A Quarterly Insight Into the HIV Services Provided in the Atlanta EMA

Issue 12 : Quarter 4 : Feb 2014—April 2014

What's New In Quality Management?

Current Topics >>>

You can now find previous newsletters in addition to the 2007-2011 Epidemiological Profile **at:**

http://seatec.emory.edu/resources/fulton.html

Atlanta Eligible Metropolitan Area (EMA) Ryan White Part A Priorities Setting

The distribution of Ryan White Part A funds is guided by the work of the planning council. One of the responsibilities of the planning council is to establish priorities for the allocation of funds. Each planning council is tasked with making decisions based on EMA priorities, available data, cost and outcome effectiveness of funded services. Additionally, gaps in services determined through an EMA-wide needs assessment representing the voice of the consumer, are also considered.

Every year the Priorities Committee is presented with data from the previous calendar year to assist in their decision-making process. Highlights from the demographic data presented at this year's meeting are:

- In 2013, a total of 13,626 clients received services representing a 5% increase over 2012 (13,003) and a 4% increase over 2011 (12,551).
- Males continue to make up the largest proportion of clients at 75.3%. The number of females has increased by only 1% since 2011, while the number of males has increased 11%. The number of transgender clients increased 8%, with a significant increase from 2012 (110) to 2013 (123).
- Clients over 40 years old make up 59.4% of those receiving services.

The utilization data presented informs the committee of service usage by consumers. The number of clients, total service visits or units, and service utilization per client were presented for each service category. Highlights from utilization data presented are:

- Outpatient/ Ambulatory Care— 11,874 Clients; 69,129 Service Visits; 5.8 Service Visits Per Client
- Case Management— 5,533 Clients; 25,412 Service Visits; 4.6 Service Visits Per Client
- Medical Transportation Services— 2,606 Clients; 16,364 Service Visits; 6.3 Service Units Per Client
- Psychosocial Support— 1,711 Clients; 4,540 Service Visits; 2.7 Service Units Per Client

Fulton County
Ryan White Part A
Quality Management

IN +CARE CAMPAIGN IN ATLANTA

There are four performance measures under the campaign that focus on gaps in medical care (INC01), the frequency of on-going patient medical visits (INC02), newly enrolled clients (INC03) and viral load suppression (INC04).

Next submission dates for In+CARE by measurement year:

08/01/2014 06/01/2013 – 05/31/2014
10/01/2014 08/01/2013 - 07/31/2014
12/3/2014 10/01/2013 – 09/30/2014

Below are IN + CARE measure percentage values for provider sites of the Atlanta EMA determined by the indicated formulas:

December '13	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site L	Site N	State Avg.	National Avg.
INC01	31.0%	17.0%	16.0%	7.0%	10.0%	7.0%	15.0%	N/A	1.0%	4.0%	13.0%	13.0%
INC02	46.0%	49.0%	68.0%	78.0%	72.0%	85.0%	69.0%	N/A	77.0%	86.0%	69.0%	70.0%
INC03	30.0%	80.0%	57.0%	50.0%	62.0%	50.0%	46.0%	N/A	100.0%	78.0%	61.0%	62.0%
INC04	56.0%	85.0%	76.0%	79.0%	31.0%	84.0%	75.0%	N/A	64.0%	81.0%	57.0%	74.0%

February '14	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site L	Site N	State Avg.	National Avg.
INC01	31.0%	5.0%	16.0%	9.0%	10.0%	7.0%	13.0%	21.0%	1.0%	3.0%	16.0%	13.0%
INC02	46.0%	72.0%	65.0%	78.0%	71.0%	87.0%	67.0%	49.0%	88.0%	82.0%	65.0%	69.0%
INC03	30.0%	100.0%	56.0%	69.0%	63.0%	17.0%	57.0%	52.0%	77.0%	65.0%	54.0%	59.0%
INC04	56.0%	88.0%	76.0%	82.0%	32.0%	87.0%	72.0%	66.0%	71.0%	80.0%	59.0%	72.0%

INC01= Total patients that had no medical visits with a provider in the last 6 months of the measurement year / the number of patients who have had at least one medical visit with a provider in the first 6 months.

INC02= The number of patients that have had at least one medical visit within each 6 month period of the 24 month measurement period with at least 60 days between their first medical visit of the first 6 months and the medical visit of the following 6 months / the number of patients who have had at least one medical visit with a provider in the first 6 months of the 24 month measurement period.

INC03 = The number of patients with at least one medical visit in each 4 month period of the measurement year / the number of patients who were newly enrolled with a provider AND had at least one medical visit within the first 4 months of the measurement year.

