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

Issue 11 : Quarter 3 : Nov 2013—Jan 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 EMA Epidemiological Profile for 2007-2011

This report is the first comprehensive epidemiological profile of the HIV/AIDS epidemic in the Atlanta Eligible Metropolitan Area (EMA). Although HIV Surveillance Reports have consistently been produced by the Georgia Department of Public Health (GDPH) HIV/AIDS Epidemiology Program (HAEP) for the state of Georgia, no integrated epidemiological profile focused on the 20 county Atlanta EMA, the epicenter of the HIV epidemic in the southern United States, has been developed. As part of increased efforts to better monitor and track the epidemic, the GDPH HAEP has worked diligently to improve the reporting system in the state, and thereby the accuracy and utility of surveillance data.

This report will serve to enhance planning efforts for both Ryan White funded agencies, the Metropolitan Atlanta HIV Health Services Planning Council, and prevention partners throughout the Atlanta metropolitan region. We will continue to work with the GDPH HAEP to study trends in the disease and to update this report biannually to ensure the most accurate and timely data are available.

Report Highlights:

Approximately 69% of cumulative HIV/AIDS cases in the state of Georgia through the end of 2011 were from the 20 county Atlanta EMA. The epidemic continues to have a disproportionate impact among Blacks (60%) and males (82%). Over the five year period 2007 – 2011, Blacks comprised an average of 62% of cases, compared to just 13% for Whites, 5% among Hispanics and 2.5% among multiracial groups. This burden can be seen in almost all aspects of the disease, from clinical markers such as CD4 and viral load, to lower rates of viral suppression when considering the HIV Continuum of Care.

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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 ongoing patient medical visits (INC02), newly enrolled clients (INC03) and viral load suppression (INC04).

Next submission dates for In+CARE by measurement year:

06/01/2014 04/01/2013 – 03/31/2014
08/01/2014 06/01/2013 – 05/31/2014
10/01/2014 08/01/2013 - 07/31/2014

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

October '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	31.2%	16.0%	14.0%	8.0%	12.0%	4.0%	N/A	N/A	N/A	3.0%	13.0%	13.0%
INC02	46.4%	50.0%	66.0%	76.0%	72.0%	85.0%	N/A	N/A	N/A	85.0%	67.0%	69.0%
INC03	30.0%	50.0%	51.0%	67.0%	59.0%	79.0%	N/A	N/A	N/A	81.0%	61.0%	62.0%
INC04	56.3%	85.0%	71.0%	76.0%	20.0%	84.0%	N/A	N/A	N/A	80.0%	50.0%	73.0%

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	N/A	17.0%	16.0%	7.0%	10.0%	7.0%	15.0%	N/A	1.0%	4.0%	13.0%	13.0%
INC02	N/A	49.0%	68.0%	78.0%	72.0%	85.0%	69.0%	N/A	77.0%	86.0%	69.0%	70.0%
INC03	N/A	80.0%	57.0%	50.0%	62.0%	50.0%	46.0%	N/A	100.0%	78.0%	61.0%	62.0%
INC04	N/A	85.0%	76.0%	79.0%	31.0%	84.0%	75.0%	N/A	64.0%	81.0%	57.0%	74.0%

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)

Graying of the HIV Epidemic: The Intersection of Menopause and HIV
William Short, MD, MPH
Duration: 1:04:52

National Quality Center:
http://nationalqualitycenter.org

ACA Resource:

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

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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	0.00%	68.82%	61.70%	69.22%	0.00%
Site B	0.00%	86.48%	100.00%	92.17%	91.67%
Site C	0.00%	79.86%	88.12%	84.14%	46.88%
Site D	100.00%	83.80%	96.80%	88.03%	68.42%
Site E	0.00%	76.26%	27.01%	87.82%	15.96%
Site F	100.00%	86.42%	99.68%	93.58%	96.43%
Site G	100.00%	39.31%	98.34%	80.60%	29.41%
Site H	0.00%	71.05%	88.10%	80.21%	62.86%
Site L	0.00%	84.31%	93.94%	89.80%	77.78%
Site N	100.00%	80.59%	99.59%	91.39%	93.59%
Total %	100.00%	72.21%	49.28%	84.74%	27.22%

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%	11.69%	9.52%	71.37%	78.37%	91.13%	19.56%	50.68%	41.73%
Site B	44.13%	82.22%	0.90%	99.66%	100.00%	98.34%	20.68%	99.32%	100.00%
Site C	75.71%	45.81%	41.71%	95.15%	98.52%	65.68%	27.19%	90.17%	75.54%
Site D	0.00%	59.09%	57.53%	97.18%	79.61%	73.93%	9.98%	78.04%	77.35%
Site E	40.19%	0.00%	0.00%	63.87%	94.86%	0.00%	38.03%	54.32%	93.50%
Site F	87.71%	58.62%	40.00%	96.95%	96.95%	71.77%	16.52%	91.38%	95.76%
Site G	10.58%	16.02%	26.56%	69.88%	91.43%	49.60%	0.00%	55.15%	84.45%
Site H	24.96%	63.16%	12.55%	93.95%	77.27%	8.96%	29.38%	83.19%	81.89%
Site L	0.00%	51.72%	30.34%	82.14%	94.16%	92.72%	14.29%	87.99%	71.38%
Site N	26.69%	40.37%	69.18%	95.72%	97.33%	83.96%	22.99%	87.47%	95.85%
Total %	32.60%	28.73%	10.65%	75.70%	91.12%	53.40%	25.65%	64.86%	82.84%

