WORKSHOP IB : CONTINUOUS IMPROVEMENT: RETHINKING AND REWORKING PROGRAM AND QI

Facilitator: Julie Shahroudi
Room 914
10:30AM – 12:00PM

Dorella Walters **Lisa Zullig** *God's Love We Deliver*	Enhancing the Home-Delivered Meal Client Experience
Elaine Ruscetta **Cherry Jones** *Mount Sinai Roosevelt/Mount Sinai St. Luke's*	Getting "Unstuck": A Staff-Led Patient Graduation Project
Lisa Reid **Karen Lugo** **William Groser** *Hudson River Healthcare*	Developing a Quality Management Program and Using Your Organizational Cascade to Effect Change

GOD'S LOVE WE DELIVER®

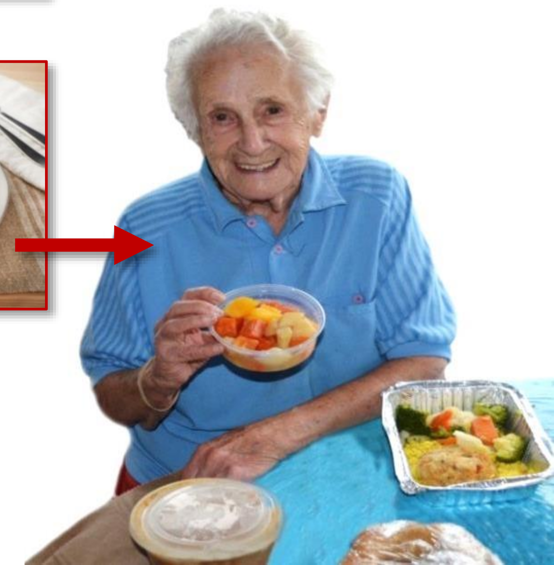
POWER OF QUALITY IMPROVEMENT:

ENHANCING THE HOME DELIVERED MEAL CLIENT EXPERIENCE

Dorella Walters, MPA
Lisa Zullig, MS, RDN, CSG, CDN
November 9, 2016

OUR STORY

- 17+ MM meals since 1985
- 1.5 MM meals delivered last fiscal year
- 6,000 meals delivered each weekday
- Delivery in all 5 boroughs of NYC; also Westchester and Nassau Counties
- 200+ illnesses served



OUR SERVICES

- Home Delivered Meals
- Nutrition Services
- HIV/AIDS Grocery Bags
- Senior Caregivers
- Children’s Meals
- Special holiday meals
- Birthdays
- Emergency Meal Kits

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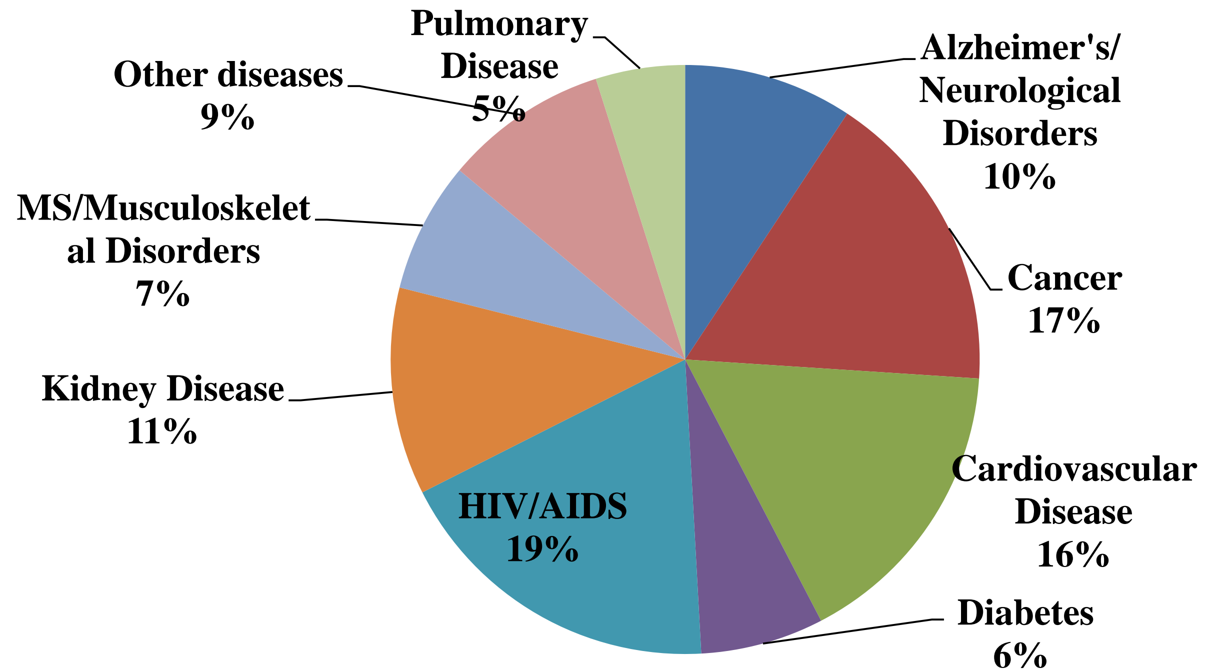
CLIENTS BY DIAGNOSIS FY16

6,650 people



39.2% of clients have Diabetes as either primary or secondary diagnosis.

27.8% report obesity in addition to their primary diagnosis.

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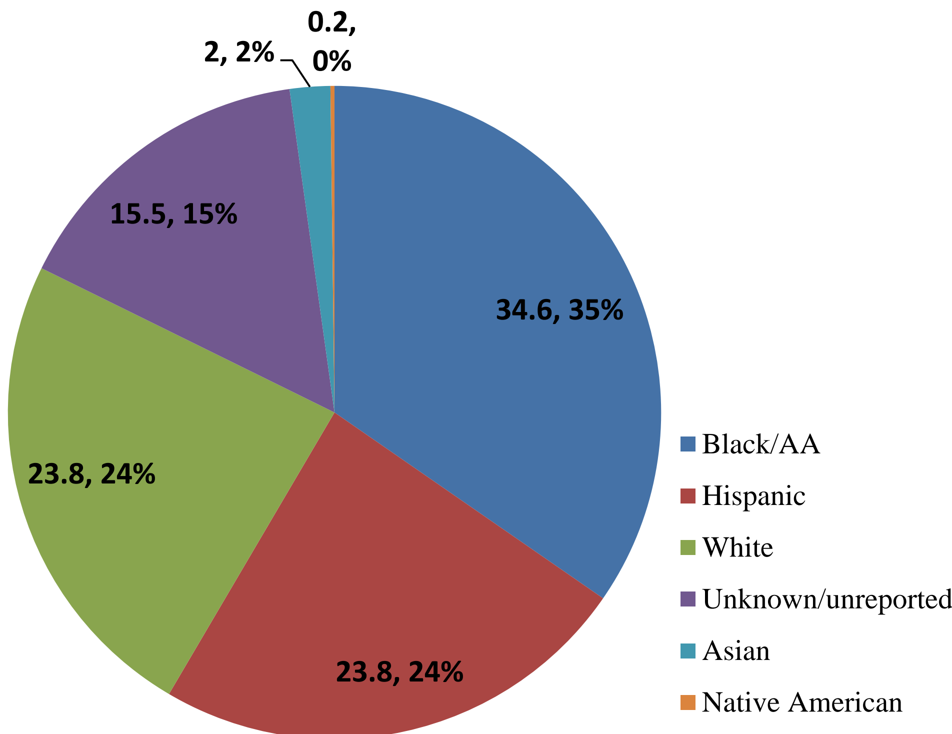
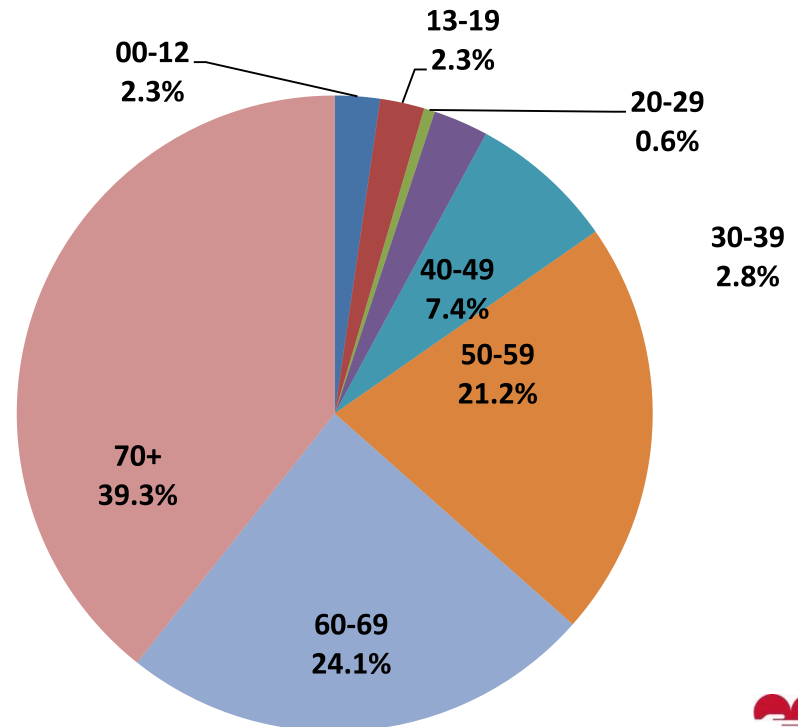
PROGRAM DEMOGRAPHICS FY16

