI activities through learning networks and/or have demonstrated improvement in 2014. Activities will continue to be closely monitored with thorough follow-up and TA as needed.*

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# Process

- Sites received a formal email and letter from the AI Medical Director requesting an improvement plan by **June 1st, 2015**
- Sites work with QI Program Manager (Belanger) to develop improvement plans
- Medical Director and QI Lead review/approve submitted QI VLS plans

  → Many of these **report improvement** in 2014
- Each clinic is prioritized to receive an organizational assessment site visit and technical assistance/coaching as needed
- Clinics will be asked to provide quarterly status reports

# VLS Quality Improvement Plan

*Requests:*

1) More **recent VLS data**
2) **12-month goal** for viral load suppression rate
3) **Drill down patient care data** to understand barriers to VLS specific to the clinic's patient population and to inform improvement efforts
4) Develop **aim statement**, list **QI interventions**, and QI project **team members**

# Community Health Center Quality Learning Network Update

## 2014 + 2015 Updates

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# Project Goals (2014)

CHCQLN Viral Load Suppression Project participants focus and report on the following indicators: **VLS at last VL test**, **VLS at first VL test after receiving an intervention**, and **VLS at every VL test**

- Enroll 100+ new patients in the CHCQLN VLS Project
- Add 5+ Community Health Centers to the CHCQLN Viral Load Suppression QI Project
- Increase year-end VLS rate of those receiving QI interventions by 10% from 2013 results
- Maintain 80% VLS rate for patients who attained VLS after receiving a 2013 QI intervention

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# Results

| CHCQLN VLS Project Data (Unsuppresed Intervention Recipients) | Reporting Period | Received QI Intervention & VL Test | Suppressed at Last VL | Rate |
|---|---|---|---|---|
| | 2013 Final Cumulative | 283 | 160 | 56.54% |
| | 2014 Final Cumulative | 448* | 306* | 68.30%* |

| eHIVQUAL data | Year | Clinic-Wide VLS Rate on Last VL |
|---|---|---|
| | NYS 2013 | 74% |
| | CHCQLN Clinics 2013 | 78% |

