



**Department
of Health**

Medicaid
Redesign Team

HIV/AIDS VBP Clinical Advisory Group (CAG) Meeting #2

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September 14, 2017

Agenda

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| 1. Opening Remarks and Objectives | 5 min |
| 2. Review of Quality Measure Set Development and Maintenance Process | 30 min |
| 3. 2018 Proposed Measure Set | 20 min |
| 4. Defining Priority Clinical and Care Delivery Goals | 30 min |
| 5. Closing Remarks and Next Steps | 5 min |

Opening Remarks and Objectives

September CAG Meeting Objectives:

1. Update on current status of the 2018 Value Based Payment Program (VBP) Measure Set.
2. Review feedback received for priority clinical and care delivery goals related to HIV/AIDS.

Section 2:

Review of Quality Measure Set Development and Maintenance Process

VBP Measure Set Development: *Crawl, Walk, Run!*



Status in VBP	<ul style="list-style-type: none"> • Several measures require final specifications and/or clinical or other data elements 	<ul style="list-style-type: none"> • Work with measure stewards to develop and finalize specifications 	<ul style="list-style-type: none"> • Fully developed VBP measures included in Measurement Years 2018 and 2019
Data Availability and Sources	<ul style="list-style-type: none"> • Assess data availability • Identify and investigate potential data sources • Survey technological capabilities 	<ul style="list-style-type: none"> • Implement new data and reporting flows • Develop additional data sources 	<ul style="list-style-type: none"> • Coordination established with Qualified Entities (QEs) for clinical data integration
Data Collection and Infrastructure	<ul style="list-style-type: none"> • Gather requirements for data collection • Begin developing infrastructure to support new data sources 	<ul style="list-style-type: none"> • Initiate testing and evaluation of data collection methodologies • Work closely with technology vendors 	<ul style="list-style-type: none"> • Data and reporting flows have been established • New data source infrastructure established

Note: Timelines will vary. The intent is to make substantive contributions within each phase to help realize NYS VBP Roadmap goals.

Quality Measurement Development and Maintenance

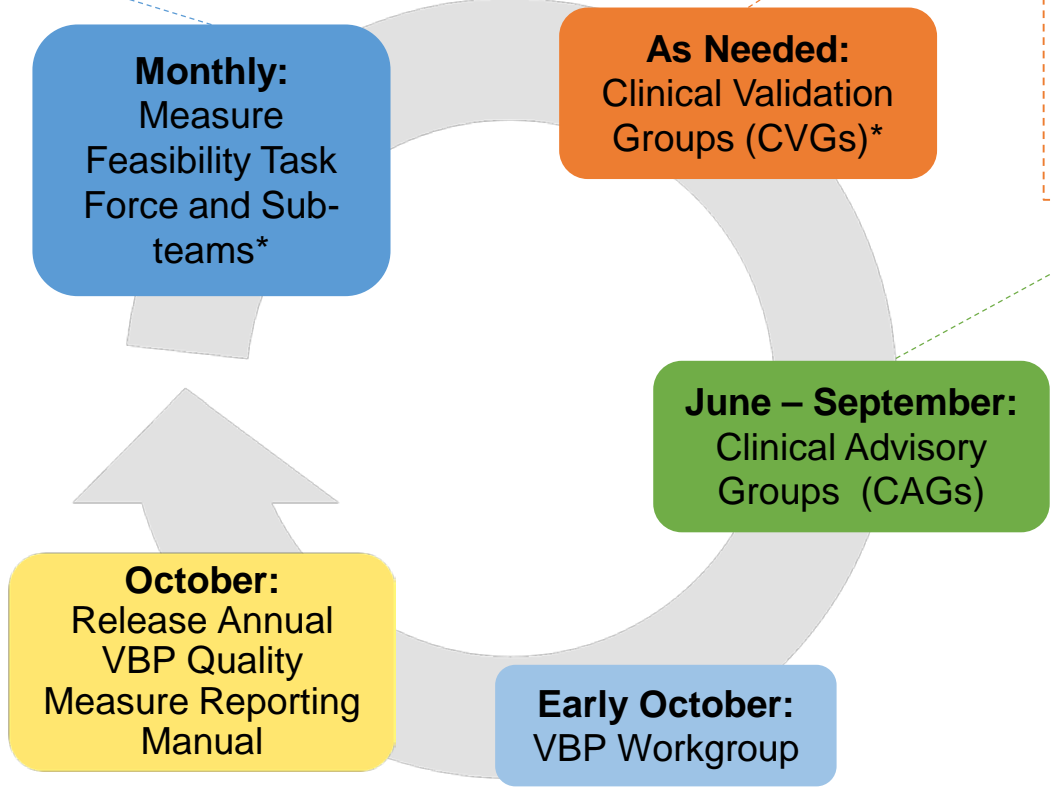
2017-2018 Measure Review Process

Purpose: Review feedback from VBP Pilot Contractors and Managed Care Organizations (MCOs) as it relates to feasibility of data collection and reporting at a VBP Contractor unit of analysis.