Total God's Love Program:
6,650 individuals: 6,351adults & 299 children

Race/Ethnicity



Total Program by Age



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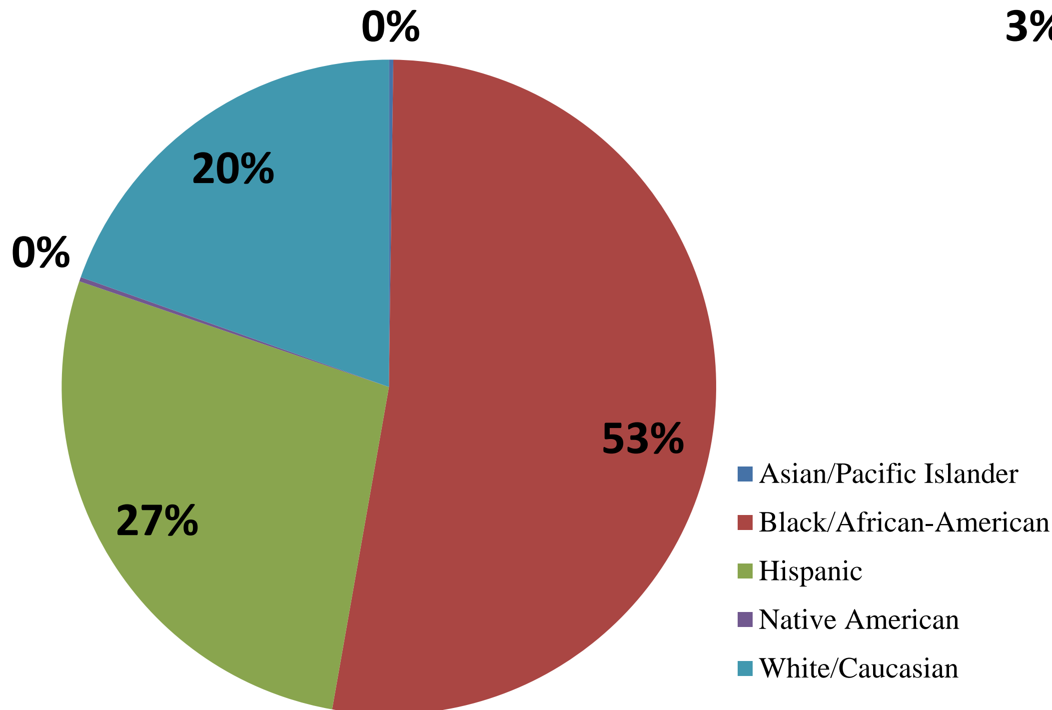
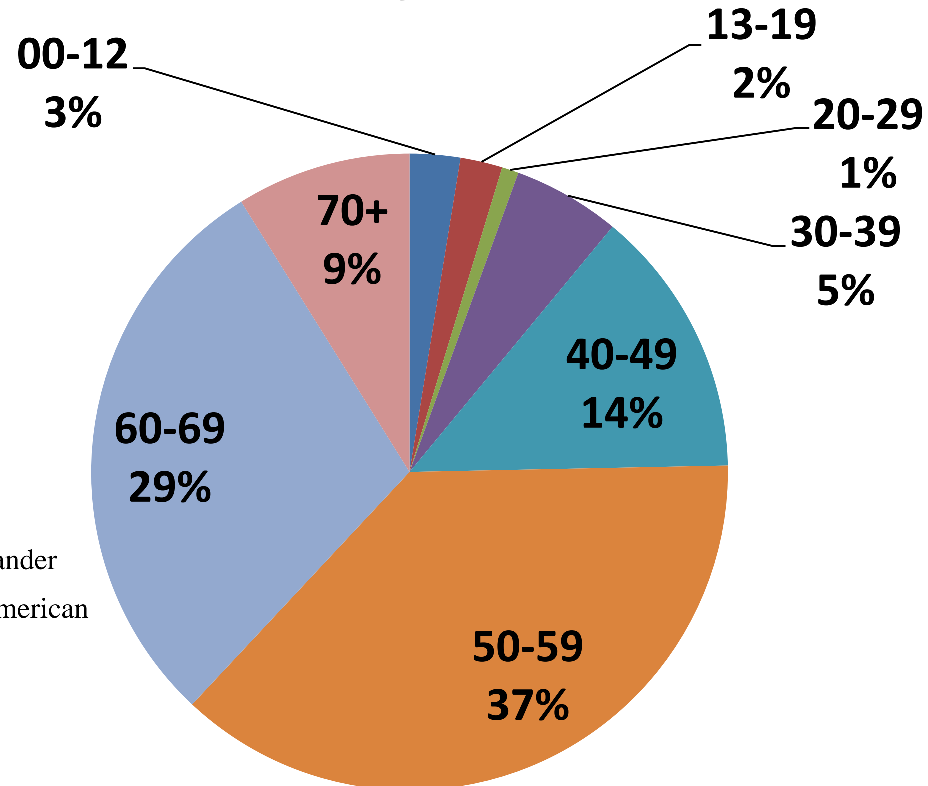
RW PROGRAM DEMOGRAPHICS FY16

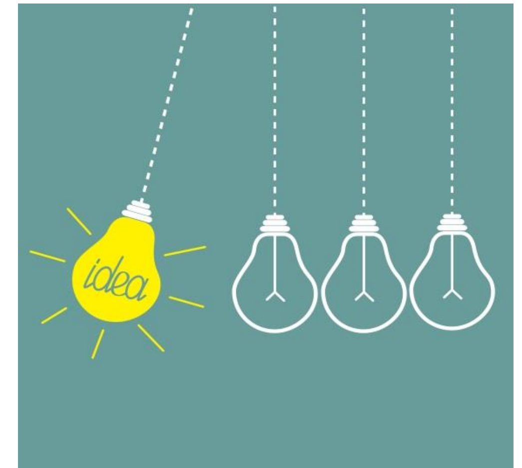
Ryan White Part A:
936 individuals: 892 clients & 44 children





HOW & WHY TO INNOVATE

- Move forward along with daily demands
- Strategic Planning
- Target areas for improvement
- Changing client needs
- Engage our community
  - CCAB, Surveys, etc



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MEAL CONTAINER INNOVATION

- Not Microwaveable
- Can’t see inside
- Condensation
- Stacking challenges
- Lids crushed

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MEAL CONTAINER INNOVATION: METHODS

- Analyzed client demographics
- Surveyed clients: reheating & storage methods
- Received feedback from Client Community Advisory Board & clients
  - Updated meal labels and reheating instructions
- Researched meal containers used by other FNS agencies in NYC and across the country

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MEAL CONTAINER INNOVATION

GOD'S LOVE WE DELIVER.

