All Those Measures: What about quality?

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Overview of the Talk

- Background
  - Model and context: HIVQUAL-US
- HIV Measures
- National Performance Data: Benchmarking
- National AIDS Strategy
- Opportunities
Acronyms

- PCMH – Primary Care Medical Home
- NQF – National Quality Forum
- HAB – HIV/AIDS Bureau
- NAS – National AIDS Strategy
What is HIVQUAL-US?

• A capacity-building program supported by the HIV/AIDS Bureau-HRSA and implemented through the NYSDOH AIDS Institute to help Ryan White Part C & D HIV care programs build and sustain quality improvement programs

• A way to monitor HIV care using a sampling strategy that promotes self-assessment through standardized record review

• A framework for quality management linking three core components
The HIVQUAL Framework

- Performance Measurement
- Quality Improvement
- Quality Management Program

Implemented through
- Coaching and Mentoring
- Peer Learning
- Involving Patients
HIVQUAL Participating Part C/D Grantees in 2011

HIVQUAL Participating Part C/D Grantees

HQ State Penetration Rate (%)
- 0
- 1 - 40
- 41 - 60
- 61 - 80
- 81 - 100

HAB Part C/D Grantees
- HQ Part C
- HQ Part C/D
- HQ Part D
- non-HQ Part C
- non-HQ Part C/D
- non-HQ Part D
HIV Measures

- HAB Measures
  - [http://hab.hrsa.gov/special/habmeasures.htm](http://hab.hrsa.gov/special/habmeasures.htm)
- NQF-endorsed measures
- HIVQUAL-US measures
Roles of Performance Measurement

- **Benchmarking and goal setting**
  - Feedback to HIV programs
  - Fostering ‘healthy’ competition and consumer choice

- **Prioritizing areas for improvement**
  - Identification of opportunities for improvement at each HIV program, state and national level

- **Measuring progress**
  - Assessment of whether QI activities improve HIV care
  - Impact on HIV care of the population
  - Ability to track progress over time

- **Identifying successful and reliable strategies**
NQF

- A not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. NQF endorses performance measures as national voluntary consensus standards through their consensus development process.
- Designated as clearinghouse for measures under the Accountable Care Act for approving measures that will be endorsed by the Department of Health and Human Services and can be used for public reporting and quality improvement.
- Measures will be used by Office of Health Information Technology for electronic reporting initiatives and benchmarking, and should not be dependent upon manual chart review.
NQF HIV Measures: Process

- Harmonization of HIV measures across entities and platforms
- Consensus measures developed by panel supported by:
  - American Medical Association
  - Physician Consortium for Performance Improvement
  - HRSA (HAB)
  - HIVMA
  - NCQA
- Goal to develop measures for those already diagnosed
- Beta testing underway (Kaiser Permanente; Alliance of Chicago)
NQF HIV Measures

• **Outcome Measures**
  • HIV RNA control for all patients on ART to below limits of quantification for lab used
  • HIV RNA control after six months on ART

• **Process Measures**
  • Medical Visit (one visit in each half of year with visits at least 60 days apart)
  • CD4 cell count twice yearly
  • PCP prophylaxis if CD4<200
  • ART prescription if CD4<350
NQF Screening and Vaccination Measures

- TB screening
- STI Screening (syphilis - annual, GC, chlamydia – ever)
- Hepatitis B screening
- Hepatitis C screening
- Injection drug use – annual screen
- High risk sexual behavior – annual screen
- Influenza vaccination
- Pneumococcal vaccination
- HBV vaccination (complete series)
Large HIV Clinical Performance Data Sets

- Veterans Administration Hospital

- Kaiser Permanente

  - Advisory committee of representative Part C/D clinicians

HIVQUAL-US Performance Data

- Data analysis not quite finished.
- Benchmarking report will be posted when complete at
  [www.hivqualus.org](http://www.hivqualus.org).
HIVQUAL-US: Performance Data Results