- **Cadence:** General Committee: Bi-monthly; Sub-teams: Monthly
- **Stakeholders:** Quality Measurement Professionals, VBP Pilots (Plans and Contractors)

Sub-teams:

- Behavioral Health (BH) / Health and Recovery Plan (HARP)
- Health Information Technology (HIT)-Enabled Quality Measurement
- HIV/AIDS
- Maternity
- Total Care for the General Population (TCGP) / Integrated Primary Care (IPC)



Purpose: Define and refine the episodes of care for each VBP Arrangement as well as for each Potentially Avoidable Complication (PAC) measure.

- **Cadence:** As necessary
- **Stakeholders:** New York State (NYS) Agencies** (OHIP, OQPS, OMH, OASAS, etc.) and Altarum

Purpose: Identify and fill critical gaps in the clinical and care delivery goals to strengthen Statewide quality measurement program.

- **Cadence:** Annual (or bi-annual) meeting
- **Stakeholders:** NYS Agencies, CAG Members (Clinicians/ Medical Professionals from across the State)

CAGs:

- BH/HARP
- Children's Health
- Chronic Conditions/ Primary Care
- HIV/AIDS
- Managed Long Term Care (MLTC)
- Maternity

* Initially for 2017-2018, the Measure Feasibility Task Force and CVGs require a more intensive effort. The workload for these groups is expected to taper off after the VBP Pilot program ends after 2018.

** OHIP: Office of Health Insurance Programs, OQPS: Office of Quality and Patient Safety, OMH: Office of Mental Health, OASAS: Office of Alcoholism and Substance Abuse Services.

Stakeholder Engagement Process for Measure Review

Department of Health Approach

Clinical Advisory Groups

The CAG activities focused on refining the priority clinical and care delivery goals for the VBP arrangement measure sets, providing recommendations for future measure development and inclusion within the measure sets to drive improvement and achieve results per VBP Roadmap.

Measure Feasibility Task Force

The Measure Feasibility Task Force reviewed the VBP arrangement measure sets to assist in building a clear picture of the current state and anticipated challenges regarding data capture, data flows, and the approaches taken by MCOs and provider organizations in the selection and utilization of measures within quality programs and VBP contracting.

Public Comment and Survey

In addition to the workgroups above, the state pursued additional outreach efforts including public engagement through request for comment on measurement specifications and a survey of the current state and challenges of measure implementation and reporting.

12 Week Intensive Stakeholder Review Process

50+

Represented Groups
and Organizations

35+

Meeting Hours

200+

Stakeholders
Engaged

Measure Calculation and Reporting Feasibility

Key Themes Identified by Stakeholders

1. Significant Resource Requirements for Data Capture

Securing resources to program data capture workflows for hybrid and non-QARR* (Quality Assurance Reporting Requirements) measures is challenging. System modifications and the build of custom workflows are limited in many systems, further complicating the work required to address data capture and extraction requirements in support of non-standard measures.

2. Disparate Electronic Record and Reporting Systems

Disparate systems and reporting processes present significant challenges for data capture and reporting. Providers must be able to extract and submit data consistent with the unique requirements from each plan contracted.

3. Lack of Clarity Regarding Data Origin and Context

Each plan takes a unique approach to data collection for measure calculation, using data from many sources including commercial lab feeds, lab data from RHIOs (Regional Health Information Organizations), and abstracted data from providers.

4. Challenges Associated with Medical Record Abstraction

Providers challenged to collect administrative data based on practice patterns, e.g. connecting previously run lab work with claims for patient visits when labs are run a week ahead of the visit.

5. Attribution and Measure Alignment for Certain Populations

MCO-assigned PCP (Primary Care Provider) driven attribution may create misalignment between the assigned PCP and providers who are providing most of the care for a member.