OUTCOMES & NEXT STEPS

- Improved client satisfaction
- Future sustainability
- Client feedback via surveys

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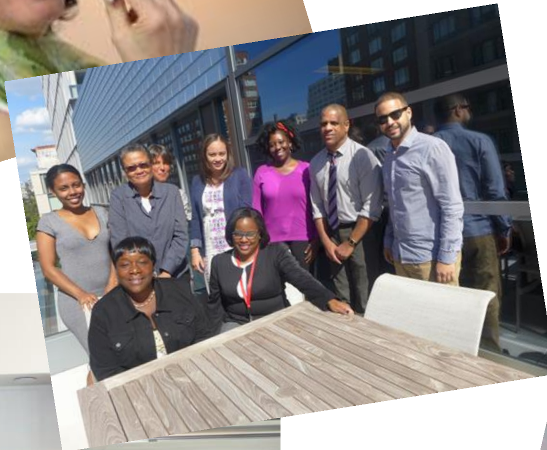
PROGRAM STAFF

How do we fit into the improvement picture?



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THANK YOU!

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Director of Nutrition Services

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Getting “Unstuck”:
A Staff-Led Patient Graduation Project

Cherry Jones, MSHE
Care Coordinator

Elaine Ruscetta, MPH
Program Manager

November 9th, 2016

MSSLW Care Coordination

- Three Sites within the Institute for Advanced Medicine
  - The Morningside Clinic (Mount Sinai St. Luke's Hospital)
  - The Samuels Clinic (Mount Sinai West Hospital)
  - The Spencer Cox Clinic (Remote Site in Chelsea)
- Team of 15 Full Time Staff
  - Program Manager (PM)
  - 1 Care Coordinator (CCs) per site
  - 3-4 Patient Navigators (PNs) per site

Background

- MSSLW CCP Quality Improvement Committee
  - Established in 2013
  - Comprised of staff from all levels (Administrators, Care Coordinators, Patient Navigators)
  - Driven by the needs and wants of front-line staff
- 2015 Project on Patient Graduation
  - Front-line staff observed that many patients had been active in the program for several years, felt “stuck”
  - Committee decided to design an intervention to support staff in knowing when & how to graduate patients to lower track as well as graduate them from the program.

The Problem

- Enrollment Duration
  - At the end of 2014, 53% of active patients had been enrolled in the CCP for more than two years, and 17% of active patients had been active for more than four years.
- Patients Assigned to “Wrong” Track
  - Staff were clear that many medical and socioeconomic factors determined patient need, and that HIV viral load alone was not enough to determine the best track.
- Low Graduation Rate

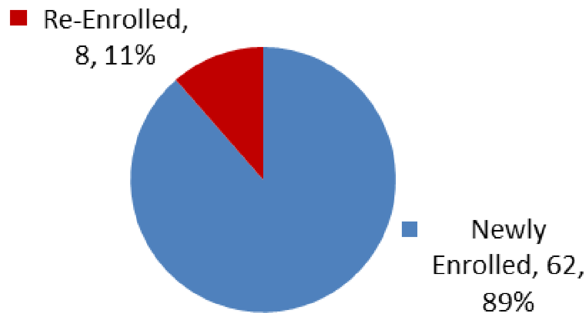
The Goals

1. Increase the number of track changes to lower intensity track (“track graduations”).

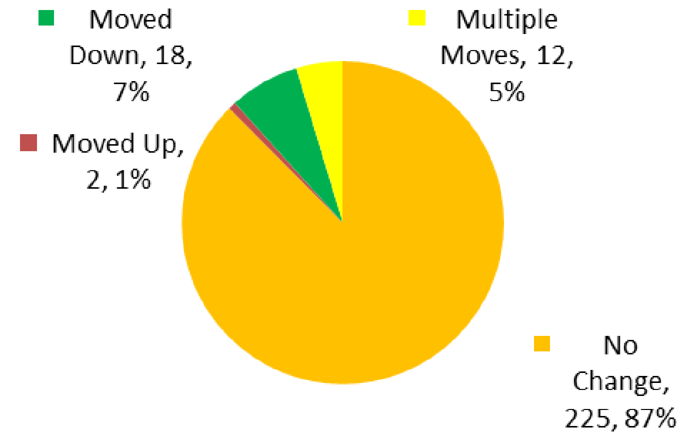
2. Increase the number of program graduations.

3. Decrease the average duration of enrollment in the program.

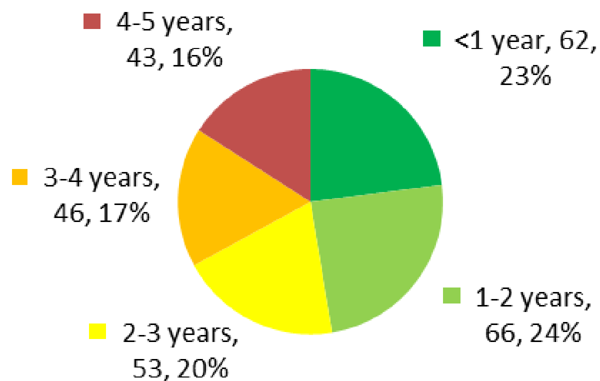
Newly Enrolled vs. Re-Enrolled in 2014



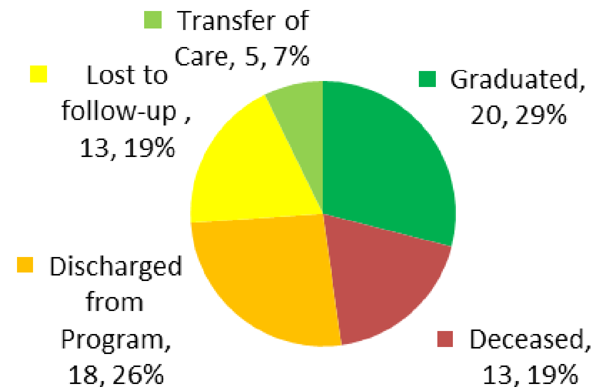
Track Changes in 2014



Number of Years in Program



Reason for Closure



The Intervention

- “Graduation Questionnaire”
  - A tool for staff to use when considering a patient’s readiness for track graduation on program graduation
  - Reviewed by CC and PN during supervision. Can also be discussed with patient as a method for demonstrating past success.
- Monthly Case Presentations on “Stuck” Patients
  - Opportunity for staff to seek guidance from whole team about next steps with “stuck” patients, especially those with long-term enrollments.
  - Presenters provided with presentation template.
  - All participants provided with graduation questionnaire.

Graduation Questionnaire: Sample Questions

- Medications:
  - Is the patient's narrative about adherence consistent? Does the patient's self-report about their adherence match their medical chart (VL, resistance tests, etc.)?
  - Can the patient independently fill their pill box? If not, have they been connected with a resource that can help them with this (e.g. visiting nurse, blister packs)
- Appointments
  - Is the patient able to independently schedule transportation to appointments, if needed?
  - Has the patient developed independent skills for tracking their appointments?

Graduation Questionnaire: Sample Questions (cont.)

- Substance Use:
  - Is the patient’s substance use interfering with their health care? Their social support? Their other goals?
  - Does the patient know where to go if they want to try to quit in the future?
- Other Medical Needs:
  - Does the patient have an established health care proxy and living will? If not, are they open to establishing these?
  - Has the patient received information (from us or from elsewhere) on their other chronic conditions? Do they know where to go for health information?

