2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Enhancing HIV Care though Statewide CQI Collaborative: Lessons Learned from Alabama, Ohio and Rhode Island

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Learning Objectives:

- Identify successes and challenges to developing a statewide CQI Collaborative
- Describe effective data collection processes and the subsequent interventions employed to improve outcomes in the continuum of HIV Care
- Describe how streamlining CQI processes can advance the quality of care
- Discuss available tools and resources to conduct joint quality improvement efforts in their jurisdiction

Ohio Participation

13 recipients with a total of **10,349** clients!

Ohio had the 2nd highest participation in the H4C Collaborative.

Goals of H4C:

1. Build regional capacity to close gaps across the HIV Care Continuum to ultimately increase viral suppression rates for people living with HIV (PLWH) within Ohio.
2. Align clinical quality management (CQM) goals across all RWHAP Parts and with jurisdictional or state goals to jointly meet the legislative CQM mandates; and
3. Implement joint quality improvement activities to advance the quality of care for PLWH within a state and to coordinate HIV services seamlessly across RWHAP Parts.

H4C Ohio Aim Statement (Beginning of Collaborative)

***Ohio** will revisit and reconfigure team membership; engage a spectrum of OH HIV agencies in H4C; create a CQM plan with a communication plan; engage all RWHAP-funded HIV medical providers in submitting data on H4C measures every 2 months; conduct a consumer QI training.*

Goal #1: Close Gaps across the Continuum

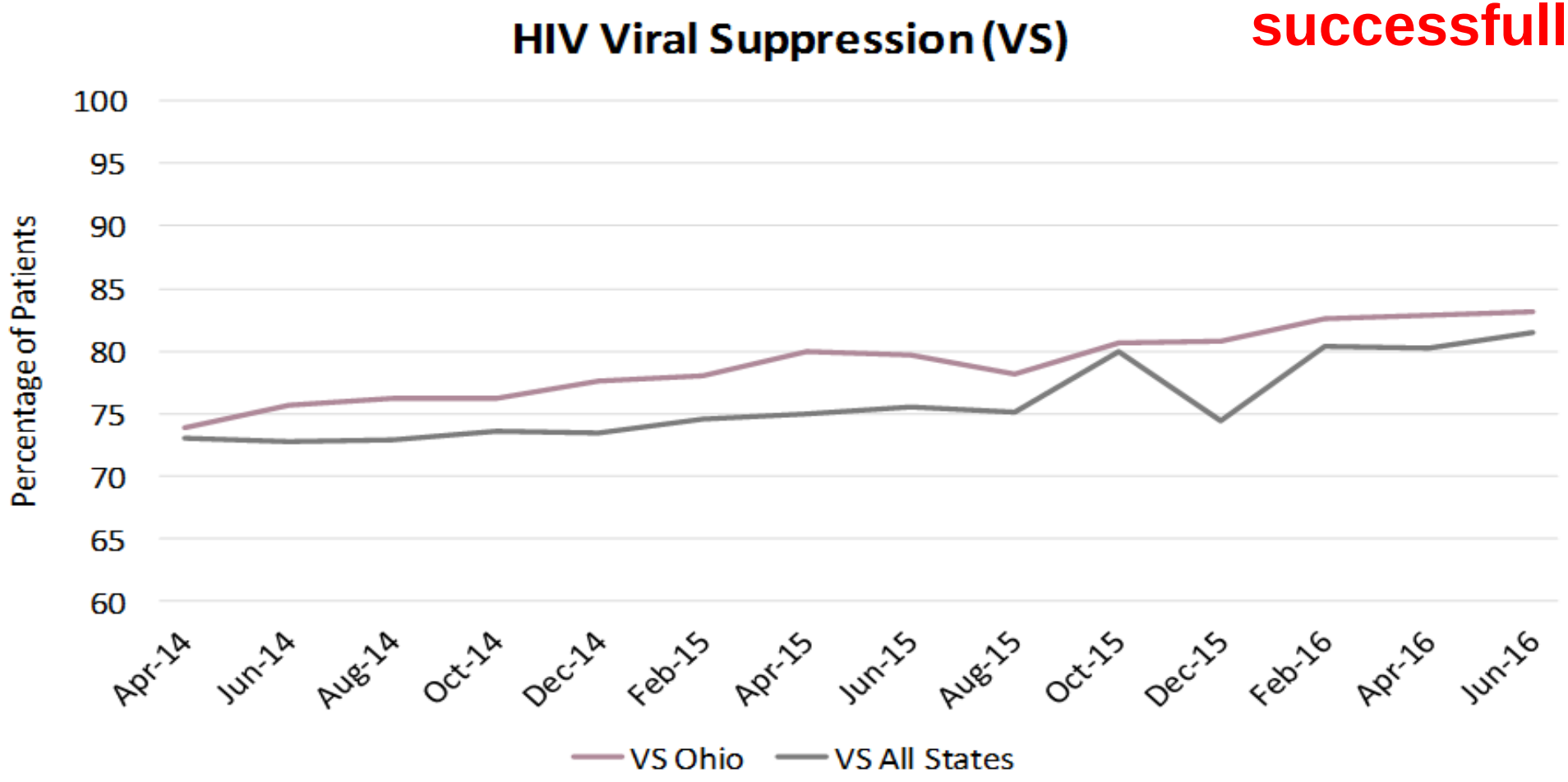
- Response Team Formation
- Data Coordination
- Streamlining Performance Measure Definitions
- Measured 4 performance measures over the duration of the H4C Collaborative (April 2014 – December 2015) and post-Collaborative (February – June 2016)
  - Prescription of HIV Antiretroviral Therapy (ARV)
  - Gaps in HIV Medical Visits (GAP)
  - HIV Medical Visit Frequency (MVF)
  - HIV Viral Suppression (VS)
- Saw significant improvements in ARV and VS rates

