Using Plan, Do, Study and Act Model to Improve Client Health Outcomes in Rural and Urban Healthcare Settings

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Disclosures

Presenters have no financial interest to disclose.

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Learning Objectives

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

1. Apply unique strategies to quality improvement in rural and urban areas
2. Identify barriers to rural and urban HIV care and learn how to use SMART goals to overcome these barriers to care
3. Assemble ideas for quality improvement project outlines for both short-term and long-term timeframes

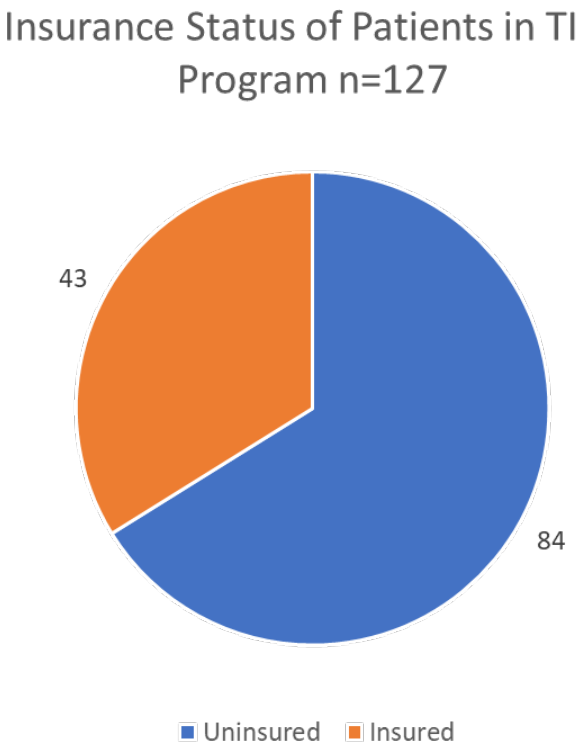
The CrossOver TIPS program
(Treatment Intervention Prevention Services)

