Quality Management Report 2015-16

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Objectives

- To present ARIES aggregate data to inform priority setting and resource allocation decisions of the CCPC
- To present Ryan White HIV/AIDS Program (RWHAP) expectations related to quality
- To discuss some of the Office of AIDS Administration (OAA) quality-related activities

Purpose of a Clinical Quality Management (CQM)

- Assess the extent to which HIV health services are consistent with the most recent public health guidelines for the treatment of HIV disease and related opportunistic infections

- Develop strategies for ensuring that such services are consistent with improvement in the access to HIV services

Performance measures

- HRSA HAB guidelines
  - Ambulatory care
  - Oral health
  - Medical case management
- National HIV/AIDS Strategy (2010, updated 2015)
  - Linkage/Retention
  - VL suppression
- HIV Care Continuum (Cascade)
  - Diagnosed, linked, HAART, retained, VL suppression
- Must include performance measures for all service categories

Disclaimers

- **First report since OAA began using ARIES in 2013**

- **ARIES data inaccurate or incomplete**
  - Statistical Analysis Report (STAR)
  - HIV AIDS Bureau (HAB) QM indicator Summary Report
  - Data entry does not show up (unknown)

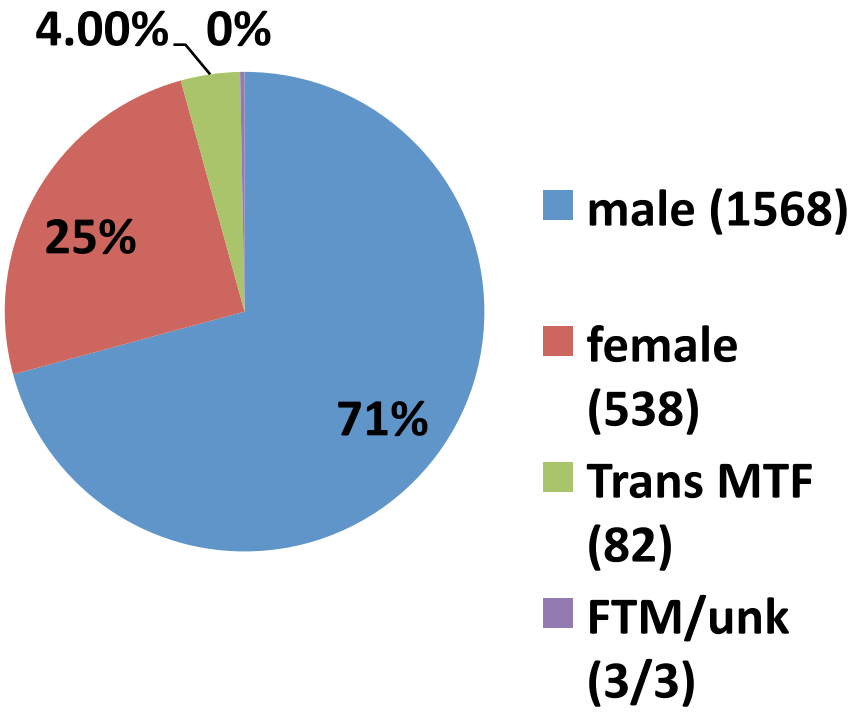
- **Filters** (Create variations in sample sizes and percentages)
  - Alameda Public Health Department (ADMIN)
  - End date of the report (12-month period)
  - Funding source is Ryan White Part A
  - Contract for Part A and MAI for 15/16 or 14/15
  - Primary service (Outpatient, MCM, EIS)