INC04= The number of patients with a viral load of less then 200 copies per mL at their last viral load test in the measurement year / the number of patients with at least one medical visit with a provider.

*provider =one with prescribing privileges

Fulton County Ryan White Part A HAB/HRSA MEASURES

To ensure that Quality Management measures are examined effectively, two HAB/HRSA measures from each Group will be selected to reflect the progress or areas for improvement at each primary care site. Each measure selected will include a small explanation for the basis of that measure.

Announcements and Resources

Listen to the most recent archived webinar from SEATEC (http://seatec.emory.edu/training_programs/archived/webinars/index.html)

Transgender Women, Hormone Therapy, and HIV
Tonia Poteat, PhD, MPH, PA-C
Duration: 1:03:40

National Quality Center:
http://nationalqualitycenter.org

ACA Resource:

HHS http://www.hhs.gov/healthcare/facts/bystate/ga.html

Direct questions regarding the Newsletter to:

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HRSA/HAB:
http://hab.hrsa.gov/special/qualitycare.htm
TARGET Center: Technical Assistance
http://www.careacttarget.org

Fulton County Ryan White Part A
HAB/HRSA MEASURES CAREWare Data*

GROUP 1 MEASURES: Serve as a foundation on which to build, especially if a clinical program has no performance measures.**

Performance Measure	Percentage of pregnant women prescribed ART	Percentage with >=200 CD4 Counts	AIDS Clients on HAART	Two Primary Care visits>= 3mos Apart	CD4<200 with PCP prophylaxis
Site A	N/A	65.87%	76.09%	69.53%	0.00%
Site B	N/A	86.18%	91.67%	90.91%	100.00%
Site C	N/A	80.39%	93.48%	87.28%	48.15%
Site D	100.00%	84.15%	96.80%	87.41%	77.33%
Site E	N/A	75.16%	26.68%	87.83%	14.98%
Site F	100.00%	85.82%	99.67%	92.44%	94.12%
Site G	100.00%	25.86%	98.23%	79.57%	28.16%
Site H	N/A	69.22%	81.63%	76.73%	80.95%
Site L	N/A	79.47%	92.54%	86.69%	81.08%
Site N	100.00%	76.48%	99.59%	89.20%	89.33%
Total %	100.00%	69.09%	49.19%	84.30%	26.49%

GROUP 2 MEASURES: Important measures for a robust clinical management program and should be seriously considered.

Performance Measure	Fulton County Adherence Assessment	Cervical Cancer Screening	Hepatitis B Vaccination	Hepatitis C Screening	HIV risk counseling	Lipid Screening	Oral Exam	Syphilis Screening	TB Screening
Site A	0.00%	7.99%	9.46%	73.34%	70.12%	90.29%	19.25%	50.58%	41.64%
Site B	83.27%	72.34%	1.03%	99.65%	97.58%	98.71%	18.34%	97.23%	99.29%
Site C	85.78%	49.27%	41.71%	95.38%	83.33%	67.57%	26.47%	72.97%	75.98%
Site D	0.00%	51.61%	54.84%	97.21%	82.40%	74.71%	10.30%	85.41%	83.56%
Site E	38.66%	0.00%	0.00%	65.10%	77.48%	0.00%	37.49%	61.93%	93.56%
Site F	83.74%	53.49%	41.27%	96.89%	90.84%	81.65%	14.84%	90.66%	95.66%
Site G	12.57%	15.60%	25.74%	67.59%	87.57%	39.03%	0.00%	44.51%	81.54%
Site H	16.91%	54.87%	17.43%	95.27%	71.00%	17.84%	29.37%	86.27%	81.61%
Site L	0.00%	46.15%	33.33%	86.32%	61.70%	94.09%	13.98%	84.80%	71.47%
Site N	24.78%	35.85%	65.88%	95.98%	78.95%	83.06%	20.91%	81.89%	96.31%
Total %	32.61%	26.14%	10.85%	76.32%	78.64%	52.59%	25.04%	65.53%	82.71%

GROUP 3 MEASURES: Represent areas of care that are considered "best practice," but may lack written clinical guidelines or rely on data that are difficult to collect. **