Graduation Questionnaire: Sample Questions (cont.)

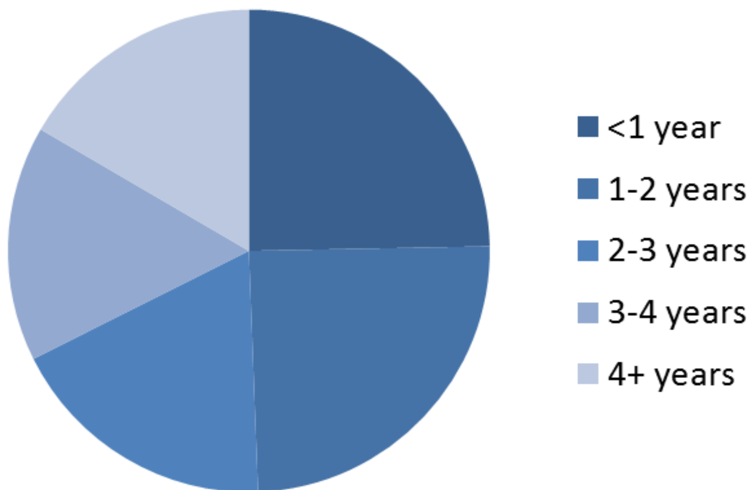
- Social/Economic:
  - Are the patient's main issues relevant to Care Coordination? If not, is there a Health Home or other organization that might better serve their needs?
  - What does the patient's social support look like? Is it working for them?
  - Can the patient maintain their skills in times of crisis?
- Care Coordination:
  - Have all core curriculum topics & relevant discretionary topics been covered? Is there anything else the patient wants to know about their health?
  - Has the patient made progress toward their care plan goals?

Qualitative Outcomes

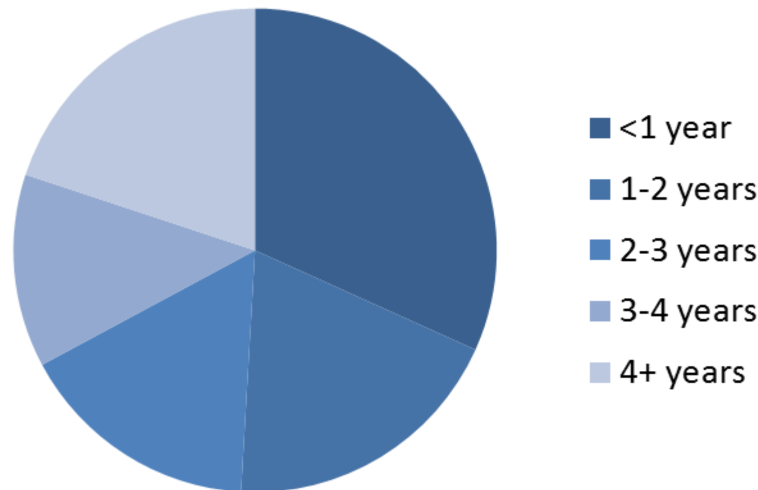
- Collaborative Process…
  - Increased team cohesion & buy-in.
  - Allowed as many staff as possible to participate.
- Intervention…
  - Placed an emphasis on a more qualitative, holistic approach to patient graduation.
  - Provided an opportunity to reflect on patient progress, identify patient barriers, and celebrate patient successes.
  - Established clearer guidelines for graduating/promoting a patient
  - Prevented over-reliance on an individual CC or PN in making the graduation/promotion decision

Quantitative Outcomes

- Program Graduation Rate
  - Fewer graduations from the program in 2015 (9/61) than in 2014 (21/62)
    - Probably due to external influences @ programmatic and organizational levels.
    - Impact on program graduation rate may take >1 year
- Enrollment Duration
  - Larger proportion of patients enrolled for <2 years
  - Small decrease in average enrollment duration



Average Enrollment Duration = 2.25 years



Average Enrollment Duration = 2.20 years

Conclusions

- Qualitative Impact
  - Collaborative approach increased team cohesion and buy-in, ensured that project was relevant to team's needs
  - Clearer and more holistic guidelines allowed the team to better asses patient readiness for graduation
  - Questionnaire became an additional tool for measuring patient progress and an opportunity to celebrate success
- Quantitative Impact
  - Decrease in number of patient graduations.
  - Small decrease in average duration of enrollment
  - Impacts may take more than one year to appear.
    - Increase team utilization of questionnaire
    - Examine 2016 data for additional patterns

Developing a QM Program and Using Your Organizational Cascade to Effect Change

Lisa Reid, LCSW
Director of Genesis Primary Care & Supportive Services

Karen Lugo, Medical Case Manager

William Groser, Peer Adherence Educator

Hudson River HealthCare, Inc.

HRHCare
COMMUNITY HEALTH

- Who we are: A network of 26 community health centers in the Hudson Valley and Long Island
- Our mission: To increase access to comprehensive primary care and preventive health care and to improve the health status of our community, especially for the underserved and vulnerable.

HRHCare Peekskill Site

Developing a Quality Management Program

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Why develop a quality management program??

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- Evaluate the effectiveness of our services and
- Continue to improve the services we provide

Developing a QM Program

- Identify a “champion” to lead
- Create an inclusive team-your input is important (and required)
- Schedule a time that works
- Implement consistently
- Create clear communication
  - Verbal
  - Written QM Plan

Developing a QM Program

Create structures that reinforce Quality Improvement

- Job descriptions include QI
- Report on progress at meetings
- Build QI into ongoing training
- Include QI in orientation for new staff
- Distribute a QI newsletter

Developing a QM Program

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- Provide staff training
  - Webinars
  - Conferences
  - Collaboratives
    - NY Links,
    - Learning Networks
  - Agency meetings/conferences

Developing a QM Program

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- Utilize resources
  - QM Plan template
  - NQC – National Quality Center
  - IHI - Institute for Healthcare Improvement
  - www.hivguidelines.org
  - HIVQUAL Organizational Assessment

Developing a QM Program

HRHCare
COMMUNITY HEALTH

- Celebrate success
  - Recognize staff accomplishments
  - Agency recognition programs
  - Genesis Conference
  - QI Newsletter
  - Board of Directors reports
  - Audits

QI Team

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QI Team Members:

- HIV Specialist
- Director
- Adherence Nurse
- Case Managers
- Peer Adherence Educator

QI Team Meeting Process

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- Each team has a QI rep/champion
- Team meets monthly, first Wednesday of every month
- Data staff run & distribute cognos reports
- Review client level data for specific indicators:
  - Viral load & Monitoring visits
  - Pap smears & mammograms
  - STI screening
  - Hepatitis A, B, C screening
  - Anal paps
- Develop action plan for follow up on patients
- Assign follow up to a team member
- Minutes record activities

QI Team

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- Review aggregate (site) data:
  - Viral load suppression rate of active patients: 63/66 = 95%
  - Retention in care 58/66 = 87%
- Discuss new strategies for performance improvement
- Implement "tests of change"
  Using PDSA model: Plan, Do, Study, Act
- Standardize new strategies across all sites

–

Consumer Involvement in QI

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- Peers on interdisciplinary treatment team
- Provide insight regarding barriers to care and strategies that might work!
- Attend monthly QI meetings
- Participate in NY Links
- Provide feedback on special projects
- Review data at Consumer Advisory Committee meetings
- Present at the Genesis Annual Conference
- Role model we have a voice in QI
- Attend NCQ Consumer Quality Training November 17

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- Using Your Organization’s Cascade to Drive Improvement

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H. Ending the Epidemic Initiative: (A New Domain From the NYSDOH – AIDS Institute Organizational Assessment)

GOAL: To assess how the HIV program generates and uses facility level cascades to identify opportunities for improvement and develop data-driven improvement plans, to align initiatives, and to ensure that accurate and timely information about the care engagement and viral load suppression status of patients is available to all members of the facility so that they can effectively achieve both patient and public health outcomes as New York State accelerates its work to end the HIV epidemic.