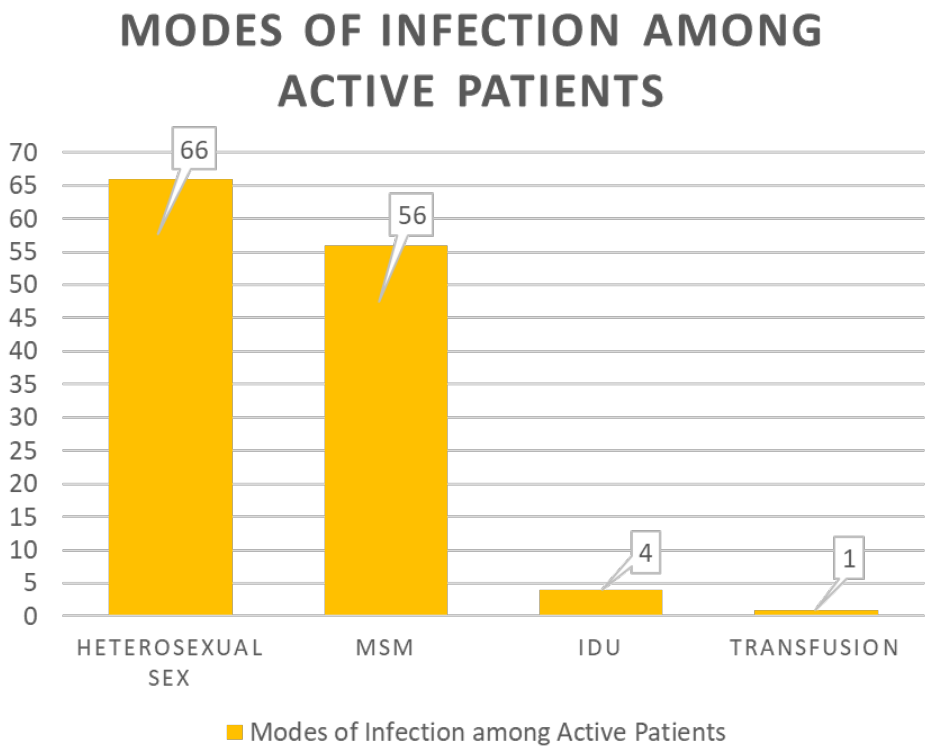
Program Overview

- CrossOver Healthcare Ministry (CrossOver) is a safety net clinic which continues to provide healthcare services in Central Virginia since 1983.
- In 2017, CrossOver served more than 5,000 patients at its two locations.
- Services offered:
  - On-site diagnostic testing;
  - Medical and nursing care;
  - Medical case management and non-medical case management;
  - Medication assistance;
  - Mental health;
  - Dental services;
  - Transportation; and
  - Specialty services.

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

TIPS Active Clients in 2017





HIV Medication and Treatment Adherence Improvement

Quality Improvement Project (QIP)

Quality Improvement Projects

Year 1

Plan:
Aid patients in adherence to visits and medications in order to improve viral suppression.

Do:
Provided transportation (bus, taxi), appointment reminder by telephone. Provided medication adherence education, and pill box for patients.

Study:
Transportation funding was limited. Follow-up phone calls (opt-in system) did not improve patient show of scheduled appointment.

Act:
Consider appointment reminder system once there is available personnel or an electronic version. Continue to reschedule missed appointments and provide pill boxes.

Year 2

Plan:
Explore correlation between viral load and treatment adherence (ART) with relationship to health literacy. Document missing appointments into eCW/EHR.

Do:
Selected 20 randomized patients and assessed patient's health literacy.

Study:

Medication adherence:
65% picked up their medication regularly, 20% did not refill medication on time, 15% became inactive.

Viral load suppression:
50% were not tested for 3rd quarter because they had been undetectable, 20% had reduction in viral load numbers, 5% had no changes in viral load numbers, and 10% had increase in viral load numbers.

Act:
Need for a validated tool for medication adherence assessment.

Year 3

Plan:
Improved visit adherence (retention in care), start using an electronic text and appointment reminder messages to notify patients in advance of their appointments.

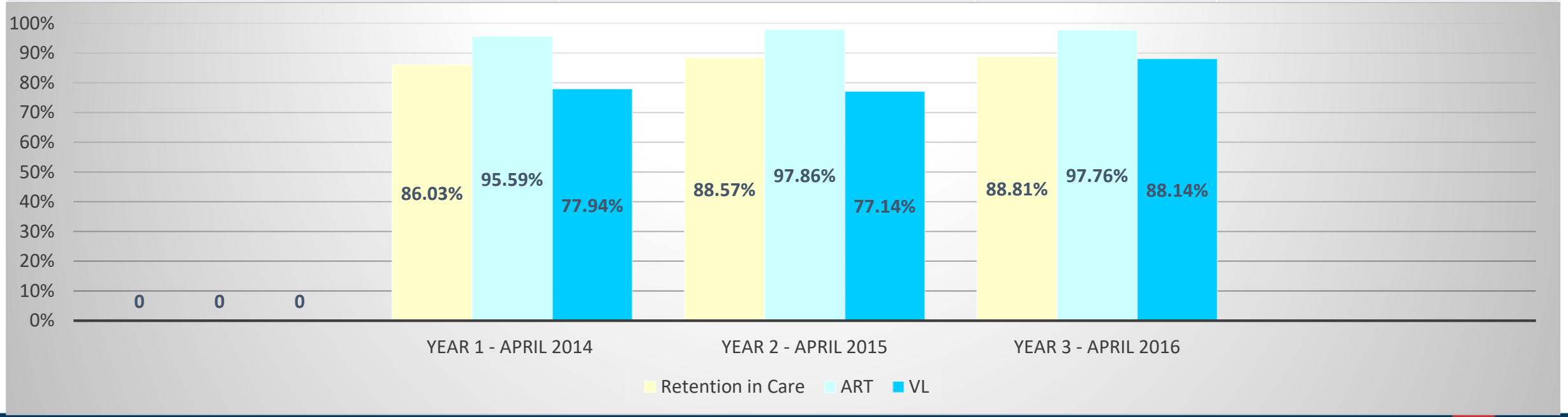
Do:
Document each missed appointment in EHR.