H4C Data Collection Template

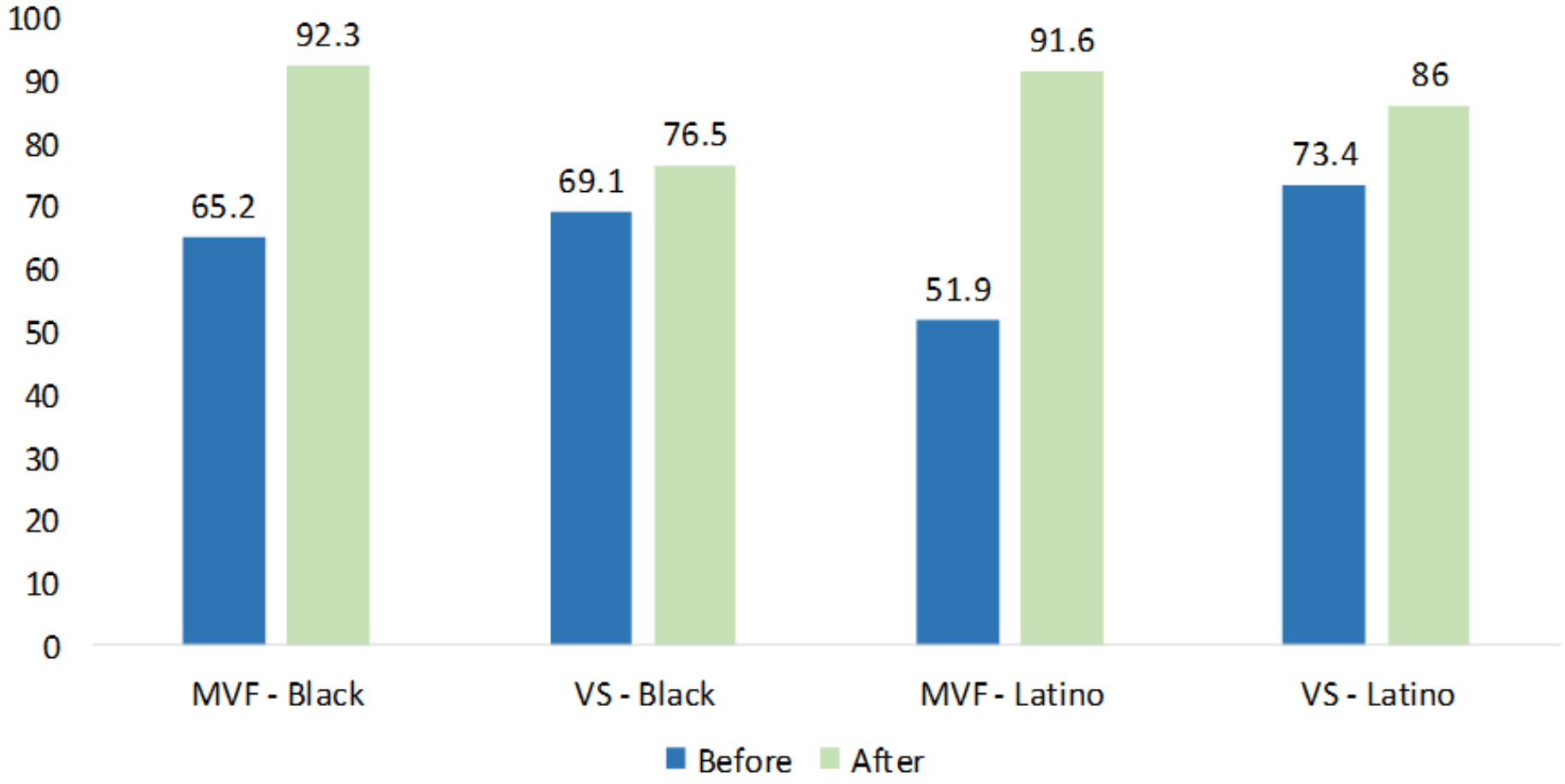
	HIV Viral Load Suppression (≤200)			Rx of ARV Therapies			HIV Medical Visit Frequency			Gap in HIV Medical Visits		
	Num.	Denom	%	Num.	Denom.	%	Num.	Denom.	%	Num.	Denom.	%
Total												
Race/ethnicity: Black												
Race/ethnicity: Latino												
Race/ethnicity: White												
Race/ethnicity: Other												
Race/ethnicity: Total												
Gender: Male												
Gender: Female												
Gender: Transgender												
Gender: Total												
Age: 0-12												
Age: 13-18												
Age: 19-24												
Age: 25-34												
Age: 35-44												
Age: 45-54												
Age: 55-64												
Age: 65 and older												
Age: Total												
Non Suppressed cohort												
(Other disparity)												
(Other disparity)												
(Other disparity): Total												

Ohio H4C Data Submission

H4C Goal 1 successfully met!



Performance Measure Improvement in Black & Latino Patients

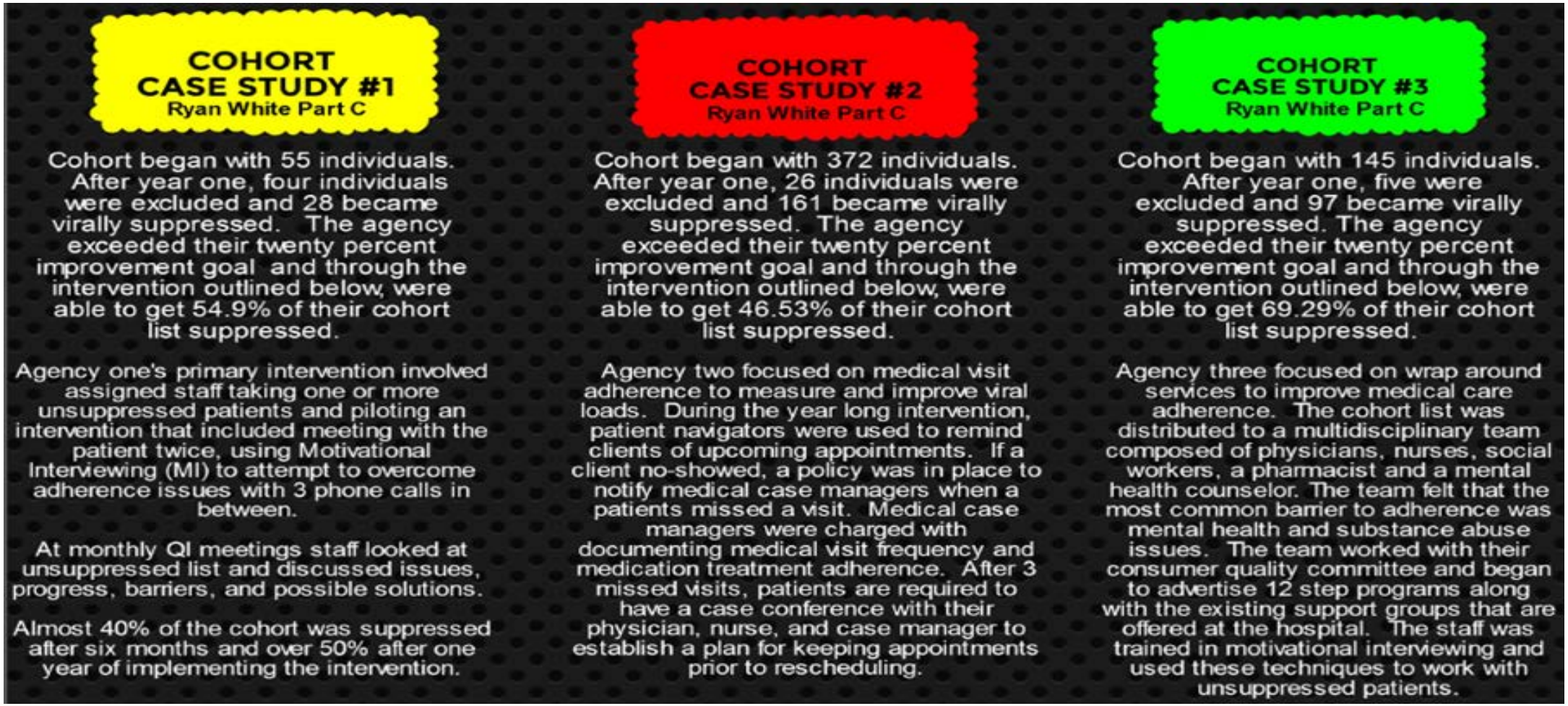


Goal #2: Aligning CQM Goals Across Parts

- Ohio Response Team in place to foster cross-Part alignment and collaboration
  - Sustained after official end of H4C Collaborative
- Written statewide CQM plan with buy-in from regional recipients
- Participated in CQII-sponsored trainings (TOT, TCB)
  - Also had capacity building at statewide meetings and CAREWare trainings
- Consumer involvement in TCQ training, QI projects, and Response Team
- Create QI projects based on identified disparities

H4C Goal 2 successfully met!

Ohio Quality Crusaders: 3 QI projects



Lessons Learned:

- Building a foundation of trust before work can be done is ESSENTIAL!
- TIME!
- Dedication
- Standardizing performance measure definitions and building a platform for transparency and open-mindedness all lead to innovative ideas
- QI training opportunities not only for providers but also consumers provides opportunity for capacity building
- Having solid funding sources is critical not only for programing but also technical assistance

Final Lessons Learned:

"Thanks to H4C, Ohio has an improved cross-Part infrastructure and communication system. We have strengthened statewide data collection and created our first ever statewide Ryan White Continuum of Care."

H4C Goal 3 successfully met!