6. Transition from Sampling to Population Level Measurement and Reporting

Population sampling is used for a significant number of measures. Movement toward a population level reporting and measurement approach will be challenging and require that resource and workflow issues be addressed to support the reporting and calculation of a population-wide measure.

* QARR is a component of the NY Medicaid Managed Care Quality Incentive Program.

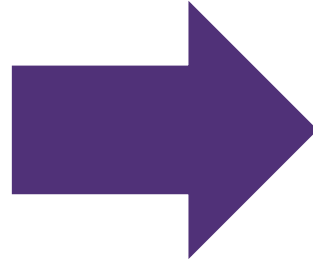
Section 3:

2018 Proposed Measure Set

The Role of the CAGs: Then and Now

Recommendations for the Initial Measure Sets

The **VBP CAGs** and subcommittees were created to address the larger VBP design questions. Their charge was to produce recommendations to the VBP Workgroup and to the State with their best design solutions. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The CAGs' scope of work included selecting Quality Measures for specific arrangements.



Identification of VBP Measurement Targets and Gaps

The CAG will focus its activities on refining the priority clinical and care delivery goals for the VBP Arrangements and providing recommendations, on an annual basis, to revise, strengthen, and improve the priority goals that will serve as the guide for long-term VBP Measure Set strategy, development and implementation.

The CAG will meet each year to review, identify, and fill critical gaps in the clinical and care delivery goals specific to the Medicaid population. The focus will be on **significant changes in the evidence base and clinical guidelines, along with opportunities for improvement** identified through experience in clinical practice and feedback from MCOs and VBP contractors.

HIV/AIDS – Specific Measures – 2018 Value Based Payment Quality Measure Set

Category 1

Measure Name	Description	Steward	VBP Category
HIV Viral Load Suppression	The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	HRSA	Cat 1 P4P
Linkage to HIV Medical Care	Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis	HRSA	Cat 1 P4R
Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	NCQA	Cat 1 P4P
Substance Abuse Screening	Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year	HRSA	Cat 1 P4R
Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Altarum	Cat 1 P4R

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set

Category 1

Measure Name	Description	Steward	VBP Category
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).	CMS	Cat 1 P4P
Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment	The percentage of patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	Cat 1 P4P
Breast Cancer Screening	Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months	NCQA	Cat 1 P4P
Cervical Cancer Screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	NCQA	Cat 1 P4P
Colorectal Cancer Screening	Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer	NCQA	Cat 1 P4P

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 1

Measure Name	Description	Steward	VBP Category
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period	NCQA	Cat 1 P4P
Comprehensive Diabetes Care: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period	NCQA	Cat 1 P4R
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.	NCQA	Cat 1 P4R
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	NCQA	Cat 1 P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	NCQA	Cat 1 P4P
Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	NCQA	Cat 1 P4P
Comprehensive Diabetes Screening: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	NQF #s 0055, 0062, 0057 Number of people (18-75) who received at least one of each of the following tests: HbA1c test, , diabetes eye exam, and medical attention for nephropathy	AHRQ	Cat 1 P4P
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period	NCQA	Cat 1 P4P

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 1

Measure Name	Description	Steward	VBP Category
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	Cat 1 P4P
HIV Viral Load Suppression	The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	HRSA	Cat 1 P4P
Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	NCQA	Cat 1 P4P
Initiation of Pharmacotherapy for Alcohol Dependence	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.	OASAS	Cat 1 P4R
Initiation of Pharmacotherapy for Opioid Use Disorder	The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence.	OASAS	Cat 1 P4P
Linkage to HIV Medical Care	Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis	HRSA	Cat 1 P4R

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 1

Measure Name	Description	Steward	VBP Category
Medication management for patients with asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. [A] ages 5-18 [B] ages 19-64	NCQA	Cat 1 P4P
Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year	Altarum	Cat 1 P4R
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.	CMS	Cat 1 P4R
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	AMA PCPI	Cat 1 P4R
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	CMS	Cat 1 P4R
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	AMA PCPI	Cat 1 P4R

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 1

Measure Name	Description	Steward	VBP Category
Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection	NCQA	Cat 1 P4P
Statin Therapy for Patients with Cardiovascular Disease	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: (1) Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year. (2) Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.	NCQA	Cat 1 P4R
Statin Therapy for Patients with Diabetes	Percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have ASCVD who remained on a statin medication of any intensity for at least 80% of the treatment period.	NCQA	Cat 1 P4R
Substance Abuse Screening	Percentage of new patients with a diagnosis of HIV who have been screened ² for substance use (alcohol & drugs) in the measurement year	NYSDOH AIDS Institute	Cat 1 P4R
Use of spirometry testing in the assessment and diagnosis of COPD	The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis	NCQA	Cat 1 P4R