- **2009 C/D**: Data analyzed from 204 clinics (Ryan White Part C/D), representing 108 grantees
  - **2007 C/D**: 168 clinics (Part C/D), representing 93 grantees
- Patients were eligible for inclusion if they had 1 visit in each 6 month period
- Excluded patients ≤ 13 years of age
- Sample calculated to achieve 90% CI ± 8%
- Over 25 indicators in the HIVQUAL data set, many with subcomponents
*Patients are ARV eligible if they were already on ARV therapy prior to or during the review period or if there were any CD4<350 or VL>100,000 in the year
Analytic Sample Demographics: Age and Gender (n=10,926)
Analytic Sample Demographics: Exposure Category and Race/Ethnicity (n=10,926)

- Heterosexual: 51.7%
- MSM: 32.3%
- IDU: 12.8%
- Other: 3.4%

- Black, non-Hispanic/Latino: 44.7%
- Hispanic/Latino: 28.3%
- White, non-Hispanic/Latino: 23.1%
- Other: 3.8%

IDU=any IDU
Other” includes hemophilia/coagulation, perinatal transmission, transfusion/blood, and other.

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## Clinic Characteristics

<table>
<thead>
<tr>
<th>2009 Part C/D</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of clinics</td>
<td>204</td>
<td>--</td>
</tr>
<tr>
<td>Ryan White Part C</td>
<td>175</td>
<td>85.8</td>
</tr>
<tr>
<td>Part D</td>
<td>10</td>
<td>4.9</td>
</tr>
<tr>
<td>Parts C and D</td>
<td>19</td>
<td>9.3</td>
</tr>
<tr>
<td>Average caseload (all patients) per clinic</td>
<td>375 (range: 3-3755)</td>
<td></td>
</tr>
<tr>
<td>Average caseload (eligible patients) per clinic</td>
<td>280 (range: 1-2510)</td>
<td></td>
</tr>
<tr>
<td>Average number of patients reported per clinic (randomized sample)</td>
<td>54 (range 1- 156)</td>
<td></td>
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<tr>
<td>Setting Other Clinical*</td>
<td>152</td>
<td>74.5</td>
</tr>
<tr>
<td>Hospital associated or based</td>
<td>52</td>
<td>25.5</td>
</tr>
</tbody>
</table>

*“Other clinical” include community health centers, community based organizations, health department clinics, drug treatment centers, private practice offices*
% of Patients by Setting

2009 C/D (N=10,926)

- 61.3%
- 38.7%

*Other Clinical include community health centers, community based organizations, health department clinics, drug treatment centers, private practice offices
Performance Data Results

- **Clinic mean**: average clinic performance score
- **Top 10% level**: value above which only 10% of clinics performed
- **Bottom 10% level**: value below which only 10% of clinics performed
# List of Key Indicators

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HIV Specialist Visits

Percent of patients who saw HIV Specialist every 6 months

- Clinic mean: 93%
  - Bottom 10%: 83%, Top 10%: 100%

Every 6 months cannot be determined from 2007 data, as only captured by trimester.
VL and CD4 Count Monitoring (clinic means)

*clinic means are shown in figure.*
Lowest CD4 Count: Clinic Means

Of 10,336 patients with at least two CD4 counts measured during the year:

- Lowest CD4<200 = 19.7%
- Lowest CD4<350 = 43.7%
- Lowest CD4<500 = 67.5%
- 80.3% - lowest CD4 >200

*525 patients with only 1 CD4 count measured and 65 with no CD4 measured were excluded.
**Clinic means are shown.
PCP Prophylaxis

- Percent of patients whose lowest CD4 count < 200/mm$^3$ in review year who were on PCP prophylaxis
  - Eligible population C/D: **13% (1416)**

**Clinic mean for eligible patients on PCP prophylaxis: 71%**

  Bottom 10%: 27%, Top 10%: 100%
  - 2007 C/D clinic mean: 86%

* And not >200 for remainder of year
Prevention Education

HIV prevention education

Of 10,926 eligible patients:

- Clinic mean for eligible patients that had prevention education in both the 1st and last 6 months of review year: 70%
  - Bottom 10%: 15%, Top 10%: 100%
- Clinic mean for eligible patients that had prevention education in either the 1st or last 6 months of review year: 86%
  - Bottom 10%: 57%, Top 10%: 100%
Patients on ART with lowest CD4 <200 during year

- Clinic mean for % of patients with lowest CD4<200 in 2009 ever on HAART in the review period: 94%
  - Bottom 10%: 83%
  - Top 10%: 100%
Baseline Resistance Testing

