WORKSHOP IC : PROGRAMMATIC IMPROVEMENT DRIVERS

Facilitator: Matthew Feldman
Rosenthal
10:30AM — 12:00PM

Erin Swepston **Julius Powell** *Sunset Park Health Council, NYU Lutheran*	Achieving Health Equity for Newly Diagnosed HIV+ Homeless Persons who Receive Care in Non-Clinical Shelter Settings
Isaac Evans-Frantz **Natasha Goykhberg** *Callen-Lorde*	Addressing Disparities for Transgender Patients
Annel Gomez **Jesse Wilkinson** *GMHC*	The Triad Management Paradigm Promotes Success in New Programs with Developing Identities

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Sunset Park Health Council, Inc.
NYU Lutheran Family Health Center

The Power of Quality Improvement: Promoting Health Equity through RW Part A Services

November 9, 2016
NYU Kimmel Center

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Interdisciplinary Team

- Dr. Tolbert-Walker, MD
  HIV Provider
- Erin K. Swepston, FNP, DNP(c)
  Front-Line Provider
- Ted Tudor, Navigator
  Lead HIV Tester
- Nathaniel Gooding
  Data Coordinator
- Miriam Bonano
  Program Coordinator
- Julius Powell, MA
  Program Administrator

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Background

- A network of clinics operating in homeless shelters, intake and outreach facilities, MICA housing and SROs
    - Providing Primary Care, Women's Health Care, Mental Health services, and HIV care to homeless and populations at risk for homelessness in Staten Island, Manhattan, and Brooklyn
- Since 2012 clinics have been utilizing Ryan White Funding to screen, assess, and link newly diagnosed HIV positive and previously positive homeless persons to care under a Priority Population Targeted grant administered by Public Health Solutions.
- Aim to improve the quality of life and clinical care of uninsured homeless persons in New York City.

Program Model

Participatory model for creating successful public health interventions that is based on the understanding that behavior change is voluntary and most effective when those who are affected are actively engaged in the process

Predisposing Factors

- any characteristics of a person or population that motivate behavior

Predisposing Factors

- Characteristics of the environment that drive action

Reinforcing Factors

- serve to strengthen the motivation for a behavior.

Program Methods

- Motivational Interviewing
- URICA - University of Rhode Island Change Assessment Tool
- AUDIT-C – Alcohol use Assessment
- DAST-10 – Drug Use assessment
- Sexual Health Risk Assessment

- This process encourages client autonomy and allows individuals to make independent decisions in their care

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Program Design
Precede-Proceed Model

Assessment and “diagnosis” of the problem is essential before developing and implementing any community health intervention plan

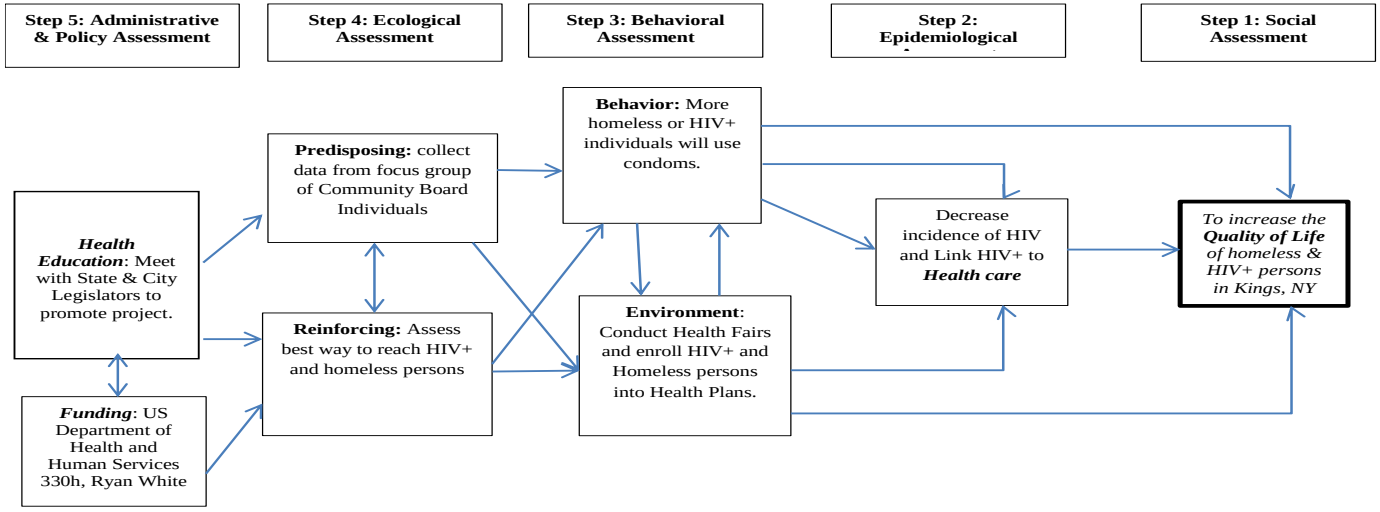
PRECEDE

Predisposing
Reinforcing
Enabling Constructs
Educational/Environmental Diagnosis Evaluation

PROCEED

Policy
Regulatory
Organizational Constructs
Educational/Environmental Development

Precede-Proceed Model



Step 6: Implementation

Complete evaluation plan;

Collect data to determine needs using focus groups and structured interviews; data analysis and synthesis;

Conduct knowledge assessment of participant's awareness of HIV risk behaviors.

Meetings with Community Boards and obtain letter of support identify barriers to HIV prevention and recommend corrective action

Step 7: Process evaluation

# of weekly Team meetings held; measure to what extent fidelity of planned objectives met.

Evidence of tasks completed at intake, and six months;

Key milestones achieved.

# of participants engaged in HIV risk behaviors at intake and 6-months, percentage coverage efficiency

Screening & assessments; importance of viral load, and monitoring discussed.

of persons referred for insurance enrollment.

Step 8: Impact Evaluation

Increase in participant's knowledge of risk perception around HIV/AIDS; consistent condom or other protective barrier use.

Desired effect of program intervention achieved.

Step 9: Outcome Evaluation

There is correspondence with health promotion and improved indicators of health.

Actual persons enrolled in a health plan; Reduction in the # of uninsured persons in Kings, NY

85% of newly diagnosed individuals receive a confirmatory result.

90% of persons linked to care within 90 days

Evidence of participant's ability to display key skillsets needed to reduce likelihood of HIV infection.

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Motivation for Quality Improvement

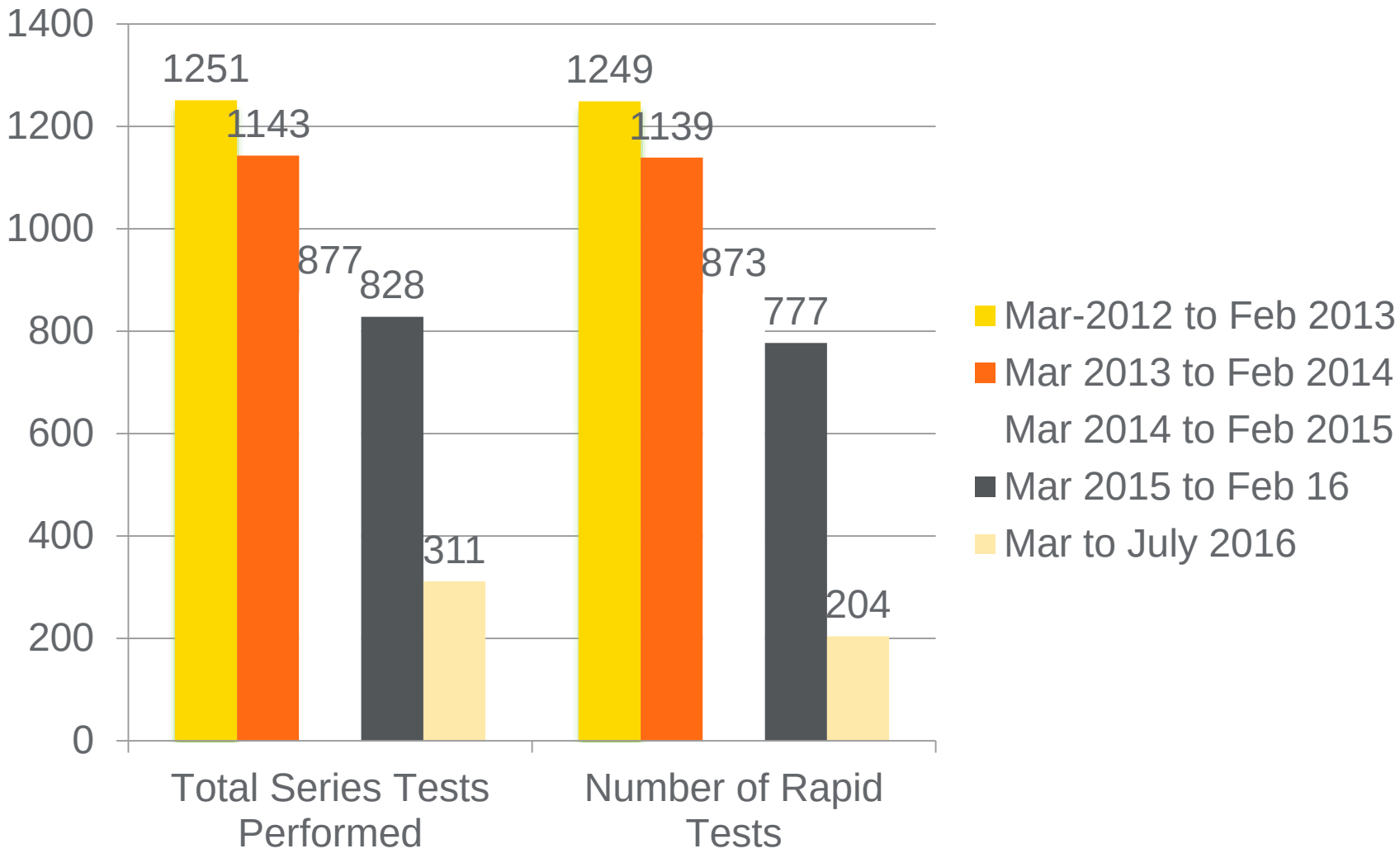
Program Success

- 3,281 HIV Tests were conducted between March 2012 and February 2015.
- Since 2012, 29 newly diagnosed and 95 Known HIV+ persons were identified.
- For the current year 311 people were tested including 3 reactive tests. We were able to link 1-Newly Diagnosed to care and have facilitated care for 12-Known positives.