Study:
Analyzed barriers to keeping medical appointments:
1= work (50%),
2=forgot appoint (20.8%),
3=lack of transportation=4.2% and
4=others (25%).

Act:
Offered after hours night clinic. Rescheduled missed appoints. Ensure patients have appointment every three months.

Year-to-Year QIP Results 2014 - 2017

Performance Measures (MCM)	Retention in Care (%)	ART (%)	VL Suppression (%)
4/1/14 to 3/31/15 (Baseline)	**86.03%**	**95.59%**	**77.94%**
4/1/15 to 3/31/16	88.57%	97.86%	77.14%
4/1/16 to 3/31/17	88.81%	97.76%	88.14%



Identified Challenges of Quality Improvement Project

Our Patient

- Limited understanding how to use medical care for preventative services
- Eligibility documentation not timely provided
- Did not show up to medical appointments
- Relocated

Our Clinic

- System change to electronic Health Records (EHR) requiring scanning of years of documents
- Transportation to clinic – bus services did not run in patients areas
- Community Advisory Board delayed due to personnel changes

Conclusion

- Build strategies to retain patients in care. (e.g. monthly and quarterly QI meetings).
- After-hours clinics, peer groups, mentors, appointment reminders, and multiple-service scheduling can help with retention and medication adherence.
- This patient population faces long-term challenges in obtaining testing and care: work hours, family/cultural stigma, concept of preventative care, fear over immigration status, moving frequently to seek better work, transportation.
- Visual tools help new patients understand the importance of medication adherence.
- Consumer-led group also helps with retention in care by giving patients a voice.
- Our patient population is transient, so retention in care and VL data will fluctuate.
- VL improvement in new patients takes 3-6 months, so VL results will have lag time.

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Quality Improvement Processes in Rural Areas

AIDS RESPONSE EFFORT (ARE)

Brittney Jones, BSW

Quality Program Manager at AIDS Response Effort, Inc. (ARE)

December 13th, 2018

Overview of ARE

ARE is a rural, community based organization that serves people that are living with HIV, experiencing homelessness, at high risk of HIV and/or Hepatitis C, and in need of prevention/risk reduction (condoms, PrEP, education).

ARE serves 100-120 Ryan White clients per year. We serve six counties over a 50 mile radius.

ARE embraces a holistic approach to health care, and that approach radiates throughout the quality improvement processes in the agency.

Our main QIP for the last three years has been on the treatment adherence of our clients, including ART prescription rates, medical visit frequency (retention in care), and viral suppression. Can we reach the National HIV/AIDS Strategy Goals of 90-90-90 at a rural community organization?

HIV Medication and Treatment Adherence Improvement

Quality Improvement Project (QIP)

ARE Quality Improvement Process

Forming Our Improvement Process

- Address each barrier
  - Find new providers-community collaborations are key, primary care physicians interested in ID care
  - Set regular data reviews with team, request records in real time, plans for clients not achieving and maintaining viral suppression
- Identify key participants
- Be realistic & use SMART Goals
- Assess the data & create your baseline
- Motivate the team!
- Relate what you are doing in real-life application
- Involve input from clients
- Have some fun with the process!

Identified Challenges in Our Rural Area

- Community Based Organization
  - No Providers on site-not a clinic setting
- Data issues
  - Dependent on third party records-some delays in reporting actual data for our HRSA required performance benchmarks
- Motivation of staff
  - Small organization and people wear many hats
- Established screening process of client needs could be improved
  - Are we truly addressing the barriers to treatment adherence?
- Limited resources within the agency and in the community

Quality Improvement Projects

Year 1

Plan:
Understanding that the agency had limited staff, Case Managers focused on requesting records to obtain a baseline of treatment adherence rates in clients, and begin to address lost-to-care clients.