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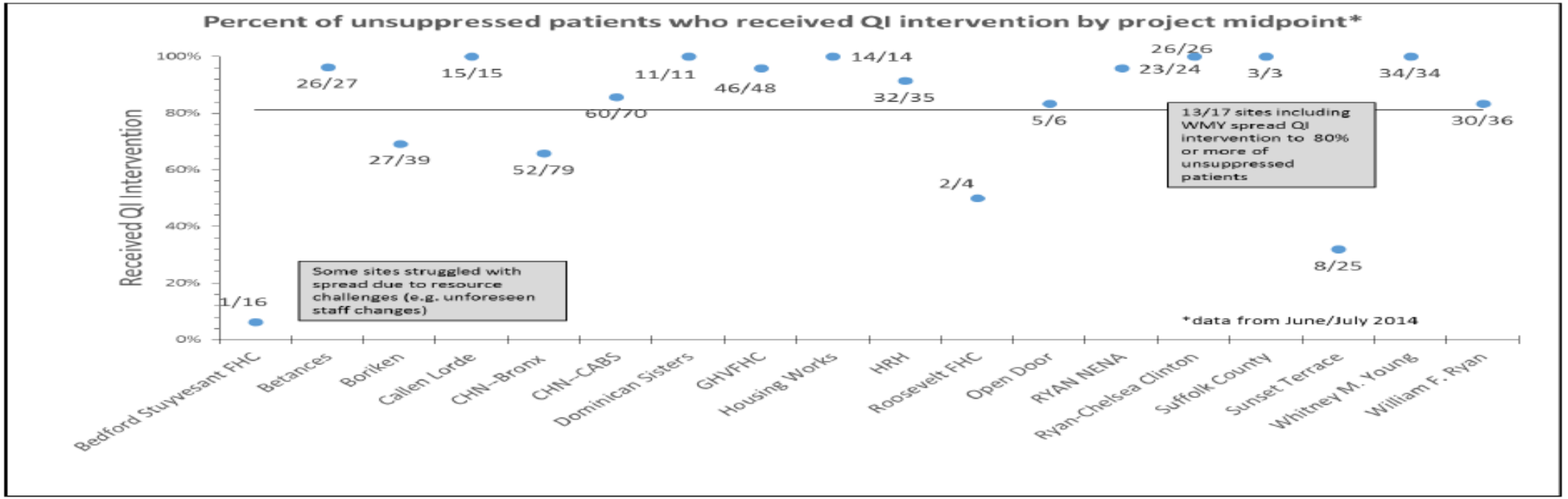