Need for Improvement

- Decline in tests performed
- Decline in location new positives while infection rates remain high…

Testing Rates



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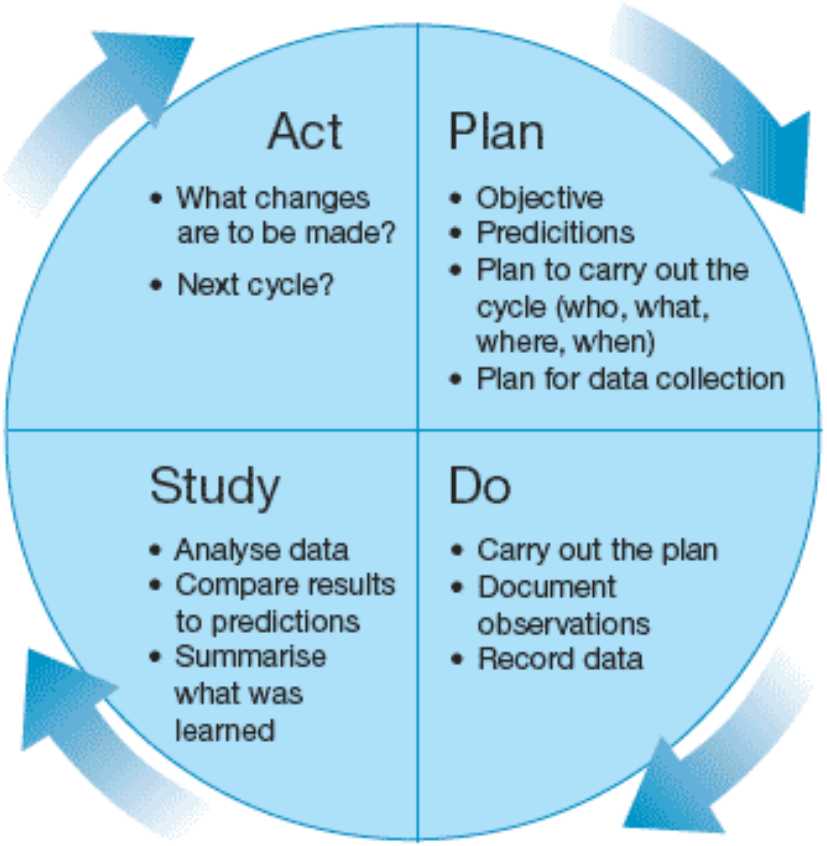
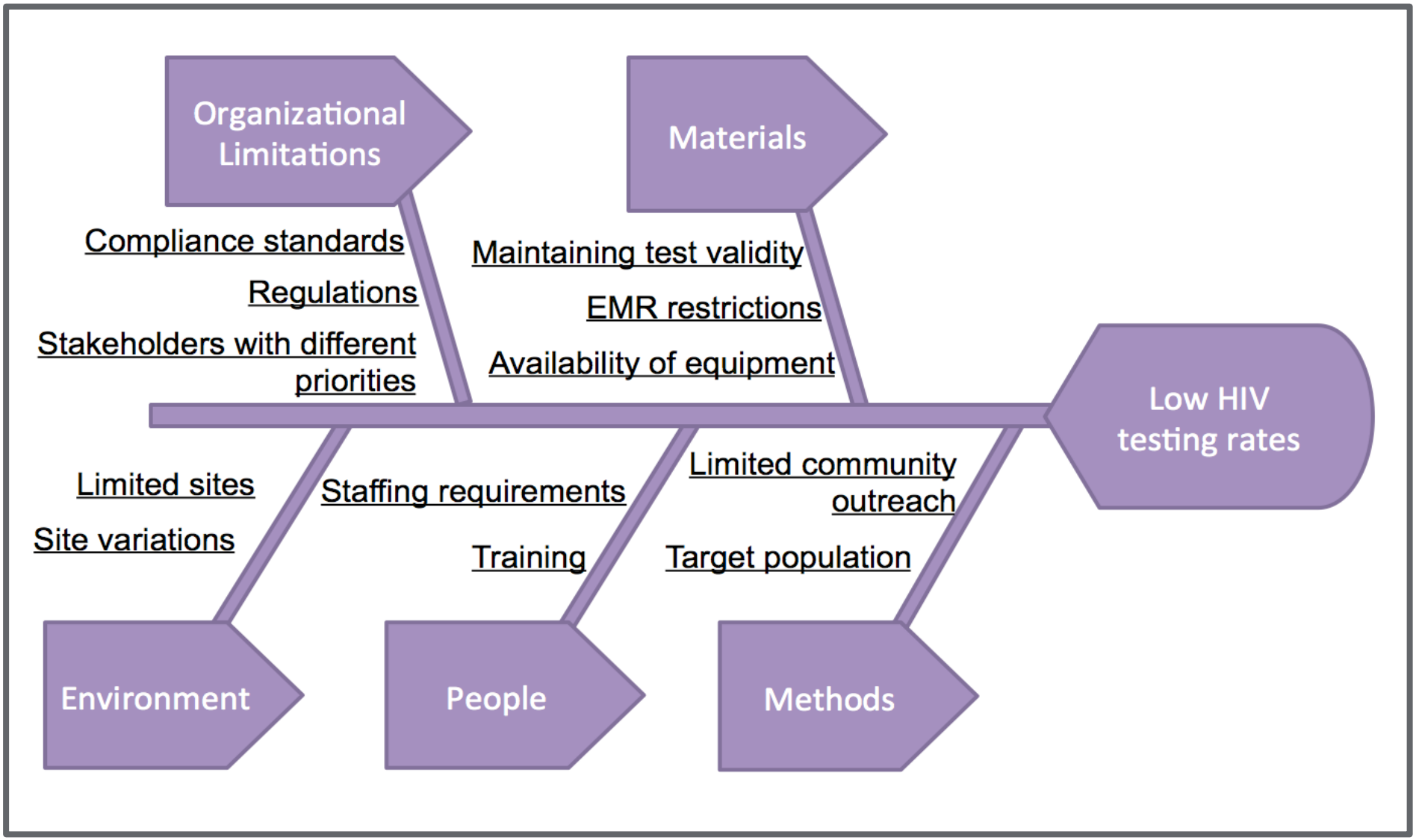
Quality Improvement Plan
Plan-Do-Study-Act Model

- Systematic series of steps for gaining valuable knowledge for the continual *improvement* of a process
- Can be used by technical experts as well as front-line health workers
- Impact in both resource-rich and resource-poor settings



Root Cause Analysis



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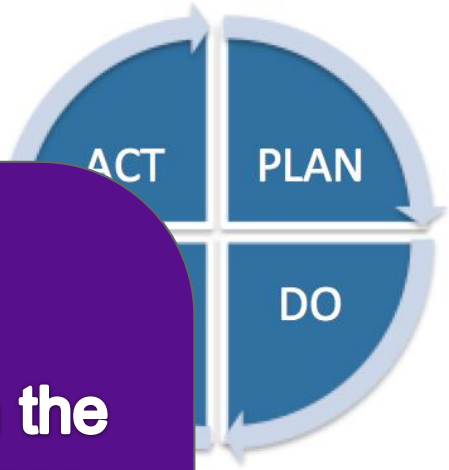

Life Intervenes

As we were preparing to begin the "do" phase of the cycle, Lutheran became fully integrated with the NYU network. This process involved the introduction of a new Electronic Medical Records System

