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

Issue 5 : Quarter 1 : May—July 2012

WHAT'S NEW IN QUALITY MANAGEMENT?

Current Topics >>>

- **Affordable Care Act and Ryan White……...1**
- **IN+CARE Campaign Data…….……………..2**
- **Announcements/ Resources…………....2**
- **Quarter 4 Measures and Data……………..3**
- **QM Spotlight—Emory Midtown...…………..4**

The Affordable Care Act and Ryan White

According to the U.S. Department of Health and Human Services (DHHS), the ACA expands Medicaid eligibility. This expansion will allow those with income below 133% of the poverty line ($14,400 for an individual and $29,300 for a family of 4) who may not have an AIDS diagnosis to still be eligible for Medicaid. The Medicare Part D prescription drug benefit Out of Pocket Spending Limit ("donut hole") will be phased out, allowing low – income clients to better afford their medications.

In addition DHHS addresses these areas of improvement in quality coverage of care under the ACA:

- **Better information.** With the passage of the new law, plans will be required to provide information in a user-friendly manner that clearly explains what is and isn't covered. (Go to www.HealthCare.gov).

- **Quality, comprehensive care.** A new comprehensive benefit package that will offer all Americans who purchase insurance policies in the individual or small group market a fair and comprehensive set of services.

- **Preventive care.** Beginning September 23, some private insurance plans will cover recommended preventive services like regular check-ups and certain cancer screenings at no additional cost to eligible people. Comparable provisions will apply to Medicare starting on January 1.

- **Coordinated care.** The law calls for new investments in community health teams to manage chronic disease and it recognizes the value of patient-centered medical homes (coordinated, integrated, and comprehensive care) as an effective way to strengthen the quality of care. This is proven to be effective as demonstrated by the Ryan White HIV/AIDS Treatment Extension Act of 2009, the pioneer in the development of this model in the HIV health care system.

Issue 5 : Quarter 1 : May—July 2012

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), that of newly enrolled clients (INC03) and viral load suppression (INC04).

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

June	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
INC01	10.63%	18.98%	16.30%	9.45%	9.65%	29.90%	3.88%	19.78%
INC02	68.95%	60.50%	48.36%	67.17%	69.72%	49.29%	76.44%	52.37%
INC03	61.21%	38.30%	33.33%	70.00%	68.75%	31.13%	73.33%	41.30%
INC04	41.97%	67.50%	57.14%	75.51%	79.84%	61.36%	77.21%	52.60%

August	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
INC01	11.12%	20.03%	11.46%	11.59%	12.35%	28.74%	4.62%	24.69%
INC02	68.25%	62.76%	52.94%	68.19%	70.48%	50.24%	80.34%	53.63%
INC03	61.99%	50.00%	0.00%	69.23%	56.25%	32.00%	76.92%	39.19%
INC04	25.06%	67.58%	58.95%	74.94%	78.64%	56.55%	77.91%	51.41%

INC01= The number of patients that did not have a medical visit with a provider in the first 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/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, a HAB/HRSA measure 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

If you have not received the Consumer Survey presentation and would like to have it sent to you, please contact:

Alecia McFarlane
Sr. Research Project Coordinator/SEATEC
Email: ajmcfar@emory.edu
OR
Kathy W. Whyte
Special Project Assistant
Ryan White Program
Email: kathy.whyte@fultoncountyga.gov

Nov. 27—Nov. 29: Ryan White 2012 Grantee Meeting; Washington, DC USA

Jan. 31—Feb. 1: SEATEC Training—Overview to Adult HIV Care; Atlanta, GA, USA

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

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	Two Primary Care visits>= 3mos Apart	AIDS Clients on HAART
Site 1	87.12%	18.81%
Site 2	81.71%	80.34%
Site 3	81.36%	72.73%
Site 4	82.33%	97.98%
Site 5	90.19%	90.99%
Site 6	69.14%	32.11%
Site7	94.86%	96.77%
Site 8	76.98%	61.67%
Total %	84%	40%

According to HRSA, clinicians should schedule routine monitoring visits at least every 4 months for all HIV infected patients who are clinically stable. In addition, the HAART measure is reflective of an aspect of care that significantly impacts survival, mortality, and hinders transmission.