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 2

Measure Name	Description	Steward	VBP Category
Asthma: Assessment of Asthma Control – Ambulatory Care Setting	Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated for asthma control (comprising asthma impairment and asthma risk) at least once during the measurement period	AAAAI	Cat 2
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	New Measure: Percentage of individuals undergoing initiation and engagement of alcohol and other drug dependence treatment (IET) who have three (3) or more same- or lower-level SUD service visits/claims between 45 days post the IET Index Episode Start Date (IESD) and 180 days post the IESD.	OASAS	Cat 2
Continuity of Care (CoC) within 14 days of discharge from any level of SUD inpatient care	1. Continuity of Care from Inpatient Detox to Lower Level of Care. The percentage of inpatient detox discharges for members 13 years of age and older with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD within 14 days of the discharge date. 2. Continuity of Care from Inpatient Rehabilitation to Lower Level of Care. The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.	OASAS	Cat 2
Diabetes Screening (HIV/AIDS)	Percentage of patients with any random blood sugar > 100 mg/dL who received diabetes screening.	NYSDOH AIDS Institute	Cat 2
Hepatitis C Screening	Percentage of patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV	HRSA	Cat 2
Housing Status	Percentage of patients with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period	HRSA	Cat 2
Lung Function/Spirometry Evaluation (asthma)	Percentage of patients aged 5 years and older with asthma and documentation of a spirometry evaluation, in the medical record within the last 24 months	AAAAI	Cat 2

HIV/AIDS VBP Arrangement – 2018 Measure Set included in the TCGP/ IPC Measure Set (Cont'd)

Category 2

Measure Name	Description	Steward	VBP Category
Medical Case Management: Care Plan	Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan ¹ developed and/or updated two or more times in the measurement year	HRSA	Cat 2
Patient Self-Management and Action Plan	Percentage of patients aged 5 years and older with asthma and documentation of an asthma self management plan	AAAAI	Cat 2
Prescription of HIV antiretroviral therapy	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	HRSA	Cat 2
Sexual History Taking: Anal, Oral, and Genital (HIV/AIDS)	Percentage of patients who were asked about sexual activity. (3 sub-measures)	NYSDOH AIDS Institute	Cat 2
Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).	NCQA	Cat 2
Utilization of Pharmacotherapy for Alcohol Dependence	The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.	OASAS	Cat 2
Utilization of Pharmacotherapy for Opioid Use Disorder	The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year.	OASAS	Cat 2

Review: Types of Clinical Quality Measures

	CLINICAL QUALITY MEASURES			
	Administrative/ Claims-Based	Hybrid	Proxy	eCQM
Numerator	Derived from Claims	Derived from Claims & Medical Record Review	Derived from EHR or CDR	Derived from EHR or CDR
Denominator	Derived from Claims	Derived from Claims	Derived from EHR or CDR	Derived from EHR or CDR
Additional Information	Supplemental data may also be used to identify numerator events & denominator exclusions	A sample of the population is targeted chart review	Approximates specification using available electronic data. May “loosen” the spec. to account for data gaps	Specification is used to build a query of the clinical data source; specs have known limitations
Uses/ Example	Health plans HEDIS reporting/ APC/ VBP	Health plans HEDIS reporting/ APC/ VBP	QEs generating measures to drive pop. Health management	MU Attestation

Source: NYSTEC, June 2017

Acronyms: EHR: Electronic Health Records; CDR: Clinical Data Repository; HEDIS: Healthcare Effectiveness Data and Information Set; APC: Advanced Primary Care; QE: Qualified Entities; MU: Meaningful Use, eCQM: Electronic Clinical Quality Measures

