
Creating an Effective EMA Wide Quality Management Program

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Ryan White HIV/AIDS Program Grantee Meeting
Workshop

Tuesday, August 26th, 2008



Workshop Overview

- Part A Quality Management Program Description and Activities
- Evaluation & Quality Management: The New York State/New York City Approach
- HIV Quality Learning Networks
- Addressing Public Health Issues in the Context of Quality



The New York Part A Quality Management Program

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Part A Quality Management Program

- Builds upon NYSDOH AIDS Institute quality program standards and statewide experience:
 - Clearly defined HIV quality of care clinical indicators for adults and adolescents
 - Clinical Advisory Committee of New York State experts refines clinical indicator definitions to reflect current standards
 - Annual quality indicator reviews at 200 HIV ambulatory care facilities throughout New York State, including New York City



Part A Quality Management Program

- Established in 2001 based on RWCA
- Builds upon NYS AIDS Institute program standards and statewide quality expectations
 - Minimizes additional resources
 - Minimizes additional burden for providers
- Focus on quality needs specific to the New York City and Tri-county EMA



Quality Management Program Goals

- Collaboration between NYC Department of Health, Planning Council, service providers, consumers, NYS HIV Quality Program
- Provide aggregate data to the EMA
- Promote QI methods and approach
- Assist in identification of gaps in service
- Build capacity for QM among EMA grantees
- *Improve care & services for PLWHIV/AIDS*



Quality Management Program Structure

- All staff and committee structure to oversee & manage quality activities
- Activities to assess quality of services by subcontractors
- Specific indicators monitored by service category
- Performance data collection strategy



Program Activities

- Part A Quality Program:
 - Development of clearly defined indicators in key service categories
 - Contracting with external review agencies to collect performance data of Part A providers
 - Part A Steering Committee to provide feedback on service indicator definitions and performance measurement systems



Part A Quality Steering Committee

- Representatives from the NYCDOHMH, Westchester County DOH, Public Health Solutions, NYSDOH, HIV Health and Human Services Planning Council of New York, consumers and providers
- Quarterly Steering Committee meetings to solicit feedback, seek recommendations and report on ongoing quality efforts
- Committee Meetings are coordinated by the NYSDOH AIDS Institute quality management staff



NY EMA Part A Indicator Portfolio

Indicators developed for following services:

- Adult Day Treatment – 2002
- Case Management – 2002, *revised 2008*
- Food and Nutrition – 2003, *revised 2005*
- Harm Reduction – 2005-6
- Home Care – 2002
- Mental Health – 2002 (*updated annually*)
- Oral Health – 2004
- Treatment Adherence – 2002, *revised 2007*
- TB DOT/DOPT – 2001



Indicator Development Initial Process

- Involve all providers in the service category
- Focus on quality needs specific to consumers and service providers in the particular service category
- Utilize group decision-making process to prioritize services provided
- Pose a specific question for prioritization of aspects of care



Indicators-Review Process

- Data collection strategy developed
- Sampling plan derived from facility case size
- Records reviewed by professional analysts at each site
- Performance measurement reports prepared
- Aggregate and facility specific results
- Comparison of service category across providers in the EMA
- Identify areas for improvement – individually and by category



Performance Measurement

- Mental Health 6 years
- Home Care 4 years
- Case Management 5 years
- Treatment Education/Adherence 4 years
- TBDOT 3 years
- Oral Health
- Food and Nutrition
- Harm Reduction

Chart review performed by IPRO/NYCHSRO



“All-or-none measurement”

- Measures performance on all components or elements of an intervention rather than focusing on each component separately (i.e., “item-by-item measurement”)
- Focuses on the patient
 - Providing *all* components is what’s desired
- Encourages a system perspective
- Offers a more sensitive scale for assessing improvements
 - Provide motivation to improve



Quality Management Plan

General Purpose

- Identify needs & gaps in services
- Ensure delivery of quality services
- Information can be used by Planning Council for priority setting
- Tool for effective collaboration through use of QM data



NY EMA Quality Management Plan

Elements of QM Plan:

- NY Part A EMA QM Program Purpose and Quality Strategic Goals
- Quality Management Program Infrastructure, including Steering Committee
- Methodology and Guiding Themes for the QM Program
- Performance Measurement, including indicator overview and data collection
- HIV Quality Learning Networks
- Annual Workplan
- Evaluation



Part A Quality Strategic Goals

Performance Measurement

- Comprehensive performance measurement systems assess the quality of services in achieving goals of access to and maintenance in care.

Capacity Building

- Providers become skilled in using QI tools and methodologies to advance their services.

Patient Outcomes

- Services improve health outcomes and quality of life for PLWHA

Priority Setting

- The Quality Program is responsive to the changing needs of the New York EMA community.