We needed to reprioritize…

collection,
s evaluation
and improvement

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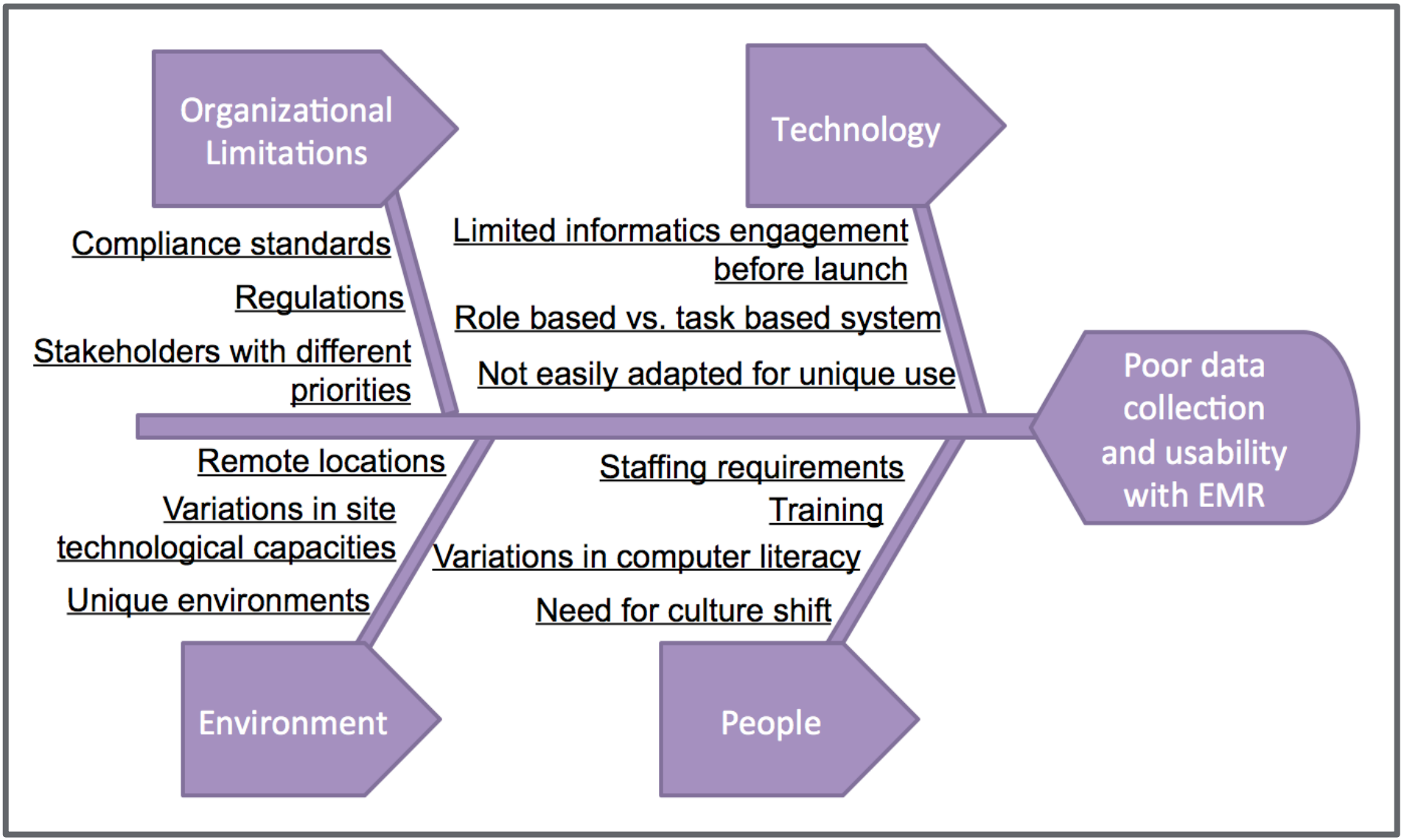
Adapting to New Technology

The goal of this quality improvement project is to effectively adapt to a new electronic system while remaining successful in our ability to reach our underserved populations and to use the new EMR to more effectively link clients to care and track our data.

Welcome to EPIC

- New Electronic Medical Records system (EMR) was rolled out to all ambulatory sites
- EPIC uses a role-based system design as opposed to the previous EMR which was a task-based model
- Usability and accessibility is defined by the login account

UPDATED Root Cause Analysis



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Quality Improvement – Back to the drawing board

AIM *What are we trying to accomplish?*	**AIM** Adapt program to be effective with a new EMR
MEASUREMENT *How will we know if a change is an improvement?*	**MEASUREMENT** Weekly data analysis and front-line assessment
CHANGE *What changes can we make to result in improvement?*	**CHANGE** Work with IT to develop better workflow for our program

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Trigger

Immediately after EPIC was rolled out, it became obvious that the system needed changes in order to work for our program.

- Work flow now required all client engagement to be documented as a scheduled encounter and all tests needed to be logged as an “order”
  - Initially no order available for rapid tests
  - Testers were unable to document encounter notes
- Role-based design prevented staff from performing tasks
- Due to access restrictions screening and testing now involved 3-4 individuals
  - Primary HIV tester was unable to “order” tests
  - Clients needed to be registered in the system, Testers would engage clients to assess needs, and tests needed to be ordered and documented by a Provider

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Organizational Priority

High Priority for All Stakeholders

- **Organizations**
  - Need to comply with grant regulations and standards in order to maintain funding streams
  - Importance of maintaining contractual obligations with community partners
  - Misuse use of capital for both cost of EMR and labor
- **Clinical Team**
  - Ineffective use of skilled staff
  - Unproductive allocation of time
  - Increase in frustration leads to decrease of work satisfaction
- **Community and Clients**
  - Emotional stress involved in time consuming process
  - Missed opportunities for testing

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Pilot Design – Part 1

Clinical team had frequent “check-ins” throughout the workday in order to effectively assess the changes that were necessary

- Work flow issues were assessed by lead HIV tester and front-line Provider
  - Limited accessibility
  - Limited documentation and reporting
- Front-line provider presented cause analysis to program administrator and discussed work-around options
- IT and Informatics teams were approached and work flow needs were discussed
  - Job roles clearly defined and outlined for IT
  - Documentation and program assessment needs explained
  - Clinical assessment tools defined
  - System utilization assessed

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Pilot Design – Part 2

Updates were made to the EMR build, templates were adjusted, and security clearances adjusted for some staff
A plan was designed that would improve the quality of care by allowing for better data collection and analysis, improved patient care and follow up, and better process monitoring

- Lead HIV tester and front-line Provider continued to assess EMR workflow and program needs in order to continuously monitor for issues
  - Work assignments adapted to encourage constant communication between staff engaged in program
  - Provider's login access was adapted to allow for quick work-around options while waiting for technical updates
- Front-line provider worked with testers to evaluate documentation needs and to help create universal templates for encounters

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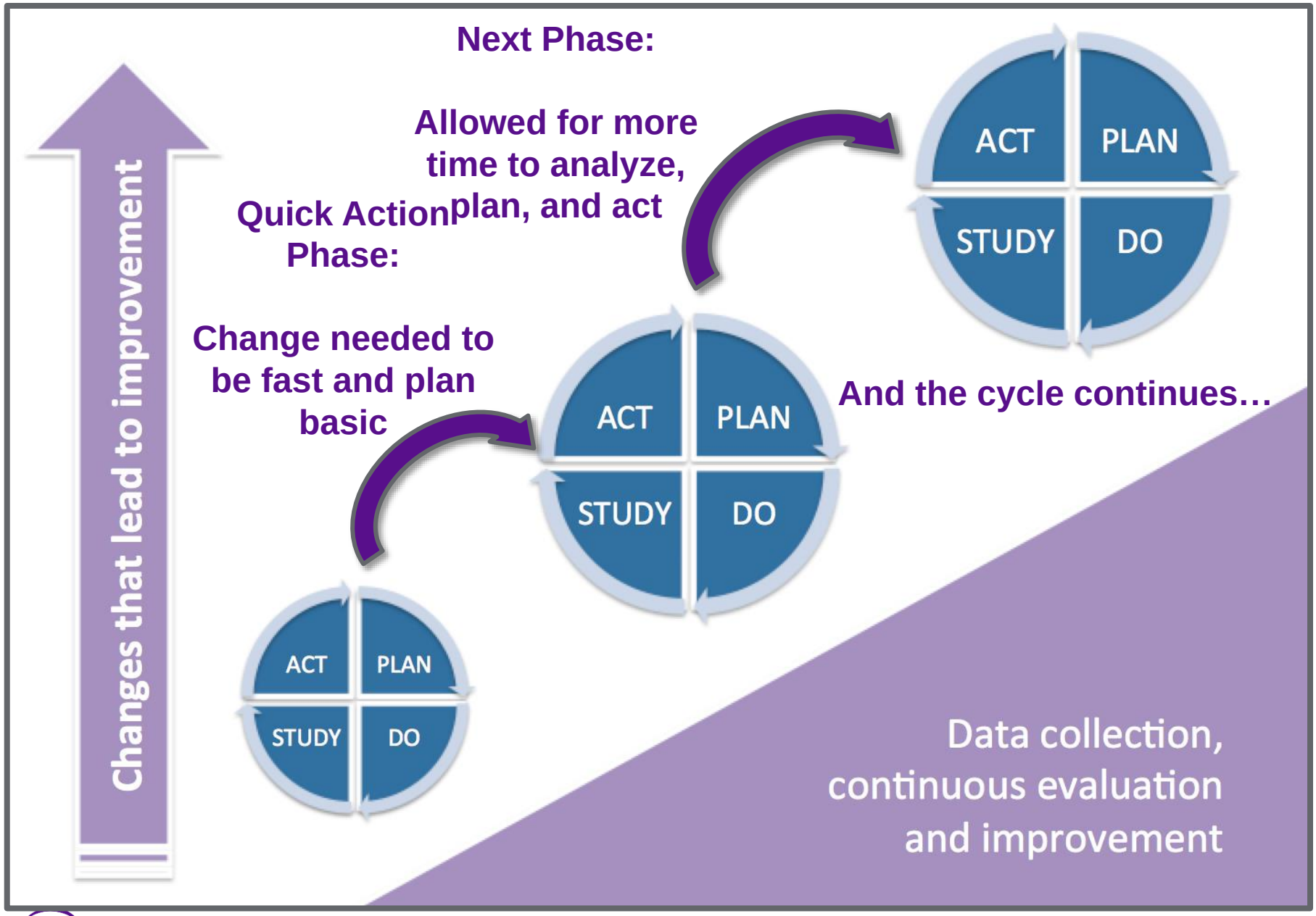
Pilot Design – Part 3

Each week the program Administrator would conference with front-line Provider to evaluate improvement. Once a plan was determined to be effective, information would be disseminated to other testers and staff.

- As floating staff members, lead HIV tester and front-line Provider were able to provide “at elbow” training to the appropriate staff members
- This collaborative engagement allowed Provider to immediately monitor and evaluate implementation and perform mini PDSA-cycles throughout the day
- Turn around time for plan and action changes was found to be minimal


Next Phase:
Allowed for more time to analyze, plan, and act
Quick Action Phase:
Change needed to be fast and plan basic
ACT
PLAN
STUDY
DO
ACT
PLAN
STUDY
DO
ACT
PLAN
STUDY
DO
And the cycle continues…
Changes that lead to improvement
Data collection, continuous evaluation and improvement

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Outcomes – Is it Working?