2194

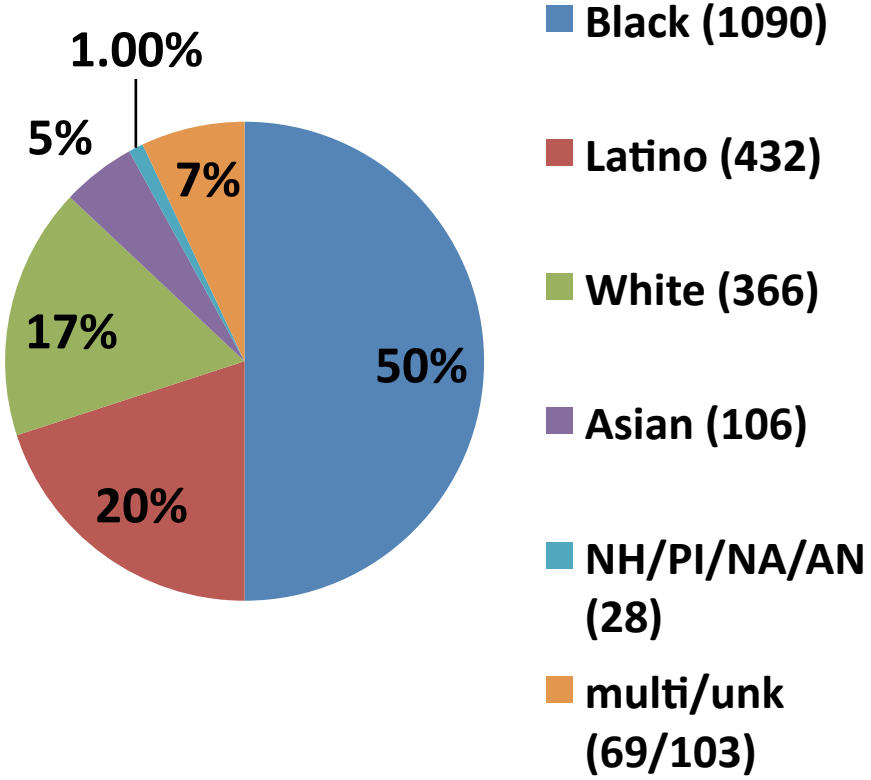
Unduplicated clients served

Demographics for FY 2015-16

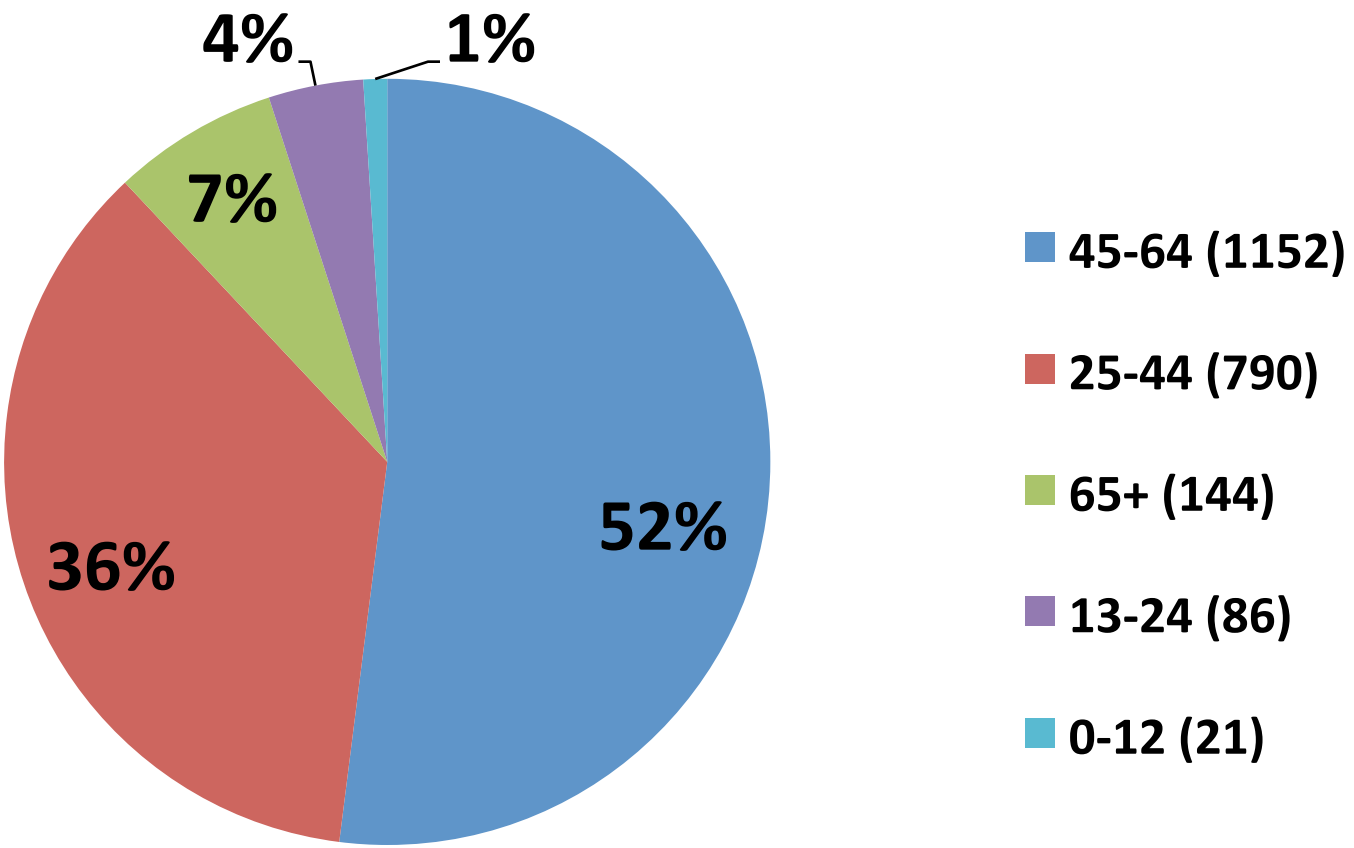
Gender



Race

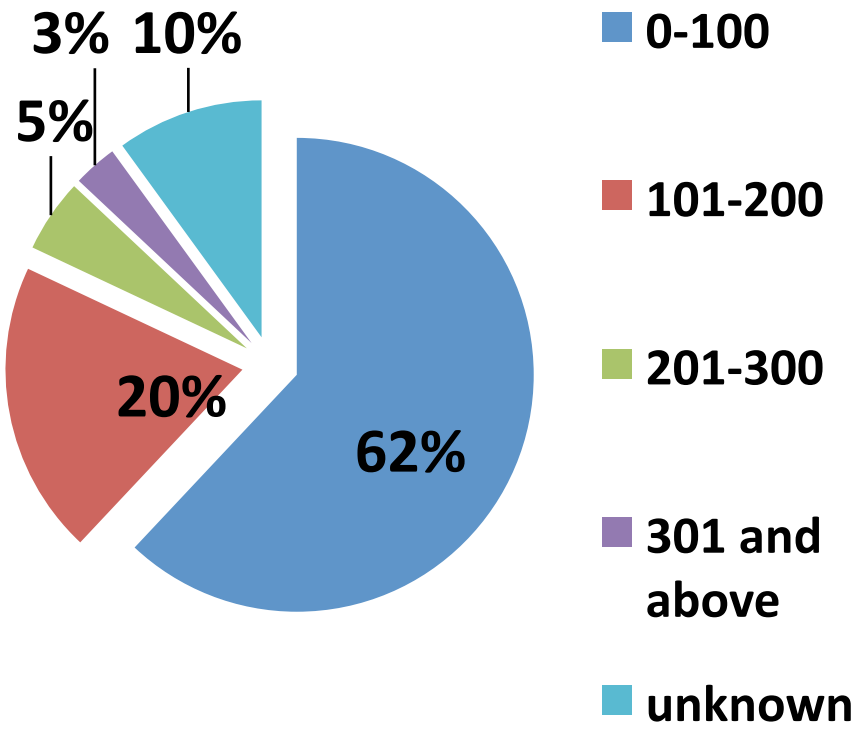


AGE

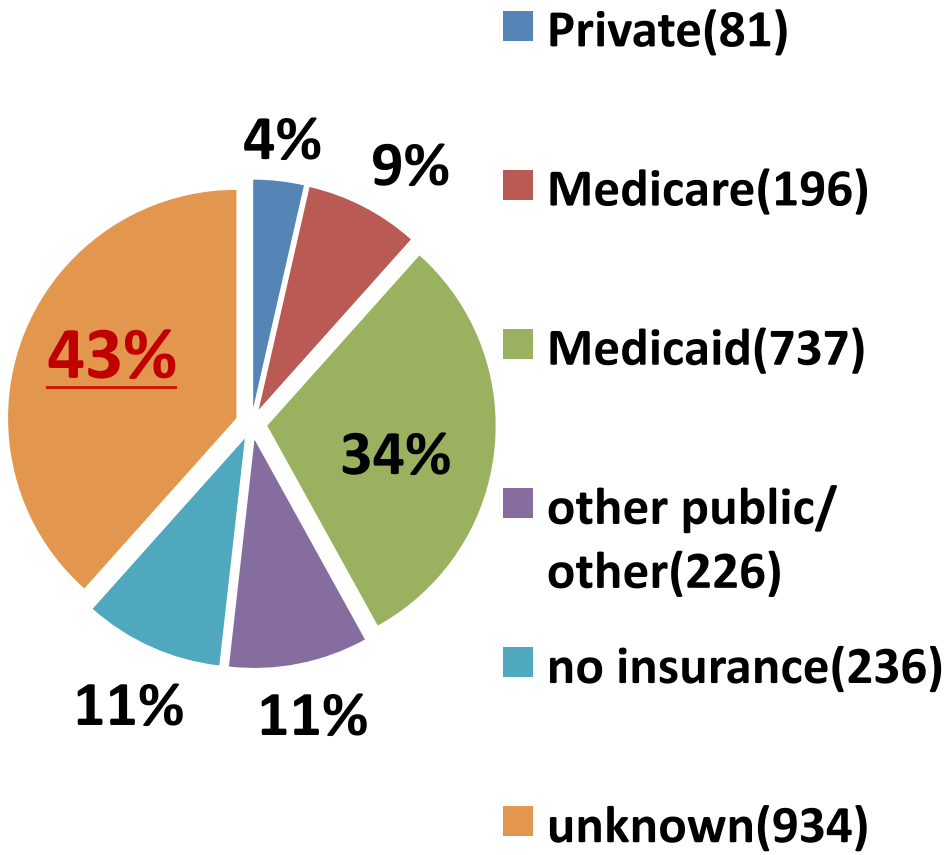


Demographics