Quality Improvement Model

▪ QI Learning Networks

- QI training
- Peer learning to share best practices
- Review data
- Present QI examples
- Identification of common issue
- Improve coordination of care



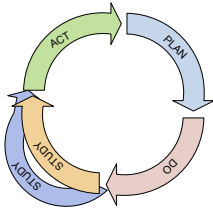
Bringing Together Evaluation & Quality Management

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Public Health Practice Unit,
NYC DOHMH HIV Care, Treatment & Housing Program

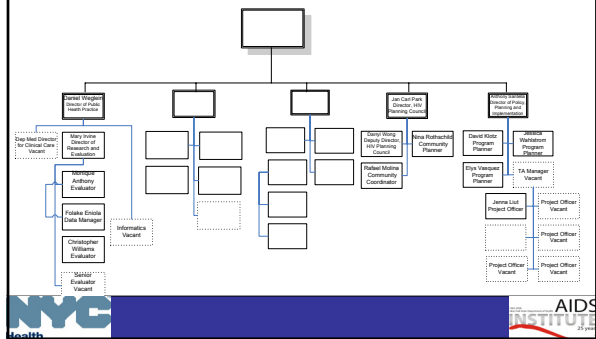


State/City Health Department Collaboration

- Multi-layer collaboration
 - Inter-agency
 - HRSA grantee and contractor
 - Research & Evaluation Unit + Quality Management Initiative



NYC DOHMH Organization



REU Lessons Learned

REU projects in 2005 – 2007 included:



- NYC Condom - Free Condom Initiative
- HIV Testing Program
 - 15 Contract portfolio funded by City tax levy dollars
 - Objective - scale-up routinized HIV testing in medical settings
 - Started operation January 2006
 - Operating budget \$3M
 - Tests conducted 30,211 (2006), 47,495 (2007)
 - HIV+ - 448 (2006), 960 (2007)



HIV Testing Program Detail

- Unit cost (fee-for-service) contracts
- Payment point - HIV rapid test (RT)
- Other required services
 - Counseling in compliance with State law
 - Confirmatory testing for all RT+
 - Linkage to primary care for all confirmed HIV+



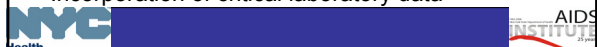
HIV Testing Lessons Learned

- Early data submissions included large volumes of HIV testing records however:
 - Test outcome detail was missing
 - Confirmatory test data was missing
 - Linkage to care data was missing
- Provider meetings were convened to
 - Share data with providers
 - Elicit programmatic challenges
 - Elicit data management challenges
- Findings drove technical assistance and standard of practice guidance



Incorporating Evaluation in RW Pt A

- Outcomes focused
 - Linkage to care/Maintenance in care
 - Adherence to regimen
 - Biomarker (CD4/VL) improvement
 - Acute care utilization
- In conjunction with standard-of-care process measures
 - Assessment completion and completeness
 - Coordination with other providers and referral
 - Incorporation of critical laboratory data



Data Systems

QUALITY MANAGEMENT PROGRAM EVALUATION

- Paper charts
- Data extraction by NYCHSRO
- Database and data entry Data analysis
- Electronic reporting into the AIRS client-level tracking database
- Electronic extracts generated by providers
- Data aggregated and cleaned by PHS
- Data analyzed by DOHMH/CTHP

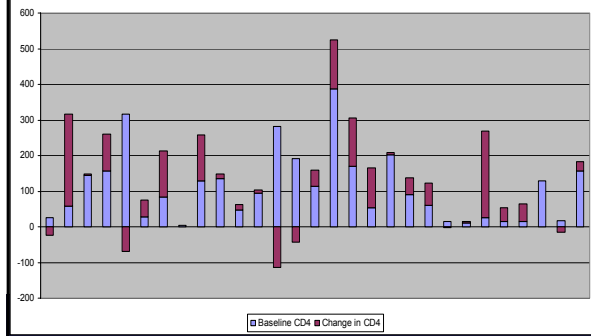


Case Example - Case Management

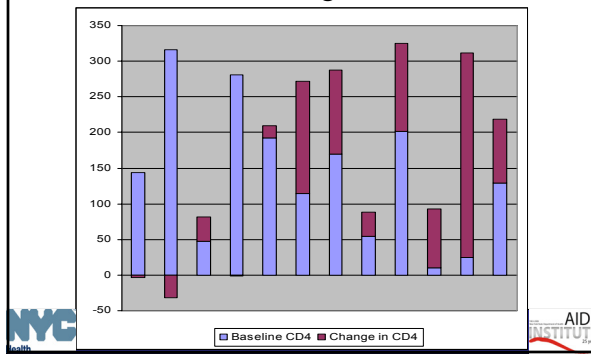
- Portfolio competed in 1998 with unstructured model
- Slated for re-competition with much greater structure 2008
- Qualitative survey 2007 – limited instances of protocol driven care
- Performance review 2006 – 0% referral to care
- Challenge - planning change in the setting of contract uncertainty
- Solution - focus on data flow (EHRs, CCRs)