Do:
Case managers implemented client reminders, improvement in screenings through provider partnerships, and treatment adherence counseling.

Study:
Retention in care rates went up and down several times through the four quarters, with the final percentage being 18%. Now be had a baseline to begin to improve upon. Screening rates of RPR, TB, Hep C, Hep B improved.

Act:
The team would work through the identified challenges of improving retention in care in the next year.

Year 2

Plan:
Case managers continued to work on accessing client records more frequently and the team focused efforts on the non-virally suppressed clients.

Do:
Enrolled new clients in HIV 101 counseling and referred them to CLEAR or other needed support services.

Study:
We saw an improvement in ART prescription to 100% and viral suppression got up to 91% in the 3rd Quarter. It ended the year at 84%. Retention rates went from 18% to 32%.

Act:
The team decided to continue focusing efforts on the non-virally suppressed and developed a plan for more improvement in retention for year three.

Year 3

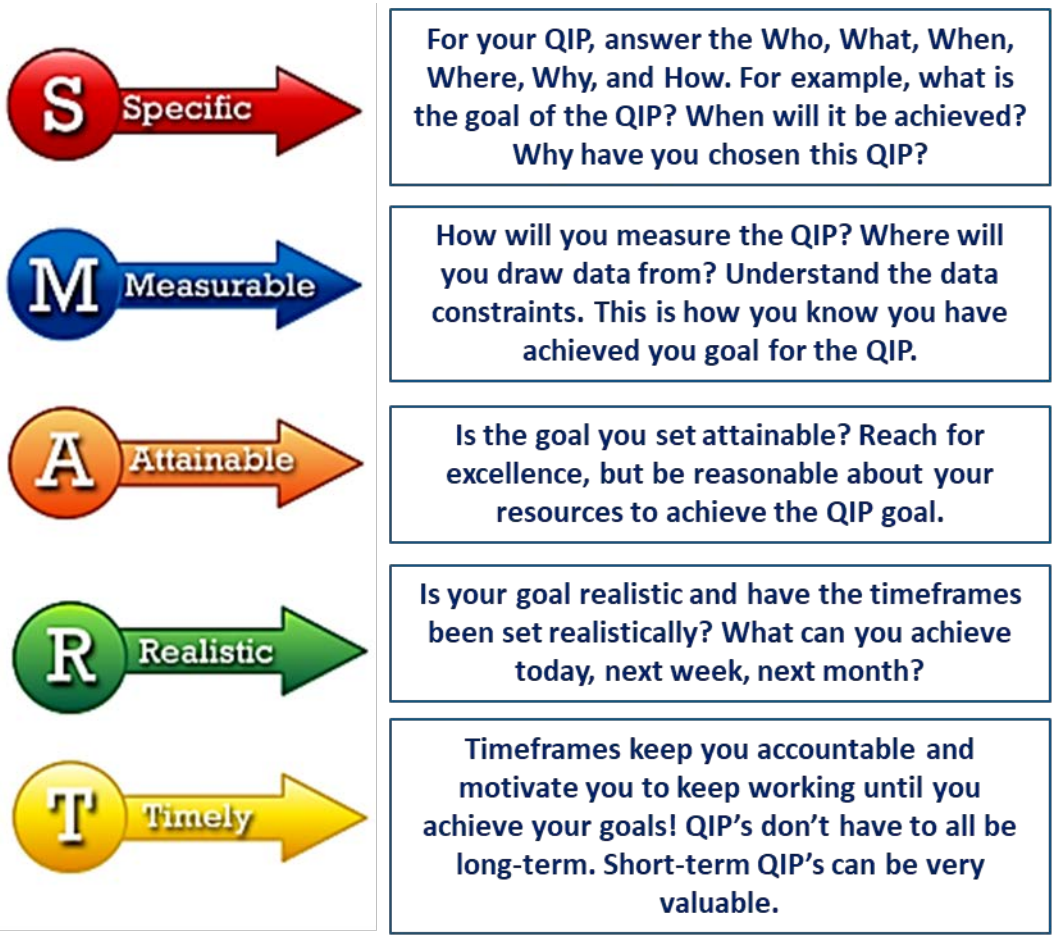
Plan:
The team focused on capturing missing data, non-virally suppressed clients and their barriers, and improving retention in care rates.