Poverty Level



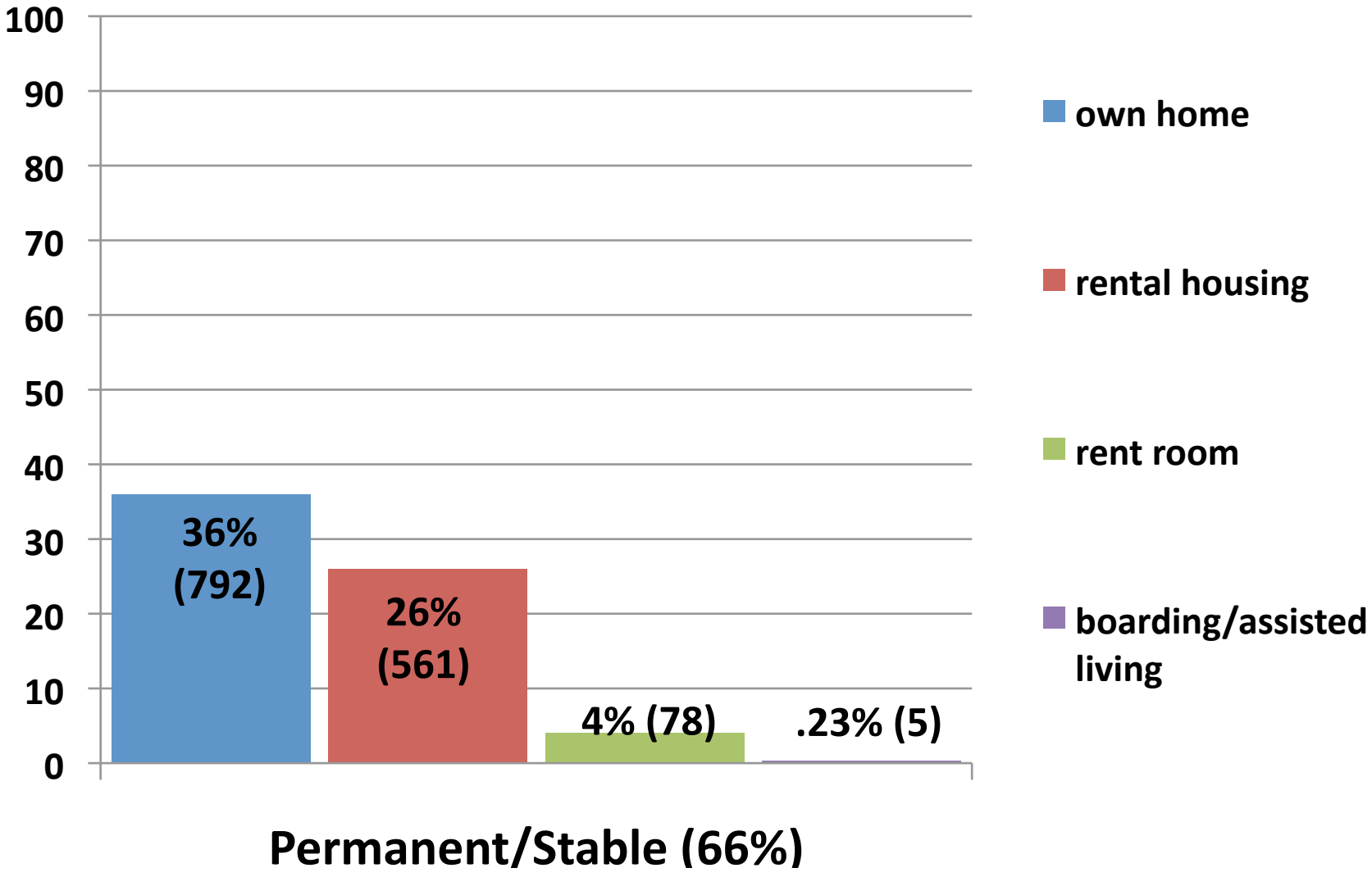
Insurance Status



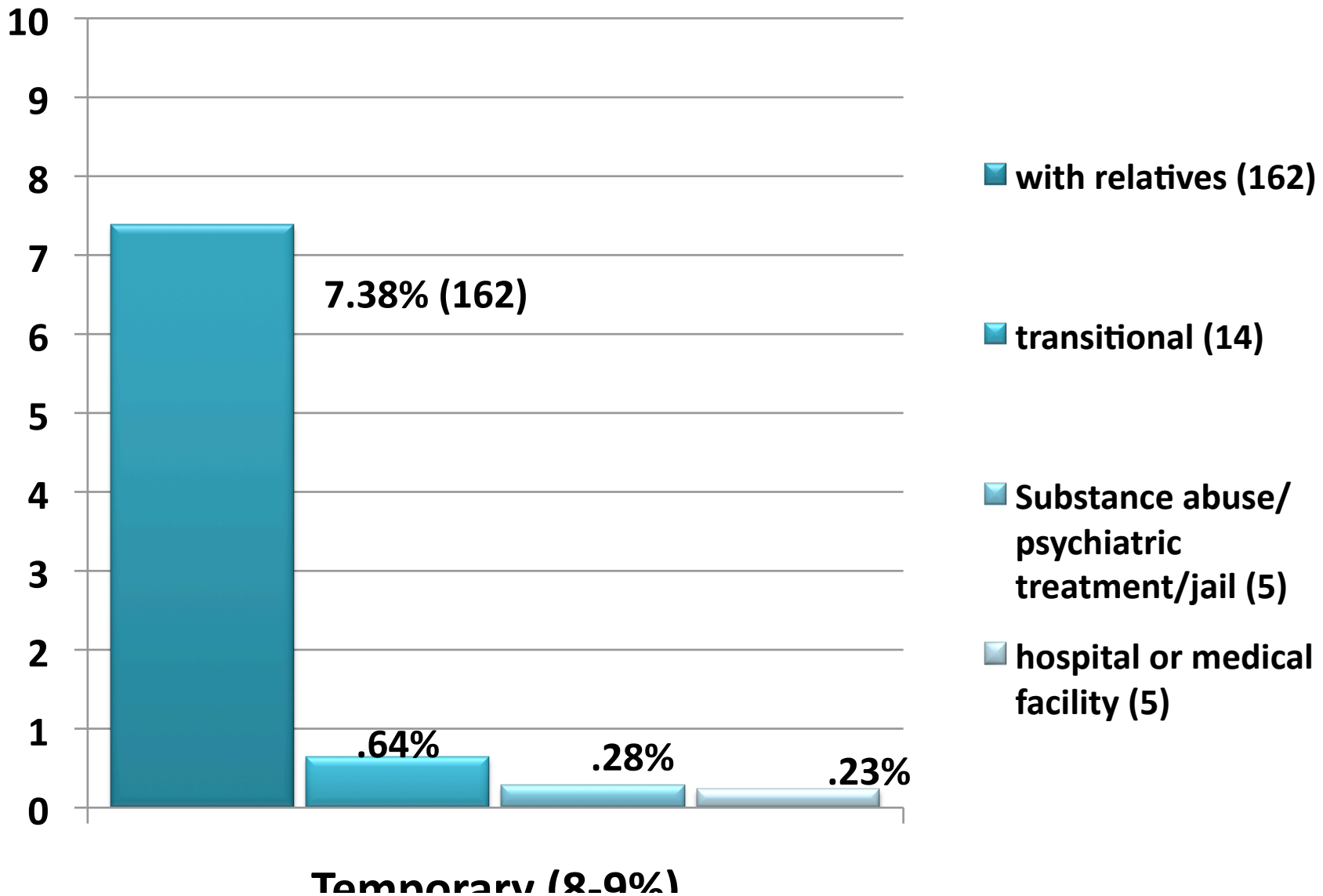
Federal Poverty Guidelines
48 states

Persons in family/ household	Poverty guideline
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