By continuing to rigorously assess our program's strategies with the PDSA model, we are able to quickly recognize the needs of the program and make any changes as they are needed.

- Facilitating continued care and linkage to care can now be more rapidly implemented and assessed with more tracking measures built in by IT
- Documentation has been streamlined with use of formatted templates that can be used by any staff member performing a test or counseling
  - "smart-sets" were coded and can be imported into encounter documentation with a keystroke
  - "smart-sets" include all documentation that was formerly only on paper
  - This work around and use of electronic documentation has allowed for reduction in lost data because everything is now linked and available in one location.

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Outcomes – Are we seeing Improvement?

Work-arounds were created to help adapt the EMR to fit the needs of our program at each priority level and facilitate the testing at each site.

- By developing close partnerships between team members:
  - Work-load has decreased (for most)
  - Utilization of front-line staff for development has increased job satisfaction
  - Communication has been streamlined, roles more established, and information burden has decreased
- Documentation templates and work flow builds:
  - Allow management to track data and evaluate program
  - Electronic documentation has reduced error and increased productivity
  - Less time consuming interaction for clients
  - Overall streamlined process has improved continuity between users, regardless of technical skill

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Conclusion

We are currently projected to maintain our testing target of 102%.

- Continue to adapt by using the PDSA Model for Improvement

Next Steps…

- Reduction in testing frequency is still an issue
- Overall linkage remains low at 66.67%
- Orasure Technologies asked to recertify 15 Staff on Nov 2, 2016
- Our aim is to quickly establish stability with EPIC and return to our original plan of increasing testing rates
  - With better data tracking, adapt our target populations to higher need groups
  - Utilize the established partnerships between team members, management, and IT to more easily implement plans and effect change

Closing Remarks

Thank You!

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Addressing Disparities for Transgender Patients

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COMMUNITY HEALTH CENTER

Isaac Evans-Frantz, MPA, CLC

Natasha Goykhberg, LMHC

Callen-Lorde: Who We Are

- LBGT Community Health Center, dates back over 40 years

- Of our 16,643 patients:
  - 4,157 (24%) were HIV+
  - 3,552 (21%) were TGNC

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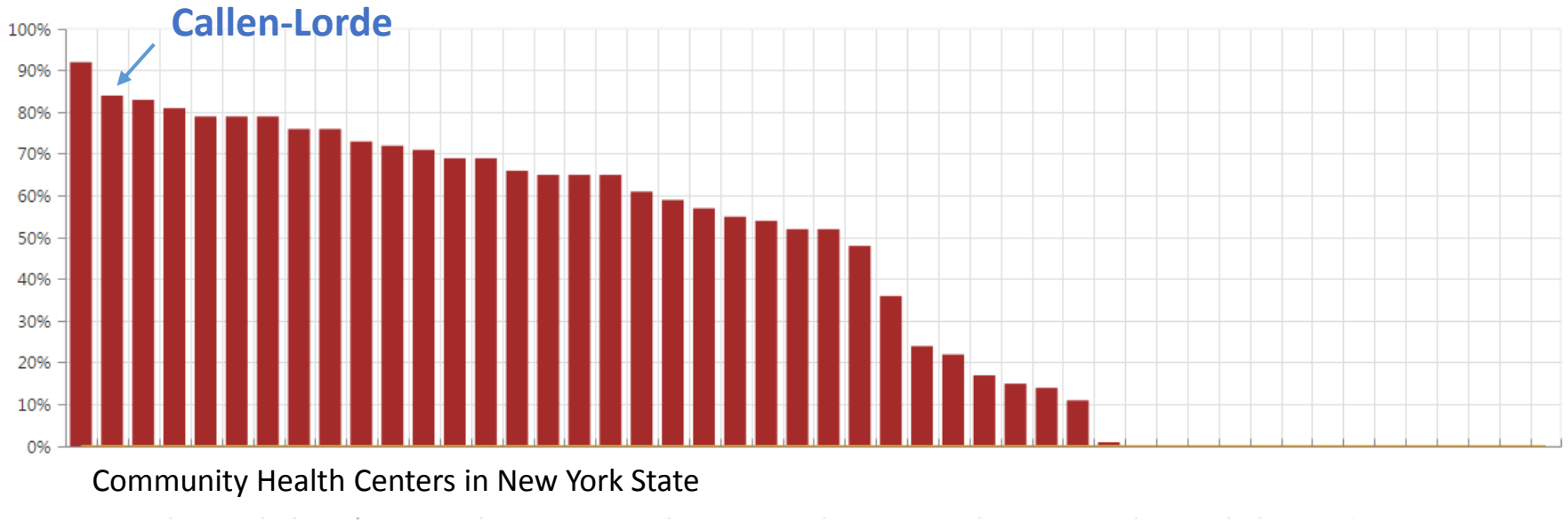
#2 IN NEW YORK STATE

Viral Load Suppression (<200 cc/mL) at Last Test as of August, 2016
(Source: Center for Primary Care Informatics)



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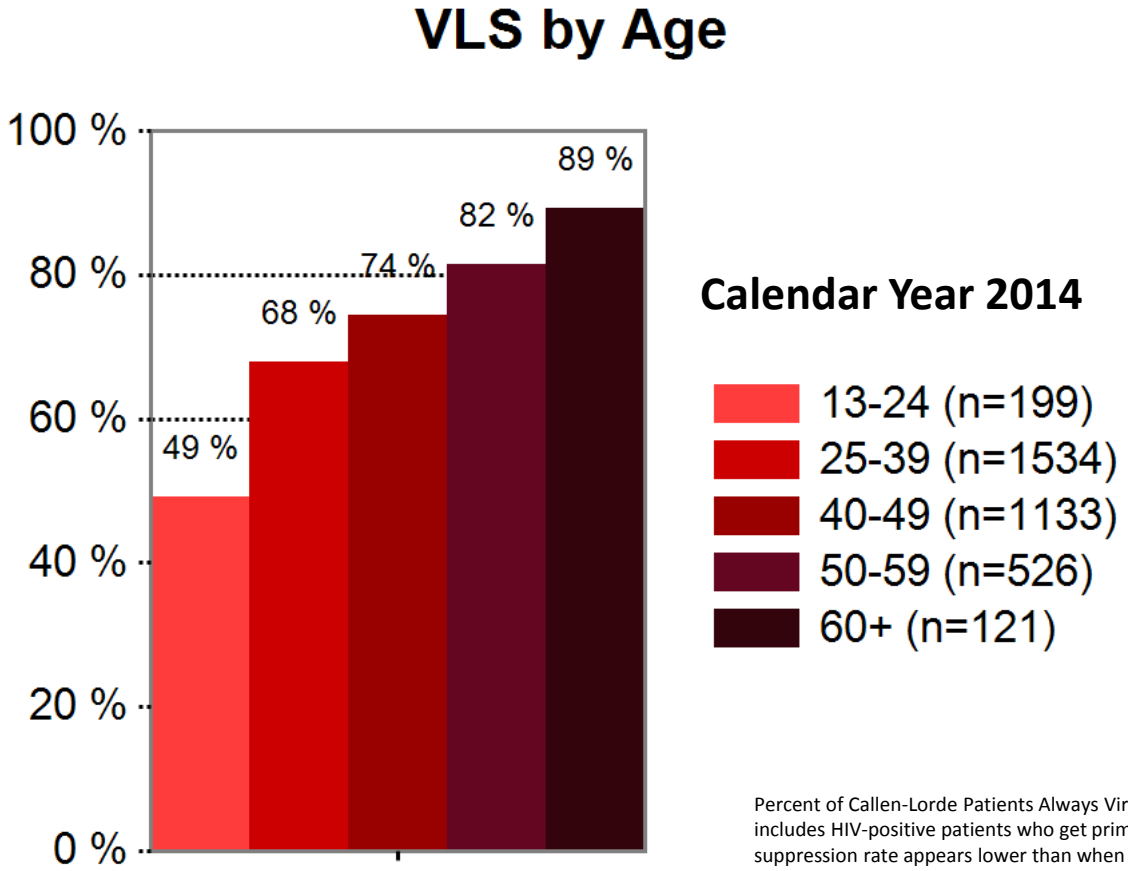
Age Disparities: Viral Suppression



Percent of Callen-Lorde Patients Always Virally Suppressed, 2014 (Denominator includes HIV-positive patients who get primary HIV care elsewhere, and thus suppression rate appears lower than when calculated based on just our primary HIV care patients. Source: NYS DOH AIDS Institute

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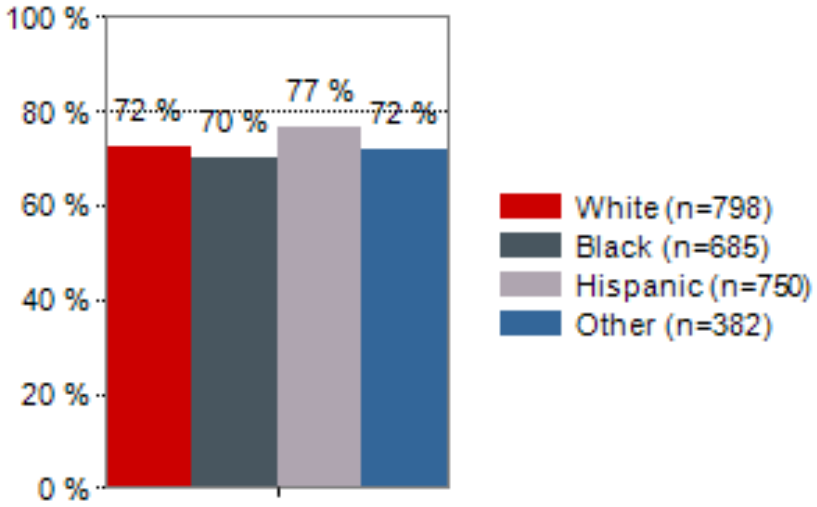
Racial Disparities Inconsistent

