Quality Management and Improvement

NASTAD Prevention and Care Technical Assistance Meeting 2016
Iowa Part B Quality Management Program

NASTAD Prevention and Care TA Meeting
July 29, 2016

Holly Hanson, MA
Part B Program Manager

Katie Herting
RW Quality Coordinator
Topics

• Overview of the Ryan White Part B Quality Management (QM) Program
  – QM Plan
  – QM Team

• Performance measure results highlights for 2015/16

• Next steps
Focus on the big picture and it’ll be reflected on the dashboard.
Demetre Daskalkis

Quality Management goals should be aligned between all RW Parts.
Laura Cheever
Iowa Ryan White Part B
Quality Management Plan
October 1, 2014 – September 30, 2015

I. Quality Statement:
   A. Mission Statement
      The mission of the Ryan White Part B Quality Management (QM) Program is to ensure the highest quality of medical and support services to achieve optimal health outcomes for people living with HIV (PLWH) in Iowa who receive care through the Ryan White program.
   B. Purpose
      The purpose of the statewide quality management program is to evaluate and improve medical and support services that are delivered through the Ryan White program. This is accomplished by bringing partners together to strengthen relationships, encourage regular communication, and review statewide service delivery performance data that can be used to improve services.

According to the HIV/AIDS Bureau at the Health Resources and Services Administration, a quality management (QM) plan should:

1) Assist medical and support providers funded through the Ryan White HIV/AIDS Program in ensuring that services adhere to established clinical practice and supportive services standards and Public Health Services Guidelines;
2) Ensure the development of strategies for improvements to quality medical care and supportive services;
3) Ensure that available demographic, clinical, and health care utilization information is used by appropriate leaders and stakeholders to evaluate and address the local epidemic and improve quality of care.

C. Overall Goals
   The ultimate goal is to ensure a seamless system of comprehensive HIV services that provides a continuum of care and eliminates health disparities for PLWH in Iowa. This will be accomplished by developing a systematic,

1. Quality Statement
2. Organizational Infrastructure
3. Performance Measurement System
4. Implementation Plan
5. Annual Quality Goals
6. Evaluation
7. Capacity Building
8. Updating the QM Plan
### Ryan White Outcome and Performance Measures

An abbreviated list of RW associated desired outcomes (highlighted) and their corresponding performance measure(s) are listed below. They are current as of 10/13/2015. Baseline and trending data can be found in ClearPoint.

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Performance Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased identification of Iowans living with HIV who have not been diagnosed</td>
<td>Positivity rate of Iowans diagnosed through the EIS (Early Intervention Services)</td>
</tr>
<tr>
<td>Increased number of Iowans living with HIV who are linked to care</td>
<td>Newly diagnosed Iowans who have one medical visit within 3 months of diagnosis</td>
</tr>
<tr>
<td>Increased retention in care</td>
<td>RW Part B clients who have 1 lab within the measurement period if virally suppressed OR 2 labs within the measurement period, at least 3 months apart if virally un suppressed</td>
</tr>
<tr>
<td>Ensure RW Part B clients are linked to supportive services</td>
<td>RW Part B clients who report permanent/stable housing</td>
</tr>
<tr>
<td>Ensure medications are provided to low-income Iowans living with HIV</td>
<td>Number of ADAP clients, Number of new ADAP clients, ADAP clients re-enrolled/recertified on time, Claim within the ADAP</td>
</tr>
<tr>
<td>Increased adherence to medications</td>
<td>Medication adherence program at NTL</td>
</tr>
<tr>
<td>Increase number of Iowans with a suppressed viral load</td>
<td>Iowans living with HIV with a viral load &lt; 200 copies, African American Iowans with a viral load &gt; 200 copies, Hispanic Iowans with a viral load &gt; 200 copies, MSM Iowans with a viral load &gt; 200 copies, Women Iowans with a viral load &gt; 200 copies</td>
</tr>
<tr>
<td>Increased suppression of viral load (individual level)</td>
<td>RW Part B client with a viral load &lt; 200 copies, African American RW Part B clients with a viral load &lt; 200 copies, Hispanic RW Part B clients with a viral load &lt; 200 copies, MSM RW Part B clients with a viral load &lt; 200 copies, Women RW Part B clients with a viral load &lt; 200 copies</td>
</tr>
<tr>
<td>Improved health outcomes for Iowans living with HIV</td>
<td>Percent of MSM tested for syphilis at three Iowa Part C sites, Percentage of Iowans living with HIV enrolled in case management*</td>
</tr>
<tr>
<td>Increased competency of staff at the provider level</td>
<td>Case manager competency*</td>
</tr>
<tr>
<td>Accountability for federal/state/other funds</td>
<td>Cost per ADAP client</td>
</tr>
</tbody>
</table>