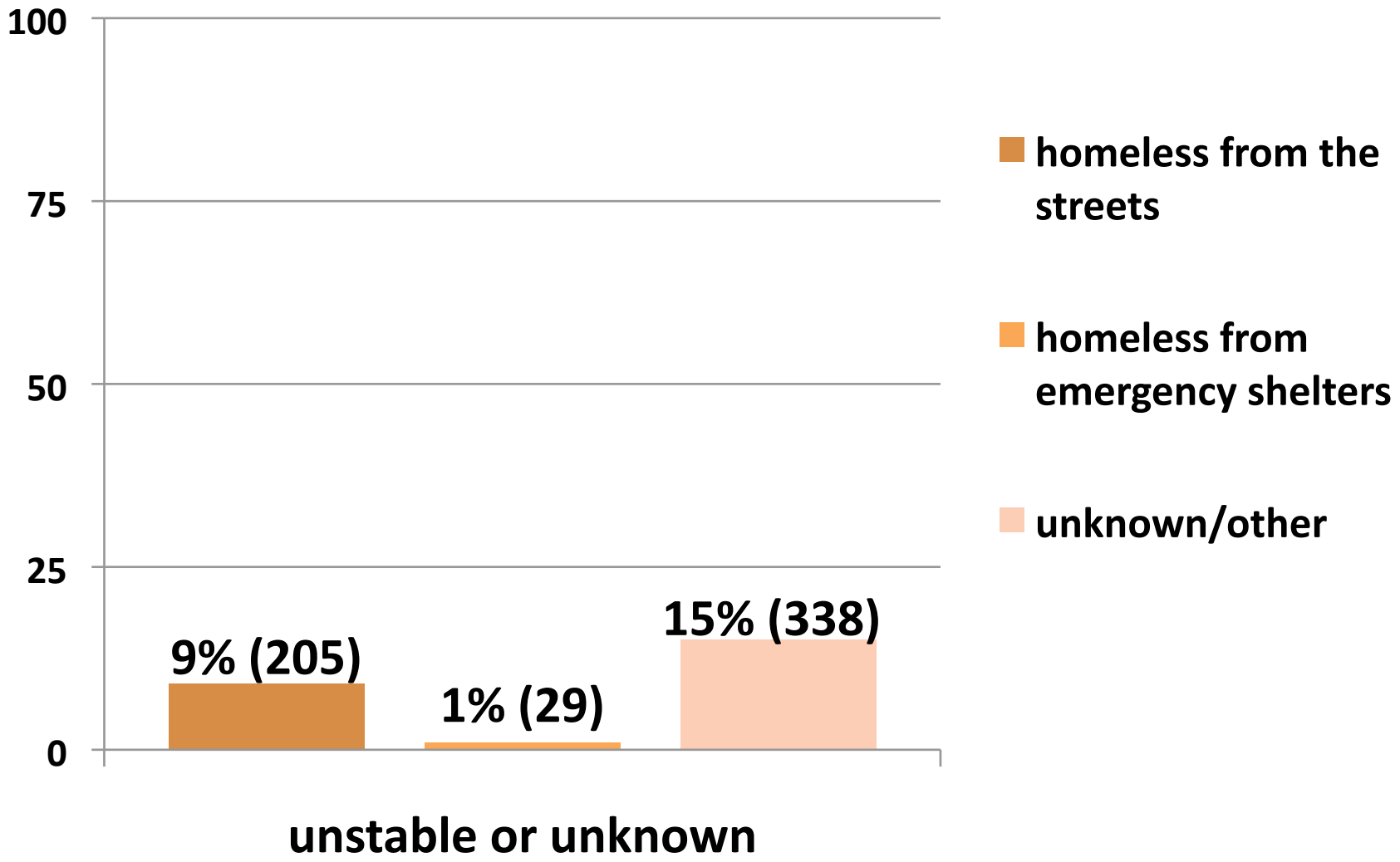
Living Situation



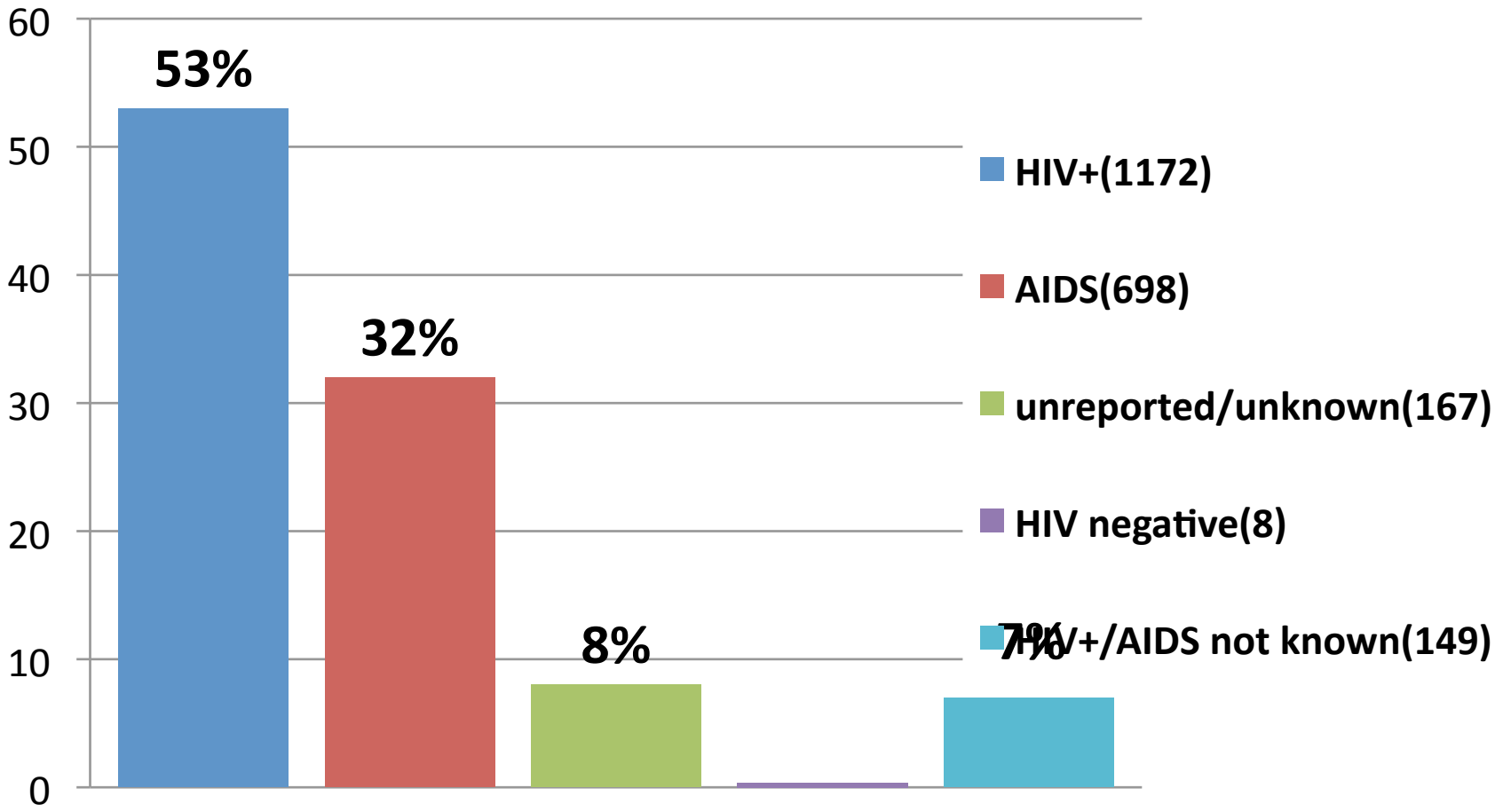
Living situation



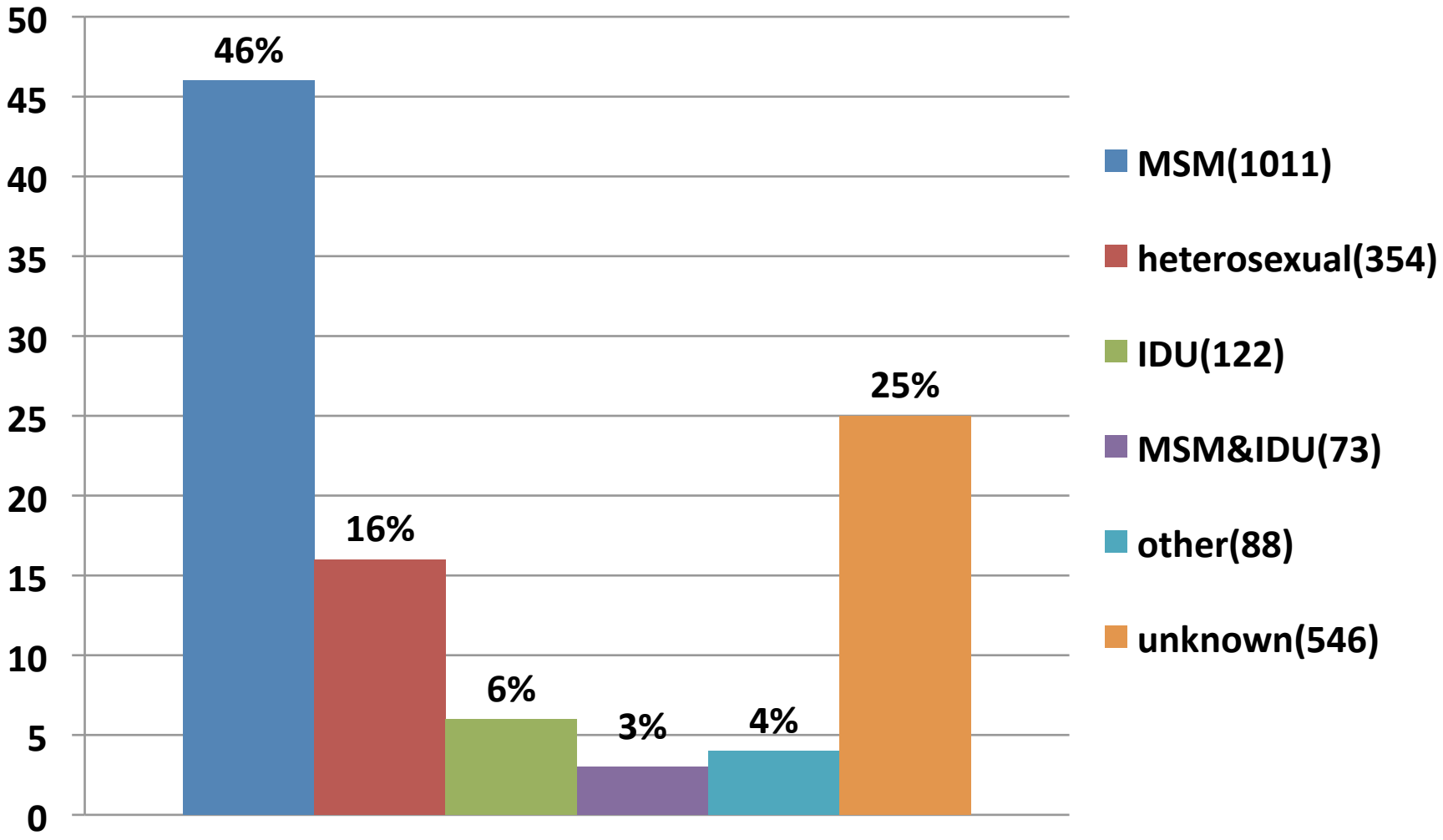
Homelessness



HIV Status


60
50
40
30
20
10
0
53%
32%
8%
7%
HIV+(1172)
AIDS(698)
unreported/unknown(167)
HIV negative(8)
HIV+/AIDS not known(149)