Do:
CM's updated the client screenings for BH, SA, HIV knowledge, Housing & Financial health to better address barriers to retention.

Study:
ARTs were maintained near 100%, VL suppression at 86%, and retention improved to 37% by end of year.

Act:
The team will utilize lessons learned from this QIP to the new one based increasing HIV Linkage and retention to care for Ryan White clients in 2018.

Setting SMART Goals for Your QIP



For ARE's Quality Improvement Process:

* Baseline data: Viral Load rates at the beginning of 2015 were **78%.** The agency set a goal of **90%** by 2017. Data would come from clinician laboratory records and entered in a data system for quarterly analysis.

* ART rates were **91%** in 2015 and ARE set a goal of **100%** by 2017.

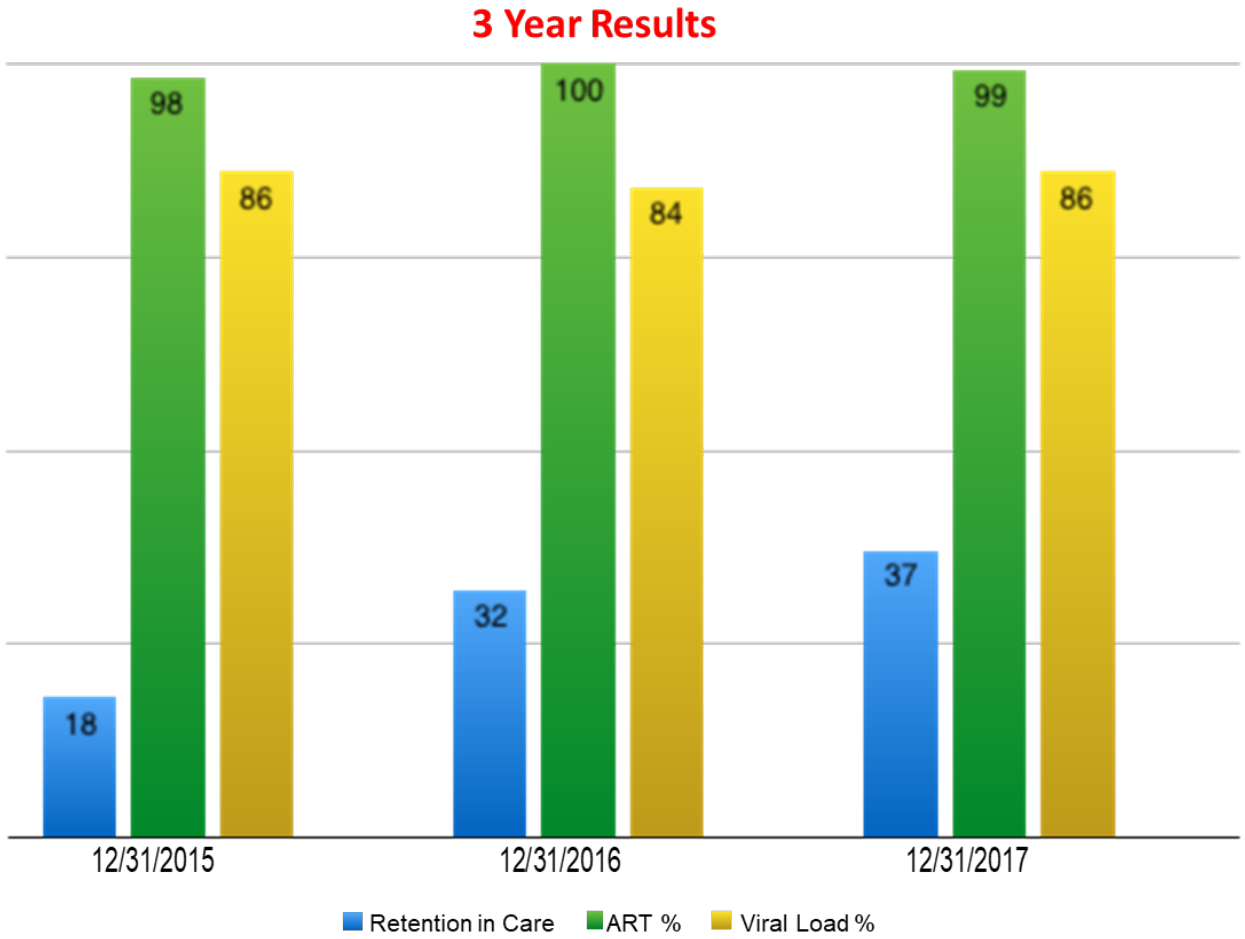
* Retention in Care (medical visit frequency) was at **24%** at the beginning of 2015, and ARE set the goal of improvement to **44%** by the end of 2017.