% of ARV naïve patients with VL > 1000 copies initiating ARV therapy who received a baseline resistance test

Clinic mean for patients receive a baseline resistance test: 53%
Bottom 10%: 0%, Top 10%: 100%

- 2007 C/D clinic mean (pilot indicator): 43.8%, small n
Viral Suppression: Always & Last

- Population – ever on ARV therapy in year. N=9,717

- Clinic mean for patients who were **always** viral load suppressed (VL ≤ 400): 61%
  - 2007 C/D clinic mean: 56%

- Clinic mean for patients who had **last viral load test** suppressed (VL ≤ 400): copies/mL: 76%
  - 2007 C/D clinic mean: 73%
Viral Suppression: Always & Last: New definition of suppressed

- Population – Patients on ARV therapy 12 weeks or more before last VL (N = 9,153)

- Clinic mean for patients who were always viral load suppressed (VL ≤ detection OR 200 copies/mL): 64%
  - Bottom 10%: 36%, top 10%: 85%

- Clinic mean for patients who had last viral load test suppressed (VL ≤ detection OR 200 copies/mL): copies/mL: 75%
  - Bottom 10%: 50%, top 10%: 94%
Ever & Always Suppressed

Clinic Means

Patients with >2 VL tests, on ART ever and seen in all 3 trimesters
(2009 N=7,368, 2007 N=6913)

 Lowest VL (EVER) 2009 2007
VL<400 88.2% 84.1%
59.2% 57.3%
7.5% 9.8%
28.9% 26.8%
3.3% 5.1%
1.1% 1.0%

 Highest VL (Always) 2009 2007
VL<400, 62.4% 57.0%
32.9% 32.9%
28.6% 26.5%
15.7% 17.0%
13.6% 16.4%
9.2% 9.7%
1.1% 1.0%

*Clinic means are shown in figure.

Lowest VL captures patients ever suppressed during the year
Highest VL captures patients always suppressed during the year
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TB Screening

- TB screen during the last 2 years for patients with no prior TB or PPD(+)
  - 2009 C/D: 9,755 eligible patients

- Clinic Mean for patients who had a TB screen: **69%**
  - Bottom 10%: 35%, Top 10%: 100%
    - 2007 C/D: clinic mean: 70%

- Clinic Mean for patients who had PPD Positive: **3%**
  - Bottom 10%: 0%, Top 10%: 7%
    - 2007 C/D clinic mean: <1%, small N
Known Hepatitis C Status

Hepatitis C status is defined as known if:

- Known (+) at start of year
- Known (-) at start of year and low risk*
- Known (-) at start of year, high risk* but retested during the year
- Unknown status at start and any result by end

Clinic mean for patients who had known HCV status as of end of 2009: 90%
- Clinic mean: 20% sero-positive

*High risk for HCV infection - active IDU, multiple partners, new abnormal LFTs
Hepatitis C Screen (revised 2009)

Part C/D 2009 N=10,926

- 83% HCV status known at start of year
  - 24% Positive (2,018)
    - 66% (1,332) last known RNA assay was positive
      - 11% (785) of whom have high risk for infection (active IDU, multiple partners, new abnormal LFTs)
        - 78% (1,046) had treatment or evaluation discussed
      - 56% (513) retested
  - 76% Negative (6,955)
  - 17% HCV status unknown at start of year

At end of year:
- 90% status known

*Clinic means are shown on this slide.
Updated indicator in 2009 review
## STI Screenings

<table>
<thead>
<tr>
<th>STI Test</th>
<th>Number eligible</th>
<th>Clinic Mean (Bottom 10%, top 10%)</th>
<th>% Positive (Clinic mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Syphilis</strong> (all patients)</td>
<td>10,926</td>
<td>80% (53%, 100%)</td>
<td>6.0%</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong> (all women, plus men with MSM or MSM/IDU risk)</td>
<td>7,673</td>
<td>58% (17%, 100%)</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Chlamydia</strong> (all women, plus men with MSM or MSM/IDU risk)</td>
<td>7,673</td>
<td>58% (17%, 100%)</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
GYN Care Indicator

**GYN Care in review period**

4,148 women eligible in 2009

Clinic mean for patients who had both a pelvic exam and a Pap test: **61%**

Of 2,578 women with a pelvic and pap smear, clinic mean of
- **24%** (632) abnormal
- With clinic mean of **89%** (555) referred for follow-up