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2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Ryan White CoEXIST HIV Provision of Care/Administration & Technical Assistance to Deliver Early Intervention Services

Amy Nunn, ScD
Cassandra Sutten Coats, ScM
Genoviva Sowemimo-Coker, MPH

Rhode Island Public Health Institute
The Miriam Hospital Center for Infectious Disease

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

RI COEXIST HIV

RIPHI Mission

To promote community health and to reduce health disparities in Rhode Island and beyond.

We develop innovative public health programs, conduct translational and policy research, and train students and public health practitioners.

Partner Agencies

RIPHI RHODE ISLAND PUBLIC HEALTH INSTITUTE

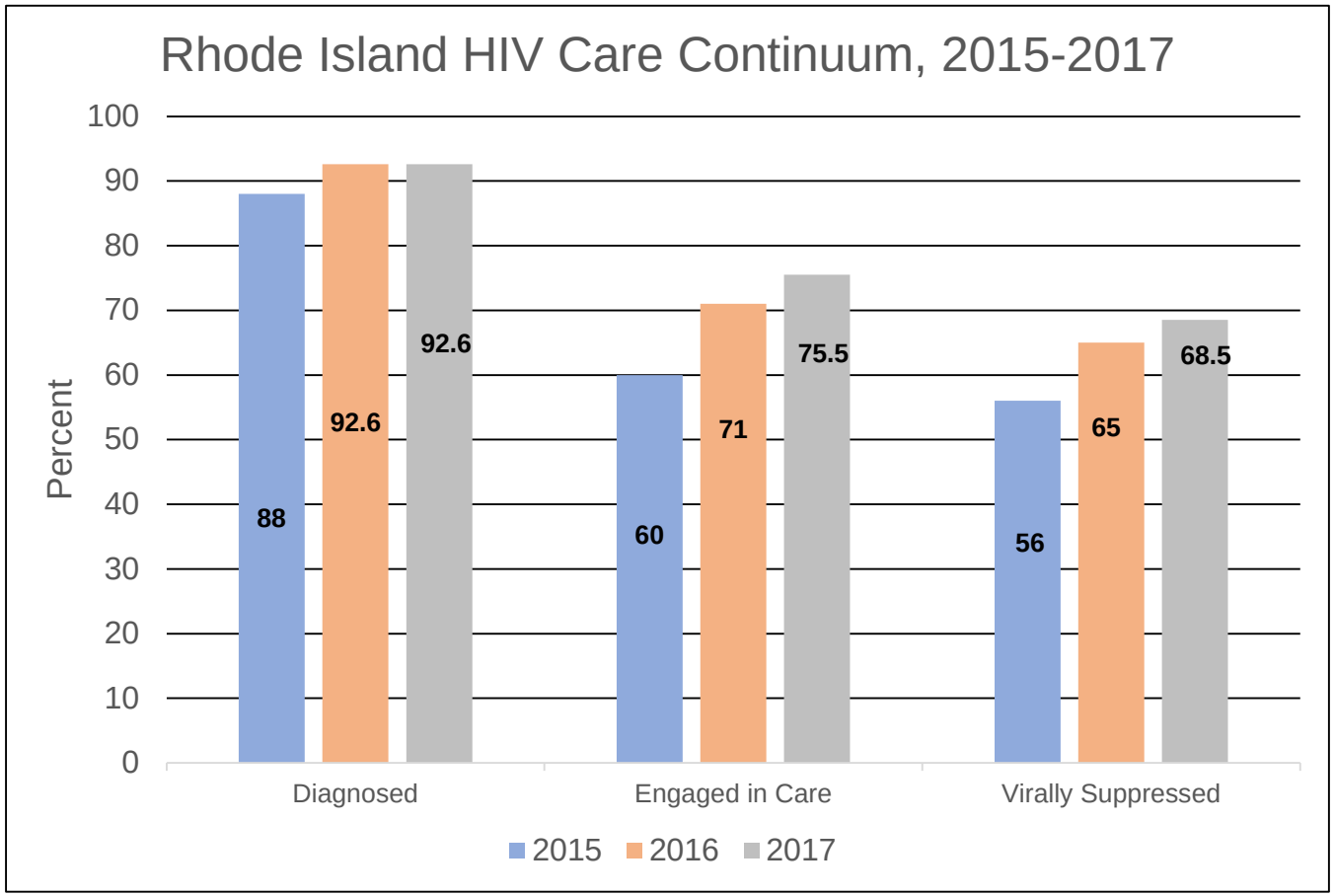
The Rhode Island STD Clinic

A collaboration between RIDOH and The Miriam Hospital

Testing for HIV and other STDs
Wednesday, Thursday, and Friday
12:30-3:30pm

RIPHI CoEXIST Background

- Approximately 400 Rhode Islanders are living with HIV and are unaware of their infection.
- There is currently no integrated tracking system to identify these individuals, link them to care, and follow them to viral suppression and beyond.
- The majority of people who are newly diagnosed with HIV meet their partners online.

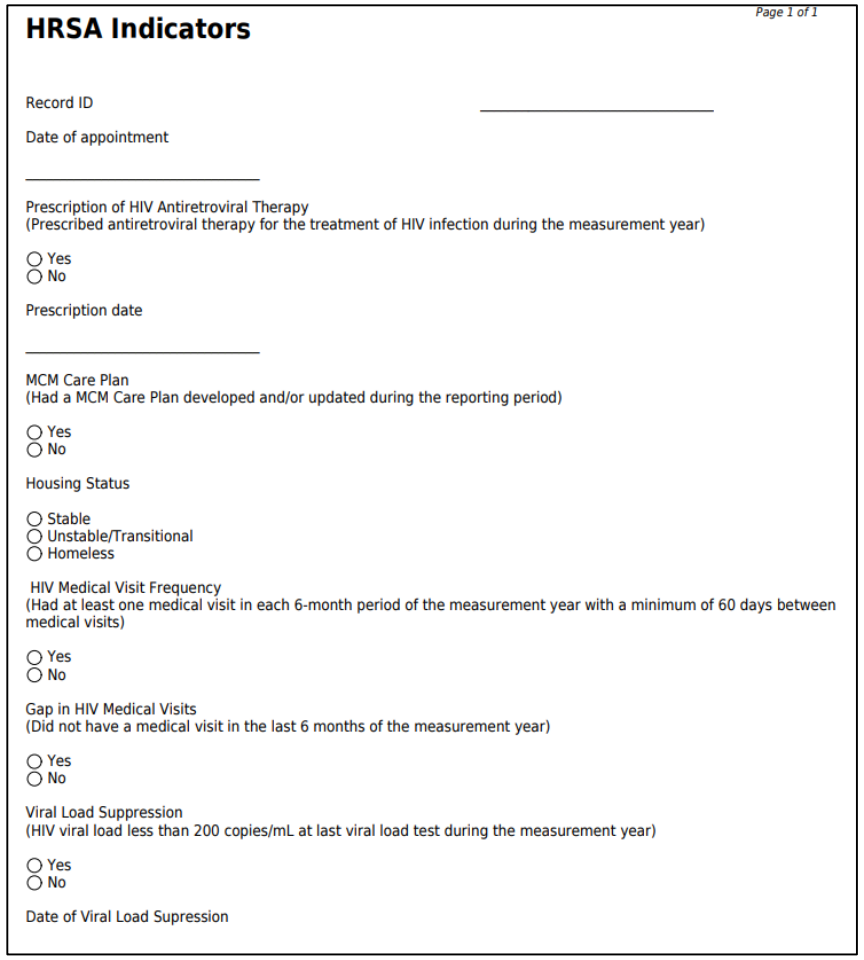


RI DOH, 2018

RIPHI Objectives

1. Develop an EIS program designed to serve all of Rhode Island;
2. Screen 400 MSM annually;
3. Link 95% of individuals with a reactive HIV rapid test to care within 7 days;
4. Achieve viral suppression in 100% of people who are diagnosed;
5. Enroll 200 high-risk MSM who do *not* have a reactive test in education & counseling, PrEP services, partner referral services, STD testing, & condom distribution;
6. Raise awareness about HIV screening and linkage to care services on “hookup apps” among MSM who may be unaware of their HIV infection, with a focus on promoting screening.