* Essentially a three year process-review quarterly, tracking on-going throughout three years.

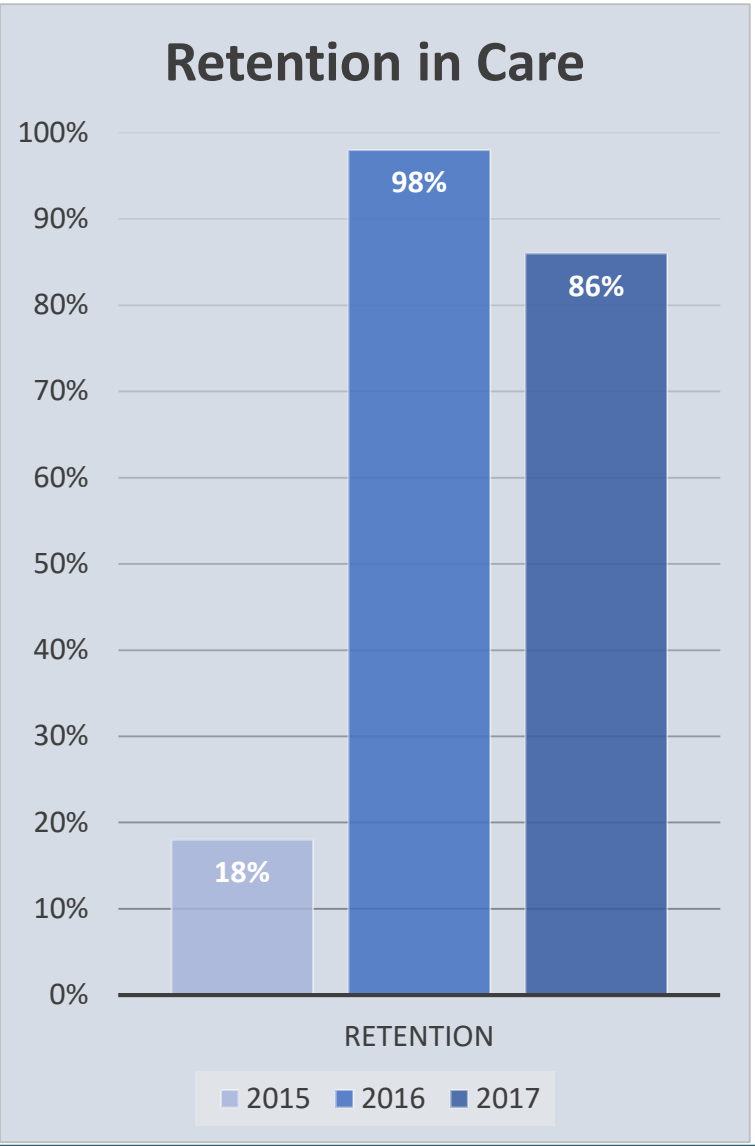
* Improvements to data tracking, including data gaps for clients lost to care/improvement in screening process to address client barriers to adherence/increase provider resources/keep team motivated