Performance Measure	Chlamydia Screening	Gonorrhea Screening	Hepatitis B Screening	Influenza vaccination	MAC prophylaxis	Mental Health Screening	Pneumococcal Vaccination	Substance Use Screening	Medical Case Management	Toxoplasma Screening
Site A	24.45%	20.98%	81.58%	0.19%	0.00%	94.35%	26.02%	94.56%	0.00%	35.67%
Site B	85.29%	85.29%	99.65%	53.63%	0.00%	85.71%	45.90%	85.71%	75.40%	90.31%
Site C	42.80%	81.06%	86.44%	63.03%	71.43%	100.00%	84.40%	100.00%	66.20%	51.54%
Site D	71.82%	70.91%	94.08%	41.20%	50.00%	83.69%	66.93%	82.40%	0.00%	90.73%
Site E	70.09%	69.94%	59.80%	0.00%	48.20%	96.42%	0.00%	95.53%	65.24%	0.02%
Site F	93.60%	93.60%	92.52%	56.96%	92.31%	87.50%	94.64%	87.50%	64.29%	95.60%
Site G	49.74%	49.22%	59.02%	56.61%	0.00%	82.91%	79.04%	97.44%	60.63%	35.78%
Site H	60.45%	64.09%	89.17%	53.40%	61.54%	91.09%	41.00%	91.09%	6.67%	37.14%
Site L	84.34%	84.34%	85.39%	41.34%	53.85%	59.57%	44.74%	59.57%	0.00%	2.43%
Site N	88.66%	88.66%	96.62%	43.03%	70.83%	97.99%	85.92%	97.99%	80.29%	85.77%
Total %	60.44%	62.81%	71.20%	23.33%	46.77%	87.50%	39.71%	88.42%	66.97%	30.00%

*All data pulled from RW CAREWare on or around, June 13, 2014 and reflects data for the year prior, through April 30, 2014.
**N/A = Sites are not currently collecting this variable and do not have data available.

QUALITY MANAGEMENT SPOTLIGHT:
Grady Infectious Disease Program

According to Ryan White Program standards, an organization has achieved success in providing quality management in clinical care when they are:

1. Providing improved access to and retention in care for HIV-positive individuals;
2. Enhancing the quality of services and client outcomes;
3. Linking social support services to medical services;
4. Making program changes to respond to the evolving epidemic;
5. Using epidemiologic, quality, and outcomes data for planning and priority setting, and
6. Ensuring accountability.

Grady Infectious Disease Program (IDP) explains how, as a service provider, they address three of these areas:

Providing improved access to and retention in care for HIV-positive individuals aware of their status: Through quarterly reports, we are able to address our primary goals of identifying all clients who have not been seen in ≥ 12 months, newly diagnosed clients from Grady hospital (who meet the criteria for enrollment), and clients who have missed their first primary care visit. IDP Client Trackers are responsible for managing a database of enrolled clients by identifying those who are non-compliant with medical appointments or at risk of falling out of care. Inclusive of their responsibilities, Client Trackers retrieve, enter, and report data as well as assist re-entry into primary medical care by contacting identified clients.

Additionally, the HIV Educator performs intakes on new and reenrolling adults in the IDP. They provide initial and ongoing health education along with counseling to individuals and groups in the clinic and community settings. HIV Educators facilitate new patient orientation that provides resources in addition to linking patients to their respective comprehensive medical team members.

Furthermore, Grady IDP utilizes members from the CAPUS grant to monitor client service acquisition and progress, with the goal of successful linkage to and engagement in comprehensive HIV care. Finally, the HIV Discharge Coordinator acts as the primary liaison between the hospital, the IDP, and other community health organizations to facilitate a smooth transition for inpatients to enhance compliance with the outpatient plan of care.

Enhancing the quality of services and client outcomes: To maintain an effective, department-specific, performance improvement plan that incorporates all of the elements of the organization's core values, as well as measures outlined by HRSA and the in-care campaign, the IDP employs FOCUS-PDCA. This organizational improvement initiative is a more detailed Plan, Do, Check, Act (PDCA) methodology that outlines a structural format we use to summarize reports.

In addition to PDCA, the Chronic Illness Care Model is referenced when quick cycles of change are required to be proactive and focused on keeping a person as healthy as possible. One quick cycle instituted was follow-up phone calls and appointments with supportive medical staff to ensure adherence to the plan of care. Patient charts are reviewed at that time to address applicable health maintenance procedures.

Any other challenges and changes at the IDP are tackled by ad hoc process improvement teams created to prepare and enact a multidisciplinary approach.

Ensuring accountability: With the implementation of the electronic medical record (EMR) system, we have been able to routinely monitor and evaluate the effectiveness of quality measures instituted. This is accomplished by reviewing reports specific to performance indicators, identifying those indicators that do not meet target, finding the root cause of the problem and re-evaluation of the process with follow-up and feedback. Any deficiencies noted represent an opportunity for education, additional audits and observations. Weekly team rounding and computer-based performance evaluations are also used as a mechanism to ensure compliance and highlight accountability.

Grady IDP
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