Improving Performance and Quality of Linkage and Engagement Services:
Training Workshop at the NMAC USCA, October 4, 2014
Our Speakers

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What We Will Discuss Today

- Basic continuous quality improvement (CQI) techniques
  - Review key terms
  - Describe important components of a quality improvement (QI) program
  - Steps in conducting QI projects (QIPs)
- We present QI activities of the Merck Foundation-funded HIV Care Collaborative (HCC) to illustrate how to undertake CQI
- QI staff of HCC-funded City of Houston project will discuss how the Houston staff use ongoing supervision and chart review to improve the quality of reengagement of HIV+ individuals lost to HIV care
- A Fulton County Health and Wellness HCC Linkage Coordinator will discuss the role of front-line workers in improving linkage and retention services
- Apply the CQI training you received today to improve your linkage, navigation, retention services
Steps to Improving Quality

- Committed Leadership and Supportive Organizational Structure
- Establish Quality Management (QM) Plan
- Determine Performance Measures and Collect Data
- Analyze Data
- Develop Project-Specific CQI Plan
- Study and Understand the Process
- Develop and Implement an QI Plan
- Re-measure and Renew Improvement Efforts If Failing to Sustain Improvement
- Celebrate Success and Hold the Gain
Key Characteristics of a QM Program

- A systematic process with identified leaders, accountability, and dedicated resources
- Use data to measure processes and outcomes to identify progress toward evidence-based goals or “benchmarks”
- Focus on linkages, efficiencies, and client and worker expectations in addressing QI
- Data collected to give feedback to providers and other key staff to ensure that goals are accomplished and improvement is sustained
- Continuous process that adapts to change
- Scalability is critical
- *All team members contribute to quality and client satisfaction and its improvement*
Definitions

- **Quality**: extent to which a service meets or exceeds established professional standards and consumer expectations

- **Quality Assurance (QA)**: broad spectrum of evaluation activities aimed at ensuring compliance with *minimum* quality standards

- **Quality Management**: has four main components: *quality* planning, *quality* control, *quality* assurance, and *QI*

- **Quality Improvement (QI)**: activities aimed at improving performance

- **Continuous Quality Improvement (CQI)**: the ongoing monitoring, evaluation and improvement processes
Definitions

- **Indicator**: a measure used to determine, over time, an employee’s or organization’s performance of a particular aspect of care or services
  - Indicators may measure functions, processes, or outcomes

- **Outcome**: Benefits or other results (positive or negative) for clients that may happen during or after their participation in a service or program
  - May be client, organization, or system-level
Quality Improvement Model

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?
- How can we sustain improvement?
- What barriers are impairing improvement?
Why is measurement important in QM?

- Measurement tests what we think is happening, versus what really is happening.
- Establishes a baseline - the starting point in our QI efforts.
  - It is ok to start out with low scores! Its what you do next that is important!
- Determines whether changes in processes actually lead to improvement.
- Avoids slippage in performance.
  - Sustaining the gain made through QI.
- Ongoing and periodic monitoring identifies problems as they emerge.
Managing Performance and Quality

- Use data for decisions to improve policies, programs, and outcomes
- Manage change
- Create a learning community
- Analyze data
- Share data with managers, staff, policy makers, clients
- Develop a regular reporting cycle
- Set standards and indicators
- Set goals and targets
- Communicate expectations to the team
- Refine indicators and define measures
- Develop data systems
- Assess and improve data quality
- Use data for decisions to improve policies, programs, and outcomes
- Manage change
- Create a learning community
QI Project Cycle

1. **Select Process for Improvement**
2. **Identify & Address Data Quality Deficiencies**
3. **Analyze Data to Identify Factors Associated With Rates**
4. **Prioritize, Plan, & Conduct QIPs**
5. **Discuss Process With Workers**
6. **Select Measure**
7. **Re-measure & Refine Processes**
Short Cycle Plan-Do-Study-Act (PDSA) for Learning and Improvement

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data
Considerations in Measurement Selection

- What question are you trying to answer?
- Is the service or process you are measuring well established in the clinical or human services fields?
  - If so, there are likely to be measures already well defined, field tested using rigorous research methods, and benchmark data are likely to be available.
  - If you “customize” a measure, you may lose the ability to benchmark performance with other providers or networks using earlier or ongoing studies.
- Does the indicator have a great impact on the programs or clients in your program?
Considerations in Selecting Measures