*Indicates the performance measure is still in development

\( RW = \) Ryan White  \( ADAP = \) AIDS Drug Assistance Program
QM Team

- Meets in-person quarterly
- Conference calls as needed
- Responsibilities:
  - Determine performance measures
  - Design continuous quality improvement activities
  - Review the QM Plan annually
QM Team

• In 2015/16:
  – Selected increasing real-time entry of housing status in CAREWare as a CQI project
  – Revised performance measures:
    • Added
      – Women Iowans Living with HIV with a Suppressed Viral Load
      – Women RW Part B Clients with a Suppressed Viral Load
      – Percent of MSM Tested for Syphilis at Three Iowa RW Part C Clinics
      – Churn Within the ADAP
    • Discontinued
      – ADAP Client Fill Rate
      – Turnover of Ryan White Staff
      – Retention of Ryan White Staff
QM Team – Time Cycle

**September 2016**
- Approve the QM Plan for the 2016/17 year
- Review and approve draft of the 2015/16 Annual Report
- Discuss new performance measures that should be added
  - Data collection for new measures would begin January 1, 2017

**June 2017**
- Review new data (that was collected in March) through subcommittee presentation of updated fact sheets
- QM Team self-assessment
- Discuss any necessary revisions to the QM Plan for the 2017/18 year

**December 2016**
- Plan CQI projects to be implemented in early 2017
- QM Program assessment of the 2015/16 year

**March 2017**
- QM training - different topic each year
- Discuss if current performance measures should be continued in the 2017/18 year
- Divide the team into subcommittees for fact sheets
Result Highlights

- On-Time ADAP Recertification
Result Highlights

- Iowans & RW Part B Clients with a Suppressed Viral Load
Result Highlights

- Churn Within the ADAP

![Graph showing Churn Within the ADAP with bars for 2013, 2014, and 2015.]
Result Highlights

• CAREWare vs. FTE CQI Project

![Graph showing percent match over time]
Result Highlights

- RW Part B Retention in Care
Result Highlights

• Annual Syphilis Screenings in MSM

![Bar chart showing syphilis screening rates for different institutions and years.](chart.png)

*2016 data is preliminary and measured from 1/1/2016 – 7/22/2016
Result Highlights

• Viral Suppression by Age

![Bar chart showing viral suppression by age groups with percentages for Iowans Living with HIV and RW Part B Clients.]

- 13-24: 64% (Iowans), 63% (RW Part B Clients)
- 25-44: 77% (Iowans), 78% (RW Part B Clients)
- ≥45: 85% (Iowans), 87% (RW Part B Clients)
- Total: 76% (Iowans), 82% (RW Part B Clients)
Next Steps

• Produce second Annual QM Report
• Design and implement continuous quality improvement projects
• Incorporate RW Part C, Prevention, and STD into the QM Program
• Develop individual contractor QM Reports
Questions?

Holly Hanson, MA
Part B Program Manager
Holly.hanson@idph.iowa.gov

Katie Herting
RW Quality Coordinator
Katie.Herting@idph.iowa.gov
Improvements in Data Quality across the HIV Continuum of Care: Timeliness, Accuracy and Completeness

VIRGINIA DEPARTMENT OF HEALTH
Division of Disease Prevention

Anne Rhodes, PhD
Director, HIV Surveillance
Data Quality: What, Why, How?

• Surveillance data is no longer just utilized for funding formulas and epi profiles

• Real-time tracking of diagnosis, linkage, care engagement, medication adherence and viral suppression are needed

• Current data systems - set up artificially with barriers based on funding streams, jurisdictions, disease status, etc.
Defining the HIV Continuum of Care

What’s considered a care marker?

- CD4 test
- Viral load test
- HIV medical care visit
- ART prescription

Linkage
Evidence of a care marker within 30/90 days of initial HIV diagnosis

Retention
2 or more care markers in 12 months at least 3 months apart

Viral Suppression
Last viral load <200 copies/mL in the time period being measured
Timeliness

- NHAS - 4th Goal calls to “strengthen the timely availability and use of data”

- Viral suppression rates for 2013 for persons living with HIV as of 12/31/2012 released by CDC in July 2016
Black Box: Real Time HIV Surveillance

- Pilot project from Georgetown, funded by NIH
- Involved DC, MD, and VA Departments of Health
- Utilized privacy technology for sharing surveillance data among jurisdictions where an algorithm for matching was set up in the “black box” and returned matches of varying strengths (Exact to Very Low) to each jurisdiction
Black Box Results

Output of person-matching across DC, MD, and VA eHARS databases:

<table>
<thead>
<tr>
<th>Person matches across jurisdictions:</th>
<th>Exact</th>
<th>Very High</th>
<th>High</th>
<th>Medium High</th>
<th>Medium</th>
<th>Very Low</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC-MD*</td>
<td>4013</td>
<td>5907</td>
<td>53</td>
<td>268</td>
<td>645</td>
<td>482</td>
<td>11 368</td>
</tr>
<tr>
<td>MD-VA*</td>
<td>856</td>
<td>2343</td>
<td>11</td>
<td>117</td>
<td>377</td>
<td>865</td>
<td>4569</td>
</tr>
<tr>
<td>VA-DC*</td>
<td>1064</td>
<td>3340</td>
<td>15</td>
<td>149</td>
<td>438</td>
<td>529</td>
<td>5535</td>
</tr>
<tr>
<td>Total</td>
<td>5933</td>
<td>11 590</td>
<td>79</td>
<td>534</td>
<td>1460</td>
<td>1876</td>
<td>21 472</td>
</tr>
</tbody>
</table>

*Bidirectional reporting results (i.e., DC-reported MD matches were equal to MD-reported DC-matches; etc.)

Over half of matches were not known to jurisdictions
Completeness

• Markers for care cannot all be tracked in eHARS

• Systems outside of health department purview often have data on care status for PLWH

• Electronic medical records/health information exchanges/all payer claims databases often available in jurisdictions
Care Markers Database: Sources

- **VACRS/E2VA/CW:** RW Labs, Med Visits, ART dates
- **ADAP:** Labs, ART, Med visits
- **HIV Testing:** Testing and Demo Info
- **MMP:** Med Visits, ART, CD4s, VLs
- **STD*MIS:** Address Info
- **Accurint:** Vital Status and Address Info
- **Medicaid:** Fee-for-Service Lab, Med Visit, ART Dates
- **eHARS:** CD4s, VLs, Demographic Info, Address Info, Vital Status
You have a new data sharing request from ABCD Healthcare.

Please log in to https://demo.rde.org/e2virginia/ to grant or deny this request.

Thanks,
the e2Virginia team.
Persons diagnosed and living with HIV as of 12/31/2015 (N=24,853)

- 100% of persons served by Ryan White 2015 (N=10,058)

Diagnosed in 2015 and linked to HIV care within 30 days
- 78% of persons served by Ryan White

Evidence of HIV care in 2015
- 70% of persons served by Ryan White

Retained in HIV care in 2015
- 56% of persons served by Ryan White

Virally suppressed in 2015
- 43% of persons served by Ryan White

Virginia HIV Continuum of Care, 2015
Accuracy

- How do people get included in/excluded from Continuum of Care analyses?
  - Death
  - Proof of out of jurisdiction address
  - No care in xx period of time?
  - Modeling methods?
  - Only care in xx period of time?

24% of current living cases in eHARS - no lab in last 5 years (n=6,005)
Overall DtC Outcomes

- Deceased: 4%
- Discharged: 1%
- Unable to be Located: 17%
- Relocated OOS: 12%
- Other: 3%
- Not in Care: 5%
- Incarcerated: 2%

In Care: 56%

N=192

Data reported to the Virginia Department of Health as of 06/09/2016
Virginia HIV Continuum of Care, 2015: Pre and Post-LexisNexis Accurint Match

Data current as of December 2015; Accessed July 2016; Virginia Department of Health, Division of Disease Prevention.
Data for 2015 should be considered preliminary and may be incomplete due to reporting delay. LexisNexis Accurint batch match as of July 2016.
LexisNexis Accurint HIV care continuum only includes persons with a last known residence in Virginia or diagnosed in Virginia (linkage to care) and considered living in both HIV surveillance and in the LexisNexis Accurint batch match were included.
Virginia Results: So Far

**Improved Accuracy of Case Numbers**
- After address and vital status updates, number of PLWH living in Virginia as of 12/31/2015 was reduced by 760 persons

**Increased Number of Care Markers for Continuum**
- Black Box, along with other sources, including Medicaid and Ryan White added 8% to retention rates in 2014 and 9% to viral suppression rates in 2015
Final Thoughts

• Data Improvement strategies should be part of plan for addressing NHAS goals

• Sharing data across jurisdictions is important for tracking linkage, care engagement and viral suppression for PLWH

• Utilizing data for public health impact requires merging of multiple sources of information across systems, agencies, and funding streams
Acknowledgements

**CDC:** Benjamin Laffoon, Dr. Irene Hall

**DC Department of Health:** Michael Kharfen, Garret Lum, Auntre Hamp

**Georgetown University:** Jeff Collman, Joanne Michelle Ocampo, Jay Smart, Raghu Pemmaraju

**HRSA:** Jessica Xavier, John Hannay

**Maryland Department of Health:** Colin Flynn, Reshma Bhattacharjee

**RDE Systems:** Jesse Thomas, Anusha Dayananda, RDE Developer Team

**Virginia Department of Health:** Anne Rhodes, Jeff Stover, Steve Bailey, Elaine Martin, Lauren Yerkes, Kate Gilmore, Sahithi Boggavarapu, Sonam Patel, Amanda Saia