Database Development



Page 1 of 1

HRSA Indicators

Record ID _____

Date of appointment

_____

Prescription of HIV Antiretroviral Therapy
(Prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year)

◯ Yes
◯ No

Prescription date

_____

MCM Care Plan
(Had a MCM Care Plan developed and/or updated during the reporting period)

◯ Yes
◯ No

Housing Status

◯ Stable
◯ Unstable/Transitional
◯ Homeless

HIV Medical Visit Frequency
(Had at least one medical visit in each 6-month period of the measurement year with a minimum of 60 days between medical visits)

◯ Yes
◯ No

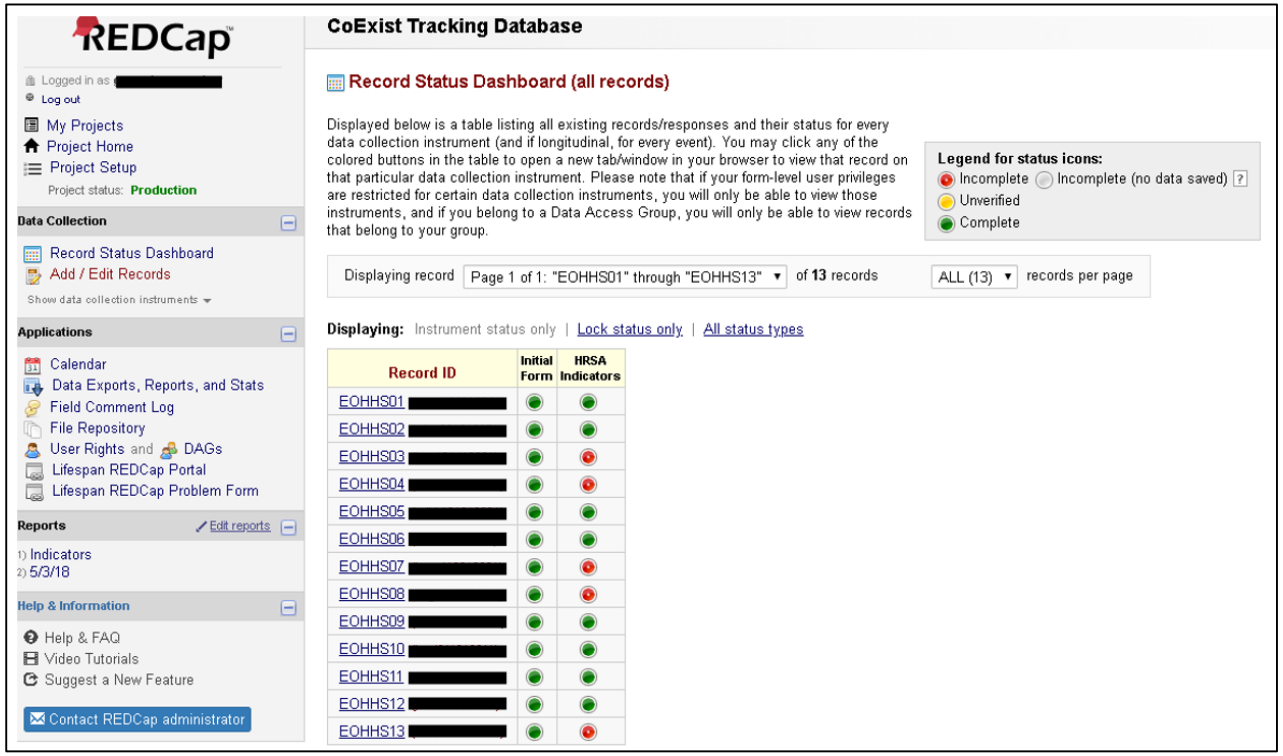
Gap in HIV Medical Visits
(Did not have a medical visit in the last 6 months of the measurement year)

◯ Yes
◯ No

Viral Load Suppression
(HIV viral load less than 200 copies/mL at last viral load test during the measurement year)

◯ Yes
◯ No

Date of Viral Load Supression



REDCap

Logged in as [redacted]
Log out

My Projects
Project Home
Project Setup
Project status: Production

Data Collection
Record Status Dashboard
Add / Edit Records
Show data collection instruments

Applications
Calendar
Data Exports, Reports, and Stats
Field Comment Log
File Repository
User Rights and DAGs
Lifespan REDCap Portal
Lifespan REDCap Problem Form

Reports Edit reports
1) Indicators
2) 5/3/18

Help & Information
Help & FAQ
Video Tutorials
Suggest a New Feature
Contact REDCap administrator

CoExist Tracking Database

Record Status Dashboard (all records)

Displayed below is a table listing all existing records/responses and their status for every data collection instrument (and if longitudinal, for every event). You may click any of the colored buttons in the table to open a new tab/window in your browser to view that record on that particular data collection instrument. Please note that if your form-level user privileges are restricted for certain data collection instruments, you will only be able to view those instruments, and if you belong to a Data Access Group, you will only be able to view records that belong to your group.

Legend for status icons:
Incomplete | Incomplete (no data saved) | Unverified | Complete

Displaying record Page 1 of 1: "EOHHS01" through "EOHHS13" of **13** records ALL (13) records per page

Displaying: Instrument status only | Lock status only | All status types

Record ID	Initial Form	HRSA Indicators
EOHHS01 [redacted]		
EOHHS02 [redacted]		
EOHHS03 [redacted]		
EOHHS04 [redacted]		
EOHHS05 [redacted]		
EOHHS06 [redacted]		
EOHHS07 [redacted]		
EOHHS08 [redacted]		
EOHHS09 [redacted]		
EOHHS10 [redacted]		
EOHHS11 [redacted]		
EOHHS12 [redacted]		
EOHHS13 [redacted]		

HIV Screening & Linkage to Care

Table 1. Demographics and key characteristics of MSM screened for HIV between August 1, 2017 and August 31, 2018 (n = 1207)

		n (%)
Age		
	15-19	44 (4.0)
	20-29	535 (44.0)
	30-39	304 (25.0)
	40+	308 (26.0)
Hispanic/Latino		258 (21.2)
Race		
	Black/African American	146 (11.9)
	White	809 (66.0)
	Other	272 (22.1)
Sexual Orientation		
	Heterosexual	25 (2.0)
	Gay	931 (75.9)
	Bisexual	190 (15.5)
	Other	81 (6.6)
Met Partners Online		502 (42%)

