INTEGRATION OF CARE COMMITTEE

April 13, 2005
9:45am-12:00pm
GMHC, 119 W. 24th Street

M I N U T E S

Members Attending: J. Grimaldi, MD (Co-chair), D. Ng (Co-chair), S. Abramowitz, PhD, P. Avitabile, R. Canosa, S. Forlenza, MD, I. Gamble-Cobb, M. Gbur, MD, E. Greeley, P. Laqueur, J. Lehane, Ph.D., E. Levine, J. Omi, R. Quattrochi, A. Richardson, B. Soskind, B. Starks-Ross, T. Troia, S. Caba (ex-officio), R. Ortiz (ex-officio)

Staff Present: D. Klotz, G. Moon, I. Gonzalez, S. Bailous

Guests: M. McClain

I. Meeting Opening/Minutes

After introductions, the minutes of the March 9, 2005 meeting were approved with one change to reflect correct attendance.

II. 2005-2008 Comprehensive Strategic Plan

Mr. McClain presented the framework for monitoring and evaluating the objectives in the Strategic Plan. Priority will be given to data that exists or is being developed, including outcome measures (e.g., improved health), input measures (e.g., number of people receiving a specific service), and process measures (completion of action steps). Data should be linked to a specific objective. A measure is a specific variable that can be measured to determine progress in achieving an objective, and baseline data (i.e., status of the measure at time Plan was developed) will be needed to determine progress. Indicators of progress are statements that define what would be considered success for the measure. External standards should be used if they exist. If not, a directional indicator may be used (e.g., “more of”, “a decrease in”).

Sources of data are: Title I Outcome Evaluation Project (a longitudinal project to evaluate effectiveness of Title I programs, just getting under way), AIDS Institute Quality Management Program, MHRA utilization data, CHAIN.

Proposed measures may include: CD4 counts, viral load, AIDS-related mortality, receipt of anti-retroviral therapy, percentage of people diagnosed with AIDS within 90 days of an initial HIV diagnosis, etc.

Summary of Discussion on Monitoring and Evaluation Plan:

- Process measures (what are called "input measures" in this presentation) are "bean counting" (e.g., MHRA data). Input is resources.
- Measures will be for the entire EMA, not just New York City
- We can measure just one element or variable.
- The number of rapid tests done may not be a good measure, as only positive tests are reported. A better measurement would be number of PLWH who are identified.
- Just testing more people is not necessarily relevant to measuring success. Rather, we have to measure testing among higher risk populations.
- We can change the baseline mid-plan, or the first measure can be the baseline for an indicator.
- A firm number is better than an estimate. It makes the findings more credible.
- SPARKS (hospitalization data) may not be useful.
- We need standardization of reporting in the Outcome Evaluation Project. Creating that can take 2 years.
- Logistical support services should be added to the Outcomes Evaluation Project, especially to capture people whose ambulatory care is not reported.
- Add CD4 percentage to absolute value as a measure.
- The correct measure would be "is there a lab test". Measuring changes in CD4 count is not our charge.
- We can use a population-based measure using time between HIV diagnosis to AIDS, or from AIDS diagnosis to death.
- A detailed discussion with the researchers involved is needed to determine available data and usefulness of that data. This will drive the measures that are adopted.

Summary of Discussion on Goals and Objectives:

- Consider changing name of Overarching Goals (e.g., Plan Purpose, Overarching Outcomes)
- Convert to objectives both the 2nd item (reduce the transmission of HIV) and 3rd item (increase the number of individuals who are aware of their status)
- Avoid conceptual divisions between 'access' and 'maintenance' related goals.
- Need to keep goals broad to allow for annual adjustments.
- Be more specific at the objective and action step level.
- In goal #2, need to define "timely" according to clinical care standards, such as care received within 3 months, not the HRSA definition, which is once a year.
- If timely receipt of HIV is considered to be a part of maintaining continuity of care, it would be possible to eliminate Goal 2 entirely, while shifted its objectives to Goal 3.
- Need to determine whether the plan should include CD4 percents as well as CD4 values as a measurement of plan achievement.

- Consider measuring the timing of the initial clinical evaluation.
- Consider adding the words 'continuous and comprehensive' to goal #2 as follows: 'increase the proportion of HIV-positive individuals who receive timely, continuous, and comprehensive HIV care," but if so, these concepts would requirement measurement.
- Consider adding to goal #3 "or re-engage if lost to care" – as a way to make explicit the importance of re-engagement.
- ATC Subcommittee's recommendation to add an objective to goal 2 to cover re-engagement in care, and add an objective to goal 3 to cover addressing barriers to care.
- Suggestion to first identify what is the universe of elements which are measurable and then revise the goals and objectives, including deleting those which are not measurable.
- Remember that rapid testing is not confirmatory of an HIV diagnosis.
- Consider reversing the goal statement with the objectives in goal #2.
- Consider replacing 'and other services' in Objective 2A with the full list of service elements which appear now in Objective 3A.
- Tease out what is meant by 'address the barriers,' such as "identify, reduce, …"

In order to complete work on this section, the Committee agreed to the following schedule:

- Small group meeting on April 20th to draft possible changes based on the above discussion
- Send out changes by e-mail with time to exchange comments electronically
- Finalize at special full IOC meeting on April 27th.

There being no further business, the meeting was adjourned.

Next full meeting: Tues. April 26th, 3-5pm at LGBT Center – joint meeting with ATC and MIC sub-committees re: reprogramming.