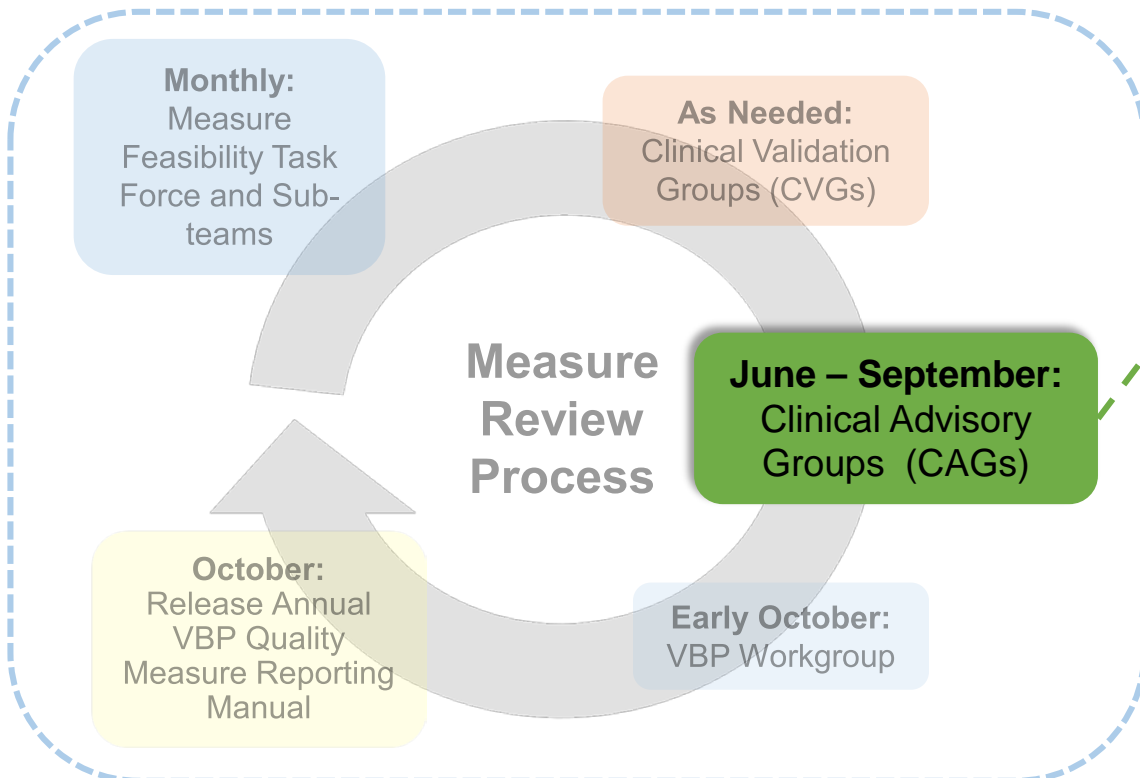
Section 4:

Defining Priority Clinical and Care Delivery Goals

Recommendations for Development of Future VBP Quality Measurement

Priority Clinical and Care Delivery Goal Setting Strategy

Clinical care delivery goal setting, facilitated by the CAGs, will establish clear targets and provide **strategic direction** for the State to consider in the development of a multi-year VBP quality measurement strategy. This process will drive the development and implementation of a high-value and responsive measure set for the VBP Arrangements.



Purpose: Identify and fill critical gaps in the clinical and care delivery goals to strengthen Statewide quality measurement program.

- **Cadence:** Annual (or bi-annual) meeting
- **Stakeholders:** NYS Agencies, CAG Members (Clinicians/ Medical Professionals from across the State)

- CAGs:**
- BH/HARP
 - Children’s Health
 - Chronic Conditions/ Primary Care
 - HIV/AIDS
 - Managed Long Term Care (MLTC)
 - Maternity

2017 Clinical Advisory Group Feedback Process

Work to Date

- The initial set of Priority Clinical and Care Delivery Goals presented to the CAGs in July was based on a review of the CAG and Integrated Care Workgroup (ICWG) Measure Set recommendations.
- Following the July CAG meetings, members were asked to submit their feedback on the priority clinical and care delivery goals and sub-goals for each arrangement's measure set.
- Responses were aggregated and used to update the goals and sub-goals targeted by each arrangement.

June 30, 2017 DRAFT 30

Worksheet: Recommendation of Additional Priority Goals

Phase	Clinical and Care Delivery Goals	Description	Additional Subgoals
1) Phase of Care	Suggested Priority Goal 1	Description	(No Subgoals)
	Suggested Priority Goal 2	Description	<ul style="list-style-type: none"> • Subgoal 1 • Subgoal 2
2) Phase of Care			
3) Phase of Care			
4) Phase of Care			

**Further instructions on how to submit additional recommendations will be sent to the CAG members following this meeting.

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Summary of Feedback

Clinical and Care Delivery Goals

Recommendations for updates and modification of the Clinical and Care Delivery Goal tables have been extracted from both the July CAG meeting member discussion and the worksheets subsequently submitted to the Department of Health (DOH).