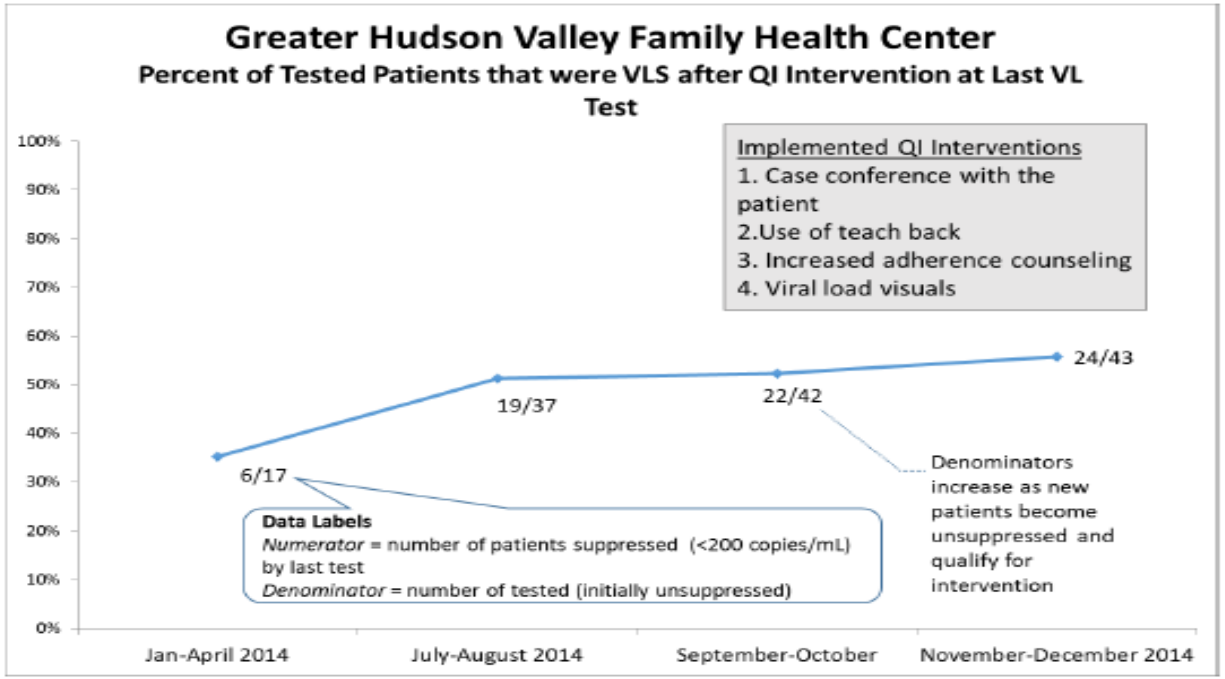
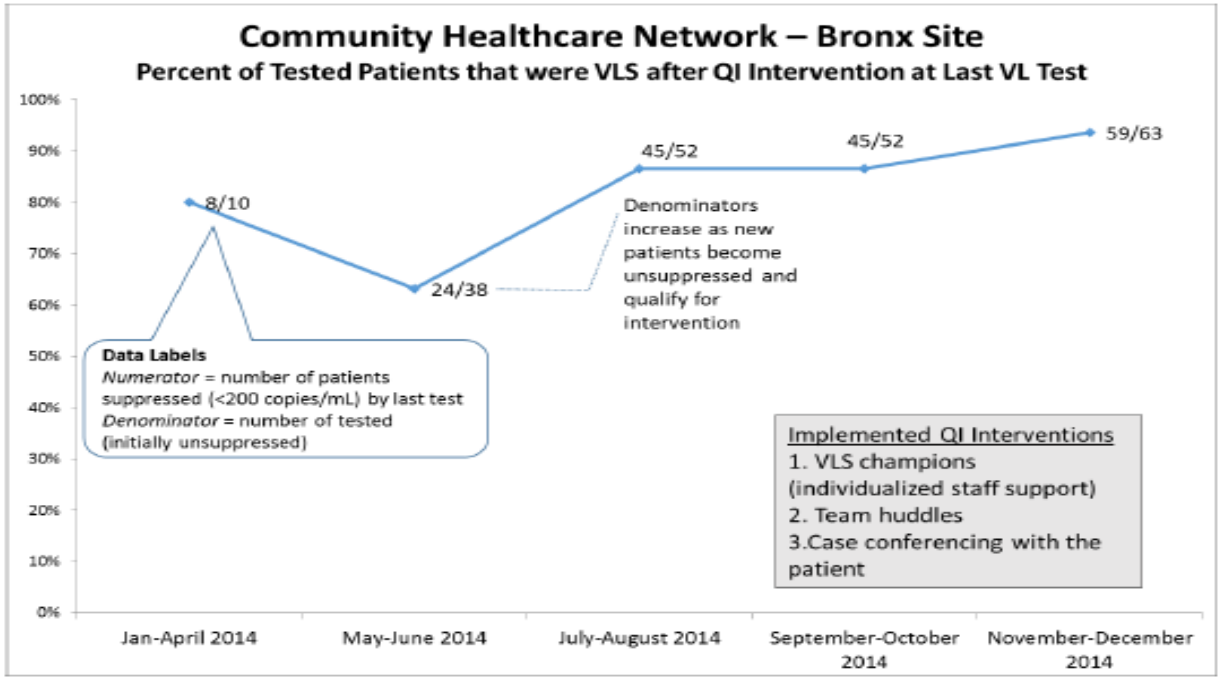
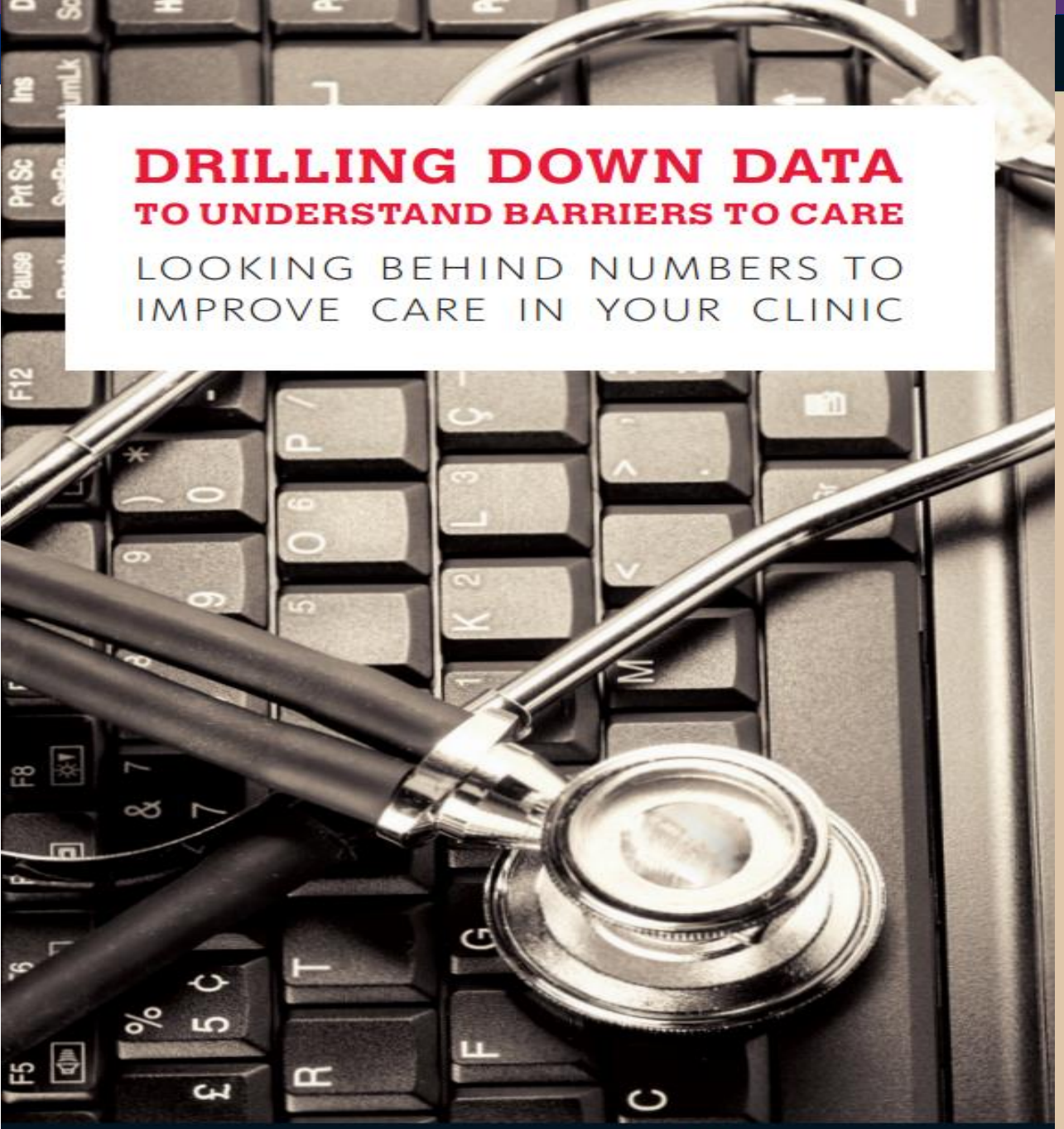