![Bar chart showing GYN Care Indicators]

<table>
<thead>
<tr>
<th>Category</th>
<th>2007 C/D</th>
<th>2009 C/D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap and Pelvic (all females)</td>
<td>69%</td>
<td>61%</td>
</tr>
<tr>
<td>Pap test (among those with a Pelvic exam)</td>
<td>96% 93%</td>
<td></td>
</tr>
<tr>
<td>Follow-up for abnormal Pap</td>
<td>85%</td>
<td>89%</td>
</tr>
</tbody>
</table>
Vaccinations

- Pneumococcal vaccination (optional)
  - Clinic mean in last 5 years: **72%**
    - Bottom 10%: 44%, Top 10%: 94%

- Influenza vaccination in this review year or last
  - Clinic mean: **77%**
    - Bottom 10%: 51%, Top 10%: 96%

- Influenza vaccination in this review year
  - Clinic mean: **59%**
    - Bottom 10%: 33%, Top 10%: 86%
Dental Care

Dental exam during review year

• Clinic mean for patients who had a dental exam in the last 12 months: 36%
  • Bottom 10%: 8%, Top 10%: 75%
  • 2007 C/D clinic mean: 42%
Tobacco Screening

Tobacco use screen

- Clinic mean for patients who were screened for tobacco use: 82%
  - Bottom 10%: 51%,
  - Top 10%: 100%

- Clinic mean: 42% current users
  - Clinic mean: 78% of current users received counseling
Substance Use Screening: Clinic Means

*Clinic means are shown on this slide. Patients reviewed at Drug Treatment Centers were excluded from the substance use screening analyses.*
Current Substance Use: Clinic Means

- Of the 2,197 patients with current substance use:
  - 52% alcohol
  - 36% marijuana
  - 29% cocaine (15% of whom via injection; 30% via intranasal; 52% via smoking)
  - 8% heroin (59% of whom via injection; 20% via intranasal, 16% via smoking)
  - 4% pills
  - 4% other drugs

- Clinic mean of 43% of patients with current heroin/cocaine injection use had safer injection/needle exchange discussed

- Clinic mean of 19% of patients with current substance use were in treatment:
  - 15% detoxification, 19% methadone, 25% residential treatment, 31% out-patient non-methadone, 12% 12 Steps Self-Help, 18% other treatment method.

*Clinics means are shown on this slide. Patients reviewed at Drug Treatment Centers were excluded from the substance use screening analyses.*
In recent years (since a NYS pilot in 2004), the indicator has used a composite score requiring that all components of the indicator (cognitive; depression; anxiety; sleeping; appetite; domestic violence; post traumatic stress disorder) be performed.

- PTSD: 45%
- Domestic Violence: 56%
- Appetite: 72%
- Sleeping: 67%
- Anxiety: 62%
- Depression: 74%
- Cognitive: 54%

*clinic means are shown on this slide.
Mental Health Screening (Cont): Clinic Means

<table>
<thead>
<tr>
<th>2009</th>
<th>Of screened, % Problem Identified (n)</th>
<th>Of problem identified,</th>
<th>Of referred noted, % Referred</th>
<th>Of referred, % seen within 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% No treatment or referral</td>
<td>% Already in Care</td>
<td>% Newly Given treatment</td>
<td>%Referral noted</td>
</tr>
<tr>
<td>Cognitive function</td>
<td>11%</td>
<td>5%</td>
<td>66%</td>
<td>14%</td>
</tr>
<tr>
<td>Depression</td>
<td>37%</td>
<td>3%</td>
<td>58%</td>
<td>20%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>29%</td>
<td>2%</td>
<td>63%</td>
<td>20%</td>
</tr>
<tr>
<td>PTSD</td>
<td>13%</td>
<td>2%</td>
<td>64%</td>
<td>15%</td>
</tr>
</tbody>
</table>

*Clinic means are shown on this slide. Mental health treatment and referral indicators newly added in the 2009 review; no comparison to 2007.*
Health Literacy Screen (optional)

Clinic mean: 57% of patients were screened for health literacy (bottom 10%: 0%, top 10%: 100%)

Clinic mean of
11% of patients had a need for a health literacy intervention

56% of patients with a need had a health literacy intervention done
Anorectal Exam & Anal Pap