- Can workers consistently, accurately, and reliably gather data needed for the measure?
- Do they agree with and understand the measure?
- Have chart abstraction instruments already been designed, field tested, and used routinely?
  - Does the measure specify the exact inclusion and exclusion criteria and time frames for assessment?
  - Patient characteristics (e.g., age, gender, clinical parameters, treatment status, etc.) and time period (hours, days, months, etc.)
Other Considerations in Measurement Selection

- Is there “evidence” upon which to base your measure?
  - Is the indicator based on accepted guideline or developed through formal group-decision making methods?
  - Is there consensus among providers about the measure’s relevance?
- Does the measure directly relate to the process or outcome you are measuring?
- Can the indicator realistically and efficiently be measured given your resources?
- Can the performance rate realistically be improved given the limitations of service systems and the population’s health care utilization behaviors?
- Are the selected measures in your control?
Quality of Data Collection Processes

- It is important to assess the quality of data recorded by workers providers in charts and electronic health records to determine if improvement is necessary BEFORE you apply new quality measures.

- Are workers reliably, accurately, and completely charting the processes which you wish to measure?
  - If not, data QI projects need to be undertaken before measurement begins.
  - Technical assistance (TA) is available.
  - You do not want to inadvertently measure the quality of the data instead of the process or outcome of interest.
Strategies Depend on Resources

- **Build on what you have**: staff, client-level data systems, internal or external QI experience
- **Build to scale**: start small, dream big
- **Client-level data systems enhance QM capability**
  - More indicators can be measured
  - Indicators can be measured more often
  - Entire populations can be measured
  - Outcome as well as process indicators can be measured
  - Alerts, custom reports help manage care

- **Personnel resources**
  - Person power for chart reviews or analysis of client-level data systems
  - QM expertise in-house, partnering HIV programs, Ryan White Program grantee staff
  - Ideally, individual trained in statistics analyze the data to ensure that accurate conclusions are made
Applying CQI Basics to HIV Linkage and Engagement Services: QI and Performance Improvement by the HIV Care Collaborative
# HIV Care Collaborative Partners

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Partner</th>
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<tbody>
<tr>
<td>National Program Office (NPO)</td>
<td>George Washington University Milken Institute School of Public Health</td>
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<tr>
<td>Bridging the Gap Initiative</td>
<td>Fulton County Department of Health and Wellness (Georgia)</td>
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<tr>
<td>Expanded Linkage to Care Initiative</td>
<td>Houston Department of Health and Human Services (Texas)</td>
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<tr>
<td>Engaging HIV+ Patients in Care Initiative</td>
<td>Philadelphia Department of Public Health and ActionAIDS (Pennsylvania)</td>
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</table>
IMPROVING ACCESS TO CARE IS THE CORE OF THE HCC’S MISSION

What we do

Aligned with the National HIV/AIDS Strategy, the HCC works closely with community partners to connect newly diagnosed HIV+ clients to high quality treatment and reconnect other HIV+ clients lost to care.

- The HCC National Program Office (NPO) provides technical assistance, evaluates the collaborative, and fosters a "learning community" among sites.

Our mission: helping link HIV+ people to the care they need

Our partners assess clients’ needs, care barriers, and treatment readiness and:

- Develop and undertake individualized care plans, including linkage to medical care.
- Coordinate with the care team and monitor client progress.
- Transition clients to medical case management.
HCC PROGRAMS MAKE A DIFFERENCE FOR THE HIV+ COMMUNITY, ONE STEP AT A TIME

The HCC works collaboratively with local community partners

- To improve timely access to high quality HIV care
- Help reduce new HIV infections among at-risk populations
- Share findings to promote innovative programs to connect HIV+ people to needed medical care, treatment, and support services

HCC’s efforts support the National HIV/AIDS Strategy’s primary goals

- Reducing HIV incidence
- Increasing access to care and optimizing health outcomes
- Reducing HIV-related health disparities
- Establishing a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV
Example of Process Mapping: HIV Care Collaborative

Linkage: Assessment, Service Planning, Referral, and Documentation Cycle

Intake
- Ryan White Program
- Eligibility
- Needs Assessed
- Needs Identified

Service Plan
- Goals and Objectives Set
- Resources Identified
- Timeline Set
- Plan Updated as Required by the Client’s Situation

Referral & Goal Attainment
- Referral Made
- Verify Referral Completed and Service Provided
- Assess If Goal Is Achieved and Identify Outcomes