The Ending the Epidemic section assesses how the program selects, gathers, analyzes and uses data based on the cascade of care to improve performance. This includes how cascade data are collected and used by leaders, staff and the quality program to improve outcomes along the cascade throughout the entire healthcare agency and to achieve program goals.

H.1. To what extent does the HIV program routinely generate and use facility level cascades to drive improvement and address gaps in care?

Each score requires completion of all items in that level and all lower levels (except any items in level 0)

Stage	Score	Criteria
Getting Started	0	☐ Facility does not report required rates of retention, treatment and viral load suppression.
Planning and initiation	1	Facility: ☐ Reports required rates of treatment, retention, and viral load suppression.
Beginning Implementation	2	Facility: ☐ Can annually construct a cascade that reports rates of retention, prescribed ART, and viral load suppression.
Implementation	3	Facility: ☐ Can conduct an analysis, based on its facility level cascade, to understand why patients do not meet expected outcomes and develop an intervention plan based on its analysis. ☐ Facility leaders, quality committee members, including providers and consumers, and facility staff use facility level cascade to develop and implement a quality improvement plan. ☐ Implements quality improvement plan, tracks the impact of interventions on facility level cascade rates, and responds to the results of QI projects. ☐ Involves community service agencies, including health homes, in process analysis and improvement plans to address linkage, engagement, re-engagement, and viral suppression. ☐ Makes its cascade visible to its internal stakeholders, and discusses it with its community advisory board.
Progress toward systematic approach to quality	4	Facility: ☐ Can measure whether or not HIV+ patients are linked to medical care when they engage with any unit of the facility (including, but not limited to emergency room and supportive services) and can identify the status of every HIV+ patient ever seen at the facility ☐ Can stratify data to identify potential disparities in care provided to sub-populations. ☐ Identifies patients who are lost to follow up and reaches out to its local health department or the State or other source to determine whether or not each patient has been engaged in care elsewhere.
Full systematic approach to quality management in place	5	Facility: ☐ Produces, at least annually, a full cascade that includes facility wide testing and linkage rates within the institution, including, but not limited to emergency departments, inpatient units and appropriate ambulatory care clinics ☐ Follows longitudinal cohorts of patients enrolled in care at the facility over a 24 month period to assess retention, treatment, and suppression.

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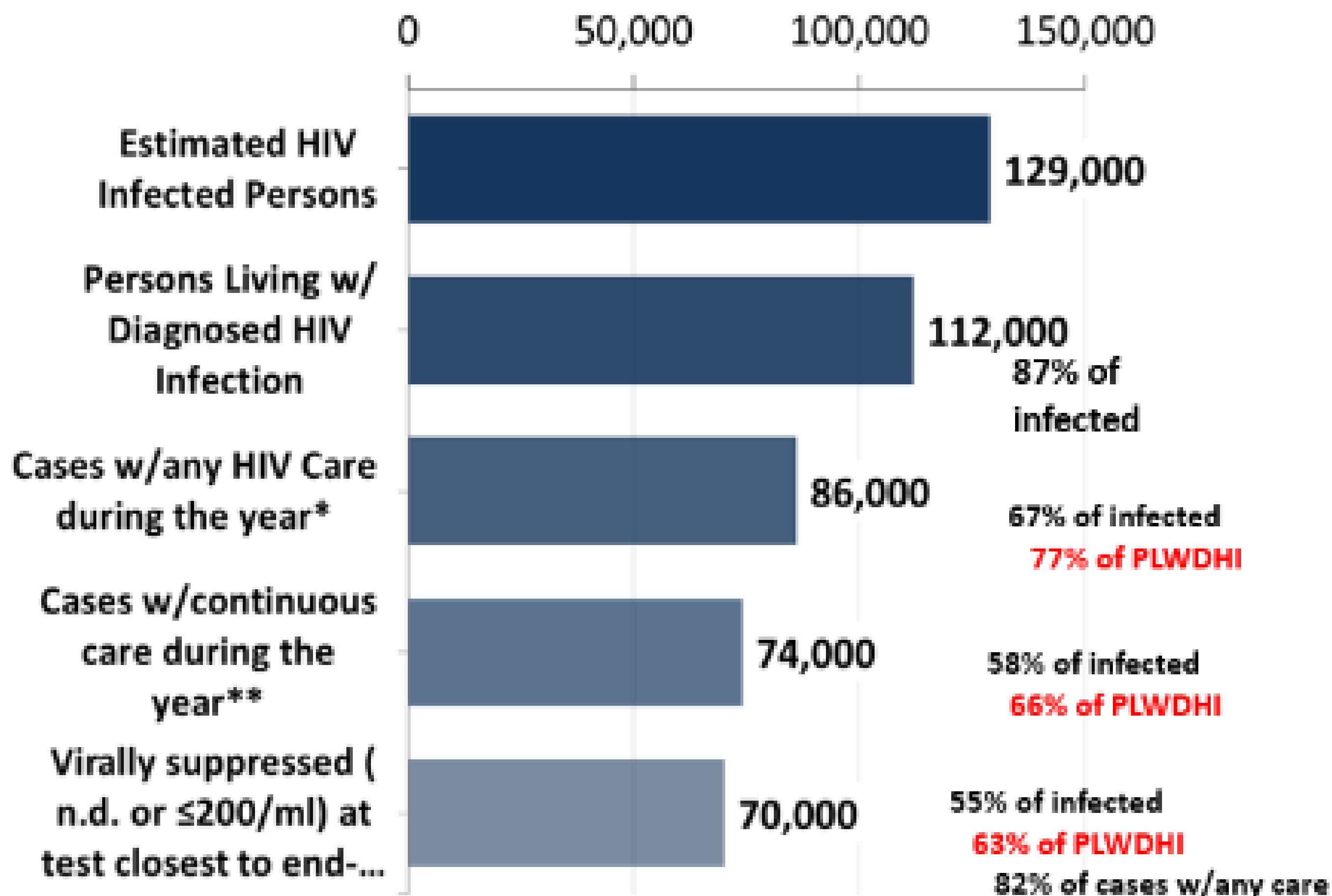
New York State Cascade of HIV Care, 2013