**Anorectal Exam (core)**
Clinic mean for patients who had an anorectal exam: 19%,
Bottom 10%: 0%, Top 10%: 47%

**Anal PAP (optional)**
Clinic mean for patients who had an anal Pap among women with abnormal cervical Pap: 9%,
Bottom 10%: 0%, Top 10%: 33%

Clinic mean for patients who had an anal Pap among patients with either MSM or MSM & IDU risk: 21%
Bottom 10%: 0%, Top 10%: 67%
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Pneumococcal & influenza vaccinations
Dental Examination
Tobacco Use Screen
Substance Use Screening
Mental Health Screen
Anorectal Exam | Colonoscopy
Diabetes Management (2009)
Hypertension (2009) |
Colonoscopy (optional)

Clinic mean for patients aged 50 and over who had a colonoscopy: **30%**

Bottom 10%: 5%, Top 10%: 51%

- **2007 C/D Clinic Mean (optional): 24%**
% of patients who had any diabetes related testing

**Clinic mean: 73%** of patients had any diabetes related tests*
- Bottom 10%: 14%, Top 10%: 100%
- 86% fasting blood glucose
- 25% HbA1C
- 4% oral glucose tolerance test

**Clinic mean of**
17% (706/5944) of patients had test results indicative of diabetes**
Of these, 75% had serum creatinine measured and 21% had a retinal exam.

* some had > 1 test;  **if FBG$\geq$126mg/DL OR OGTT $\geq$200 OR HbA1C $\geq$6.5% = diabetes

*New indicator in 2009 review.*
Hypertension (optional)

Clinic mean: 99.7% (3,706/3,724) of patients had blood pressure measured

- Bottom 10%: 99%, 10%: 100%

- No hypertension: 82% (2,938)

- Stage 1 hypertension: 14% (600)
  - 46% (273/600) received treatment

- Stage 2 hypertension: 4% (168)
  - 74% (127/168) received treatment

*of patients with known treatment info

New indicator in 2009 review
HIVQUAL Measures: Next Steps

- Clinical subcommittee reviews data, other measures

- Major consideration:
  - Alignment with NQF-endorsed measures
  - Ongoing role of “advanced” indicators
What about improvement?

- Clinic-level improvement

- Regional group projects
  - Pushing the envelope
  - Peer learning
  - Driving high yield results
HIVQUAL Quality Management (QM) Regional Groups

Alabama
Arizona
Central California- Bay Area

Central Florida
Chicago/Milwaukee
Connecticut
Eastern Pennsylvania
Massachusetts
Miami
Midwestern
Mississippi
North Carolina
Northern California
Pacific-Virtual (AK, HI, MT, ID)
Philadelphia
Puerto Rico
San Diego
South Carolina
Southern California
Tri-State (OH, WV, PA)
Low Rates for Hep. B Imm.: A Root Cause Analysis

**Materials**
- No appropriate educational materials available
  - **There is no lab test**

**Processes**
- Clinical staff does not communicate effectively
  - **Policies & Procedures**
    - No clear immunization policies established / “standing orders”
    - Difficult to identify patients who need the service in the records and systems
      - **Appointments**
        - Pts. w/ multiple appts.
        - Reminder/follow up processes are not standard
        - We assume the patient knows the information
        - Time is limited to explain and monitor
        - Personnel/staff tasks/responsibilities not defined

**Low Imm. Rates for Hep. B**
- Staff
  - Problems with communication
  - Too little time w/ pt.
  - Provider does not order vaccine or lab.

- **People**
  - Imm protocols not followed / unaware
  - Pt. does not like the provider
  - Forget
    - Do not believe necessary
    - Cost vs. other needs
    - Busy caring for others
  - Priorities
  - Multiple competing health problems
  - Unemployed
  - Stigma
    - Lack of support system
    - Confidentiality/divulgence
  - Psychosocial
    - Multiple appointments for each service / standby time
  - Location
    - No transportation
    - Appts. outside working hours.

- **Resources**
  - Appointment availability
  - Multiple appointments for each service / standby time

- **Co-morbidities**
  - Homeless
  - Substance Abuse
  - Transferred to other clinic

- **Patients**
  - Encarcerated

- **Mental Health**
Puerto Rico Regional Group: Baseline and Interim % Rates for Hepatitis B Immunization*

5 of 6 facilities achieved improvements, from a baseline mean of 29% (range high/low: 3%-65% / 67%-91%) to follow-up mean of 73% across facilities.