Calendar Year 2014

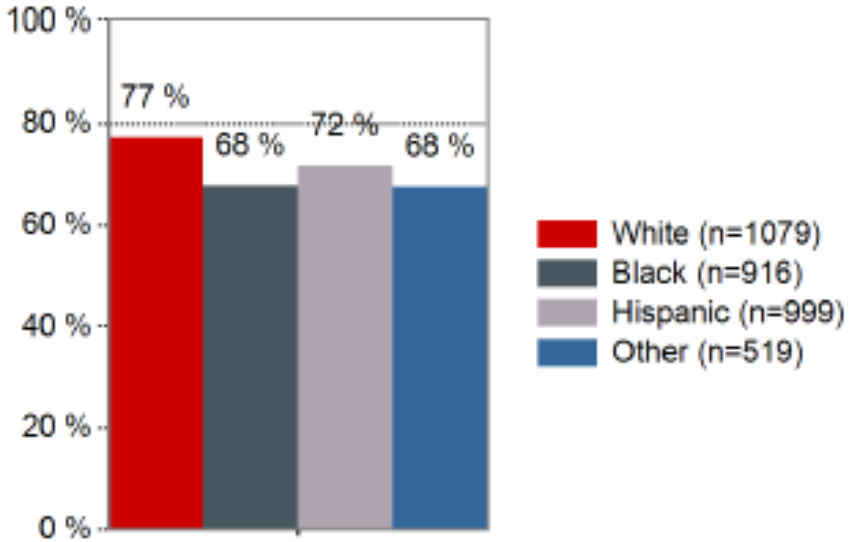
small Disparity:

Retention by Race



BIG Disparity:

VLS by Race



VLS = In this case, always virally suppressed during 2014

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HIV Quality Dashboard

Callen-Lorde HIV Quality Dashboard 2016

Indicator (%)	Population	Benchmark	Target	Baseline		As of June 30, 2016 (preliminary)	Data Source	Proposed Target FY 2017 (Highlighted targets appear on Summary Quality Dashboard and are set by Clinical Care Committee of the Board.)	Planned Intervention
				As of June 30, 2015	As of Dec. 30, 2015				
PrEP Quality of Care	All Patients on PrEP					metric under construction	HIT	metric under construction	Baseline data collection to identify any gaps in quality of care for HIV, STI and kidney testing.
Patients Tested Annually	**All HIV- patients**		55	53	unavailable	54	HIT	58	INSTI rapid testing (60-seconds to get result)
	Adult HIV- TGNC		55	47	unavailable	46			
	HOTT HIV-		55	58	unavailable	51			
Linkage to Care	Patients with Positive Test at CL	72		82	80 (67/84)	Unavailable	P&O Dept.	82	New process developed to track patients and decrease wait times.
Retention in Care (12-month)	**All Adult HIV+ Patients**	83		85	80	83 (2521/3060)	HIT	85	Retention and Adherence Prog following newly diagnosed patients and others who qualify
					84	86 (3019/3495)	CPCI (AI)		
	Adult HIV+ TGNC Patients	83		78	76	78 (235/303)	HIT	85	Exploring evidence-based groups, prioritizing virally unsuppressed trans pts for groups
	HOTT Program HIV+ Participants			70	64	72 (41/57)	HIT	79	Chart review and patient tracking form
Prescribed ART	All HIV+ Patients			unavailable	91	96 (3256/3407)	CPCI (TY 2/16)	95	No intervention planned at this time; continue to monitor.
Viral Load Suppression	**All Adult HIV+ Patients**	76		87	88	87 (3225/3708)	HIT	85	Population Health Team giving data from Provider Data Cards to programs for outreach.
				83	83	83 (3391/4075)	CPCI (AI)		
	Adult HIV+ TGNC Patients	76		78	75	76 (285/376)	HIT	82	Exploring evidence-based groups, prioritizing virally unsuppressed trans pts for groups
	HOTT Program HIV+ Participants			78	75	77 (1768/2310)	HIT	84	Chart review, patient tracking form, provider data cards

Red fill means we are more than 10% below our goal or benchmark and are not yet steadily improving.
Orange fill means we are moving steadily towards our goal or are within 10% of our goal or benchmark.
Green fill means we are meeting or exceeding our goal or benchmark.
Benchmark is generally the median for the industry. Abbreviations: HIT = Health Information Technology; CPCI = Center for Primary Care Informatics (data warehouse); AI = NY State DOH AIDS Institute; P&O = Prevention & Outreach
IEF 8/22/16

Added in 2016:

- Data Source
- Planned Intervention

Indicators Reorganized in 2016:

- To follow care continuum
- To allow for comparison across groups

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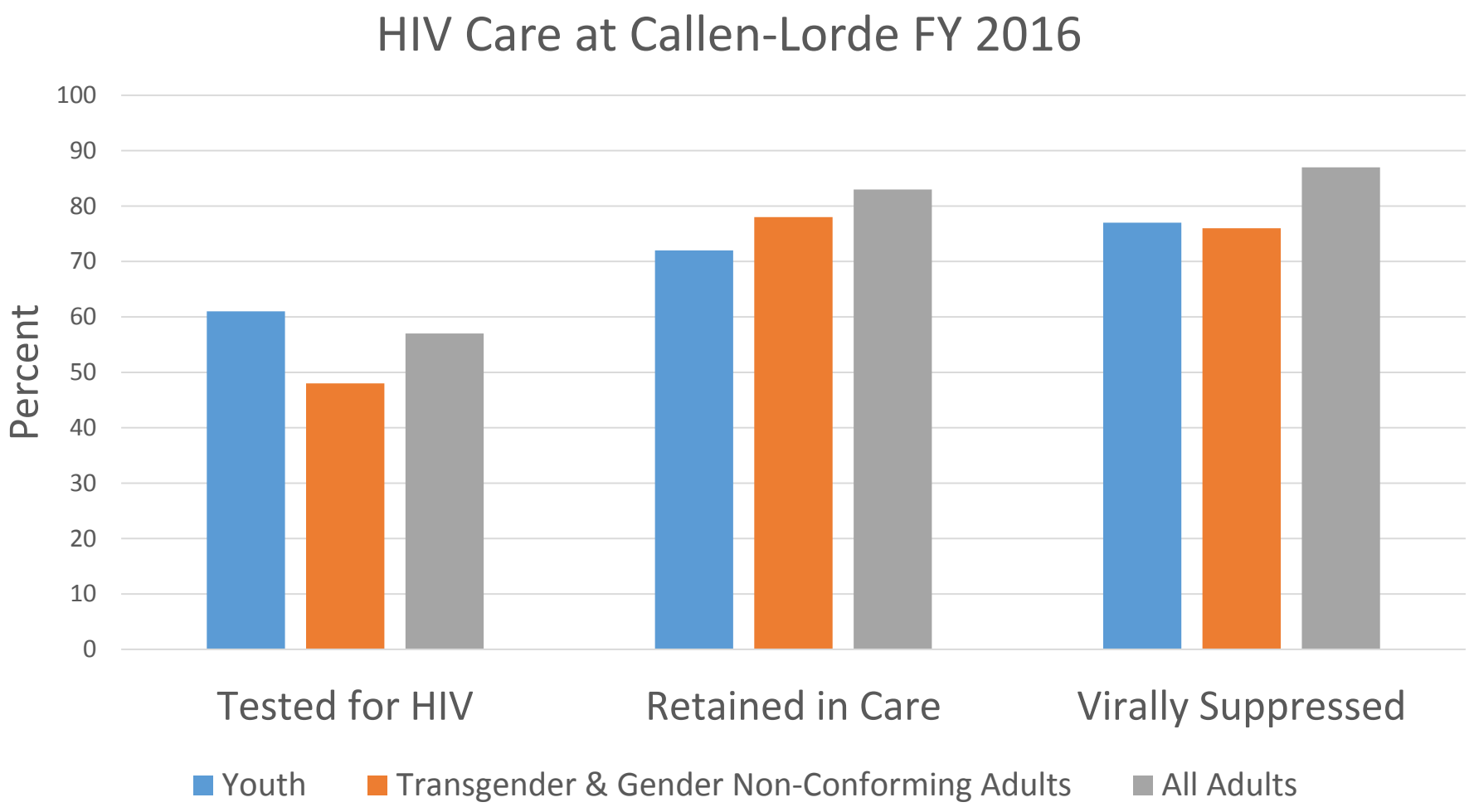
Identifying Disparities across the Continuum



Note: Each of these metrics has a different denominator.