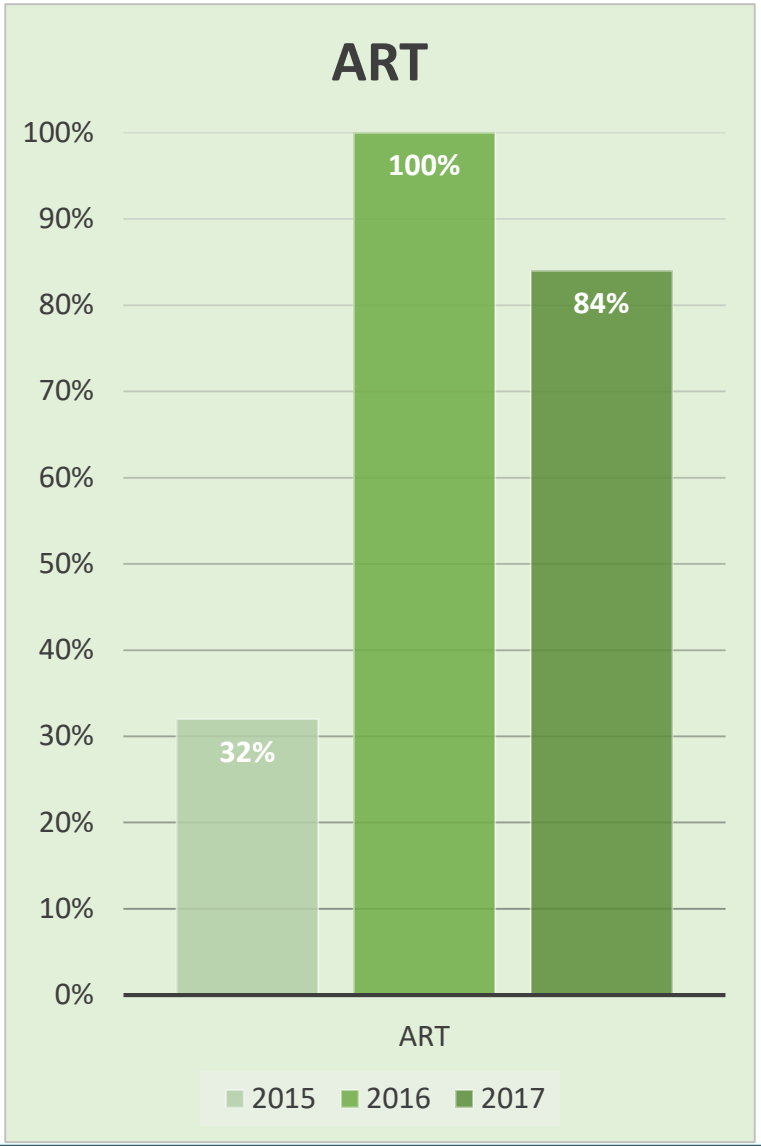
QIP 3 Year Results

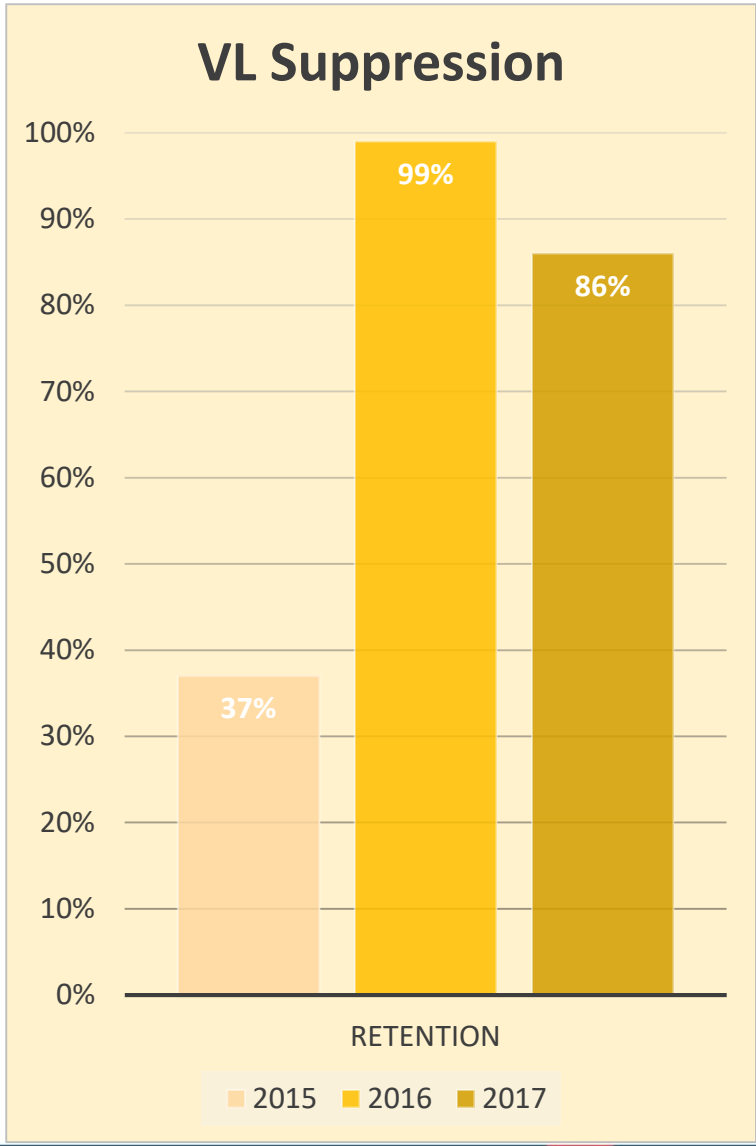
- Overall there were improvements across all treatment adherence measures.
- Viral Suppression-
  - Viral suppression dipped in the 2nd year. High number of intakes and newly diagnosed during the measurement year.
  - Almost achieved 90% viral suppression, will continue to track those non-virally suppressed and link them to support services.
- ART prescription-
  - Improved to nearly 100% by year end 2017. Had one client initiate care, then moved out of the area before being prescribed ARTs.
- Retention in care-
  - Vast improvements from the beginning of 2015 to the end of 2017. Percentage is still much lower than National Strategy goals. Will be a concerted effort to identify more ID providers to serve clients. Empower clients to maintain ID care, through prevention interventions like CLEAR. Some clients only seeing ID physicians one time per year now.