HIV Screening & Linkage to Care

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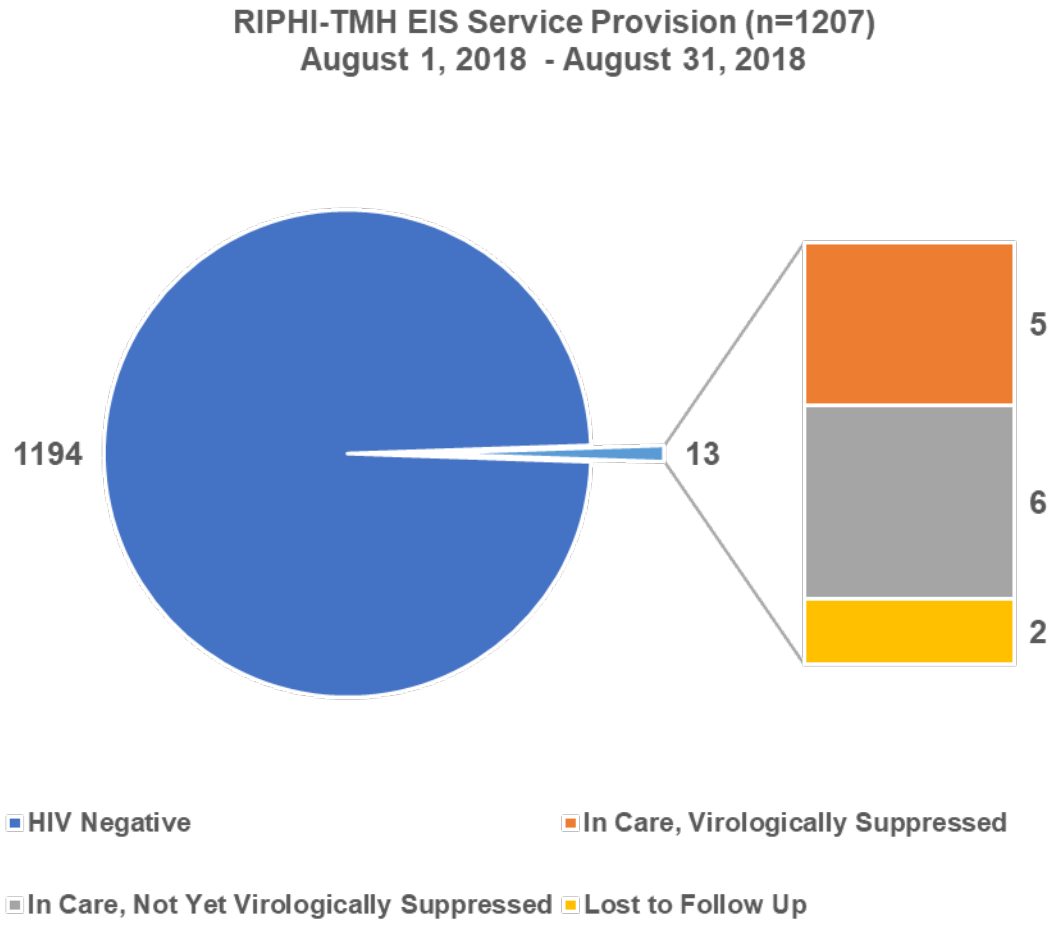
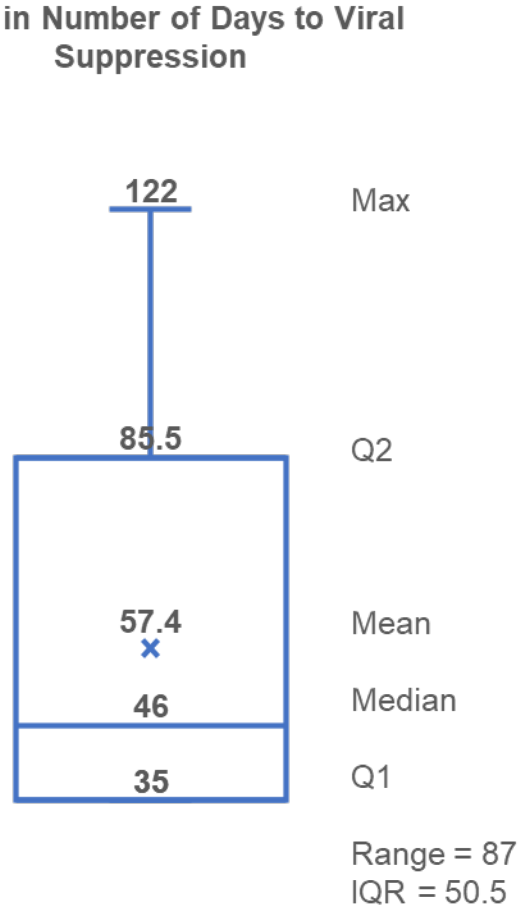
	Gay	931 (75.9)
	Bisexual	190 (15.5)
	Other	81 (6.6)
Met Partners Online		502 (42%)

Table 2. Demographics and key characteristics of MSM receiving a reactive HIV test between August 1, 2017 and August 31, 2018 (n = 13)

		n (%)
Age		
	15-19	0 (0)
	20-29	7 (53.8)
	30-39	5 (38.5)
	40+	1 (7.1)
Hispanic/Latino		6 (46.2)
Race		
	Black/African American	2 (15.4)
	White	6 (46.2)
	Other	5 (38.5)
Sexual Orientation		
	Heterosexual	1 (7.7)
	Gay	10 (76.9)
	Bisexual	2 (15.4)
Ryan White Eligible		1 (7.7)
Rapid Test Location		
	TMH	7 (53.8)
	Other	6 (46.2)

Clinical Outcomes





Lessons Learned

Challenges

- Developing infrastructure for real time data collection can be time consuming or expensive
- Investment in data collection may be low compared to investment in service provision

Successes

- Identified gaps in the HIV care continuum and developed and formalized new linkage to care protocols between a local ASO and STI clinic
- 100% of diagnosed individuals were successfully linked to care
- We are continuing follow-up of all 10 individuals who are currently in care, 50% of whom are virally suppressed

Lessons Learned

1. Real-time CQI efforts dramatically improved linkage and retention in care at a local ASO and an STD clinic.

2. Technological investments facilitate easier data tracking, management, and analysis to identify and stop gaps in existing protocols and procedures.

3. Large-scale successes in CQI in statewide initiatives requires robust collaborative training and community engagement.

4. Statewide CQI initiatives must be tailored to respond to participating partners' needs to have maximal effect.

ALABAMA QUALITY Management Group

Ashley Tarrant, MPH
Jitesh Parmar, MBA, MPH

Learning Objectives:

- Identify successes and challenges to developing a statewide CQI Collaborative
- Describe effective data collection processes and the subsequent interventions employed to improve outcomes in the continuum of HIV Care
- Describe how streamlining CQI processes can advance the quality of care
- Discuss available tools and resources to conduct joint quality improvement efforts in their jurisdiction

Mission Statement

"The Alabama Regional Quality Management Group exists to ensure that those living with HIV/AIDS in the state of Alabama receive quality healthcare through the collaboration of healthcare partners throughout the state. The mission will be achieved by continuously collecting and analyzing data collected by healthcare partners and evaluating the effect on patient outcomes in accordance with the National HIV/AIDS Strategy, and by nationally and locally recognized standards of care and current HIV research."