Documentation of Steps Undertaken in Cycle
<table>
<thead>
<tr>
<th>Chart Review: HCC Process Assessment</th>
<th>Assessment</th>
<th>Individualized Care Plan</th>
<th>Referral</th>
<th>Follow-up to Achieve Goal Documented?</th>
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<tbody>
<tr>
<td>Children, Other Family Members</td>
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<tr>
<td>Dental, Vision, Hearing</td>
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<tr>
<td>Education, Vocation, Literacy</td>
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<tr>
<td>Employment, Income</td>
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<td>Food and Nutrition</td>
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<td>Insurance, Disability, Entitlements</td>
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<td>HERR</td>
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<td>HIV &amp; Other Medications</td>
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<td>Home Care</td>
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<td>Housing Services</td>
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<td>Legal</td>
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<tr>
<td><strong>MEDICAL CARE</strong></td>
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<tr>
<td>Mental Health Treatment</td>
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<tr>
<td>Social Support</td>
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<td>Substance Abuse Treatment</td>
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<td>Transportation</td>
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<tr>
<td>Treatment Adherence</td>
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<tr>
<td>Other Services</td>
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### HCC Intervention Mapping

<table>
<thead>
<tr>
<th>Task</th>
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<tbody>
<tr>
<td>Intake/assessment, screen for RW eligibility, and orientation to HCC intervention</td>
</tr>
<tr>
<td>Identify barriers to OAMC, make referrals, and follow-up to ensure barriers are addressed</td>
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<tr>
<td>Assist the client to schedule labs and OAMC visit</td>
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<tr>
<td>Assist the client to arrange transportation, child care, and other logistics before the OAMC visit</td>
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<tr>
<td>Remind client about visits to ensure the visit is kept and/or accompany the client to visit as needed</td>
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<tr>
<td>Assist the client to schedule follow-up OAMC visits</td>
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<tr>
<td>Coordinate OAMC follow-up with the medical provider and facilitate follow-up activities</td>
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<tr>
<td><strong>HCC Intervention Mapping</strong></td>
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<td>--------------------------------</td>
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<tr>
<td><strong>Ongoing coaching to clients to keep OAMC and other appointments and adhere to ARV and other medication regimens</strong></td>
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<tr>
<td><strong>If MCM is required, assist client to schedule appointments</strong></td>
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<td><strong>Participate in case conferences or to coordinate services</strong></td>
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<td><strong>Meet with the client and MCM to discuss transition, and transition client to MCM as requested</strong></td>
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<tr>
<td><strong>Communicate with the client or emergency contact by phone, mail, or home visit to locate clients lost to OAMC</strong></td>
</tr>
<tr>
<td><strong>Close case &lt; 3 month if the client dies, is incarcerated, moves out of the geographic area, voluntarily withdraws from the intervention, meets sites’ criteria for administrative closure, or is lost to care</strong></td>
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<tr>
<td><strong>Close case 180 days after HCC intake date, unless barriers to OAMC could not be addressed (requires the supervisor’s approval)</strong></td>
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</table>
HCC Data Quality Assessment and Improvement Processes

- Identifying Data Needs
- Refine Forms Design
- Data Extraction From Charts or EHRs
- Database Design & Management
- Data Entry & Cleaning
- Data Quality Assessed & Improved
- Data Analysis & Reporting
Linkage and Re-Engagement Process Measures

- Completed cycle: assessment, ICP, referral, and goal attainment
- Case closure rate (productivity measure)
- Time (months) in intervention (productivity measure)
- HCC worker turnover rate
- HCC worker continuity measure
- Client transition from HCC worker to care team (new)
HCC Medical and Case Management Quality and Performance Measures: Based on HIV/AIDS Bureau (HAB) Measures

<table>
<thead>
<tr>
<th>HAB OAMC Quality Measures</th>
<th>HAB Medical Case Management Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prescription of ART</td>
<td>• Individualized care plans</td>
</tr>
<tr>
<td>• Medical visit frequency</td>
<td>• Gap in medical visits</td>
</tr>
<tr>
<td>• PCP prophylaxis</td>
<td>• Medical visit frequency</td>
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<tr>
<td>• CD4 count</td>
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<tr>
<td>• Viral load monitoring</td>
<td>• Housing status</td>
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<tr>
<td>• Viral load suppression</td>
<td>• Late HIV diagnosis</td>
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<tr>
<td>• Drug resistance testing before initiation of ART</td>
<td>• Linkage to HIV medical care</td>
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<tr>
<td>• TB screening</td>
<td></td>
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<tr>
<td>• Cervical cancer screening (women)</td>
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<tr>
<td>• Hepatitis B screening and vaccination</td>
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<tr>
<td>• Hepatitis C screening</td>
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<tr>
<td>• HIV substance abuse screening</td>
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<tr>
<td>• Mental health screening</td>
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<td>• Drug resistance testing before initiation of ART</td>
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<td>• TB screening</td>
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**HAB System-Level Measures**

| • Viral load monitoring                                                                   | • Disease status at time of entry into care                              |
| • Drug resistance testing before initiation of ART                                        | • Housing status                                                         |
| • Late HIV diagnosis                                                                     | • Linkage to HIV medical care                                            |
| • Housing status                                                                         |                                                                           |
| • TB screening                                                                           |                                                                           |

