**General Questions**

**Q: When are the cascades due?**

A: March 31st, 2017

**Q: How do I submit my cascade?**

A: Send it to QOCReviews@health.ny.gov

**Q: What are the 3 components that need to be submitted?**

A: 1) The cascades, one for newly diagnosed patients and one for established patients, 2) Your methodology, 3) Your improvement plan

**Q: Are community-based organizations required to submit cascades?**

A: Only organizations providing HIV medical care are currently being asked to complete cascades.

**Q: How are the organizational HIV treatment cascades different from other cascades, such as those used in surveillance?**

A: The organizational cascade focuses on patients seen locally at your organization so it can be used to drive improvement at your organization. Cascades have been traditionally used as a visual tool to understand population health.

**Q: Will a template for data entry and data visualization be provided?**

A: No. Organizations are encouraged to be creative while developing their cascades. As long as their cascade meets all of the technical requirements in the guidance document, organizations should develop the cascade that best works for their them. Organizations are encouraged to reach out to their Quality Improvement Coaches or to QOCReviews@health.ny.gov with any questions.

**Q: Where can I find information about when a patient is considered diagnosed?**

A: In New York State, to the extent permitted by law, the terms “clinical/symptomatic HIV illness or AIDS,” “AIDS or HIV-related illness,” and other similar terms shall mean laboratory-confirmed HIV diagnosis (source: [NYSDOH June 23, 2016 Policy Statement Defining Program Eligibility by HIV Status](https://www.health.ny.gov/hiv/programs/eligibility_documentation.pdf)). For further detail, please visit hivguidelines.org.
Q: Would the DOH be able to assist us in determining if patients are in care elsewhere---this is the group of patients between the Open and the Active caseload?

A: In NYC, DOHMH has a site that you can contact to assist in finding if patients lost to care are in care someplace else. The link is https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page

A similar service is available through the NYSDOH/AIDS Institute. NYS has a portal where providers can submit inquiries on their patients with diagnosed HIV infection who are thought to be lost to care. The Provider Portal is on the NYSDOH Health Commerce System; https://commerce.health.ny.gov.

Q: My HIV facility is part of a much larger health system. Am I responsible for finding all HIV+ patients who touched the larger health system or just at my organization?

A: Providers are encouraged to get in touch with their cascade coach to discuss the details of their situation. However, you are likely responsible for identifying patients only at your facility and nearby locations that are considered a part of your organizations.

Q: Is a facility expected to know whether patient is virally suppressed if that patient is engaged in HIV care elsewhere and touched the facility for unrelated care (e.g. surgery)?

A: Ideally organizations would know the suppression status of this patient but it is not required for this review. However, organizations would ideally be able to confirm that this patient is in care.
Definitions

Q: What are the exclusions for Active patients?

A: Incarcerated, deceased, or in care elsewhere by the end of the review year (12/31/16) are excluded, as well as patients of unknown care status,

Q: What are the exclusions for Open patients?

A: There are no exclusions for open patients.

Q: How should we consider the timeframe related to the exclusion categories?

A: To promote standardization to the extent possible, we will ask facilities to consider status of patients at the end of the 12-month period. Patients who have died before the end of the year, patients who are incarcerated at the end of the period and those who have been confirmed to have transferred care elsewhere at the end of the year should be excluded. Any deviations from methodology should be included in the description submitted with the cascade including specific exceptions.

Q: In the linkage to HIV medical care measure, how is “routine HIV medical visit” defined?

A: A routine medical visit is defined as any medical visit with a medical provider with prescribing privileges.

Q: In the linkage to HIV medical care measure, how is “date of diagnosis” defined?

A: Date of diagnosis is the date on which the medical provider receives the patient’s confirmatory test result.

Q: Successful linkage to care has historically been defined using a time frame of 90 days. Why the change?

A: Delayed linkage to care has been associated with increased risk of hospitalization and death, as well as increased risk of forward HIV transmission. In reducing the timeframe to 3 days if linked internally or 5 days if linked externally, we are pushing the envelope in the hope of ending the epidemic by 2020.
Situations

Q: If a patient schedules a routine HIV medical visit within the applicable time frame, but does not attend, is that patient considered successfully linked?

A: No. The patient is only linked when they attend a routine medical visit.

Q: If a patient presents to an HIV program with a positive result from a rapid test, is this patient considered a newly diagnosed patient or an established patient?

A: A patient is not considered as diagnosed with HIV until a confirmatory test has been conducted. Once this test has been done and the patient is found to be HIV-positive, they will be considered a newly diagnosed patient.

Q: If a patient is receiving case management services only (no medical care, dental or specialty services), do we include them?

A: Yes, as a part of the open caseload. We want to be sure that people who touch your system, regardless of the service, get linked into care and treated. Since the purpose of case management services is to help patients who are at-risk or who have already fallen out of care, these patients are exactly those who should be included in the open caseload.

Q: If a patient receives case management services, but not medical services, in an HIV program, are they considered open or active?

A: This patient is a part of the open caseload. A patient is only considered active if they are linked to HIV medical care in the HIV program.

Q: If a patient receives a definitive HIV diagnosis at an HIV program, and then chooses to receive care elsewhere, how is this patient accounted for?

A: The patient is considered to be “externally linked” and must be shown to attend a routine HIV medical visit within 5 calendar days to be considered successfully linked.

Q: If patients have visited a facility and then transferred care, should they be excluded?

A: Patients confirmed to have transferred care outside of the organization are excluded from the active caseload, but remain in the open caseload. Ideally, each report will include the number of confirmed transfers, deaths, and patients incarcerated in their methodology statements.

Q: If a patient is incarcerated but is still able to receive their routine care, should they be excluded from the active caseload?

A: No, if the patient is still able to receive ongoing care at your facility they can be considered a part of the active caseload.
Q: If a patient was incarcerated but only briefly during the review period, are they still excluded from the active caseload?

A: To promote standardization to the extent possible, we will ask facilities to consider status of patients at the end of the 12-month period. If a patient is incarcerated at the end of the review period and was not receiving services at your organization, they would be excluded from the active caseload. If they were no longer incarcerated at the end of the 12-month period, they would be in the active caseload. If they are incarcerated at the end of the year but still received regular care during the review period while they were incarcerated, they may be included in the active caseload so long as this exception is specified in the methodology.