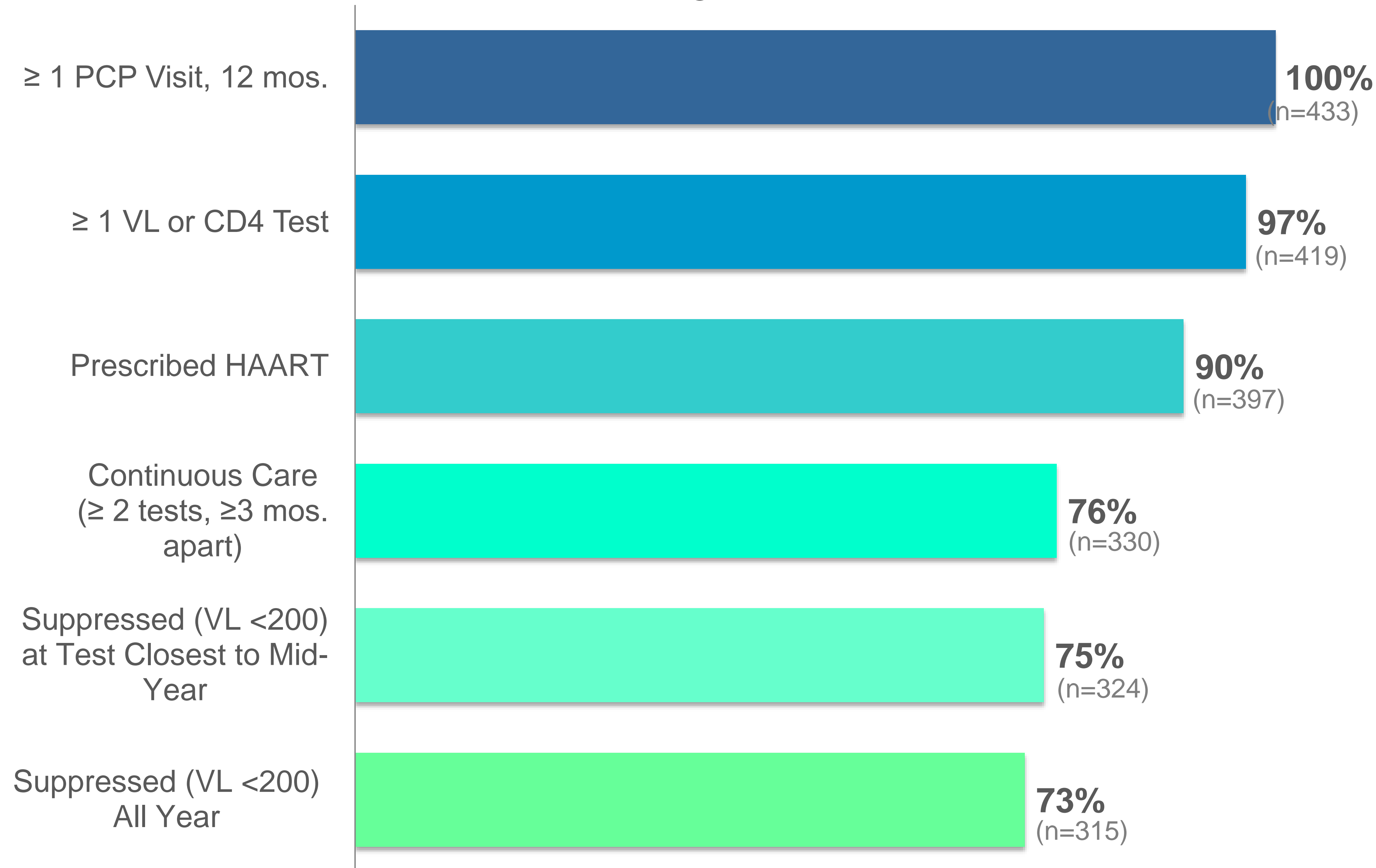
Persons Residing in NYS† at End of 2013

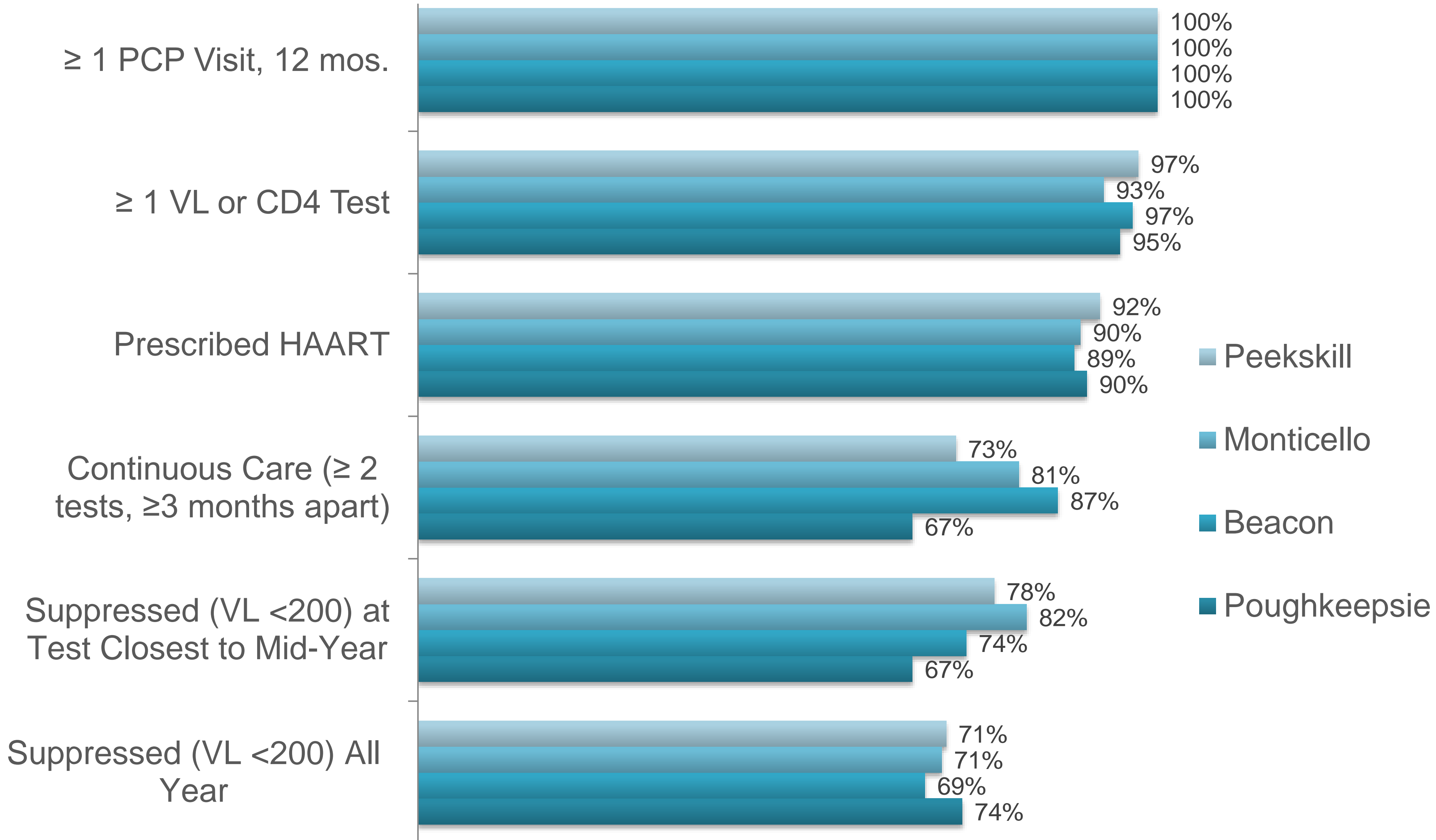


* Any VL or CD4 test during the year; ** At least 2 tests, at least 3 months apart