Vision Statement

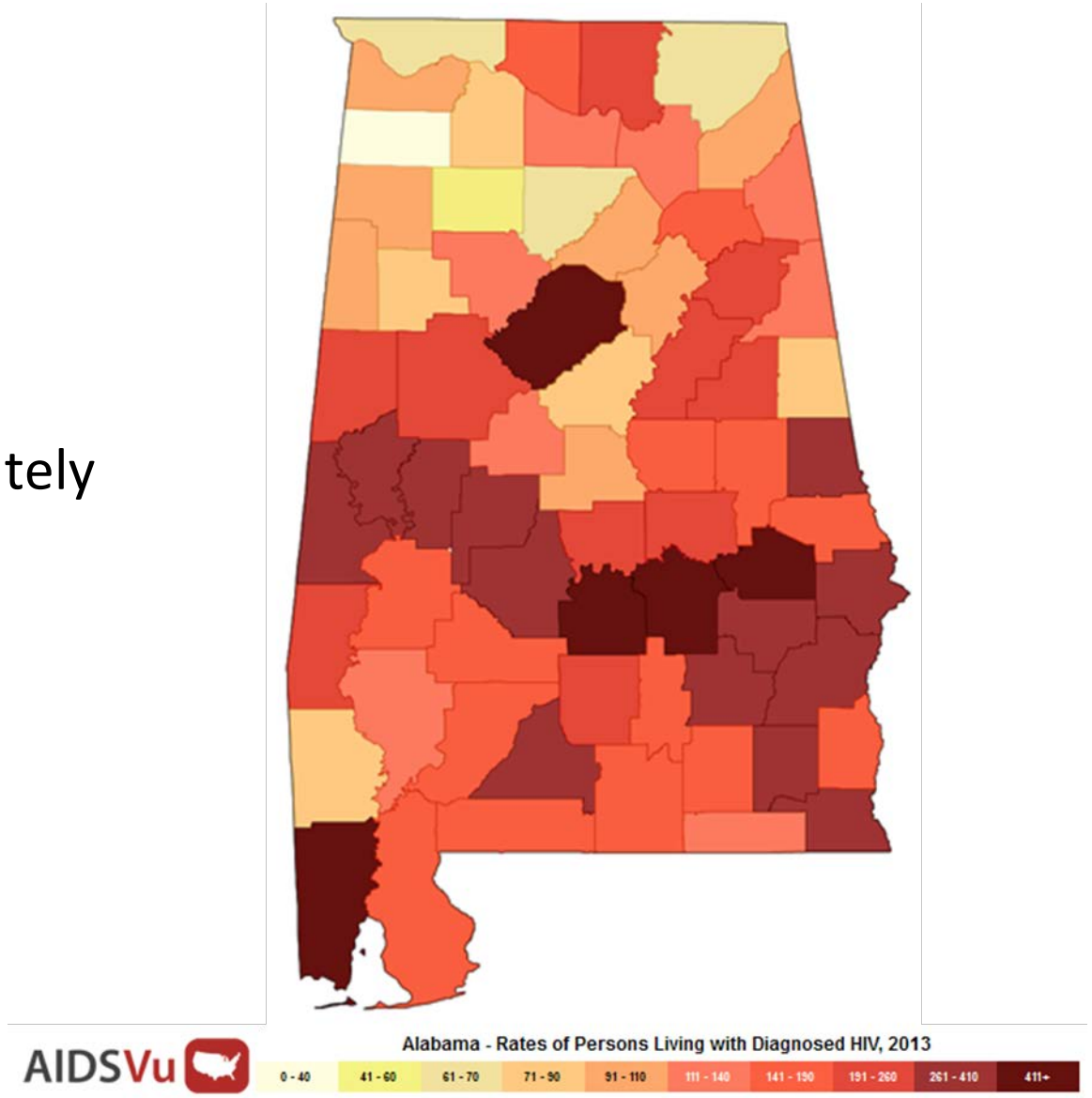
"We envision optimal health for everyone living with HIV/AIDS supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities."

Group Members

- Thrive Alabama-Huntsville, AL
- 1917 Clinic/CFAR-Birmingham, AL
- UAB Family Clinic-Birmingham, AL
- Health Services Center-Anniston, AL
- Whatley Health Services-Tuscaloosa, AL
- Unity Wellness Center-Auburn, AL
- Medical Advocacy and Outreach-Montgomery, AL
- Alabama Department of Public Health-Division of HIV/AIDS Prevention and Care-Montgomery, Alabama
- Franklin Primary Health Center-Mobile, AL
- University of South Alabama Family Specialty Clinic-Mobile, AL
- Birmingham AIDS Outreach-Birmingham, AL
- AIDS Alabama-Birmingham, AL
- AIDS Alabama South, LLC – Mobile, AL
- Selma Friends for Life– Selma, AL

Group Impact

- Alabama has 12, 758 individuals diagnosed with HIV
- AQMQ provides services to 6,350 individuals living with HIV; approximately 49.8% of individuals living with HIV in Alabama.



History of AQMG

- Formed in 2006 under the guidance of the National Quality Center.
- Original group members were quality leaders in RW Part C and D clinics from Huntsville, Alabama to Mobile, Alabama.
- Participants represented all 67 counties in the state of Alabama.

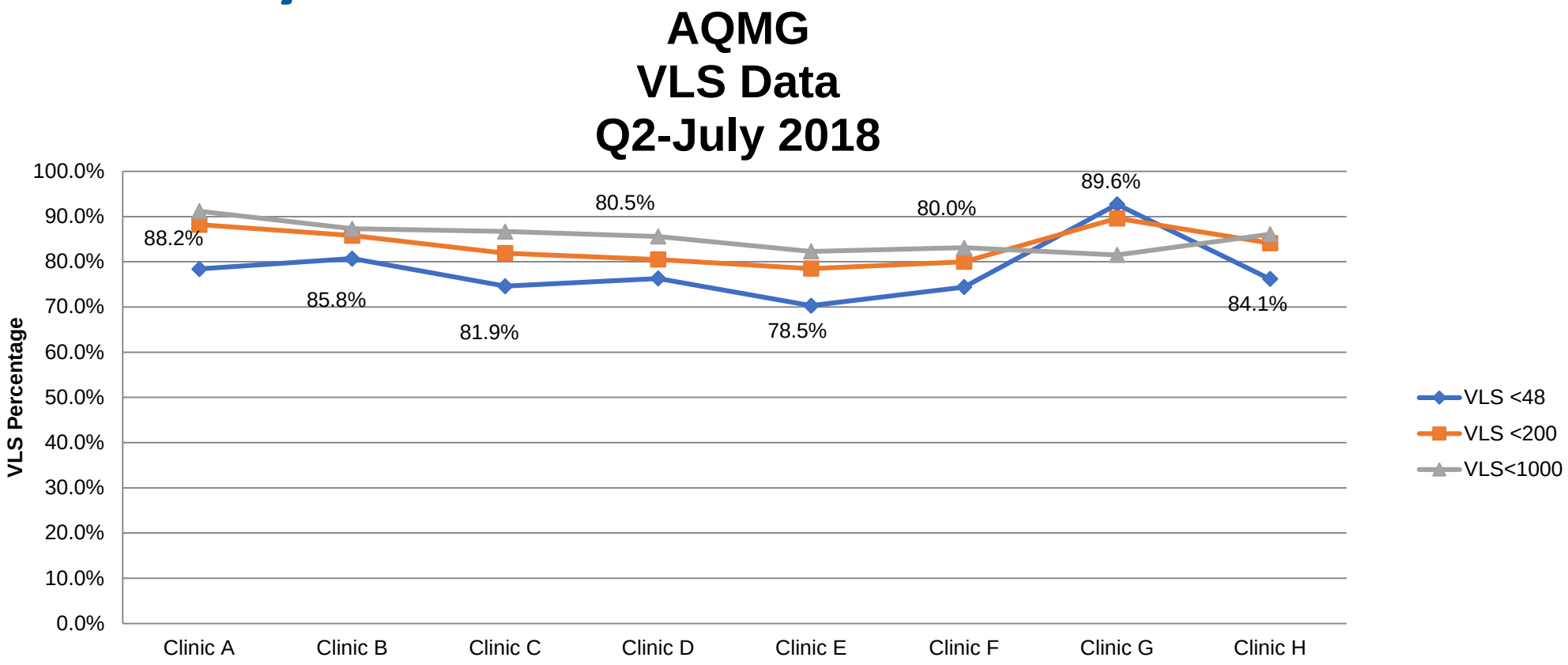
Goals of AQMG:

1. Collect, prioritize, and analyze agreed upon data using approved CQI methodologies.
2. Identify and promote effective CQI strategies through training opportunities.
3. Enhance understanding and local application of CQI knowledge, methods, and tools directed toward improving patient care.
4. Assist Ryan White grantees in meeting HRSA's QM requirements.
5. Assist with the establishment and implementation of the state quality management plan.