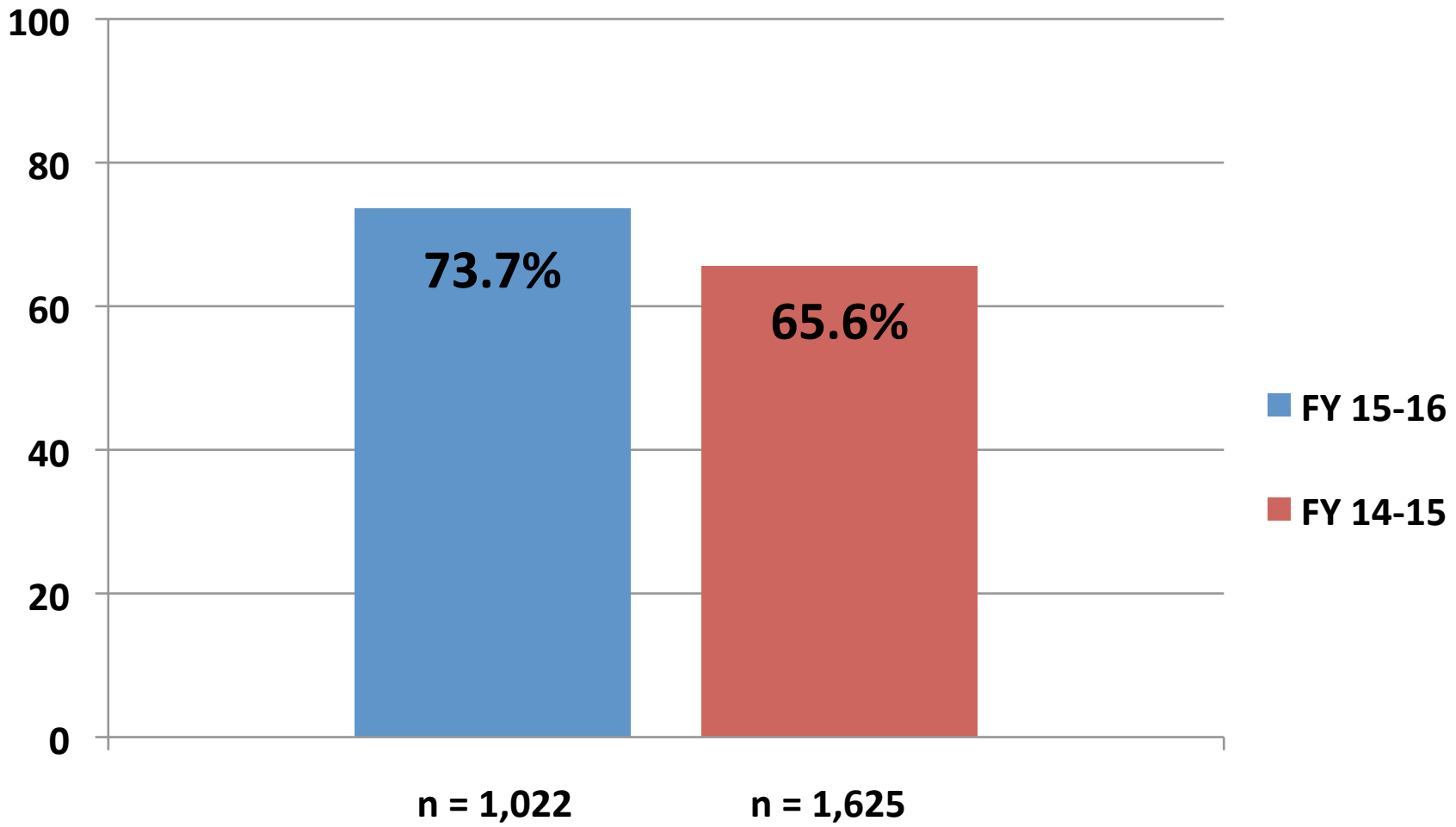
HIV Exposure



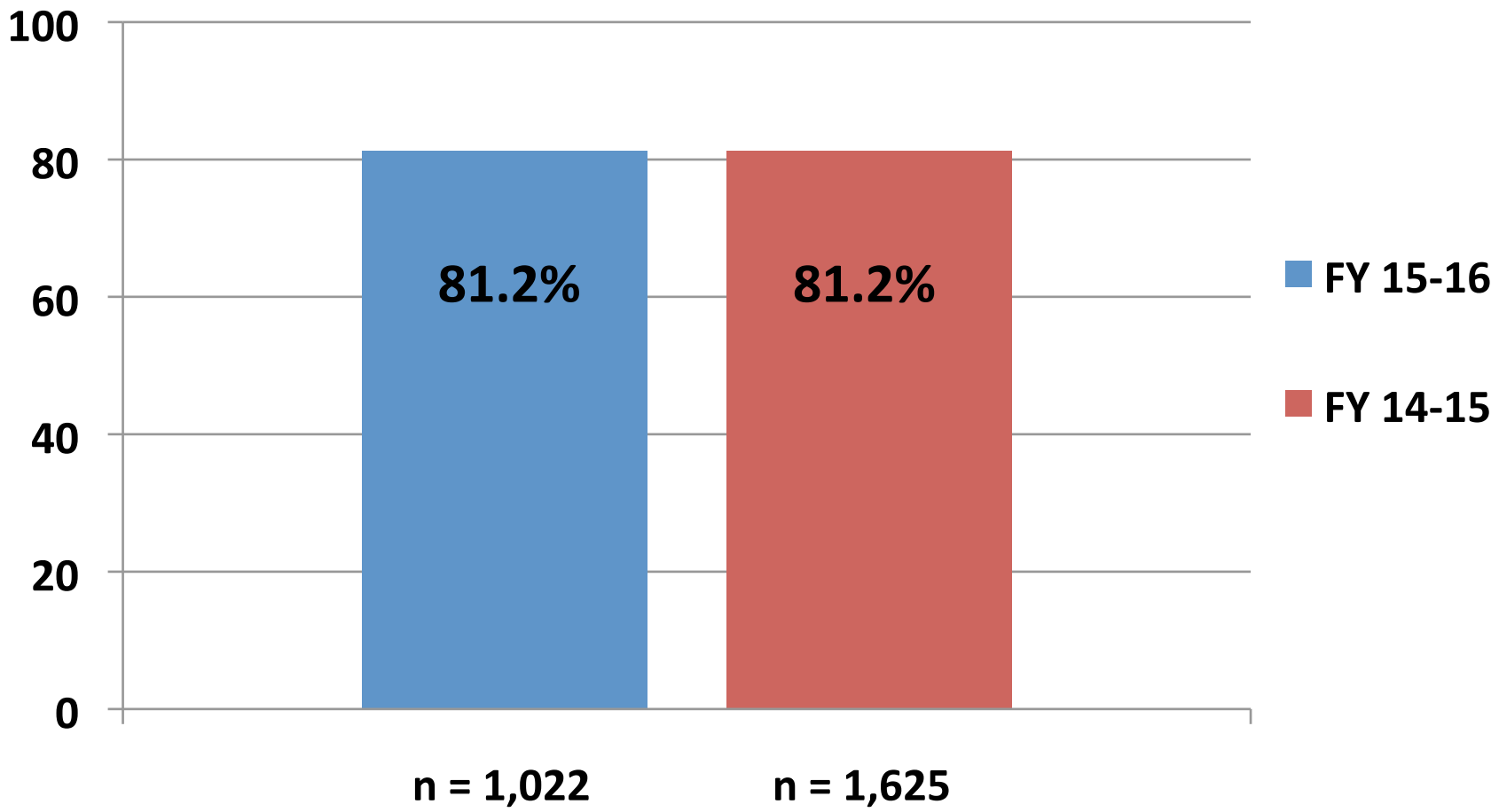
FY 15-16 SERVICE SUMMARY UDC 2,194	FY 14-15 SERVICE SUMMARY UDC 2,208
MCM 1,394 (60%)	MCM 1,358 (62%)
Ambulatory Care 613 (28%)	Ambulatory Care 939 (43%)
Legal Services 300 (14%)	Psychosocial Support 327 (15%)
Early Intervention Services (A&B) 257 (12%)	Legal Services 284 (13%)
Medical Transportation 248 (11.5%)	EFA 279 (12.5%)
Psychosocial Support 238 (11%)	Medical Transportation 247 (11%)
EFA 196 (9%)	Food Bank/Delivered Meals 189 (9%)
Oral Health 168 (8%)	Mental Health 186 (8.5%)
Food Bank/Delivered Meals 165 (7.5%)	Early Intervention Services (A&B) 164 (7.5%)
Mental Health 142 (6%)	Housing Services 154 (7%)
Non-MCM 113 (5%)	Oral Health 94 (4%)
Housing Services 101 (4.5%)	Substance Abuse 83 (3.5%)
Substance Abuse 79 (4%)	Home and Community Based Health 32 (1%)
Health Ed/Risk Reduction 24 (1%)	Linguistic Services 13 (.5%)
Home and Community Based Health 22 (1%)	Child Care 10 (.5%)
Linguistics and Child Care 10 (.5%)	

Viral Load Suppression

(most recent viral load status was below <200)