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We Identified Disparities Beyond

Community Viral Load, San Francisco, 2005–2008

	N	%	Mean CVL
San Francisco	12,512	100	23,348
Sub-populations			
Transgender	291	2	64,160
Non-transgender	12,221	98	22,376
Latino	1822	15	26,744
African American	1825	15	26,404
IDU	1011	8	33,245
MSM-IDU	1791	14	36,261
Not on treatment	2924	23	40,056

Das M, Chu PL, Santos G-M, Scheer S, et al. (2010) PLoS ONE 5(6): e11068. doi:10.1371/journal.pone.0011068

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We Are Taking Action

Example: **Transgender Patients Virally Suppressed**

Rationale			**HIV-infected individuals who achieve viral load suppression can reduce the risk of disease progression and reduce risk of transmission of HIV. Additionally, we have identified a statistically significant disparity in viral load suppression between our patients of trans experience and our overall non-trans patients.**	
Timeline/when data captured			Monthly	
Individual(s) Responsible			Facilitator of Trans Ops Committee Senior Director of Research & Education	
Performance Improvement Interventions			1. Population Health Department identifies patients eligible for Retention & Adherence Program, which provides care coordination. 2. Mental Health Department prioritizes transgender virally unsuppressed patients with unmet mental health needs for treatment. 3. Transgender Operations Committee ("Trans Ops") explores possibility of evidence-based groups for trans women of color living with HIV.	
Start Date	**End Date**	**Individual(s) Responsible**	**Performance Improvement Action Steps**	**Status**
1/1/16	6/30/17	Chief Medical Officer	Providers review the charts of patients who are virally unsuppressed.	Ongoing
3/1/16	3/31/16	Senior Director of Innovation, Informatics & Quality	Small break-out groups at Quality Management Group brainstorm barriers for viral load suppression for trans patients, and possible interventions.	Complete
4/1/16	4/30/16	Senior Director of Innovation, Informatics & Quality	One small break-out group at Quality Management Group identifies interventions to try.	Complete
4/10/16	5/31/16	Chief Mental Health Officer	Speak with Senior Management about possibility of prioritizing virally unsuppressed trans patients for mental health groups.	In progress; speaking with Trans Ops
5/1/16	6/30/16	Senior Director of Research & Education	Speak with administrator of Healthy Divas program in San Francisco and share findings with HIV Ops.	Complete

- Rationale
- Individual(s) Responsible
- Quality Improvement Intervention(s)
- Action Steps:
  - Start Date
  - End Date
  - Individual Responsible
  - Action
  - Status

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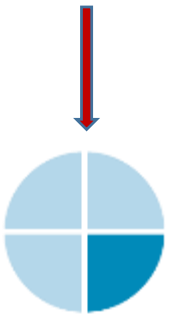
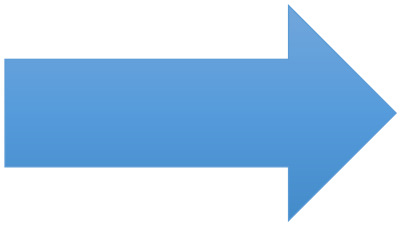
HRSA Guidance

Connect Theory to Practice

Reference
PDCA Cycle Stage



Reference
Stage in Continuum



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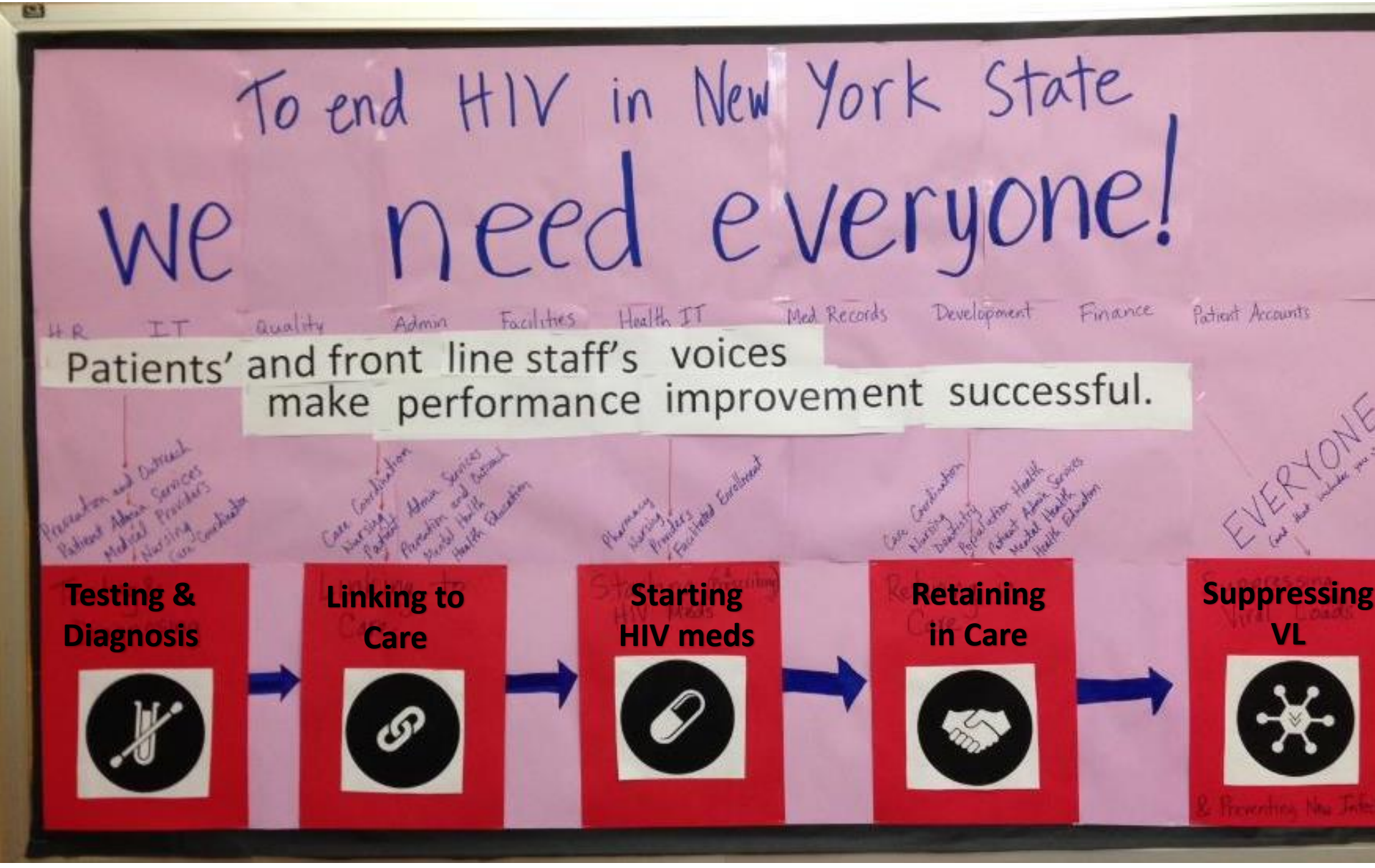
We are engaging patients!



We are engaging patients!

We Got Push Back at First

- "We already have a viral suppression rate of 88%. Why do we need this?"
- "There's no way we can come up with interventions for every measure!"
- "I don't have the bandwidth."

- "Why for trans patients are we only talking about HIV?"

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Strategies that Worked

- Share a plan for the plan.
- Set up meetings with departments.
- Acknowledge people's work.

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Closing Words from Our Namesake

"In the end, for each individual, it is as rational to believe [they] will be among the survivors as it is to assume that [they] won't…. We must fix our hearts and minds on a clear image of the day when AIDS is no more. Make no mistake about it; that day will come." - Michael Callen, *Surviving AIDS,* 1990

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THANK YOU!

What questions do you have for us?

Natasha

Isaac: iefrantz@callen-lorde.org
Natasha: ngoykhberg@callen-lorde.org

The Triad Management Paradigm Promotes Success in New Programs with Developing Identities

Annel Gomez, SCG Program Coordinator
Jesse Wilkinson, MA, Director
Research & Evaluation
November 9, 2016

GMHC
END AIDS. LIVE LIFE.

GMHC

END AIDS. LIVE LIFE.

GMHC IS THE WORLD'S FIRST AND LEADING PROVIDER OF HIV/AIDS PREVENTION, CARE AND ADVOCACY. BUILDING ON DECADES OF DEDICATION AND EXPERTISE, WE UNDERSTAND THE REALITY OF HIV/AIDS AND EMPOWER A HEALTHY LIFE FOR ALL.

OUR MISSION: GMHC FIGHTS TO END THE AIDS EPIDEMIC AND UPLIFT THE LIVES OF ALL AFFECTED.

GMHC Services

- Coordinated Care
- Mental Health
- Prevention
- HIV & STI Testing
- Substance Use
- Legal
- Financial Management
- Advocacy
- Rental Assistance
- Meals & Nutrition
- Workforce
- Wellness
- Outreach and Education

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Overview of Presentation

- Program Background
- Project Background
- Goals & Aims
- Methods
- Results
- Lessons Learned & Next Steps

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What is Supportive Counseling?