Percent of unsuppressed patients who received QI intervention by project midpoint*
Received QI Intervention
100%
80%
60%
40%
20%
0%
26/27
15/15
11/11
14/14
26/26
23/24
3/3
34/34
46/48
32/35
60/70
5/6
30/36
27/39
52/79
2/4
1/16
8/25
Some sites struggled with spread due to resource challenges (e.g. unforeseen staff changes)
13/17 sites including WMY spread QI intervention to 80% or more of unsuppressed patients
*data from June/July 2014
Bedford Stuyvesant FHC
Betances
Boriken
Callen Lorde
CHN–Bronx
CHN–CABS
Dominican Sisters
GHVFHC
Housing Works
HRH
Roosevelt FHC
Open Door
RYAN NENA
Ryan-Chelsea Clinton
Suffolk County
Sunset Terrace
Whitney M. Young
William F. Ryan


Greater Hudson Valley Family Health Center
Percent of Tested Patients that were VLS after QI Intervention at Last VL Test
Implemented QI Interventions
1. Case conference with the patient
2.Use of teach back
3. Increased adherence counseling
4. Viral load visuals
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
6/17
19/37
22/42
24/43
Denominators increase as new patients become unsuppressed and qualify for intervention
Data Labels
Numerator = number of patients suppressed (<200 copies/mL) by last test
Denominator = number of tested (initially unsuppressed)
Jan-April 2014
July-August 2014
September-October
November-December 2014


Community Healthcare Network – Bronx Site
Percent of Tested Patients that were VLS after QI Intervention at Last VL Test
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
8/10
24/38
45/52
45/52
59/63
Denominators increase as new patients become unsuppressed and qualify for intervention
Data Labels
Numerator = number of patients suppressed (<200 copies/mL) by last test
Denominator = number of tested (initially unsuppressed)
Implemented QI Interventions
1. VLS champions (individualized staff support)
2. Team huddles
3.Case conferencing with the patient
Jan-April 2014
May-June 2014
July-August 2014
September-October 2014
November-December 2014

# Interventions Tested (2014)

- Increased adherence counseling (18)
- Outreach phone calls (15)
- Case conference without patient (13)
- Teach back (13)
- Adherence journal (12)
- Visual aids (11)
- Pillboxes (7)
- Home and hospital visits (5)
- Group education sessions (4)
- Adherence groups (4)
- Scripted messaging (3)
- Checklist of interventions/VLS toolkit (3)
- Adherence calendars (2)
- Medication alarms (2)
- Increased VL tests (2)
- Letters encouraging appointment adherence (2)
- Peer education (2)
- Pre-visit labs (2)
- Transport to clinic for DOT (2)
- Pharmacy/medication tool to assess issues (1)
- Medication reminder texts (1)
- Motivational interviewing (1)
- Personalized treatment plans for all unsuppressed patients (1)
- Appointment within 2 weeks if change in medication (1)
- QI Team meetings (1)



# DRILLING DOWN DATA
## TO UNDERSTAND BARRIERS TO CARE

LOOKING BEHIND NUMBERS TO IMPROVE CARE IN YOUR CLINIC

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE



## 1 IDENTIFY PATIENTS WHO ARE NOT RETAINED

Compile a list of patients who have not been seen during the time period used to define retention. Remove those from the list who meet the exclusion criteria.