Feedback has been analyzed to create a summary of key themes and incorporate recommendations into the updated Clinical and Care Delivery Goal tables that follow.

Key Themes

1**Addition to the TCGP/IPC Goals**

Addition of clinical and care delivery goals related to HIV risk assessment, prevention, and testing consistent with CAG recommendations.

2**HIV/AIDs Management and Monitoring**

Feedback included emphasis on goals related to proactive outreach and patient engagement in care and education in support of successful self-management.

3**Psychosocial Health**

Recommendations included the addition of goals related to psychosocial health including substance abuse screening and treatment and strengthening goals around depression to include successful management.

4**Health System Factors**

Comments submitted included emphasis on the need for goals around transitions of care and successful coordination of care.

Priority Clinical and Care Delivery Goals

HIV/AIDS

Based on feedback received, the Clinical and Care Delivery Goals table for HIV/AIDS has been modified to include:

- HIV risk assessment, Pre-Exposure Prophylaxis, and screening have been added to the TCGP/IPC clinical and care delivery goals consistent with CAG recommendations.
- Patient engagement in care through proactive outreach, development of a patient centered care plan, and patient education on HIV/AIDS prevention and disease management.
- Goals supporting patient self-management including patient education and support for care plan compliance and successful disease management.

Focus of Care	Priority Clinical and Care Delivery Goals	
<p>TCGP/IPC Physical Health Clinical and Care Delivery Goals (added per CAG recommendations)</p>	<p>Sexually Transmitted Infection Prevention</p> <ul style="list-style-type: none"> - HIV Risk Assessment (Identification of at-risk patients) - HIV Pre-Exposure Prophylaxis (PrEP) 	<p>Sexually Transmitted Infection Early Detection</p> <ul style="list-style-type: none"> - HIV Screening - HIV Re-screening for at-risk patients (high-risk negatives)
<p>1) HIV/AIDS Diagnosis and Baseline Evaluation</p>	<p>Diagnosis</p>	<p>Baseline Evaluation</p>
<p>2) HIV/AIDS Management and Monitoring</p>	<p>Immunization/Vaccinations</p> <ul style="list-style-type: none"> - Prevention and Control of Seasonal Influenza with Vaccinations <p>Outcomes</p> <p>Prophylaxis</p> <p>Patient Engagement</p> <ul style="list-style-type: none"> - Proactive outreach to engage patients in care - Patient education on use of HIV/AIDS prevention and disease management to decrease the number of newly infected members, reinfection rate, and spread of disease - Patient engagement in care plan development 	<p>Patient Self-Management</p> <ul style="list-style-type: none"> - Housing Status - Patient education on disease management - Adherence to care plan <p>Screening</p> <ul style="list-style-type: none"> - Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis - Hepatitis C Screening - Sexual History Taking: Anal, Oral, and Genital <p>Therapy/Medication Management</p> <ul style="list-style-type: none"> - HIV Antiretroviral Therapy <p>Viral Load Monitoring</p> <ul style="list-style-type: none"> - HIV Viral Load Suppression

Priority Clinical and Care Delivery Goals

HIV/AIDS

(continued from previous slide)

Based on feedback received, the Clinical and Care Delivery Goals table for HIV/AIDS has been modified to include:

- Psychosocial health factors including substance abuse screening, prevention, and treatment.
- Health system factors including care coordination and medication reconciliation for transitions of care and use of clinical practice guidelines to support the delivery of quality, evidence based care.

Focus of Care	Priority Clinical and Care Delivery Goals
3) Prevention and Chronic Disease Management	Chronic Disease Screening and Management <ul style="list-style-type: none"> - Cardiovascular Disease - Hypertension - Obesity - Diabetes - Chronic Pulmonary Diseases
4) Psychosocial Health	Depression Screening <ul style="list-style-type: none"> - Early Identification; Initiation of treatment - Ongoing management, monitoring, and severity assessment Substance Use <ul style="list-style-type: none"> - Screening and Prevention of Drug Abuse and Excessive Alcohol Use - Use of Medication Assisted Therapy to reduce opioid and alcohol use or dependence Tobacco Avoidance and Cessation
5) Health System Factors	Access to Care <ul style="list-style-type: none"> - Effective linkage from HIV testing to HIV care Transitions of Care <ul style="list-style-type: none"> - Care Coordination – Timely follow up and Medication Reconciliation after inpatient discharge for mental health Delivery of evidence based care <ul style="list-style-type: none"> - Use of CPGs in delivery of care