- SCG aims at linkage, retention, and maintenance to care for anyone living with HIV and/or AIDS
- It incorporates a holistic approach utilizing both individual and group level counseling, faith-based counseling, and client assistance and accompaniment services to address the client's mental health, substance use, and social service needs

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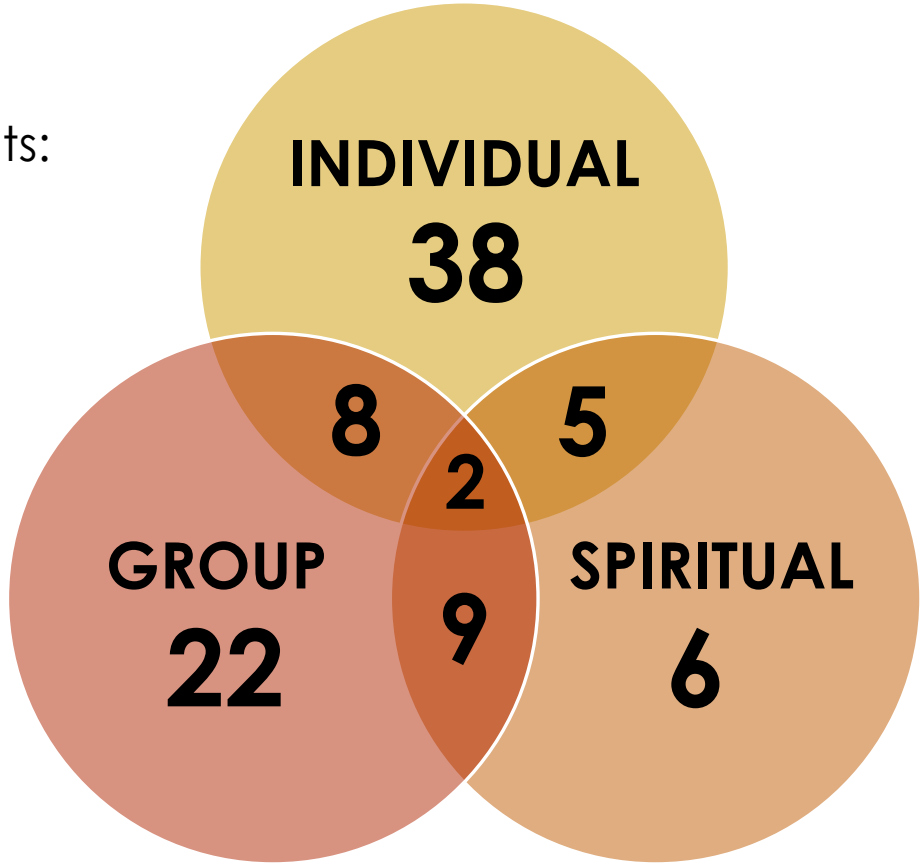
SCG Service Breakdown

Total active clients:

90

as of October 2016



GMHC

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Project Background

- Program began in September 2015
- Services offered some similar services to existing programs
- Few referrals led to low enrollments and struggled to meet program deliverables
- Expected deliverables were trending at or below 50%
- CQI project began in April 2016 to increase referrals and new enrollments

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Goals & Aims of Project

- Establish new program's identity and differentiate from established programs
- Identify barriers to meeting expected enrollments
- Increase internal referrals and subsequent intakes

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Methods

- Program meets for monthly Triad meetings
- Review of program data via our dashboard containing month's actual vs. expected deliverables
- Largest problem (low enrollments) was identified and brainstorming session was scheduled
- Brainstorm session was used to conduct a root cause analysis
- Work plan was later developed to address and monitor identified areas for improvement

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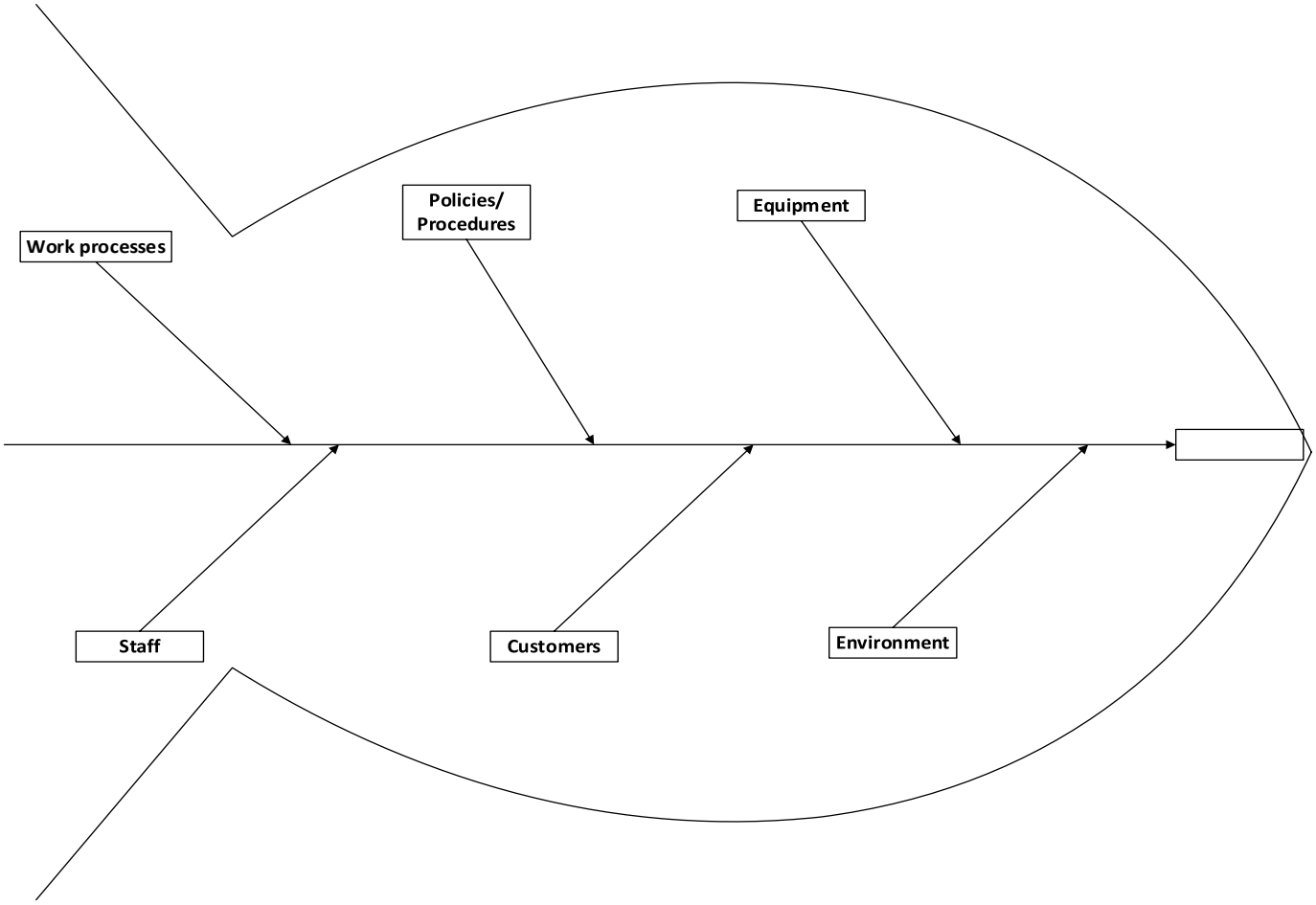
Brainstorm Session



Results

- Programmatic issues viewed within larger agency context
- One root cause was lack of agency awareness of program and how it differed from existing programs
- Initiated program presentations at agency all-staff meetings
- Provided funders with a clear picture of challenges faced and our improvement plans

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Results

- Electronic Health Record (EHR) referral process was clarified for ease of staff use
- Outside staff increased knowledge of program
- Intake Department and Care Coordination departments each began to send 10+ referrals every month

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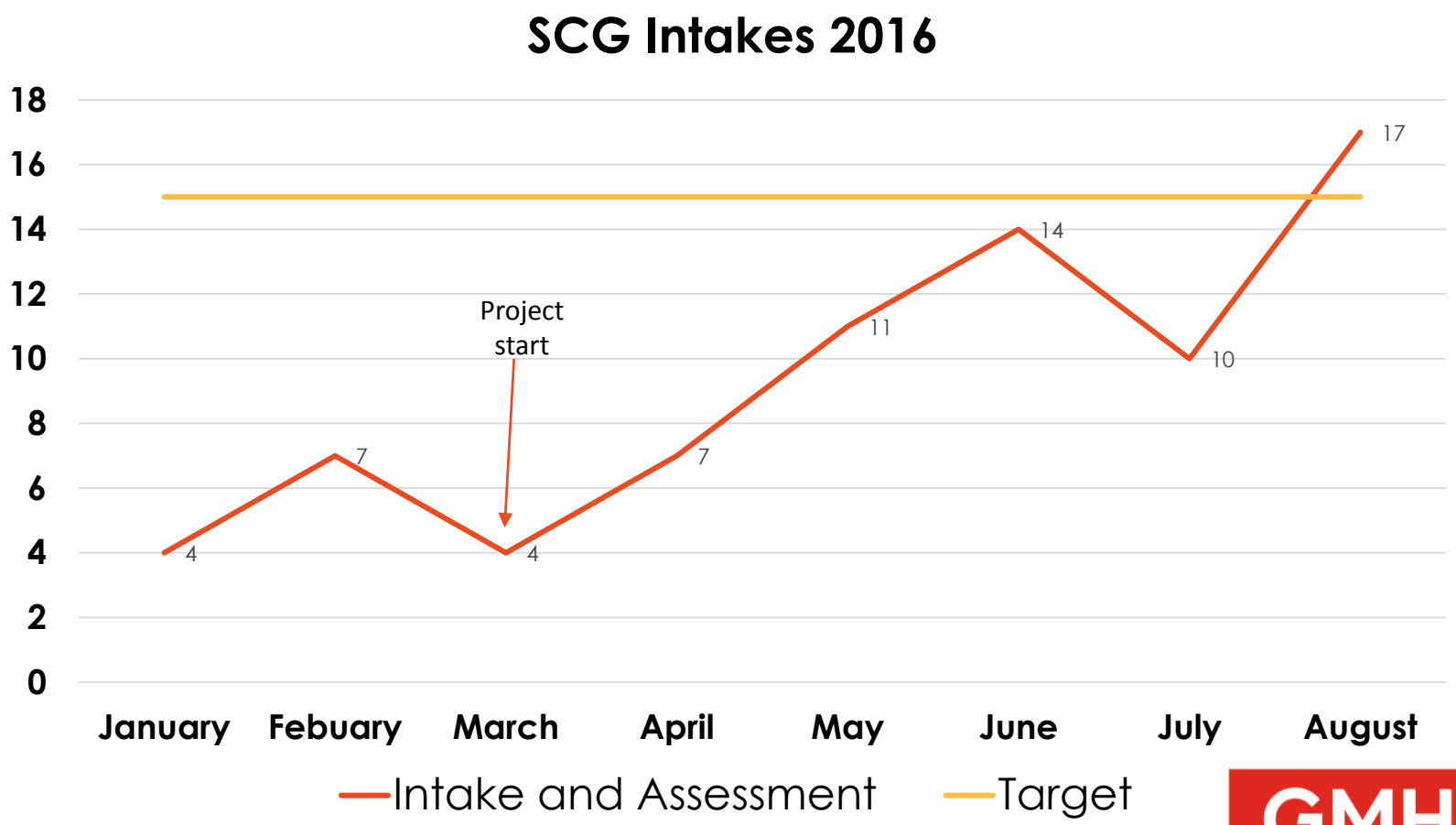
Results



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Lessons Learned!