EXAMPLE:

**EXCLUSION CRITERIA:** The patient has died, transferred care, is incarcerated, or has been admitted to a long-term or residential care facility. These patients should be removed from your denominator.

| 1012 | 56 | 19 | 37 |
|---|---|---|---|
| Total patient case load | Original list of not-retained patients | Excluded: known status *(e.g., died, transferred care, incarcerated)* | Remaining list to drill down |

The remaining group of patients are those to include in the drill down process.

## 2 ASSESS REASONS FOR NON-RETENTION

For those patients not retained, conduct an assessment of the factors causing absences from care. Multidisciplinary provider teams should review all available information from patient records as needed to identify any barriers to care, competing patient concerns, and other reasons for non-retention.

EXAMPLE:

**MULTIDISCIPLINARY TEAM MEMBERS:**
Case managers, patient navigators, pharmacists, nurses, physicians, others involved.

**PATIENT RECORDS:**
Medical records, case manager or patient navigator notes, emergency room records, correctional facility records.

## 3 CREATE A TABLE

Compile all the identified reasons for non-retention and tally the number of patients experiencing each. This table will be used to prioritize areas in need of improvement and to develop targeted interventions.

EXAMPLE:

**KEEP IN MIND:** Patients grouped in the same category may have different reasons for experiencing that difficulty. For example, patients experiencing issues with transportation may not be able to pay for fares, may live too far from available transit, etc. Individualized solutions will likely be required for each patient.

| BARRIER | NUMBER OF PATIENTS |
|---|---|
| TRANSPORTATION | 35 |
| HOUSING INSTABILITY | 11 |
| INSURANCE | 2 |
| DISCLOSURE ISSUES | 15 |
| REFUSES TREATMENT | 2 |

## 4 DEVELOP A TARGETED FOLLOW-UP PLAN

Using the data from steps 2 and 3, identify the barriers that are most critical to patient health and that affect the most patients. Develop a plan to address these issues. Consider prioritizing your follow-up strategies by examining the needs of key populations or by looking at health indicators such as average viral load (see *Prioritization Strategies*).

EXAMPLE:

1. One clinic identified incorrect contact information as a major barrier to retention among its patient population. Staff searched Medicaid and pharmacy records for updated contact information and visited the patient's home if they were unable to locate the individual through other means.

2. This clinic also identified transportation as a barrier to retention for one patient with a very high viral load. Staff members arranged transportation to the clinic for this patient, which proved important in engaging the patient in care (see HIVQUAL Brief 11, *Improving Patient Retention in Western New York* for more information).

# EXAMPLES:

**PRIORITIZING BY AVERAGE VIRAL LOAD:**

| BARRIER | NUMBER OF PATIENTS | AVERAGE VIRAL LOAD (COPIES/ML) |
|---|---|---|
| TRANSPORTATION | 10 | 290 |
| HOUSING INSTABILITY | 4 | 1,580 |
| INSURANCE | 1 | 74 |
| DISCLOSURE ISSUES | 13 | 5,439 |
| REFUSES TREATMENT | 1 | 30,982 |

**IDENTIFYING BARRIERS TO RETENTION AMONG MSM:**

| KEY POPULATION | BARRIER | NUMBER OF PATIENTS |
|---|---|---|
| MEN WHO HAVE SEX WITH MEN (MSM) | TRANSPORTATION | 4 |
| | HOUSING INSTABILITY | 6 |
| | INSURANCE | 1 |
| | DISCLOSURE ISSUES | 11 |
| | REFUSES TREATMENT | 1 |

# Which Populations Face Challenges Achieving VLS in CHCQLN Clinics?

Subgroups most commonly identified by CHCQLN providers:

- Patients who currently use or have previously used drugs (6 clinics)
- Patients with mental health issues/mental illness (5 clinics)
- MSM (4 clinics)
- People of color (4 clinics)
- Newly diagnosed or new to care (4 clinics)

# Current Activities and Priorities: What's New?

- Ending the Epidemic!
- NYLinks expansion across the state
- Azara: quarterly complete FQHC data
- HepQual
- STI measures
- Smoking cessation campaign
- Stigma reduction
- Tackling issues of medication access

# Thank you

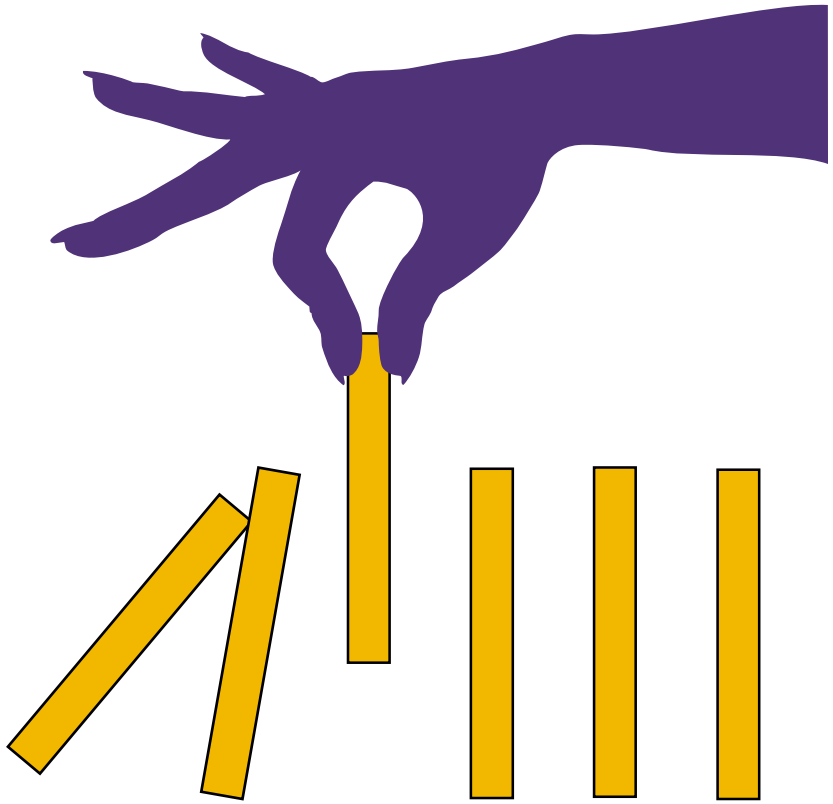
Special Thanks to Jacob Lowy, Dan Belanger, Chris Wells, Minna Yoshikawa, NYLinks Team

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Discussion of Interventions

- For the business case we would like to come up with different scenario's featuring different interventions
- We are looking for interventions at provider level for the Medicaid population:

1. What interventions could help to identify patients who remain undiagnosed and link them to care?
2. What interventions would be useful to link and retain individuals diagnosed with HIV to anti-HIV therapy
3. What interventions would help to facilitate access to PrEP and nPEP for high risk individuals