**NQC In Care Campaign**

| • Retention: Gap measure                                                                  | • Retention: Medical visit frequency                                    |
| • Retention: Clients newly enrolled in medical care                                       | • Retention: Clients newly enrolled in medical care                      |
| • Mental health screening                                                                 |                                                                           |
| • Drug resistance testing before initiation of ART                                        |                                                                           |
| • TB screening                                                                           |                                                                           |

While Much Was Achieved in Year 1, Room For Improvement Remained

- Awareness among workers and supervisors about the HCC intervention needed to be improved
  - Fidelity to the intervention is important, with some flexibility available to address clients’ unique needs

- Increased capacity and streamlining of HCC activities is needed to address the workers’ processes

- Increased referrals were needed for individuals that are newly identified HIV+, loosely engaged, or lost to care

- Strategies were needed to expand locator strategies beyond, phone, mail, and emergency contacts

- Efficiencies were needed to free HCC workers to provide high priority services
  - Alternative approaches were needed to transport clients to their eligibility determination and medical visits
Other Areas of Improvement in Year 2

- Duration of time in the HCC intervention must be shortened to free HCC workers to serve additional clients
  - Average time of HCC enrollment currently is about 5.5 months across the three sites, with a substantial number of clients enrolled from 5 to 9 months
  - Case closure rates vary significantly among HCC sites, and is impacted by poor documentation of case closure
  - HCC worker attachment and reluctance to discharge HCC clients is in play for some workers

- Scope of navigator/linkage worker/coordinator practice needs to be addressed to avoid “scope creep”
  - While HCC workers are not case managers, they sometimes provide case management to address short-term needs while awaiting case management
Other Areas of Improvement

- Improvement was needed in
  - Documentation!
  - Ascertainment and documentation of pre-HCC HIV testing and treatment histories, HIV risk factors, CDC HIV/AIDS stage (i.e., HIV+ not AIDS, CDC-defined AIDS)
  - The “hand off process” to transition the client from the HCC worker to the care team
  - Ensuring the team is ready for the hand off process and does not contribute to loss to care
  - Established formats for progress notes
  - Quantifying the HCC intervention “inputs”

- Training was needed for HCC workers
  - Strategies for locating clients
  - Documenting intake, assessment, and intervention activities
  - Eligibility determination for the Ryan White Program and other services
Quality Improvement Resources


- **National Quality Center:** [http://nationalqualitycenter.org/](http://nationalqualitycenter.org/)


- **National Association of County and City Health Officials (NACCHO) QI:** [http://www.naccho.org/topics/infrastructure/accreditation/quality.cfm](http://www.naccho.org/topics/infrastructure/accreditation/quality.cfm)

Overview

- Standardization
  - Workflows
  - Documentation
    - Examples: General Consent, Client Assessment Record
- Standard Operating Procedures/Training
  - Examples: Documentation, Release of Information, Case File Management
- Reporting/Database
- Quality Assurance/Improvement
Overview

Bureau of HIV/STD & Viral Hepatitis

Office of QI & Compliance

Expanded Service Linkage

Merck Foundation

Ryan White Part A Grantee
Continuous Quality Improvement Plan

- HDHHS Accreditation Process
- Division of Community Health Services
  - CQI Committee
- Bureau of HIV/STD & Viral Hepatitis Prevention
  - Program Management
- Office of QI & Compliance
Program Management
- General QA on every case file at 2 weeks, 30, 60, 90, and 120 days on 100% of the cases

Office of QI & Compliance
- Quarterly QA on 10-20% of every active/closed case files per each program

Community Health Services--CQI Committee
- Biannual case review on 10% of each programs case files, during a designated period of time, for a specific quality indicator
For Today’s Presentations and to Learn More About the HCC, check out Hivcarecollaborative.org or contact Dr. Julia Hidalgo at Julia.hidalgo@positiveoutcomes.net