Source: Puerto Rico Regional Group
* % of HIV+ clients who completed the vaccinations series for hepatitisB
Puerto Rico Regional Group: Hepatitis B Screening

Improvement Activities:

• Funding for immunizations identified for non-covered patients
• Screening lab changed
• Addition of a registered nurse administering immunizations
• Staff verifying immunization status at each visit
• Immunization register given to patients; registered nurse keeps a copy and calls patients the day before
• Medical orders are written and kept in record
• Clarification of health concerns and myths
• Letter/appointment reminders
TRI STATE REGIONAL GROUP:
Baseline and Interim % Rates for Retention in Care

OHIO-West Virginia-Western PA

<table>
<thead>
<tr>
<th>Program</th>
<th>Jan-April 2005</th>
<th>May-Aug 2005</th>
<th>Sept-Dec 2005</th>
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<tbody>
<tr>
<td>Program A</td>
<td>67</td>
<td>85</td>
<td>91</td>
</tr>
<tr>
<td>Program B</td>
<td>25</td>
<td>23</td>
<td>81</td>
</tr>
<tr>
<td>Program C</td>
<td>13</td>
<td>0</td>
<td>74</td>
</tr>
<tr>
<td>Program D</td>
<td>57</td>
<td>0</td>
<td>55</td>
</tr>
<tr>
<td>Program E</td>
<td>3</td>
<td>24</td>
<td>65</td>
</tr>
<tr>
<td>Program F</td>
<td>9</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Program G</td>
<td>0</td>
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Retention in Care

• 7 of 10 facilities achieved improvements, from baseline mean of 83.7% (range high/low: 87%-93% / 81%-82%) to follow-up mean of 87.7% across facilities.

Activities:

• Regular conference calls and biannual face-to-face meetings
• Group collaboration to reduce the number of patients with “unmet” need defined as: “individuals who are living with HIV, are aware of their HIV+ status, but are not engaged in regular medical care.”

Grantees also initiated individual improvement projects, including:
• Reducing no show rates and lost revenue
• Reducing new women patient no shows and improvement in long-term patient engagement in care
• Increasing the number of patients with undetectable viral load through targeted case management
• Improving medication reconciliation between outpatient and inpatient
• Sharing of best practices
Patient Retention Over 1 Year

Patient A
- Kept Appointment
- Missed Visit

Patient B
- Kept Appointment
- Missed Visit

Patient C
- Kept Appointment
- Kept Appointment

Patient D
- Kept Appointment
- Missed Visit

Four Retention Measures

• Missed visit

• No visit within 3 months

• At least 2 visits in the year separated by at least 3 months

• 2 visits during the year, at least one in each six month half of the year
Patient A:
- Kept Appointment: Yes
- Missed Visit: Yes
- No Visit Within 3 Months: No
- 6 Month Period With No Visit: Yes
- Retained?: Yes

Patient B:
- Kept Appointment: Yes
- Missed Visit: Yes
- No Visit Within 3 Months: No
- 6 Month Period With No Visit: No
- Retained?: No

Patient C:
- Kept Appointment: Yes
- Missed Visit: No
- No Visit Within 3 Months: Yes
- 6 Month Period With No Visit: Yes
- Retained?: Yes

Patient D:
- Kept Appointment: Yes
- Missed Visit: Yes
- No Visit Within 3 Months: No
- 6 Month Period With No Visit: No
- Retained?: No
QI Regional Groups: Next Steps

- Sustaining groups
- Defining role of HIV ambulatory groups vs. state and Part A initiatives
  - Differentiation
  - Harmonization
- Addressing national priorities
- Achieving results
Achieving results?

- So what might those results look like?
National AIDS Strategy

- Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months) from 73 percent to 80 percent.
- Increase the percentage of Ryan White HIV/AIDS Program clients with permanent housing from 82 percent to 86 percent (from 434,000 to 455,800 people). This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.
- Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65 percent to 85 percent.
National AIDS Strategy

By 2015:

- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.
Too many measures?