3 Year Results of QIP Implementation

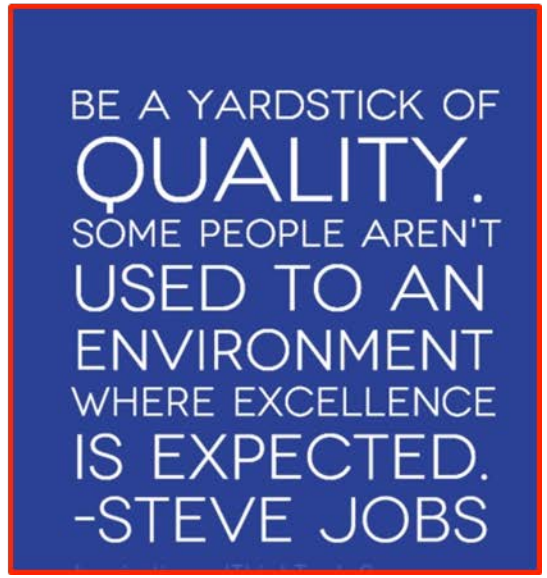






Lessons Learned from QIP

- A better screening process for clients' needs. Use your internal assets to improve client care.
- Quality improvement processes can be overwhelming for staff-be patient, value input from the team, and remind staff of the client impact of investing in quality improvement
- If you don't reach your initial goal in the established timeframes you can re-assess, plan, and start fresh. Don't give up.
- Quality improvement processes are fluid, SMART goals can change over time, and these practices will become the standard for care in your rural agency.



QUESTIONS?

Thank You!

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