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

Issue 7 : Quarter 3 : Nov—Jan 2013

What's New In Quality Management?

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The National Quality Center's Training of Consumers on Quality

The National Quality Center (NQC) is hosting a Training of Consumers on Quality (TCQ), in Atlanta from Sunday, May 12th—Tuesday, May 14th. The purpose of the training will be to build the capacity of consumers so they are equal partners in the planning, implementation, and evaluation of quality improvement (QI) efforts, clinically and regionally. Through this training the NQC hopes to prepare those living with HIV/AIDS to be formally engaged in ongoing quality management programs, internal QI teams and regional QI activities.

Some of the learning objectives of the training are as follows:

- Increase understanding of the Ryan White Program and its quality requirements and expectations
- Increase understanding of basic vocabulary for quality improvement tools, methodologies, activities and processes
- Increase awareness of basic HIV care and treatment terminologies so that participants better understand basic indicator definitions and performance data reports
- Increased knowledge related to health numeracy and health literacy, and understanding of performance measurements

Attendees of the training are expected to actively participate and engage in the sessions so that they will be able to increase or begin their involvement in QI activities within their local committees or at their organization. A limited number of slots are available to consumers nationwide, but a portion of those slots have been set aside for Atlanta/State of Georgia residents.

Applications must be received by close of business 4/5/2013 at https://www.surveymonkey.com/s/tcqapplication

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).

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

Fulton County Ryan White Part A

December '12	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
INC01	11.02%	18.77%	13.67%	15.14%	8.96%	29.12%	4.94%	21.17%
INC02	67.58%	60.90%	48.83%	70.55%	78.48%	48.13%	77.70%	53.89%
INC03	65.03%	51.92%	0.00%	50.00%	42.86%	28.36%	73.33%	47.37%
INC04	59.71%	68.72%	63.51%	75.12%	79.84%	46.21%	79.83%	52.45%

February '13	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Site 8
INC01	11.19%	15.14%	16.56%	14.21%	8.12%	26.90%	4.72%	21.60%
INC02	65.03%	62.11%	48.48%	68.74%	80.96%	45.44%	81.22%	52.73%
INC03	67.38%	51.35%	57.14%	61.90%	50.00%	32.73%	76.67%	46.55%
INC04	59.21%	70.04%	69.44%	76.54%	80.33%	47.05%	78.49%	54.27%

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

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

You can now find previous newsletters and other Fulton County Ryan White Program and SEATEC documents at :

http://www.seatec.emory.edu/resources/fultoncounty.html

May 12th—May 14th: NQC Training of Consumers on Quality (TCQ); Atlanta, GA

National Quality Center:
http://nationalqualitycenter.org

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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	% of Clients with > 2 CD4 Counts Performed	CD4 Count <200 with PCP Prophylaxis
Site 1	65.50%	12.80%
Site 2	77.60%	55.56%
Site 3	63.92%	0.00%
Site 4	55.68%	52.78%
Site 5	79.12%	89.47%
Site 6	50.54%	0.00%
Site7	79.97%	88.42%
Site 8	65.59%	0.00%
Total %	65%	23.28%

According to HRSA, clinicians should perform CD4 lab test at least twice per year and at least 3 months apart for all HIV infected clients. In addition, pneumocystis pneumonia (PCP) is the most common opportunistic infection of people with HIV; therefore, HIV-infected clients with CD4 counts less than 200 are expected to receive PCP prophylaxis.

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

Performance Measure	Hepatitiis C Screening	Syphilis Screening
Site 1	64.14%	61.56%
Site 2	94.57%	94.98%
Site 3	93.54%	90.73%
Site 4	74.11%	60.83%
Site 5	90.72%	86.64%
Site 6	65.74%	50.24%
Site7	95.61%	83.89%
Site 8	88.25%	77.04%
Total %	73.77%	67.11%

The US Public Health Guidelines state that" all HIV-infected patients should be screened for HCV infection." HIV/hepatitis C co-infection may predispose PLWHA to liver toxicity from HAART and exacerbate side effects of ARVs. In addition, the guideline recommend screening for STDs at least annually, to support a focus on treatment decisions that affect a sizeable population.

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
Site 1	37.93%	56.78%
Site 2	48.94%	87.01%
Site 3	59.20%	59.20%
Site 4	47.00%	40.33%
Site 5	77.18%	77.67%
Site 6	90.40%	91.88%
Site7	94.09%	94.09%
Site 8	54.02%	53.77%
Total %	58%	68%

STDs have been found to increase the risk of HIV transmission by increasing the viral burden in genital secretions. For this reason, HRSA recommends the screening of STDs, including chlamydia and gonorrhea, to treat infections and decrease HIV transmission to sexual partners.

**All data pulled from RW CAREWare on March 11, 2013 and reflects data for the year prior, through January 31, 2013

QUALITY MANAGEMENT SPOTLIGHT: Cobb & Douglas Public Health CDS Clinic

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.

Cobb & Douglas Public Health CDS Clinic explains how they address three of these areas:

The Cobb & Douglas Public Health CDS Clinic (Cobb Douglas Services) provides primary healthcare to uninsured and underinsured individuals with HIV. The clinic is primarily funded through Ryan White grants and is the only Ryan White clinic in public health District 3-1.

Enhancing the quality of services and client outcomes:

The CDS Clinic has a current Quality Management (QM) Plan and designated staff members that serve on the Quality Management Team (QMT). The QMT meets monthly and is responsible for planning, directing and improving the health care services of the CDS Clinic. Key clinical and programmatic staff serve on the QMT. Quality management indicators not meeting established goals are addressed and given specific timelines to monitor progress as indicated in the clinic's QM Plan. Also, indicators meeting established goals are reviewed to ensure continued success. The team reviews client satisfaction surveys and addresses quality management issues related to client satisfaction. Through the efforts of the QMT, the clinic's immunization rates have increased 35% (comparison rates: June 2010 (41%) and January 2012 (76%)). This increase was attributed to the implementation of a chart audit conducted prior to each appointment. Through the efforts of the QMT, the clinic was also able to increase the percentage of patients who had annual lipid screenings. Several QMT recommended processes were implemented which resulted in a 7% increase (comparison rates: 2010, 47%; 2011, 54%).

Linking social support services to medical services:

The CDS clinic has three case managers to provide social support services to patients, including a bi-lingual (Spanish) case manager. The case managers work closely with clinical staff to identify and resolve barriers. Having the case managers within the clinic structure allows for immediate linkage to support services. Often, the case managers are consulted during patient visits and can provide immediate resolution of barriers such as transportation or lack of food by issuing public transportation passes or grocery store vouchers. The clinic also has a linkage to care coordinator that can assist clients to access social support services.

Using epidemiologic, quality, and outcomes data for planning and priority setting:

The CDS Clinic has a MPH trained Epidemiologist that serves on the Quality Management Team and provides a population based perspective to the meetings. The Epidemiologist and Data Clerk provide data to the Program Manager and Quality Management Team to help develop evidence based policies and procedures. The Epidemiologist also generates an annual Epidemiologic profile of all CDS Clinic patients which includes general demographics (age, sex, race/ethnicity), HIV/AIDS status, insurance status, risk factors and household income. These data provide staff with an overview of the patient population and allows the Epidemiologist to identify trends.

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