# E. Introduction to Outcome Measures

# How Are the Outcome Measures Going to be Used?

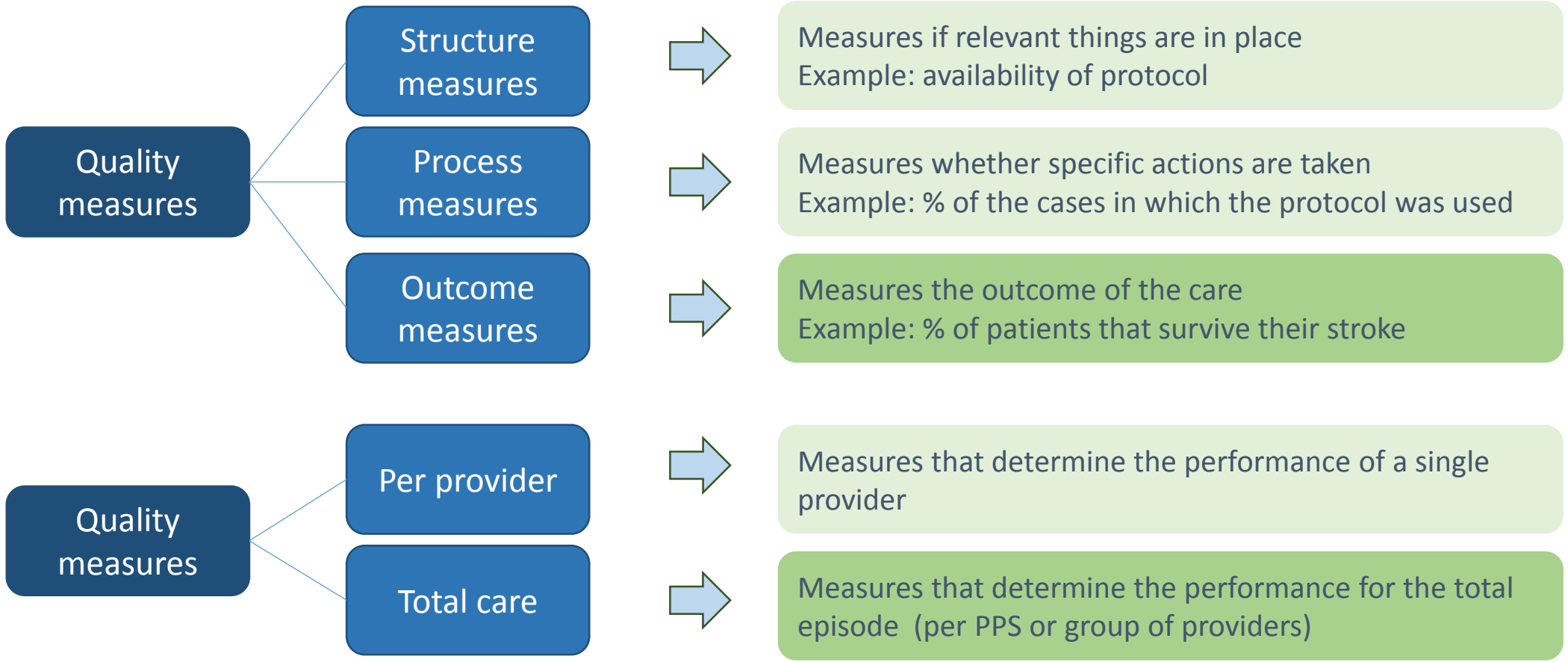
## NY State / MCO relationship

- MCO's will be held accountable for the quality measures and will get upward or downward adjustments based on the value of the care of their network.
- The State will make the outcomes of the recommended measures transparent to all stakeholders. The outcome measures set by the CAG and accepted by the State will be mandatory for the VBP arrangement involved.

## MCO / Provider relationship

- How the providers and MCOs translate the outcome measures into financial consequences and which measure(s) they want to focus on is left to these stakeholders.
- Improvement of outcome measures could affect payment in different ways:
  - A higher or lower score leads to a higher or lower percentage of savings available for the providers
  - A higher or lower score leading to a higher or lower negotiated rate

# To Assess Value, a Small, Key Set of Outcome Measures is Needed. Focus Should Be on the *Performance* of the Overall Episode.



# Suggested Process for Fine Tuning Outcome Measures

| Pilot 2016 & Data Analyses | Evaluation of Outcome Measures |
| --- | --- |
| **Pilot 2016**: In 2016 a pilot project may be started on the HIV/AIDS population with use of quality measures<br><br>**Data Analyses:** 2016 may be used to do additional data analyses (if necessary) within pilot sites:<br>▪ Explore addition of clinical data elements | **Evaluation of Outcome Measures**: If this pilot is going to run, at the end of the pilot period, projects will be evaluated and outcome measures for the HIV/AIDS population will be refined.<br><br>The CAG will probably be re-assembled annually during the first few years to discuss results of outcome measures and suggestions for improvement. First-year review could result in recommended modifications for the outcome measures set. |

# Discussion on Outcome Measures

- Next meeting we will talk about outcome measures.
- Question at hand: what are the outcome measures that should be used in VBP development?
- Please give some thought to this question before the next meeting.
- Prior to the next CAG meeting, if there are important outcome measures that you feel should be incorporated as part of the HIV/AIDS sub-population, please feel free to submit to us in advance