



INTEGRATION OF CARE COMMITTEE

March 23, 2010

Cicatelli Associates, 505 Eighth Ave., 20th floor

3:30- 5:00pm

DRAFT MINUTES

Members Present: Damian Bird (Co-chair), Brent Backofen, Nancy Cataldi, Steve Gordon, Elaine Greeley, Deborah Greene, JoAnn Hilger, Geraldine Joseph, Leslie Mack, Jun Matsuyoshi, Jan Carl Park, MA, MPA, Kimberleigh Smith, Ed Viera, Jr., Lisa Zullig, MS, RD

Members Absent: A. Cohall, M.D., J. Edwards, T. Hamilton, M. Irizarry, P. Laqueur, C. Numa, M. Piñón,

Staff Present: *NYC DOHMH:* David Klotz, Kinga Cieloszyk, M.D., M.P.H.; *NYSDOH:* Tracy Hatton

I. Welcome/Introductions/Minutes

Mr. Bird welcomed members, followed by a moment of silence and introductions. The minutes of the February 23, 2010 meeting were approved with several changes.

II. Introduction to the Ryan White Part A Quality Management Program

Ms. Hatton, Director of the NYSDOH AIDS Institute's Quality Management Program, gave an overview of the QM program, which was established in 2001, as mandated by the 2000 reauthorization of the CARE Act. The framework for the QM program is: performance measurement, quality improvement, and learning networks. Highlights of the presentation include:

- QM principles are: patients are the first priority; focus on systems of care, not individual staff; activities and change based on measured, accurate data; emphasis on working in teams;
- QM goals are: collaboration between NYC DOHMH, Planning Council, providers, consumers, AI Quality Program; provide aggregate data to the EMA; promote QI methods and approach; assist in identification of service needs; build capacity for QM among EMA grantees; improve care & services for PLWHA;
- The EMA as a whole has a QM plan that includes goals and a performance measurement system;
- Through the QM program the City and State Health Departments partner to address, in the context of quality, HIV issues such as: adherence barriers, health literacy, access and

- linkage to care, retaining patients in care; care coordination, involvement of clinicians in QM, chart documentation standards, and Part A program integration with clinical care;
- Performance measurement identifies common issues through performance data, prioritizes areas for improvement, creates benchmarks and goals, and measures progress over time;
 - Performance indicator development involves providers and focuses on quality needs of consumers and providers in specific service categories, prioritizing aspects of care and refining them into measurable indicators;
 - Performance reviews are conducted using the indicators by sampling cases from programs and aggregating data;
 - In Harm Reduction for 2008, where 24 programs were reviewed with 697 patients in the sample, 91% of HR patients received a comprehensive assessment, but only 81% of clients were assessed for incremental changes in risk behavior;
 - 89% of HR patients were assessed for primary care status; of these 99% indicated that they had a regular primary care provider;
 - Scores indicate the need to strengthen efforts regarding buprenorphine and overdose prevention;
 - The QM program runs quality Learning Networks for Mental Health and Supportive Counseling, Early Intervention Services, Medical Case Management (Tri-County), Harm Reduction, Food and Nutrition, and Care Coordination (about to start);
 - Learning Networks bring together providers within the same service category to focus on performance measurement and quality improvement, and to use performance review data to identify areas to improve, track performance over time and collaboratively develop strategies to address areas in need of improvement;
 - 2010 plans for the QM program include: support quality efforts/QM plans, Learning Networks, Organizational Assessments, quality projects; develop provider capacity; include consumers in quality programs; improve; and link service improvements to clinical care outcomes.

Discussion followed, with the following comments made:

- The low rates of usage of buprenorphine may be due to the fact that methadone is cheaper and widely available;
- Harm Reduction is enabling, particularly for those who can not control their substance use. Programs should move clients towards treatment and abstinence;
- Consumers participate in the Learning Networks and are involved in indicator development. Also, agencies have consumers on their QM teams.

III. IOC Involvement in the Quality Management Program

Dr. Cieloszyk, Deputy Medical Director for Clinical Care of the HIV Care, Treatment and Housing Program, presented on the IOC role in the QM program. Highlights of the presentation include:

- The goal of the Part A clinical QM program, as outlined in the EMA's QM plan, can be summarized as: The best care we know how to give, for every client, at every site, every day. IOC will provide comments on this plan;

- Each Part A-funded agency must also have a comprehensive QM plan in place by March 31st;
- Current evaluation shows that Harm Reduction programs have much room for improvement with their QM plans (fewer than 50% have plans, and most have poor quarterly follow-up/retention in care);
- There is a big drop off between annual and quarterly assessments, which the QM staff will work with the agencies on;
- The QM program will review and update indicators, starting with HR and MH programs (e.g., document assessment within 30 days)
- HRSA wants the Planning Council to assess quality of care efforts, help set quality of care priorities, and propose suggestions for QI projects that should be undertaken to improve the delivery of services;
- IOC will begin this effort by reviewing and suggesting improvements for the Part A QM Plan, reviewing HR performance data, reviewing and suggesting improvements for HR indicators, and discussing QI projects for HR providers.

IOC members will receive a tool to help them assess the EMA's QM plan prior to the next meeting, on April 27th.

There being no further business, the meeting was adjourned.