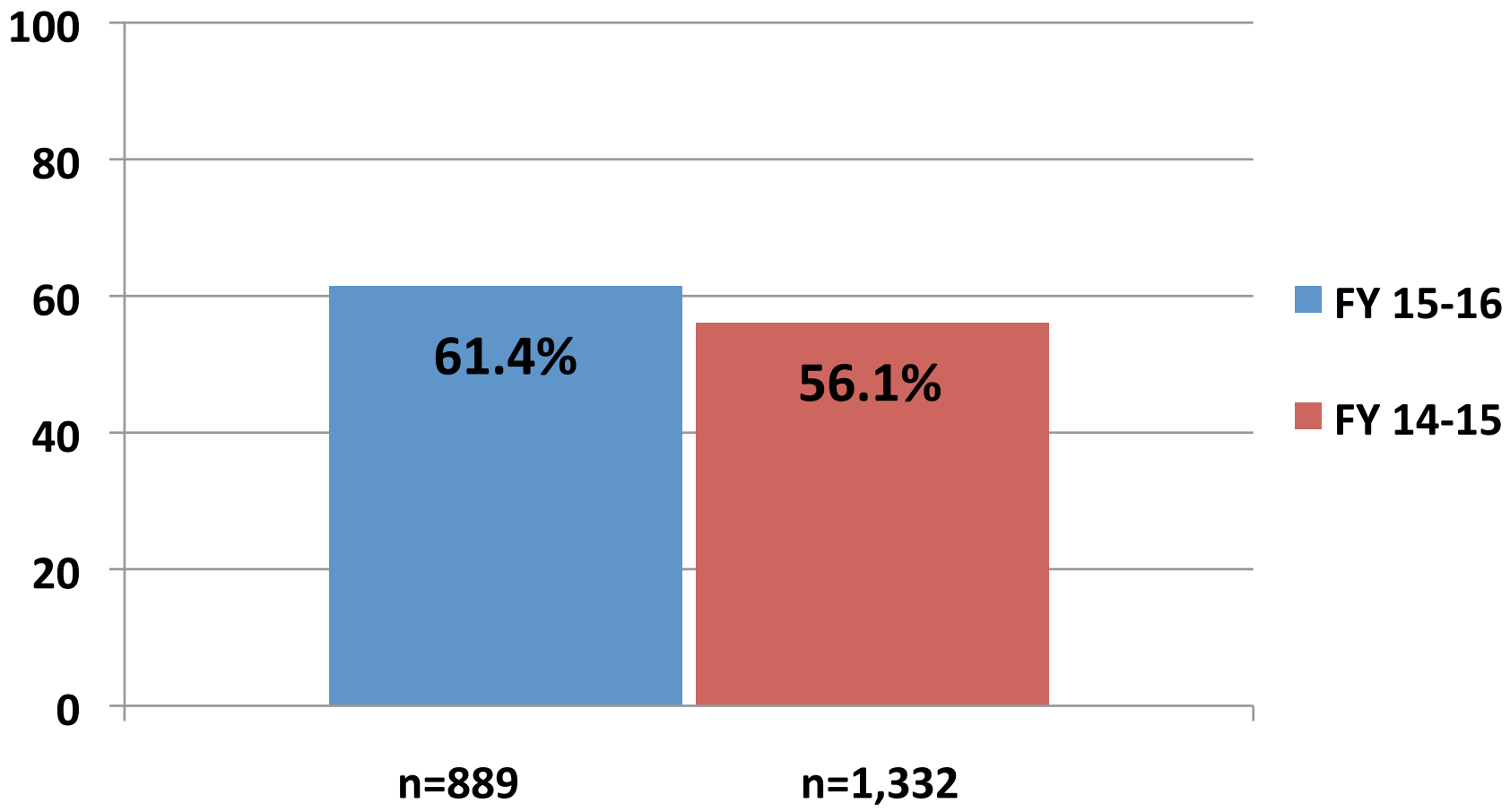


Prescribed ARV Therapy



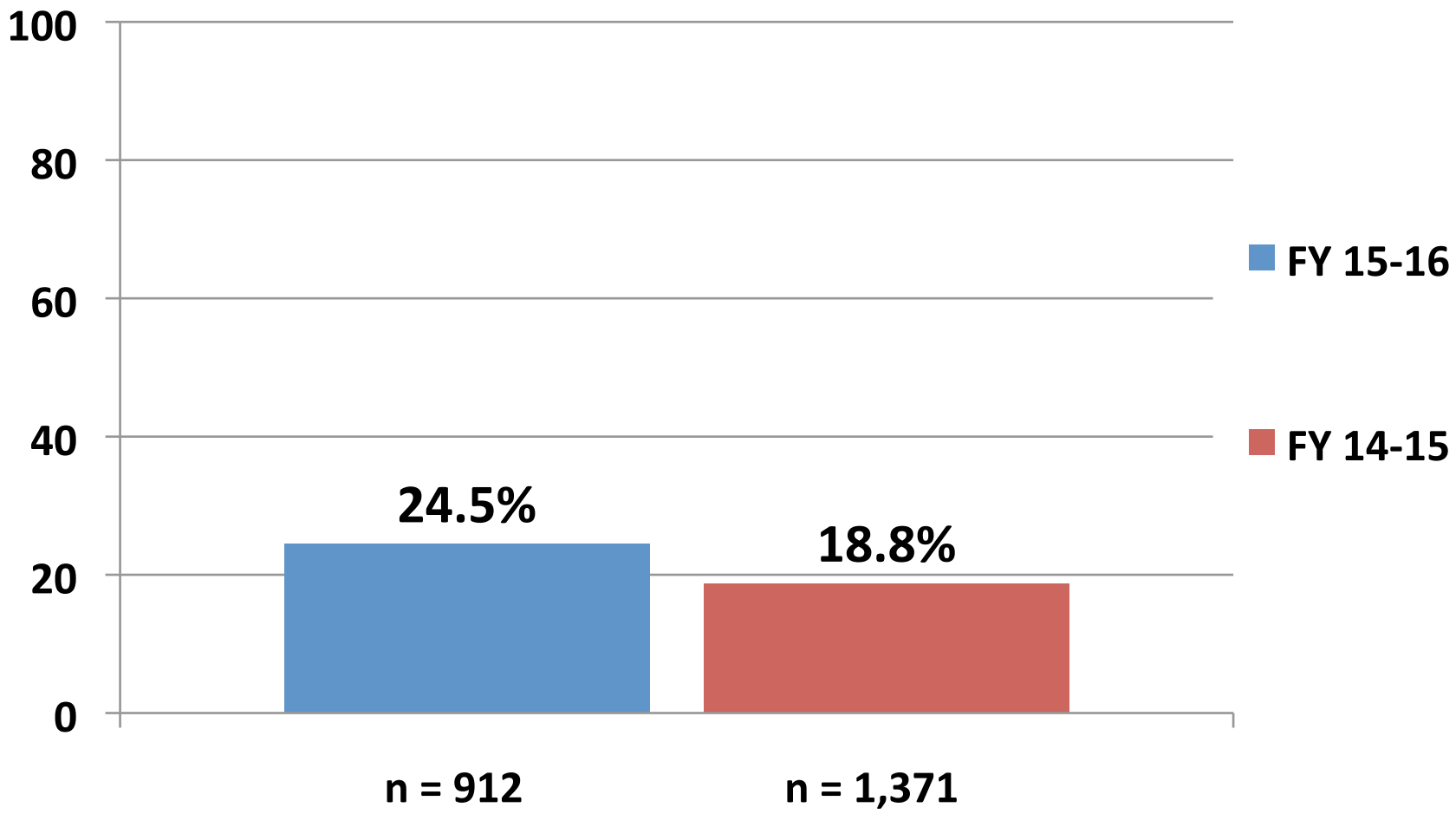
Gaps in Medical Tests

(medical visits in first and last half of the year)