- Triad tools allow programs to ensure both client and funding needs are met
- 3rd party evaluator provides staff insight on how to improve, enhance, and implement better program outcomes

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Next Steps

- Continue to introduce agency staff to our referral tool
- Conduct periodic presentations in and out of agency to maintain relationships
- Have open dialogue with SCG staff about any future problems and potential CQI projects
- Ensure that Triad meetings continue every month

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Management Techniques with Regular Evaluation Ensures Adequate Service Delivery!

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November 9, 2016

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Background

- FNS program serves 400 clients each year with a staff of 5 including 2 dietitians and management.
- In May 2015 the FNS program lost one of only two staff dietitians (resignation)
- Hiring took some time and there was a significant reduction in output
- Contract deliverables were at risk of underperforming
- Presented problem at the Food and Nutrition Triad meeting

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Goals

- **Goal**: increase service output (including intake assessments, reassessments and counseling) and meet deliverables in fourth quarter

- Implemented a continuous quality improvement project

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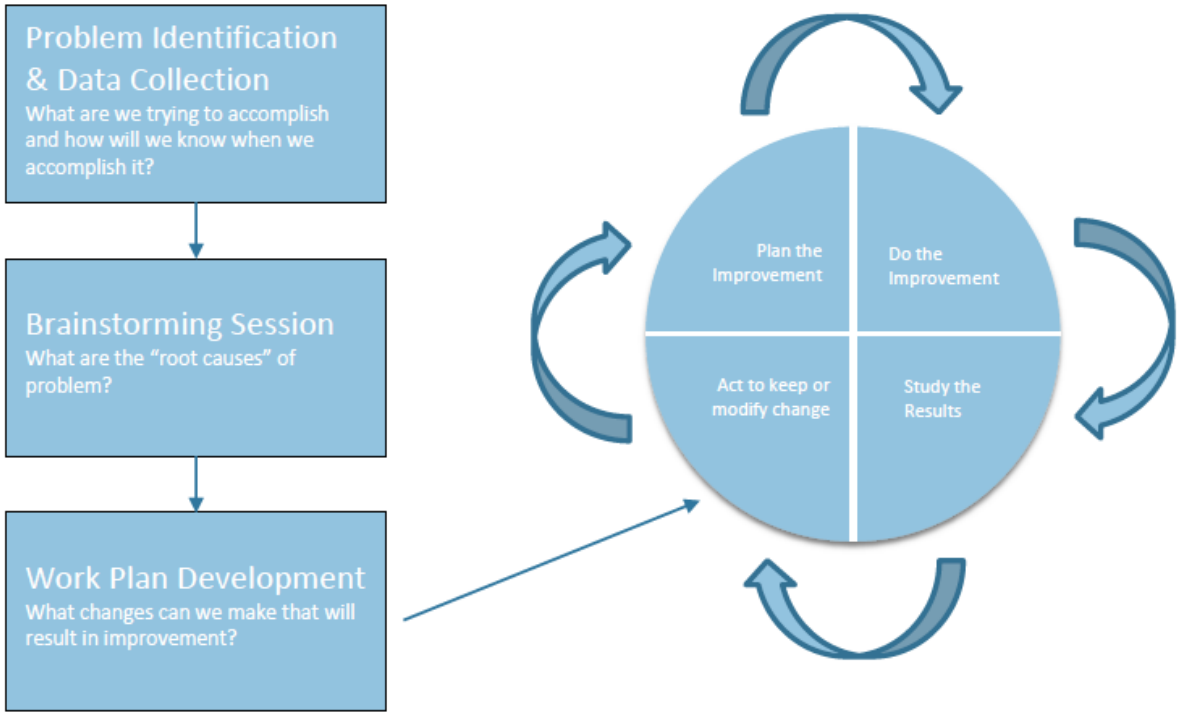
PDSA Cycle



Phases of the CQI Process

Methods

- Staff brainstormed ways to do more with less
- Began to streamline assessment and reassessment process
  - Clients sign in for pantry and checked manually when due for reassessment
  - Appointments scheduled for assessment and reassessments as needed

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PDSA
Identified Issue

Deliverables under 80% between June & September

Clients made appointments but the "*no – show*" rate was a problem

ROOT CAUSES – no-show rates

- Clients complain of not getting metro – card
- Clients who receive reminder calls still have trouble with transportation or request to r/s
- Clients cancel due to illness
- Clients do not have active phone #'s for reminder calls

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PDSA: Interventions

- Client seen immediately on pantry pick up day with registered dieticians available on pantry days to see clients

- An excel spreadsheet was developed for monitoring purposes to inform staff when clients were due for reassessments.

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PCSM Cycle: Identified Issue

Process took longer than desired amount of time

ROOT CAUSES – arduous work processes

- Counseling rooms not always available
- Dietician had to print forms outside of shared area
- Administrative tasks done at a later time

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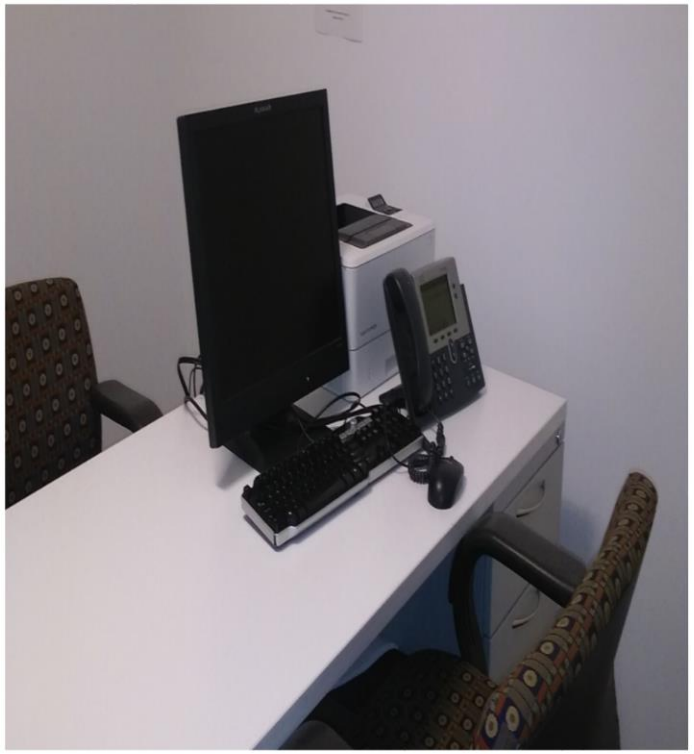
PCSM Cycle: Interventions

- Designated counseling room with printer made available
- Administrative tasks done during interview: Forms printed immediately & signed
- Clients print medical information electronically



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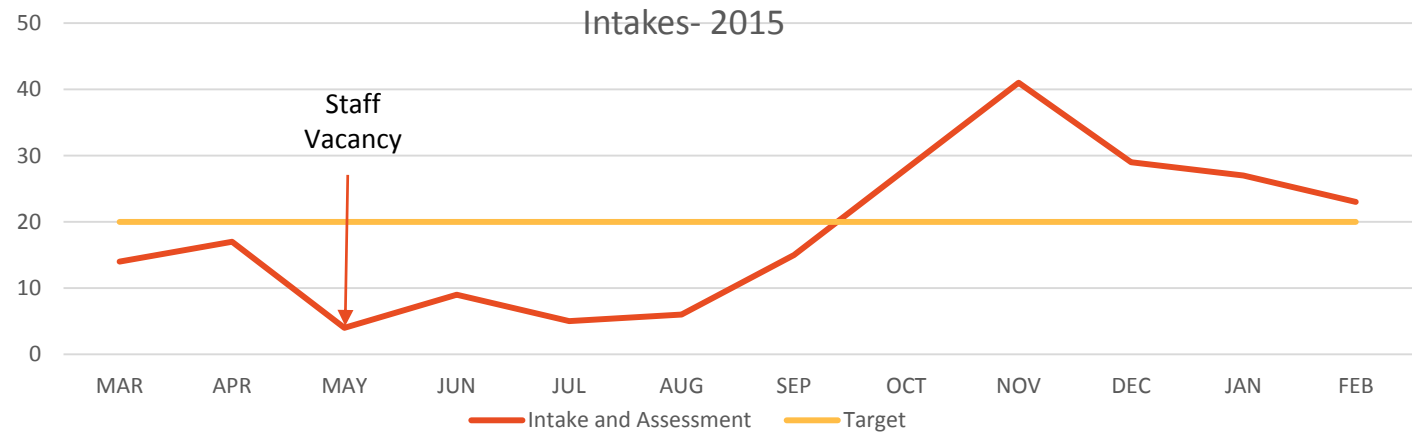
PDSA Cycle: Results

- Deliverables met by end of the year
- Ended contract at 93% of MIR!



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Lessons Learned!

- Committee/interdepartmental, timely review & implementation can have positive outcomes
- Incremental process changes allows for time to see effect
- May require policy changes and additional resources

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Next Steps

- Continue to monitor progress of project and make changes as needed

- Continue to hold monthly triad meetings

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