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

Performance Measure	HIV risk counseling	TB Screening
Site 1	90.15%	91.15%
Site 2	92.98%	73.62%
Site 3	94.74%	80.11%
Site 4	83.82%	92.12%
Site 5	78.43%	91.23%
Site 6	79.39%	44.44%
Site7	92.53%	94.17%
Site 8	38.30%	86.29%
Total %	84%	83%

In providing effective HIV care and promoting risk reduction HRSA states that "Medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors." TB screening remains important in HIV care because TB is an AIDS defining opportunistic infection that can be deadly and whose risk is higher and more progressive in those who are HIV infected.

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	Mental Health Screening	Substance Use Screening
Site 1	89.08%	88.14%
Site 2	78.11%	78.11%
Site 3	100.00%	100.00%
Site 4	91.27%	90.48%
Site 5	75.70%	75.70%
Site 6	78.99%	78.99%
Site7	96.38%	96.38%
Site 8	62.02%	61.67%
Total %	82%	81%

A newly infected patient's ability to cope with their diagnosis or other social, psychiatric , and medical issues can greatly affect the management of their HIV. An extension of this coping may be substance use and is therefore important in the screening process where providers address multiple social, psychiatric and medical issues.

**All data pulled from RW CAREWare on August 28, 2012 and reflects data from May 1, 2012 - July 31, 2012

QUALITY MANAGEMENT SPOTLIGHT: Emory Midtown

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.

Emory Midtown explains how they address three of these areas:

The Emory Infectious Diseases Clinic at Emory University Hospital Midtown is a well-established provider with extensive experience in caring for patients diagnosed with infectious diseases including hepatitis, HIV, Sexually Transmitted Diseases (STDs), transplant or travel related infections.

Use data for planning and priority setting: At the Emory ID Clinic, we are able to determine areas of improvement through different methods, such as quarterly chart reviews and Press Ganey surveys.

Quarterly chart reviews are conducted by the CQI nurse and medical director, with a minimum of 5 charts per provider. Results are shared with physicians and areas of improvement are discussed in order to meet the EMA standards. Based on results from chart audits completed in November 2011, a quality improvement project was developed to increase the number of pap/pelvic exams completed within one year. Since the implementation of this project, the number of paps/pelvics increased from 60 to 78%.

Another area of improvement was chosen based on results of the Press Ganey surveys, specifically in the area of "promptness in returning calls." In the months of February, March, and April, we received a score of 66.1, 78.8, and 75% respectively. In May, the nursing staff met to discuss a quality improvement plan for triaging phone calls with the goal of returning calls within 2 hours. For the months of May, June, and July, results show an increase in scores of 88.9 and 84.5, and 80.4% respectively.

Providing improved access to and retention in care for HIV-positive individuals aware of their status: The clinic strives to accommodate new patients by scheduling their appointments with MD/NP within two weeks after receiving the referral. Patients schedule follow-up appointments at the time of check-out and a reminder card is provided. They receive an automated reminder call or a letter prior to their next appointment. If a patient cancels his/her appointment during business hours, the appointment is immediately rescheduled. If a patient fails to attend the appointment, the medical secretary contacts him/her within 24 – 48 hours by phone or mails a letter asking to reschedule.

Emory ID views patient retention as a top priority. The retention team is responsible for the protocol set in place which consists of a series of phone calls and letters sent to patients who have not been seen in the previous 6 months. When the patient is reached, the next available appointment is given and barriers to care are discussed. The patient is then referred to an identified provider to address those barriers.

Enhancing the quality of services and client outcomes: Prior to each medical visit, the decision support form is generated from Lab Tracker. This tool lists upcoming due dates for immunizations and screening tests important to HIV patients. On a daily basis, the CQI nurse verifies the data and highlights which indicators are due. The tool is attached to the chart where it serves as a prompt and guide for the provider during the patient visit. When the visit is completed, the provider returns the tool to the CQI nurse with added comments or clarifications used to update patient data as needed.

Emory recently implemented a new large-scale project with the purpose of standardizing the delivery of care across all clinic sites and to leverage technology to improve patient health. A secure patient portal is now available for patients to communicate with physicians, request prescription refills, view their health history, complete pre-visit forms, and view lab results. The enhanced workflow also helps physicians and support staff by decreasing errors, saving time, and allowing team members to be more engaged with patients and meet the individualized needs of our patients.

Emory Midtown ID Clinic
550 Peachtree St., 7th Fl.
Atlanta, GA 30308
Phone: (404) 686-8114