Data Collection & Analysis

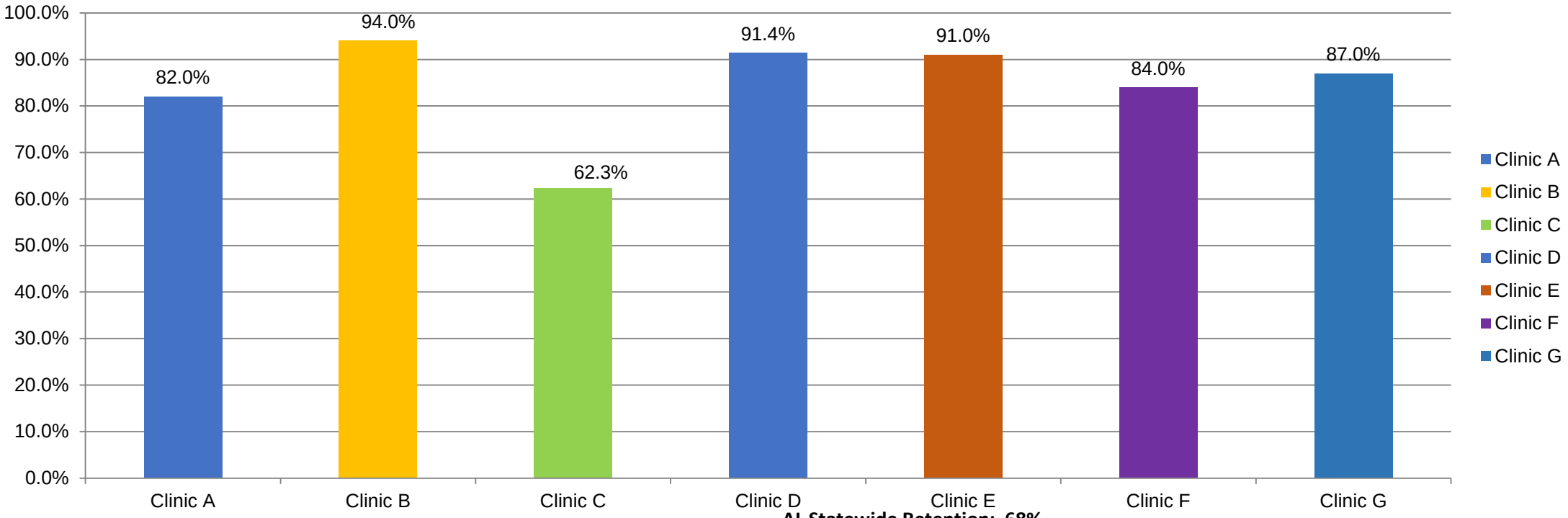
- Viral Suppression
- Retention in Care
- No Show Rates
- New Patients

Data Analysis



Mean VLS: 87.3%
AL Statewide VLS: 73%
2020 National AIDS Strategy Goal: 80%

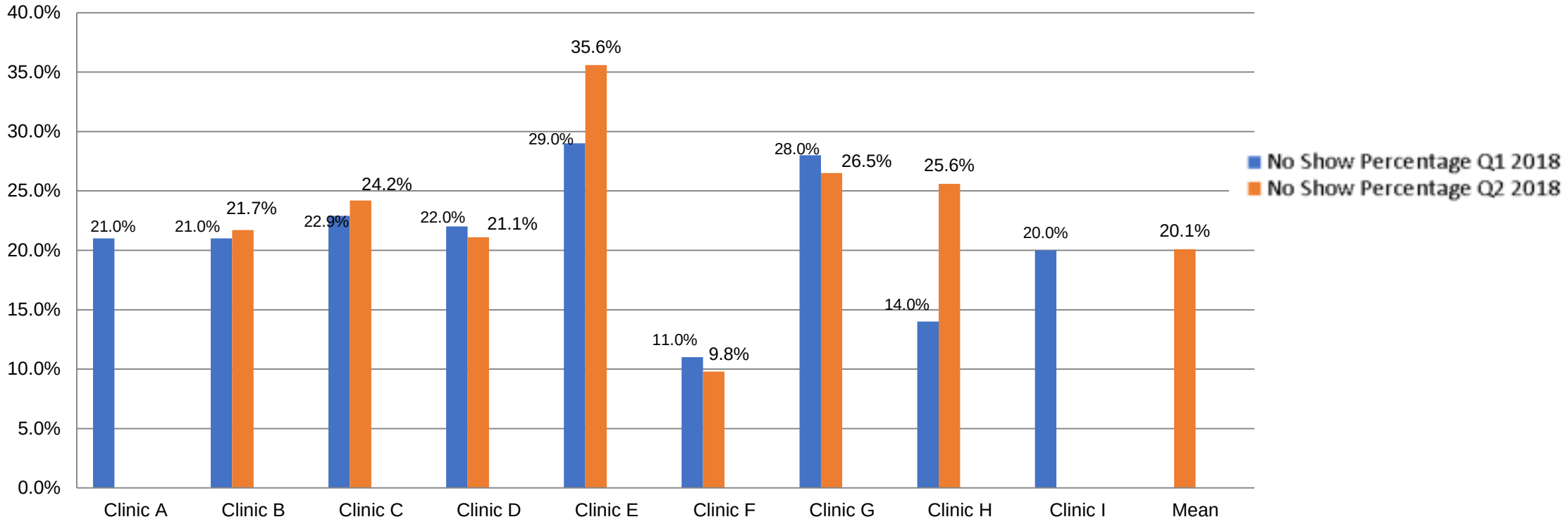
AQMG
2017 Retention In Care



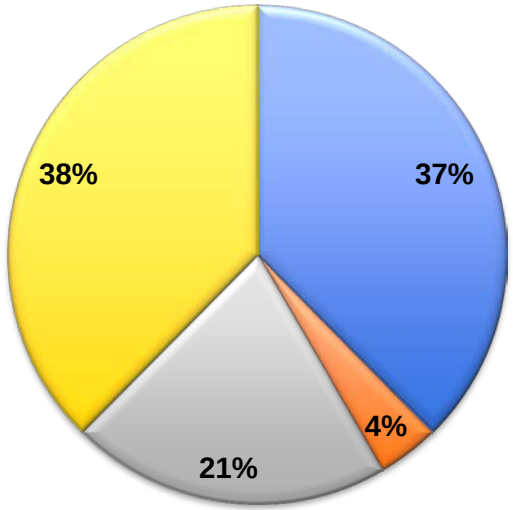
AL Statewide Retention: 68%

2020 National AIDS Strategy Goal: 90%

AQMG
No-Show Percentage Q1-Q2 2018



AQMG
New Pt Composition
2018-Q2



- 1) Newly Diagnosed (within past 90 days) Identified PLWHA who are new to care
- 2) Previously DX PLWHA who never been in care
- 3) PLWHA returning to care after more than 12 month absence
- 4)PLWHs newly enrolling into the program who have transferred from another medical provider

AQMG Successes

- Routine meetings for past 12 years.
- Multidisciplinary team
  - Consumer representation
- Congressional presentation
- Drivers of policy changes
  - Data sharing agreements
  - Data 2 Care Project
- Secured funding for Data 4 Care Intervention
- Created brand identity for group

AQMG Challenges

- Peer-Led group
- Consumer involvement
- Geographical disbursement of members
- Remaining Focused

Sustainability Plan for Ohio

Continue to:

- Meet in-person at least quarterly to sustain relationships & trust
- Gather, review & share All-Parts data regularly on key performance measures
- Identify QI Training opportunities for consumers as well as providers
- Dedicate resources as needed for logistic support in accomplishing the above
- Participate in CQII's ECHO End+Disparities collaborative

Sustainability Plan for Rhode Island

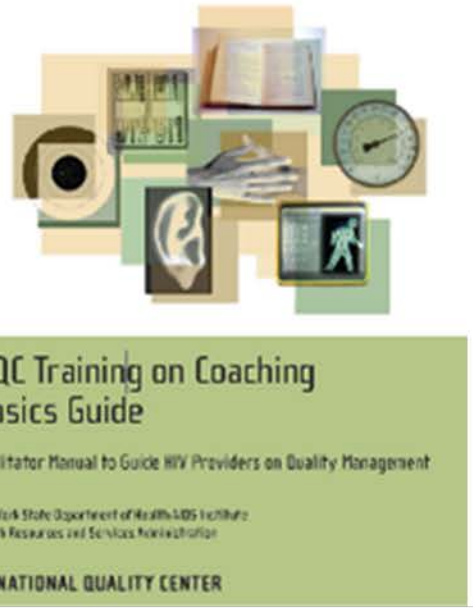
- Continue quarterly meetings to sustain and improve relationships with relevant stakeholders
- Review clinical outcomes to ensure we are meeting service category deliverables
- Attend regular QI training events for research team and key providers
- Allocate resources to ensure there is logistic and financial support for trainings.