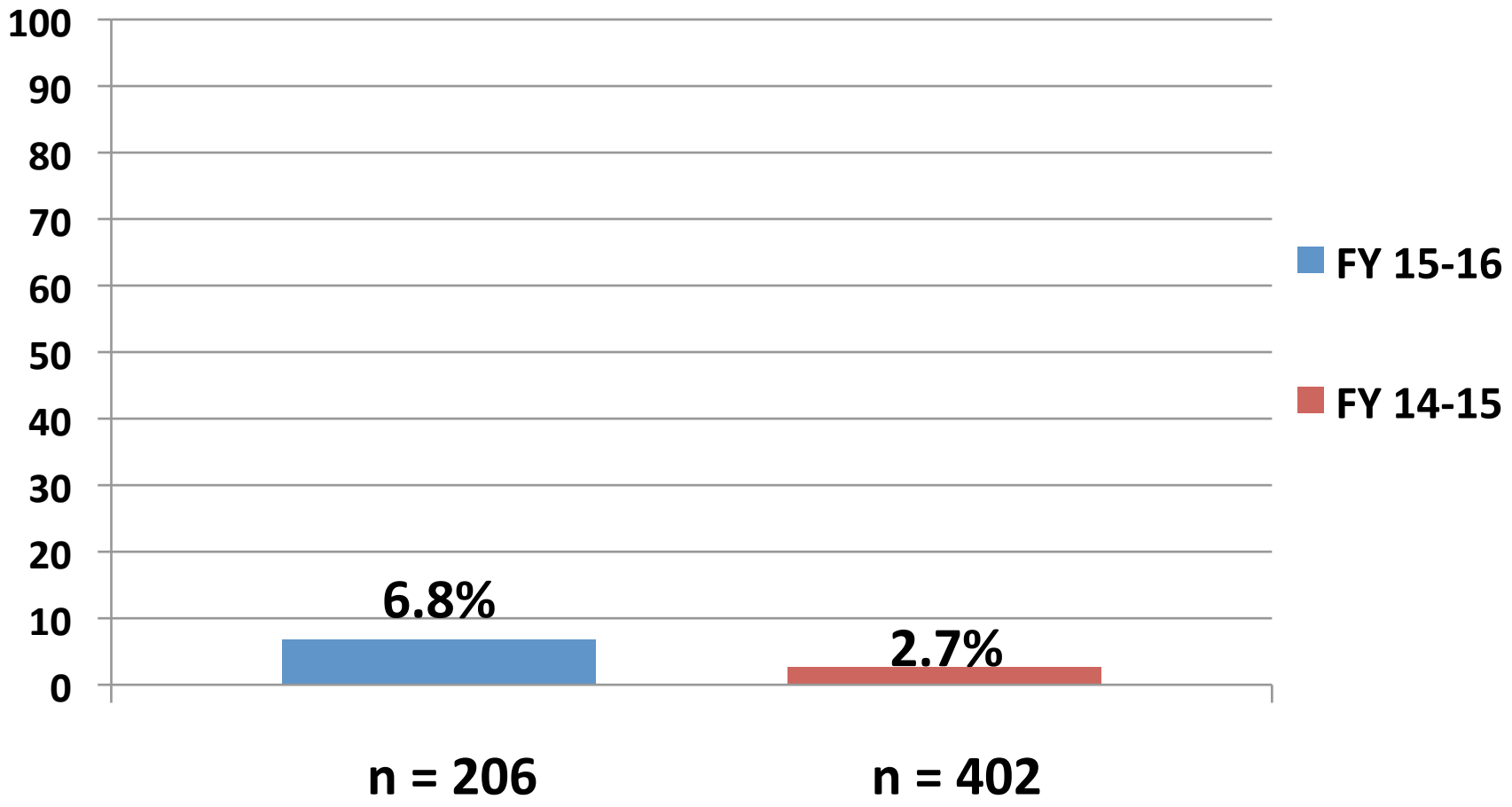


Medical Visit Frequency

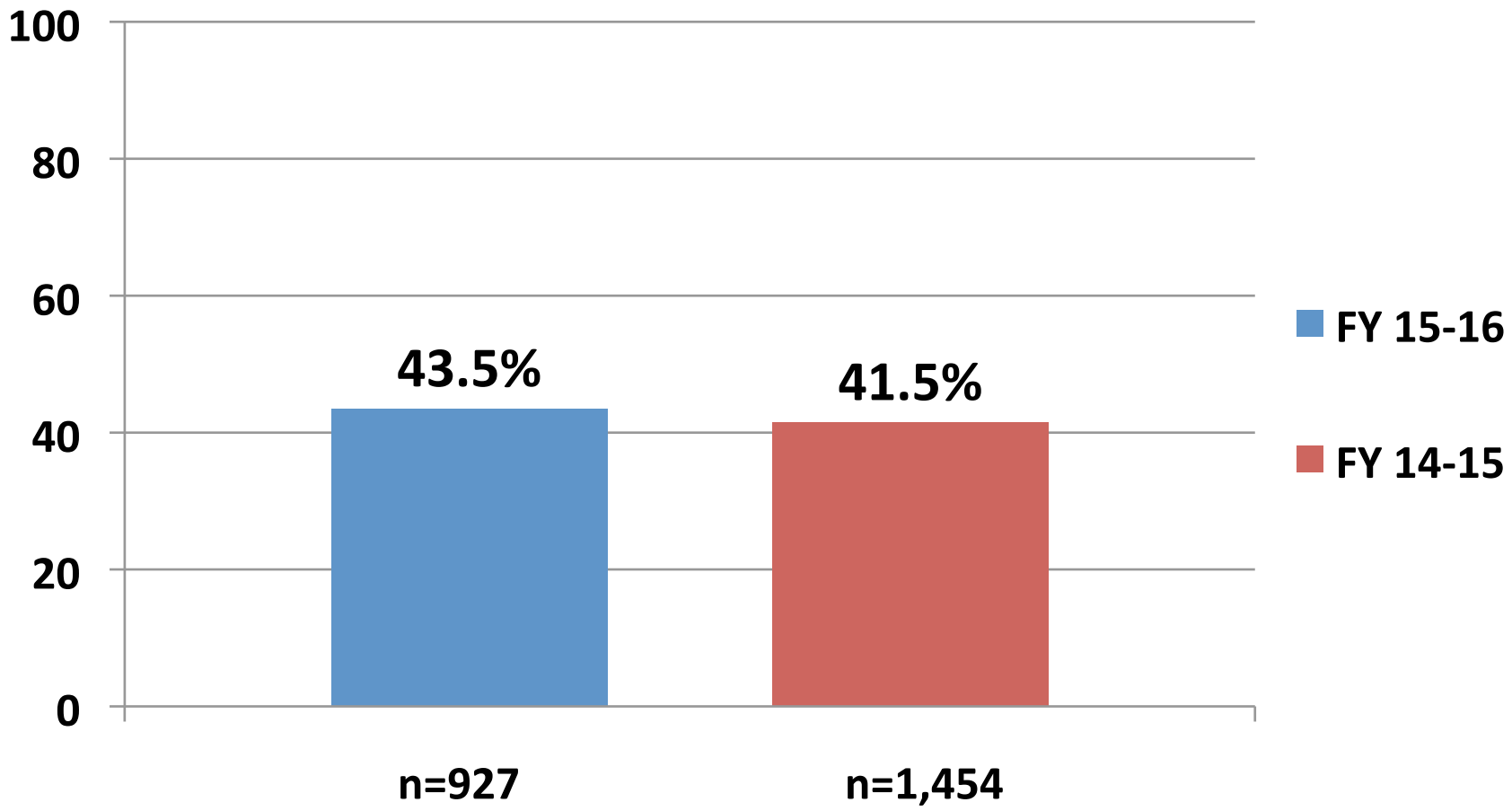
(at least one medical visit at least 60 days apart in each 6-month period)



Cervical Cancer Screenings

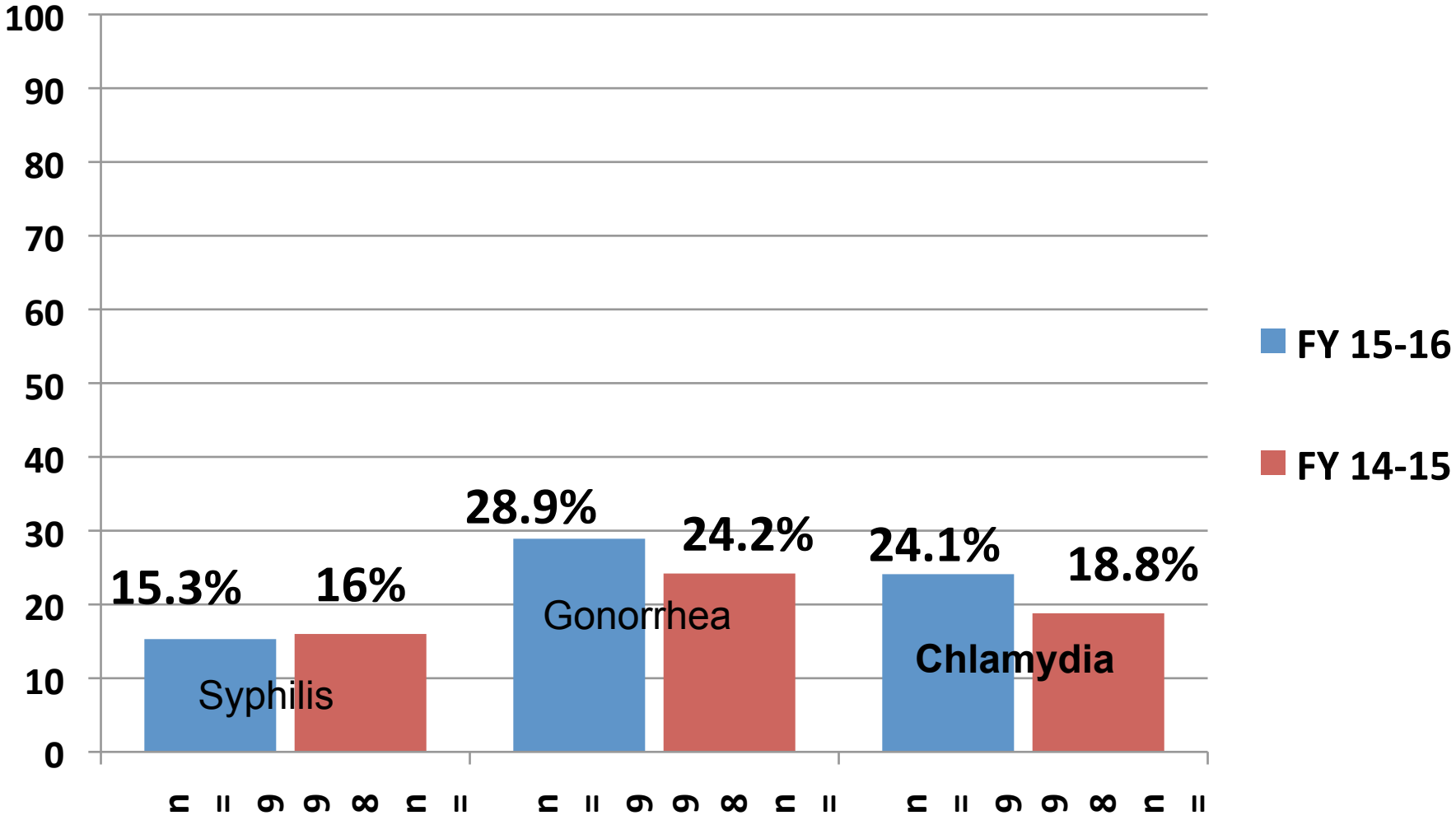


Hepatitis C screening (since diagnosis)



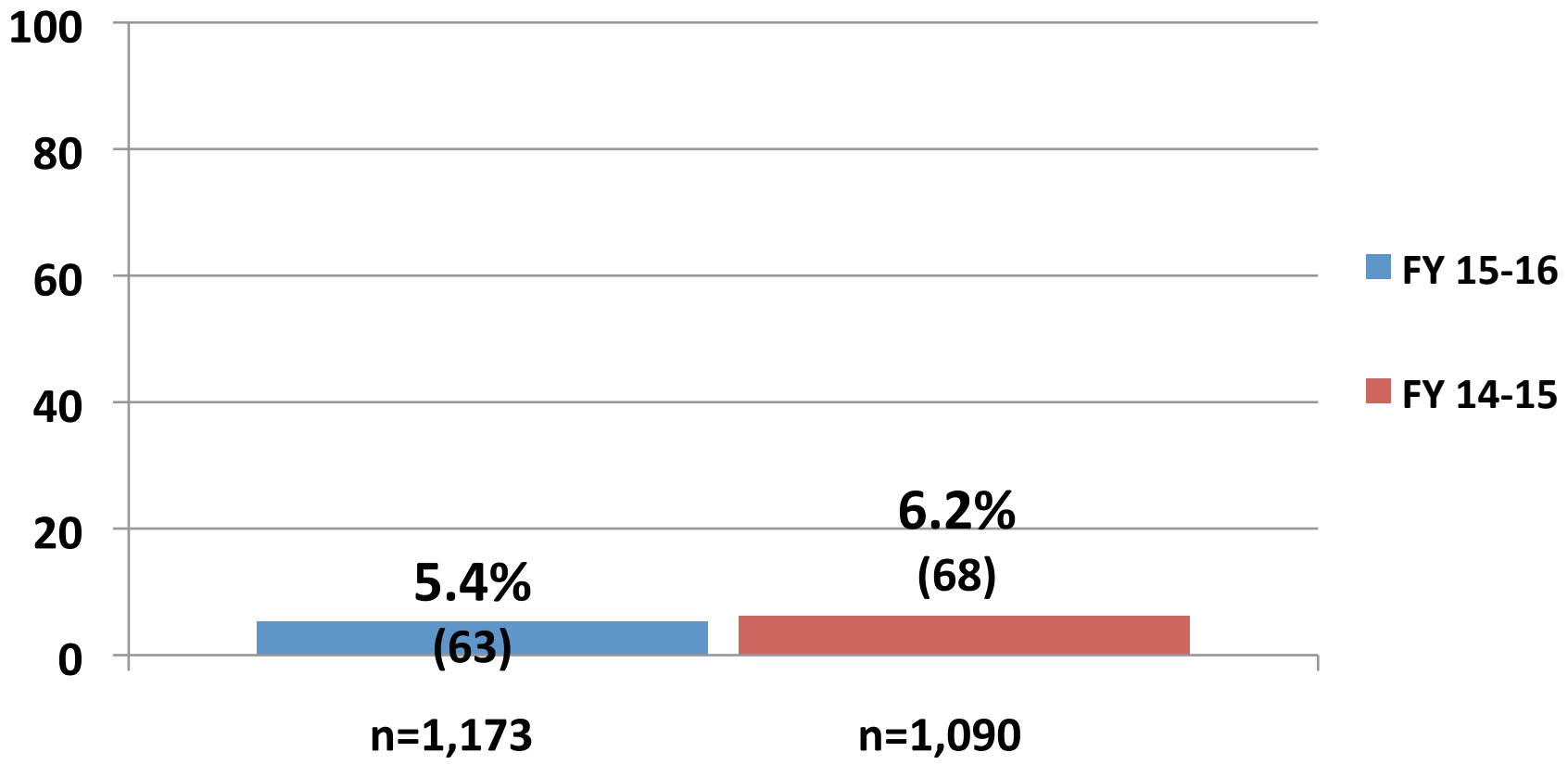
STD Screening

(during the 12-month period)