- How can we focus our activities?
  - Improvement priorities
    - Externally required vs. locally driven
- Common goals on major health outcomes
  - National AIDS Strategy
  - National Quality Forum: Is it enough?
- Triple Aim
- Primary Care Medical Home
Opportunities: Measurement

- Focusing on outcomes
  - Viral load suppression
  - Mortality
  - Hospitalizations

- Meaningful use
  - Incentives for measurement through HIT:
    - National Quality Forum endorsed measures

- Equity
Opportunities: Program

- Primary care medical home

- High reliability organization

- Triple Aim
Primary Care Medical Home: Standard 6

- Measure Performance: The “practice” measures or receives data on the following:
  - At least 3 preventive care measures
    - Language requires use of standardized measures.
  - At least 3 chronic or acute care clinical measures
  - At least 2 utilization measures affecting healthcare costs
  - Performance data stratified for vulnerable populations to assess disparities in care
Primary Care Medical Home: Standard 6 Element B

- Measure Patient/Family Experience: The “practice” obtains feedback from patients/families on their experiences with the practice and their care:
  - Conducts survey to evaluate experiences on at least 3 of these categories:
    - access, communication, coordination, whole-person care/self-management support
- Uses PCMH version of the CAHPS survey tool
- Obtains feedback on experiences of vulnerable patient groups
- Obtains feedback from patients/families through qualitative means.
Primary Care Medical Home: Standard 6  
Element C  MUST PASS

- The practice uses an ongoing quality improvement process to:
  - Set goals and act to improve performance on at least 3 measures from Element A.
  - Set goals and act to improve performance on at least 1 measure from Element B.
  - Set goals and address at least 1 identified disparity in care or service for vulnerable populations.
  - Involve patients/families in QI teams or on the advisory council.
Primary Care Medical Home: Standard 6 Element D: Demonstrate CQI

- The practice demonstrates ongoing monitoring of the effectiveness of its improvement process by:
  - Tracking results over time.
  - Assessing the effect of its actions.
  - Achieving improved performance on one measure.
  - Achieving improved performance on a second measure.
Primary Care Medical Home: Standard 6 Element E: Report Performance

- The practice shares performance data from Element A and Element B:
  - Within the practice, results by individual clinician.
  - Within the practice, results across the practice.
  - Outside the practice to patients or publicly, results across the practice or by clinician.
Primary Care Medical Home: Standard 6 Element F: Report Data Externally

- Ambulatory clinical quality measures to CMS or states.
- Ambulatory clinical quality measures to other external entities.
  - Must be electronically extracted.
- Data to immunization registries or systems.
- Syndromic surveillance data to public health agencies.
High Reliability Organizations: Chassin and Loeb. *Health Affairs*. 2011. 30: 559-568

<table>
<thead>
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<th>Leadership</th>
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<tbody>
<tr>
<td>Organization commits to goal of high reliability for all clinical services. Organization aims for near-zero failure rates in vital clinical processes. Some services demonstrate near-zero failure rates in some vital clinical processes. Reward systems for staff prominently reflect accomplishment of quality goals. Information technology integral to sustaining quality improvement. Physicians routinely lead quality efforts.</td>
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<th>Safety Culture</th>
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<td>Safety culture is well established. Measurement of safety culture is routine and drives improvement. Regular reporting of close calls and unsafe conditions leads to early problem resolution.</td>
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<th>Robust Process Improvement</th>
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<td>Robust process improvement tools used throughout organization. Patients engaged in redesigning care processes. Mandatory training of all staff in robust process improvement. Proficiency in robust process improvement required for career advancement.</td>
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Future Directions

- Triple Aim
  - Population health
  - Experience of care
  - Per capita costs

- Can we align our measurement systems with the triple aim?
- Beyond alignment, how can we use them to demonstrate value?

- Models beyond HIV
  - Point of care service integration for infectious diseases
  - Chronic disease management
Future Directions

• During the past 3 decades, HIV providers have built comprehensive care clinics that deliver high quality services.

  • How can we show these successes more effectively?
    • Robust and reliable measurement is necessary to move forward.

  • How can these successes be transferred beyond HIV and throughout the healthcare system as we continue to provide excellent care to people living with HIV?
    • Successful measurement and demonstration of results can lead to achieving criteria for programs that meet advanced standards for quality.
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