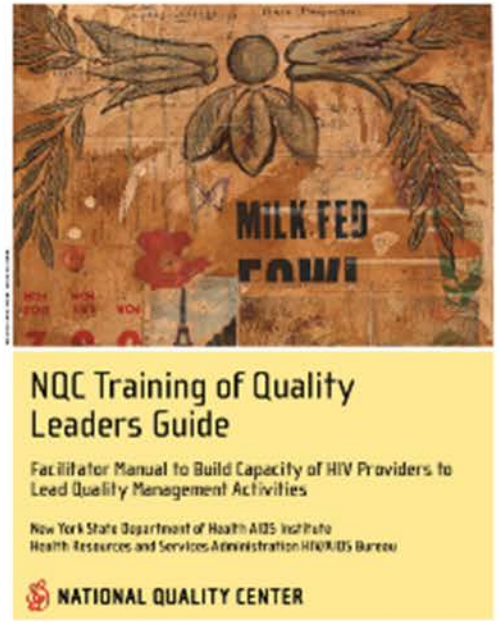
Sustainability Plan for Alabama

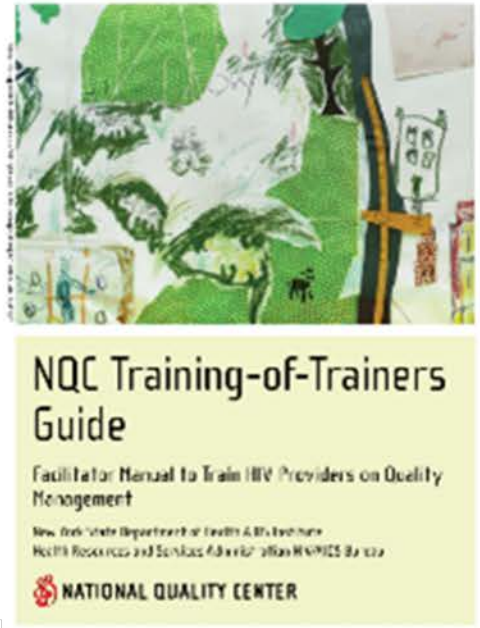
- Continue quarterly meetings to sustain and improve relationships with relevant stakeholders
- Evaluate methods to engage remaining agencies who do not participate in the group.
- Continue data collection and review of clinical outcomes to ensure we are meeting and/or exceeding HRSA standards.Continue group discussions to determine additional projects and funding opportunities.

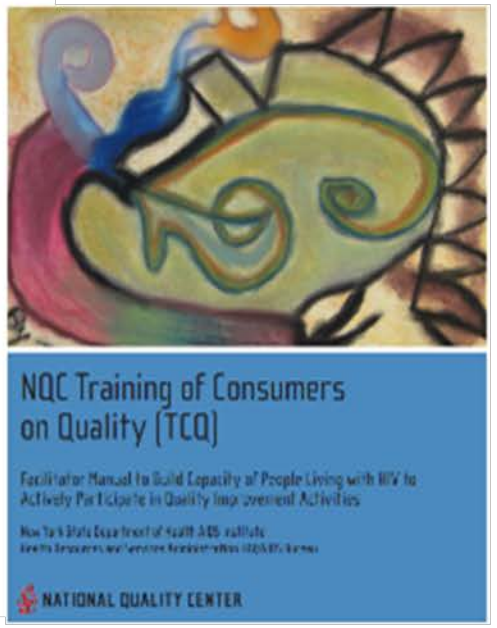
Advanced Training Programs

- ✓ Training-of-Trainers (TOT) Program
- ✓ Training of Quality Leaders (TQL) Program
- ✓ Training on Coaching Basics (TCB) Program
- ✓ Training of Consumers on Quality (TCQPlus) Program

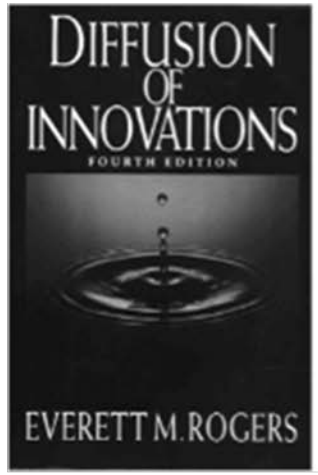


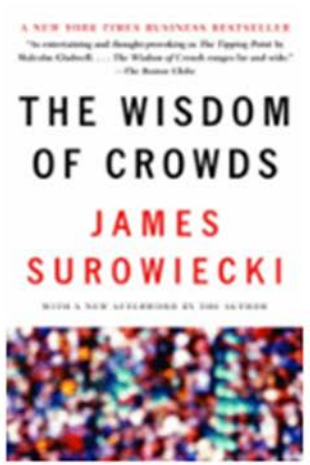


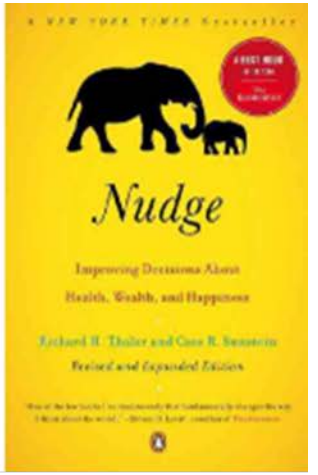


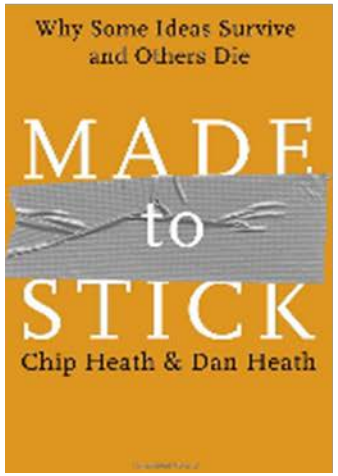


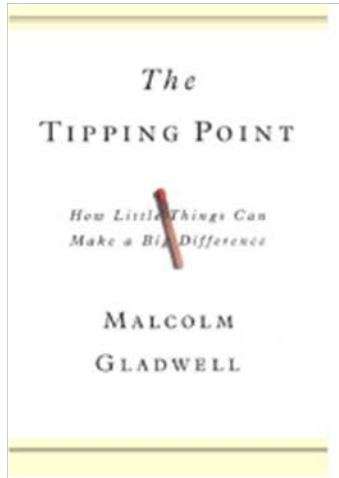
Additional Resources

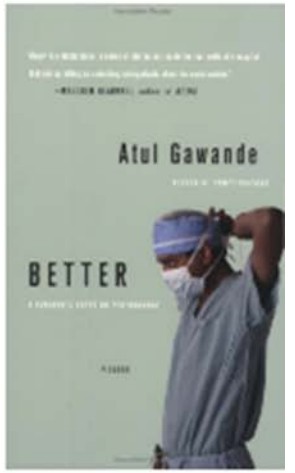













Q&A