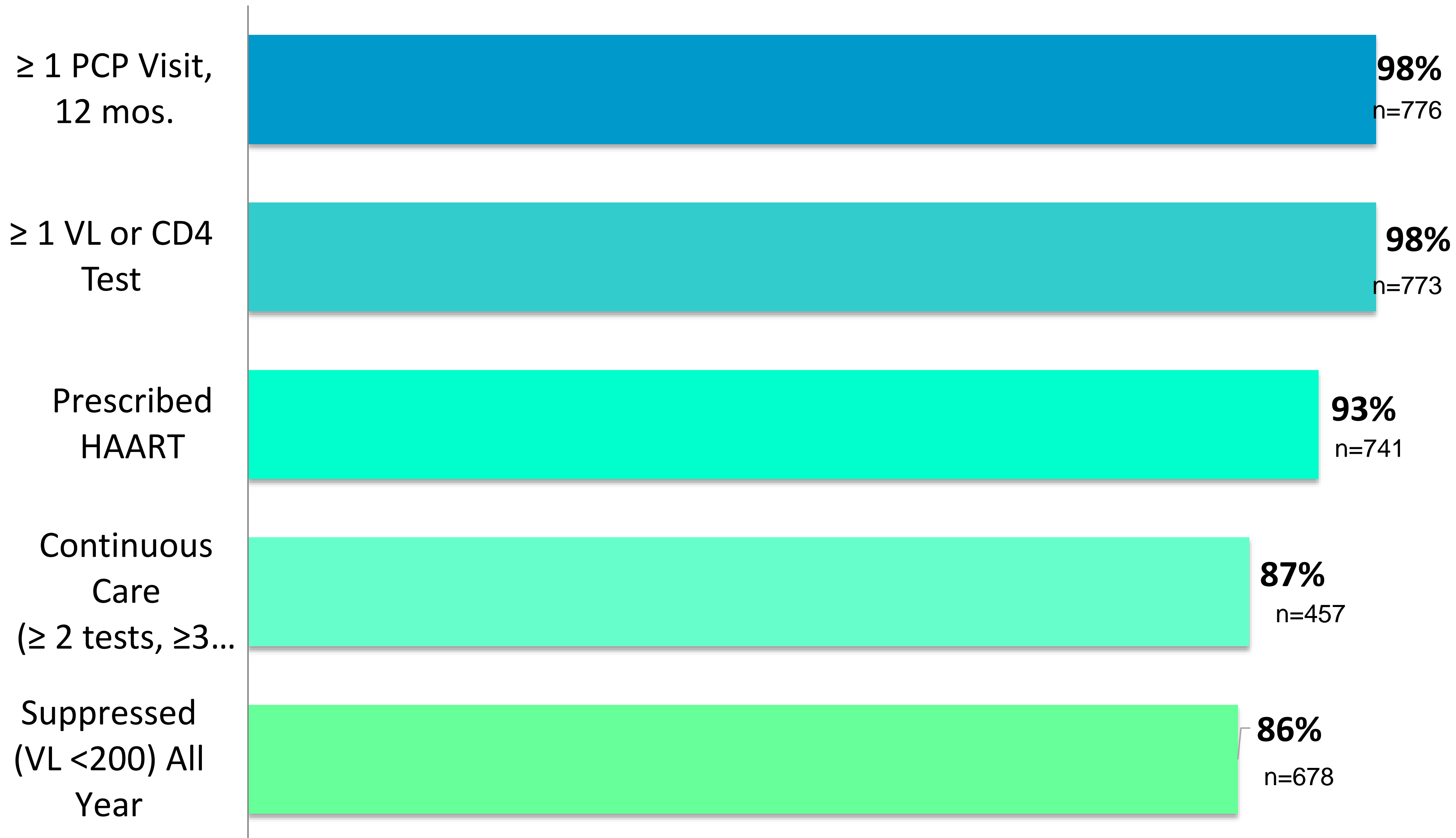
†Persons presumed to be residing in NYS based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.

Cascade of HIV Care at HRHCare's Hudson Valley Sites in 2014

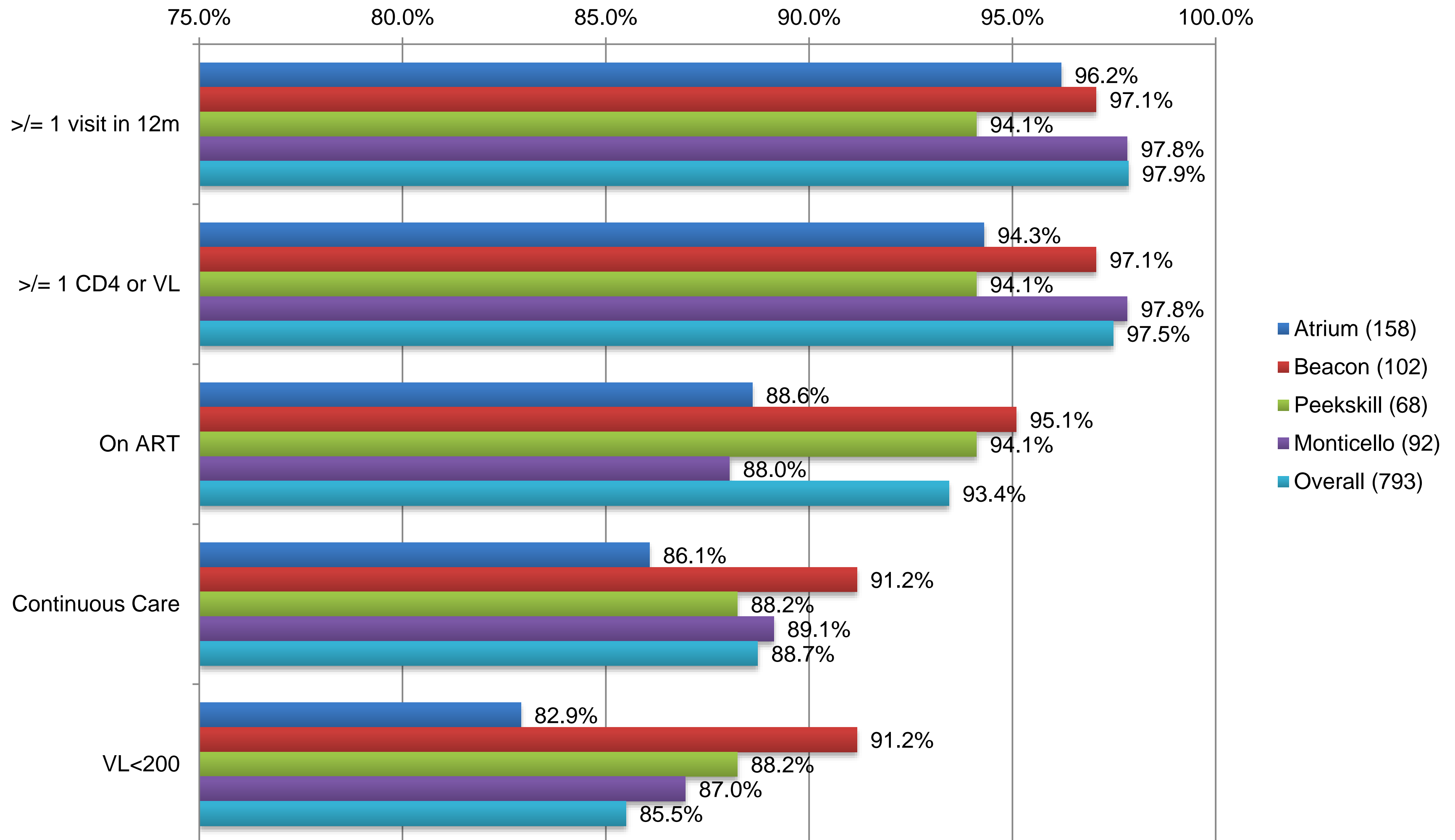



HRHCare Hudson Valley Cascade 2014
≥ 1 PCP Visit, 12 mos.
100%
100%
100%
100%
≥ 1 VL or CD4 Test
97%
93%
97%
95%
Prescribed HAART
92%
90%
89%
90%
Continuous Care (≥ 2 tests, ≥3 months apart)
73%
81%
87%
67%
Suppressed (VL <200) at Test Closest to Mid-Year
78%
82%
74%
67%
Suppressed (VL <200) All Year
71%
71%
69%
74%
Peekskill
Monticello
Beacon
Poughkeepsie

