2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Identifying and Addressing Gaps within the HIV Treatment Cascade using QI and a Multidisciplinary Approach

Barry White, MS

Stacey Hargrove, BSW

Ryan White Part B, Quality Program Data Manager

Ryan White Part B, Quality Program Coordinator

East Carolina University Adult Specialty Care – Greenville NC

Disclosures

Presenter(s) has no financial interest to disclose.

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Identify opportunities for improvement by cross-examining HIV treatment cascade data among newly diagnosed patients
2. Discuss collaborative approaches and lessons learned in the development and implementation of quality initiatives conducted by multi-disciplinary teams
3. Describe the linkage to care process using the Define-Measure-Analyze-Improve-Control Methodology

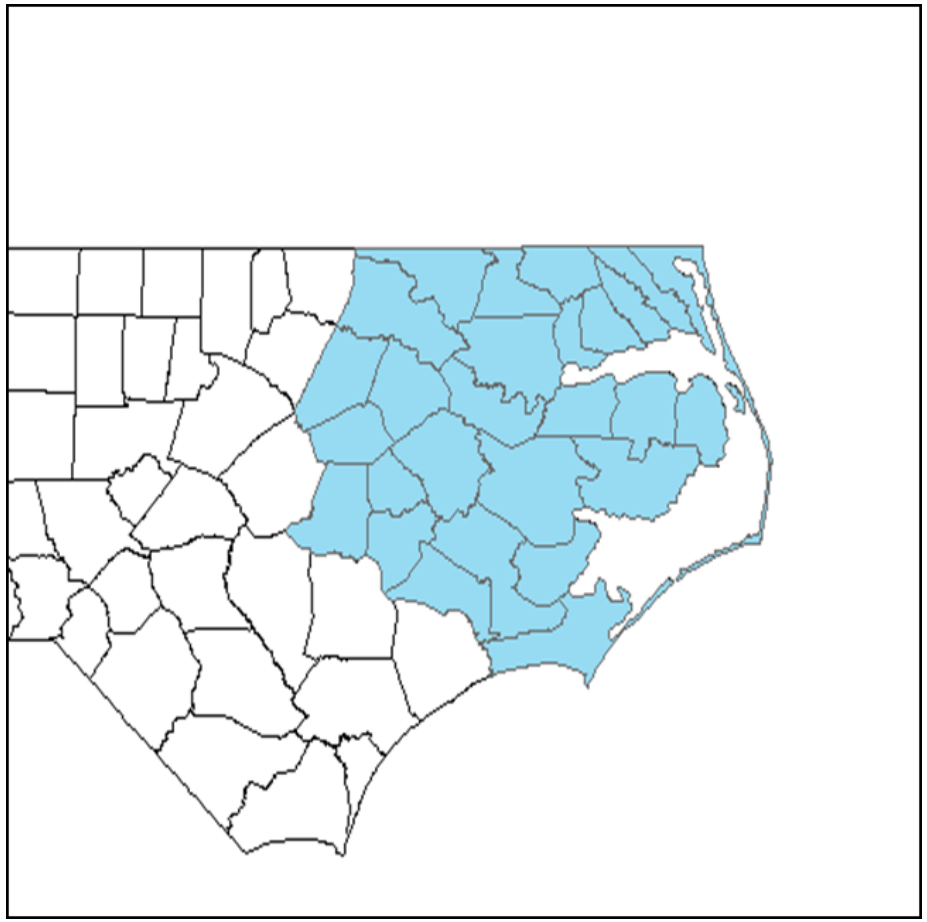
Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

East Carolina University HIV Program

- Primary Provider for HIV Care in Eastern North Carolina (ENC) - 30 Counties
- 14 counties covered by our existing RW Part C (RWPC) grants
- 5 counties covered by new Ryan White Part C (RWPC) -New Geographic Service Area (NGSA) Grant
- 11 Counties Serviced by our RWPB Grant



Core Medical & Support Services Provided

Four RW Grants

- RWPC: men >25 year of age; covers 14 counties in ENC
- RWPC-NGSA: covers men > 25 years of age- living in 5 counties (Lenoir, Wayne, Greene, Jones, and Carteret)
- RWPD: women, infants, children and youth (WICY); and men <25 and; 28 counties
- RWPB: gaps in services in 11 counties