MCM Care Plan

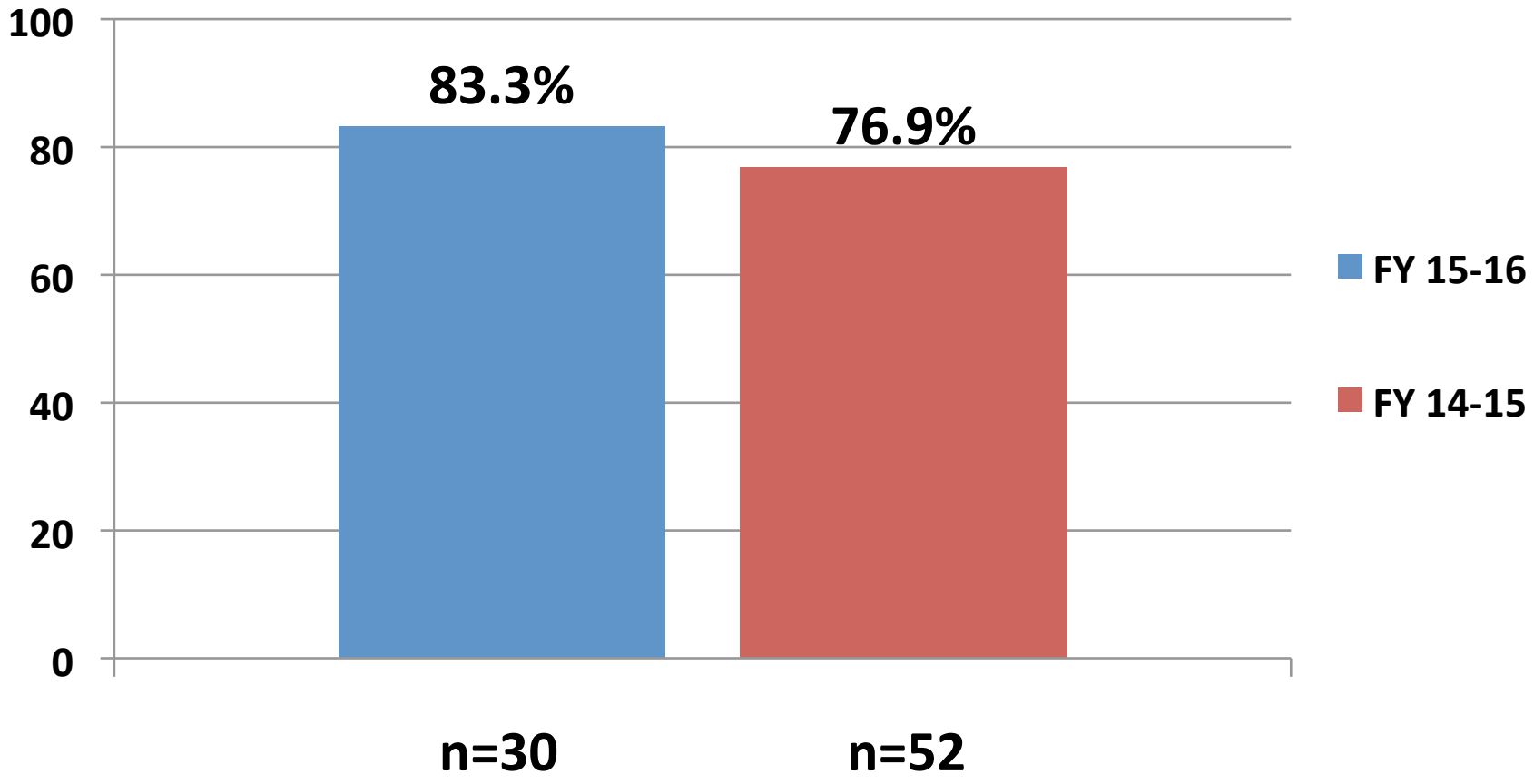
(MCM clients who had care plans created twice during the year at 3 months apart)



Linkage to HIV Medical Care

EIS (early intervention services) Part A&B

(newly diagnosed who received medical care within 3 months of HIV diagnosis)



Ryan white quality expectations for CQM Program

Policy Clarification Notice 15-02

- **To provide more clarity around the components of a CQM program**
  - Improve patient care
  - Improve health outcomes
  - Improve patient satisfaction

- **Identify specific QM activities**
  - Performance measure (all categories to evaluate effectiveness of the service)
  - Chart reviews, site visits agency reports
  - Quality improvement activities (identify improvement opportunities and monitor for improvement); not all service categories but those with biggest impact
  - Assess the capacity of the sub-recipients for their ability to conduct these activities, such as prioritizing measures and collecting data
  - Coordinate these activities among the funded recipients

Relevant Activity	Quality assurance	Clinical quality management (CQM)
Performance measurement prioritization and alignment w/ other RWHAP Parts		X
Development of Service Standards	X	
Data extraction for CQM purposes (collect, aggregate, analyze and report on measurement data)		X
Chart audit/reviews	X	X
Monitoring site visits	X	If monitoring CQM
Extracting data for stakeholder reports	X	
Electronic health record interface with other providers; systems operations	X	
CQM committee in planning for quality improvement projects		X

Core Service Indicators

Outpatient/Ambulatory Health Services indicators
90% RW clients have a HIV specialist medical visit in each 6-month period
10% RW clients missed a visit in the last 6 months of the period
85% RW clients have been assessed for mental illness
85% RW clients have a suppressed viral load
95% RW clients are prescribed ARV medication
Medical Case Management
95% RW clients have a HIV specialist medical visit in each 6-month period
80% RW clients have case management updates in their care plan in each 6-month period
55% RW clients were assessed for partner services
90% RW clients were assessed for adherence to HIV medication
Mental Health
90% RW clients have a medical visit in each 6-month period
95% RW clients remain in mental health treatment at 3 months
85% RW clients are assessed for adherence to HIV medication

Oral Health
95% RW clients have a medical visit in the last 6-month period
95% RW clients receive oral health education at each visit
95% RW clients have a periodontal screen annually
Early Intervention Services
50% RW clients who are newly diagnosed are linked to HIV care in 30 days
55% RW clients receive risk reduction counseling
60% RW clients are offered referrals
Substance Abuse Services
80% RW clients have a medical visit in the last 6-month period
75% RW clients are assessed for adherence to HIV medication
85% RW clients are screened for mental health
80% RW clients are in substance abuse treatment for at least 90 days

Home and Community-Based Health
100% clients with a medical visit in the last 6 months
95% clients who are assessed for adherence to HIV medication
90% clients with a care plan including goals and timelines
90% clients with a physician order with a diagnosis
Medical Nutrition Therapy
80% clients with a medical visit in the last 6 months
80% clients with a comprehensive nutrition assessment including medical and psychosocial hx, labs, anthropometry
80% clients with improvements in health parameters at follow-up

Support Service Indicators

Food Bank/Home-delivered Meals
90% RW clients have a medical visit with an HIV specialist in every 6-month period 65% RW clients report an improvement in, or maintenance of a healthy weight status 60% RW clients report an improvement in food security
Medical Transportation
90% RW clients have a HIV specialist visit in every 6-month period 50% RW clients used transportation services for at least two appointments (core or support services) in the last 6-month period
Housing Assistance
90% RW clients have a HIV specialist visit in each 6-month period 60% RW clients who report housing stability in the last 6-month period
Non-medical Case Management
80% RW clients were assessed and offered referrals and resources from at least one needed service during the first visit such as medical, social, community, legal, or financial 80% RW clients at a subsequent visit have documentation of the outcome of referrals offered
Psychosocial Support
90% RW clients have a HIV specialist visit in each 6-month period 85% RW clients reported a reduction in high risk behaviors 70% RW clients were offered assistance with partner services

EFA
90% RW clients have a HIV specialist visit in each 6-month period 25% RW clients report a reduced need for EFA than in the previous year
Legal
90% RW clients have a HIV specialist visit in each 6-month period 85% RW clients obtained/maintained housing, income, health care access for the past 6-months
Child Care
90% RW clients have a HIV specialist visit in each 6-month period 50% RW clients used this service once in each 6-month period 80% RW clients report that this service helped them to keep all HIV medical appointments
Linguistics
90% RW clients have a HIV specialist visit in each 6-month period 50% RW clients who needed translation services receive it through the language line

Ongoing improvements to be made to the CQM Program

- **Measurement of data**
  - ARIES data input issues
    - Unknown data
  - ARIES reports
    - What are the parameters/filters you choose
    - How do you compare and sync this data with other reports
- **Development of Quality Improvement teams**
- **Quality Management Plans**
- **Quality Improvement Projects**