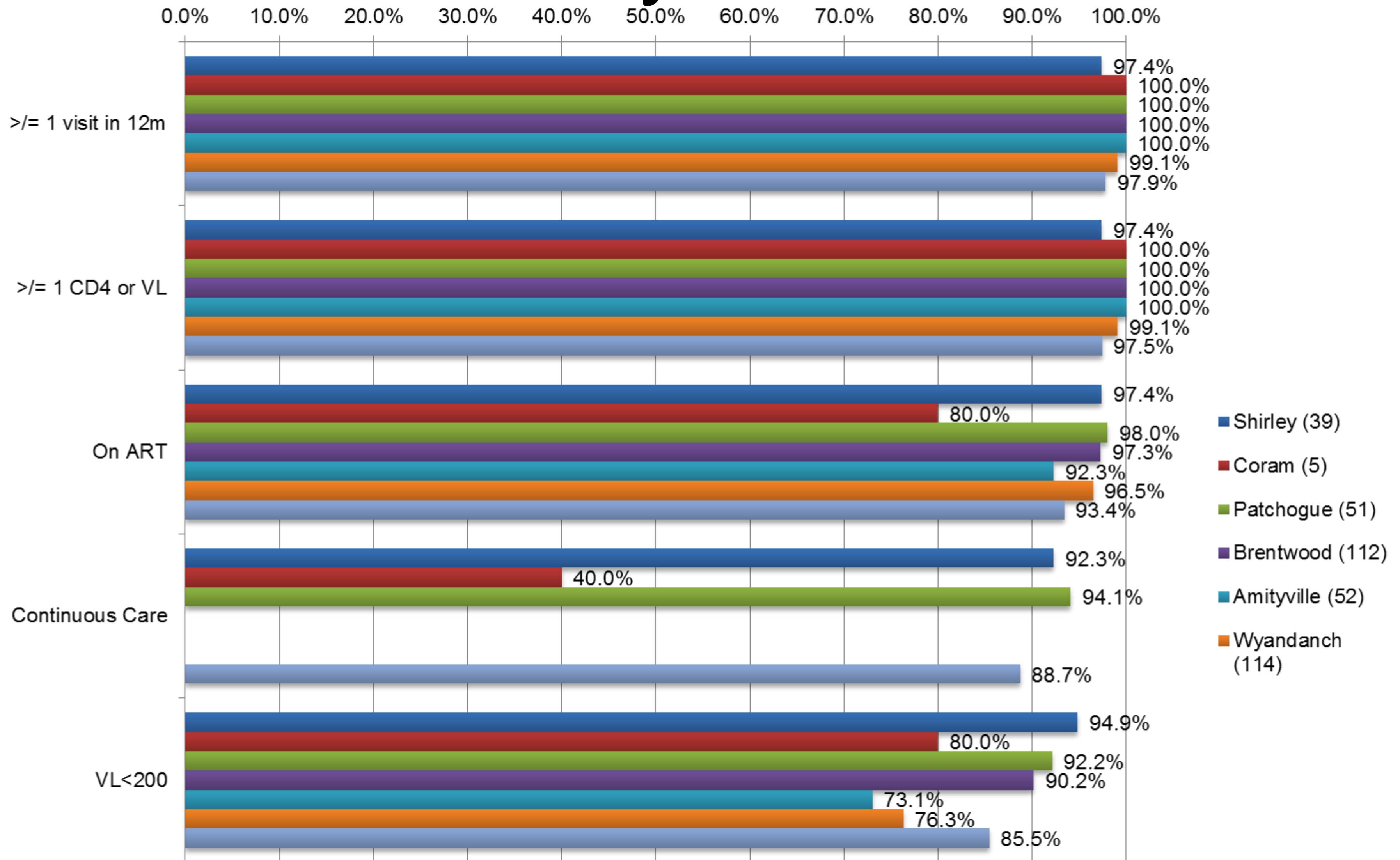
HRHCare Cascade of HIV Care 2015



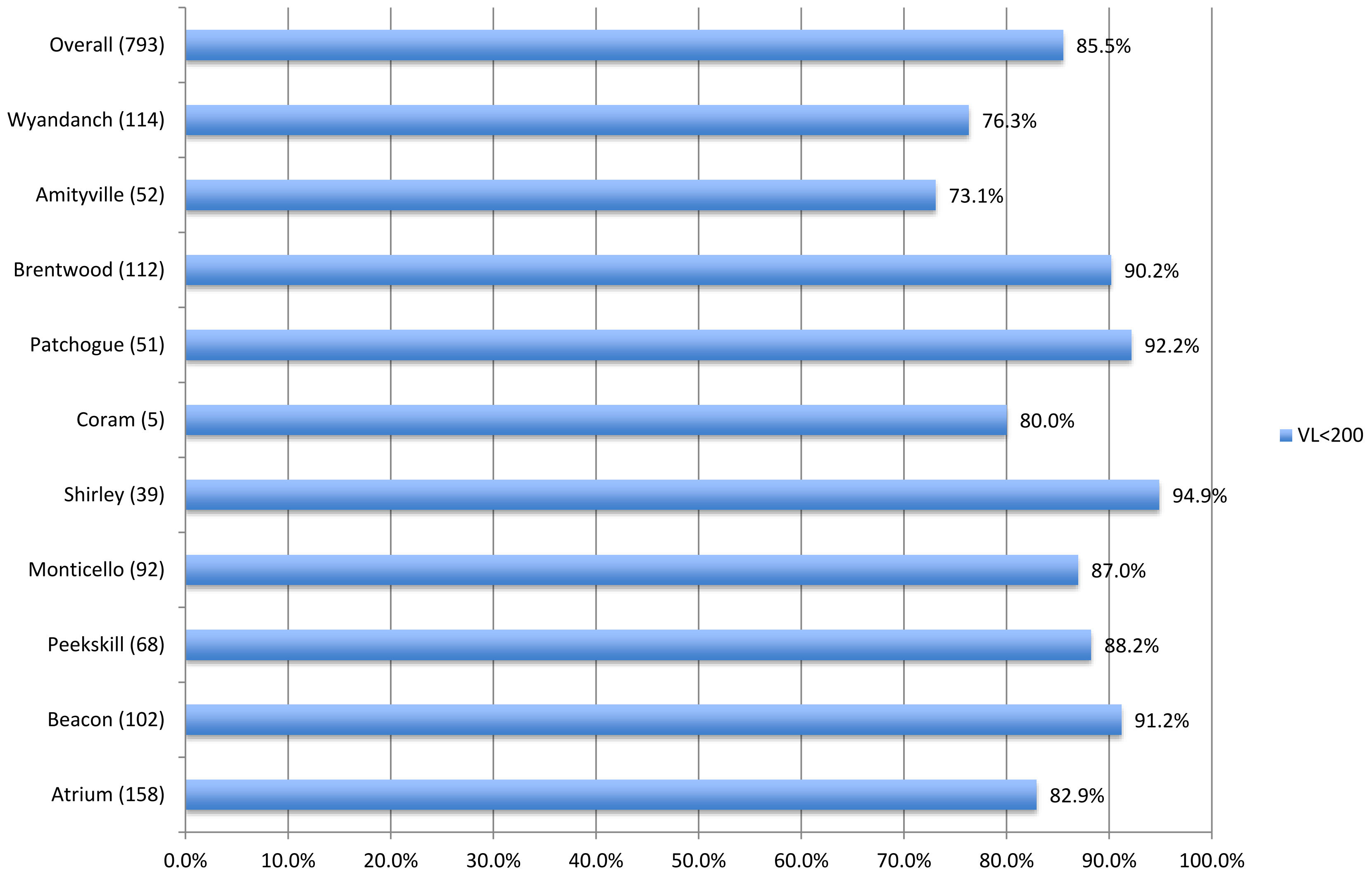
HRHCare Hudson Valley Cascade 2015



Suffolk County Cascade 2015



Viral load <200 at last Viral Load - 2015



Use of the Treatment Cascade

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- Quality Improvement
  - Viral load suppression
  - Retention in care
- Program Development
  - Adherence strategies
  - Evidence based approaches:
    - Peer Support Intervention
- Site specific Cascades
  - – Educate staff and patients on QI
  - – Celebrating success

HRHCare VLS Project

- Standardized lab review process
- Adherence education script
- Referral to intensive Retention and Adherence Program (RAP)
  - 82% suppressed in 9 months
- Case manager present in medical visit
- Replicate RAP in other sites

Thank you!

- Lisa Reid, LCSW
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- Karen Lugo, Medical Case Manager
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