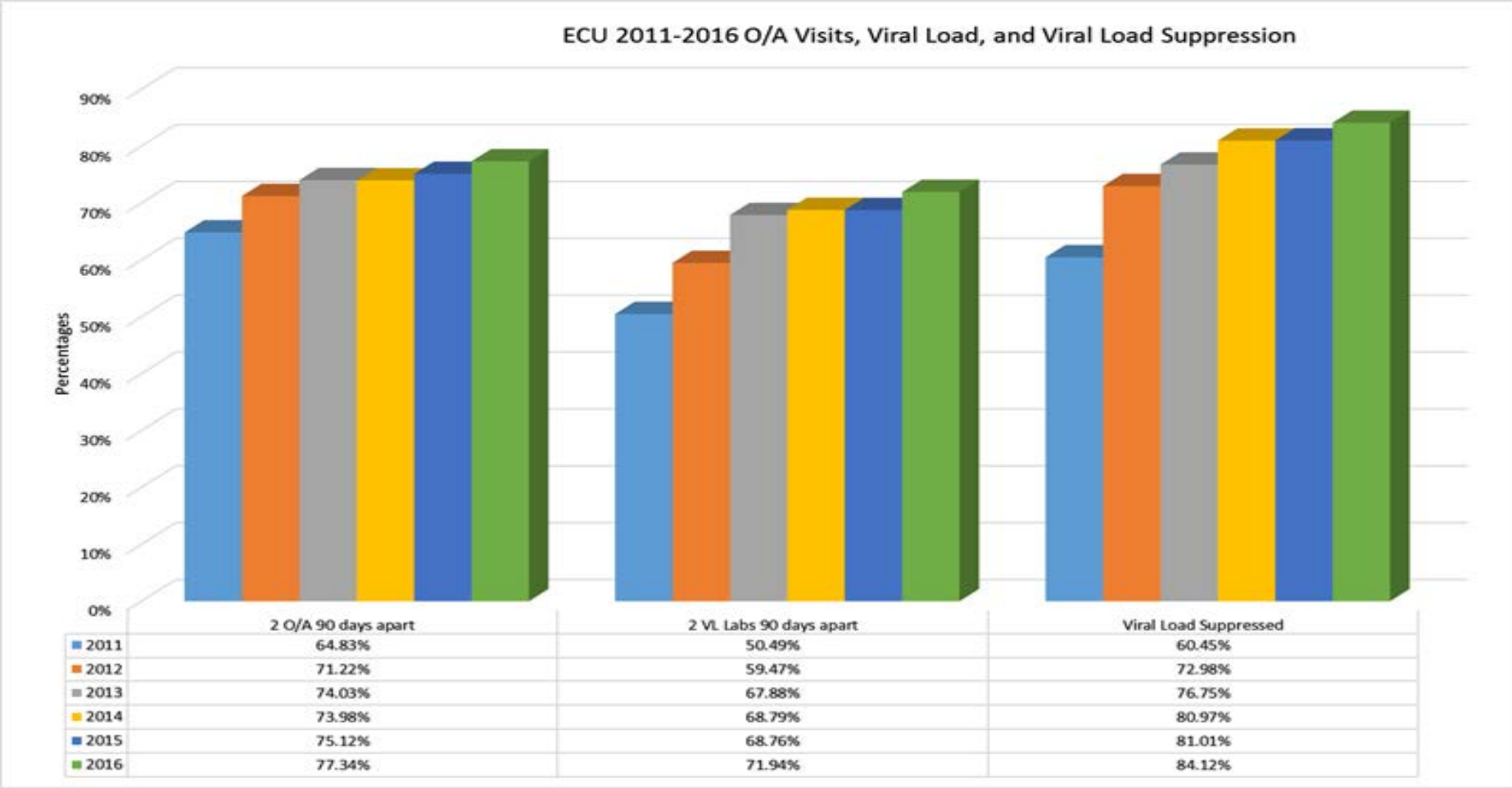
Other Grants

- Gilead – ED HIV Testing
- HRSA/Boston University – Community Health Worker

RW Program Income:

- 340b Program – RWPC/RWPD Program Income

5 year study improving VLS



	2 O/A 90 days apart	2 VL Labs 90 days apart	Viral Load Suppressed
2011	64.83%	50.49%	60.45%
2012	71.22%	59.47%	72.98%
2013	74.03%	67.88%	76.75%
2014	73.98%	68.79%	80.97%
2015	75.12%	68.76%	81.01%
2016	77.34%	71.94%	84.12%

The Road to 85

For five (5) years, our clinic utilized Plan-Do-Study-Act cycles to guide improvement in patient's treatment adherence

Through our PDSA cycles we Identified that there were several areas that needed attention

- Data Issues
- Education on HAB
- Patient Barriers to Care
- Employee responsibilities

Data and HABs

Data Issues

- Data was being collected from 3 different systems
  - Centricity, Epic, Paper Charts
- CAREWare was newly introduced to the clinic in 2011
  - Multiple people entering data
  - Understanding on what data was needed and why
  - Double entry of data lead to creation of data bridge project

Understanding of HABs

- 100% meeting of goal is great but not realistic for most, 85% ideal
- Show the performance of the practice and where there are gaps in specific areas
- How to use the HAB measures to aid in Quality Improvement

Barriers to Care

Throughout the five year project we were able to identify several barriers to why patients were not virally suppressed nor making their appointments

- Stigma
- Housing
- Transportation
- Education about the Disease
- Mental Health/Substance Abuse
- Name of the Clinic

Addressing Barriers

ECU is a One Stop Shop

- Outpatient Ambulatory Outpatient Services (OAMC)
- Early Intervention Services: HIV testing: Linkage to care
- Treatment Adherence Clinical Counseling
- Nutritional Screening and Treatment:
- Medical Case Management:
- Behavioral Health Services:
- Oral Health Services
- Non-Medical Case Management Services:
  - HIV Medication Assistance Program (HMAP)
  - Prescription Assistance program (PAP)
  - Transportation Assistance

Employee Responsibilities – Multidisciplinary Approach

- All employees who are paid from Ryan White will participate in QI
  - Front Desk, Nurses, Case Managers, Providers, IT, Nutritionist, MH/SA Counselor
- Ability to Identify and address barriers more efficiently
- The Creation of a Case Manager/Provider/Patient Model

RIC & VLS Summary

- When we first started looking at our data only 64% of our patients were meeting HAB 1 and only 60% were Virally Suppressed (approx. 1200 patients)
- At the end of the 5 year study we had reached 77% meeting HAB 1 and achieved a VLS rate of 84% (approx. 1500
- At the end of 2017 we were at 84% patients coming in at least twice a year and achieved a VLS rate of 86% (approx. 1566 patients)

Lessons Learned

1. Quality Improvement is not an overnight success.
2. Every process within the services offered need to be evaluated to create well-designed and well-functioning workflow
3. The obvious solution is not always the best solution nor conducive to workflow.
4. All staff need to be trained on any practice or policy changes that developed out of the outcomes. Until staff is trained and utilizing the changes, the complete product will not be effective.

Thank You

Barry White – Clinical Data Manager – whiteba@ecu.edu

Stacy Hargrove – Associate Program Manager – Hargrovest@ecu.edu