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	13.87%	13.56%	81.08%	0.84%	0.00%	97.19%	27.46%	97.80%	0.00%	40.22%
Site B	93.00%	93.00%	99.66%	52.54%	50.00%	100.00%	46.72%	100.00%	76.45%	89.15%
Site C	15.97%	81.47%	86.53%	60.03%	50.00%	100.00%	84.71%	100.00%	63.16%	51.82%
Site D	80.00%	79.09%	93.68%	41.21%	46.67%	82.00%	68.39%	93.15%	79.39%	90.41%
Site E	64.86%	64.78%	58.32%	0.00%	58.08%	94.83%	0.00%	95.00%	65.96%	0.02%
Site F	93.94%	93.94%	93.26%	57.27%	94.12%	100.00%	93.96%	100.00%	83.33%	94.79%
Site G	62.11%	56.12%	61.31%	54.95%	12.82%	62.99%	77.41%	91.73%	64.77%	36.88%
Site H	59.91%	59.24%	87.05%	49.82%	0.00%	90.74%	37.92%	91.85%	7.09%	29.40%
Site L	84.66%	84.05%	85.71%	43.83%	61.54%	93.83%	45.31%	99.10%	94.16%	2.27%
Site N	86.04%	86.04%	96.40%	40.64%	65.22%	99.41%	88.75%	99.41%	78.42%	89.02%
Total %	55.92%	60.36%	70.68%	22.82%	52.73%	90.25%	40.58%	95.77%	72.13%	30.55%

**All data pulled from RW CAREWare on or around, April 24, 2014 and reflects data for the year prior, through January 31, 2014.
***N/A = Sites are not currently collecting this variable and do not have data available.

QUALITY MANAGEMENT SPOTLIGHT: Open Hand

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.

Open Hand explains how, as a support service provider, they address three of these areas:

Enhancing the quality of services and client outcomes

Open Hand focuses on providing comprehensive nutrition care, combining healthy foods, nutrition education and individualized nutrition assessment. We also provide guidance services to assist individuals and families served, improve their health and quality of life. To measure the impact of these services, the agency redesigned our annual Client Satisfaction Surveys as part of the evaluation of how the services received have impacted various aspects of clients' health as well as their ability to maintain their living situation or remain together with their family (83.4% responses positive). Results of the 2013 survey demonstrate clients living with symptomatic HIV/AIDS reported their health care providers had told them of health improvements at their last appointments. Examples include improvements in their blood pressure (40%), cholesterol levels (30.9%), blood sugar/glucose (25.9%). As a result, some of their providers have lowered their medication dosage required (6.2%). Clients also reported the meals they receive from Open Hand help them maintain a healthy weight (73.3%), make it easier for them to take their medications (38.6%), increase their energy levels (51%), decrease their stress levels (46.5%), and improve their mood (37.6%).

Making program changes to respond to the evolving epidemic

Although weight loss and wasting remain common in HIV infection, nutrition-related problems such as obesity, diabetes, hyperlipidemia and hypertension also increasingly affect people living with HIV. Life Expectancy of HIV patients has lengthened significantly due to antiretroviral therapy. However, co-morbidities have increased with an emerging aging population. Effective nutrition interventions to treat related co-morbidities improve morbidity and mortality in HIV-infected patients.

All Open Hand menus incorporate evidence-based nutrition recommendations while also accommodating participant preferences and demographics, including ethnic and religious backgrounds. Open Hand's Healthy Balance menus are prepared to control carbohydrates, limit sodium and fat, and meet the demands of modified diets in order to meet the nutrition needs of the aging population. These menus comply with federal recommended daily allowances and the Dietary Guidelines for Americans. Additionally, therapeutic and preference menus are prepared to accommodate individual clients' dietary requirements or individual/cultural preferences via Mechanical Soft, Renal, Vegetarian, No Pork and No Seafood menus. Open Hand has also revamped its pantry program to incorporate the inclusion of more fresh fruits and vegetables. In doing so, we aim to increase fruit and vegetable access, consumption, utilization, and knowledge in at-risk clients whose nutritional needs are not currently being met.

Ensuring accountability

In an ongoing effort to improve quality, all menu items are tasted in Daily Product Review (DPR) by our expert team of foodservice professionals prior to packaging. This important quality assurance measure ensures that all foods provided to our clients meet and exceed high quality standards. The DPR team members include Open Hand's Senior and Executive staff and aim to identify chef errors in order to seize opportunities for focused culinary training, clarification of recipe methods, and the necessity to modify preparation of a product. Product review not only ensures consistent execution, it also drives reformulation of menu items to enhance appearance, flavor, depth, texture, complexity, and authenticity of the cuisine. Attention to the quality of ingredients, methods of preparation, variety of menu items, and composition of meals ensures our ability to provide satisfying and healthful meals which contribute to an improved quality of life.

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