Sample Data – 3 month CD4 change



Sample Data – 6 month CD4 change



Future Challenges and Directions

- Apply the methodology to more providers
 - Add service categories
 - Organize geographically?
 - Reach more widely than funded organizations?
- Increase grantee technical assistance capacity
 - Program design and operations
 - Data management
 - Leverage existing systems
 - Build new ones
 - Reduce data cycle times



HIV Quality Learning Networks

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Quality Learning Network Model

- Group Learning – identifying early adopters and best practices
- Trainings and case studies focused on quality improvement, quality management program structure and performance measurement
- Quality coaching and support
- External performance measurement and capacity building for tracking performance
- Information sharing on state of the art and emerging issues impacting on service delivery



Quality Learning Network Framework

- Quality of Care Performance Data and Data Driven QI Projects
- Specific HIV Quality Management Program
- Peer Learning
- Targeted Coaching and Support

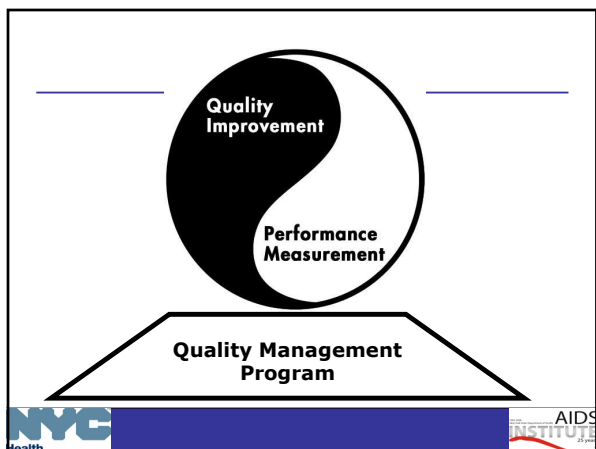


Quality of Care Performance Data and Data Driven QI Projects

- Identify common issues through performance data
- Measure tests of change
- Monitor changes in performance scores

Quality Management Program

- HIV-specific quality infrastructure supportive of performance measurement and quality activities
- Inclusion of HIV specific quality improvement in overall organizations goals for quality



Peer Learning

- Exchange of ideas through Quality Learning Network activities –half or full day meetings, provider presentations, website, conference calls and next steps mailings
- Sharing of successful strategies and best practices
- Dissemination of innovation



Targeted Coaching and Support

- Assist providers as needed in identifying quality infrastructure needs and developing action plans
- Provide guidance as needed in developing specific quality improvement projects and in selecting and testing changes
- Support and sustain quality efforts



Core Components

- Provider group with shared interests/structure/services, etc.
- Network director(s)
- Inclusion of program staff from state and city
- Planning group and faculty
- Annual schedule of meetings/conference calls/other communications



Core Components

- Performance measurement data
- Current performance measurement indicators
- Curriculum/workplan that includes Quality Learning Network framework elements
- Coordination resources and processes



Typical Quality Learning Network Meeting

- Focus on three main areas: performance measurement, quality management program development, and quality improvement activities
- Sharing of best practices and/or report backs by early adopters
- Group and organization specific goal-setting



Successes

- Regular meetings and conference calls foster enthusiasm and "group identity"
- Each Network has a core group that maintains stability
- Ability to engage providers on quality topics, such as retention, coordination of care, improving client assessments, linking clients to primary care
- Cross Network sharing and communication



Challenges

- Management of large groups and mix of providers
- Provider infrastructure issues
- Keeping momentum
- Engaging clinicians
- Sustainability issues
- Shifting focus from “mandated” data collection to data utilization for quality
- Building leadership buy-in and competency



Addressing Public Health Issues in a QM Program

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State/City Health Department Collaboration

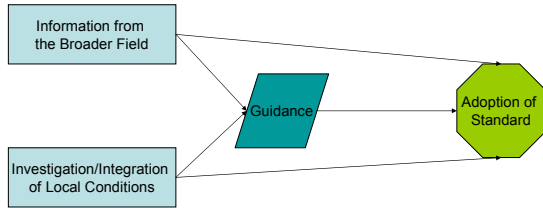
Address public health issues in context of quality:

- Adherence barriers
- Health literacy
- Access to care
- Retaining patients in care
- Care coordination
- Accountability/service documentation



Collaborative Model for Addressing Public Health Issues

Various (incl. key informants, experts) NYC, WC & NYS DOH Network Providers



Case Study 1: Case Management

2007-08 emphasis on coordination of care:

- Refinement of performance indicators
- Presentation of care coordination models, summary of care coordination literature
- Feedback from qualitative study of funded providers (models of case mgmt. in EMA)
- Communication of developing EMA priorities/initiatives, integration of services
- Bringing it home

Ex: Related Indicators

Coordination of services (every 120 days)

- Coordination of services is documented on a trimester basis in the client's record.
- Coordination of services should be related to the need areas noted in client's service plan.
- Coordination of services entails communication between the case manager and any medical, supportive service, or other provider necessary to address client needs and goals.

Ex.: Related Indicators (ctd.)

Access to Primary Care:

- Clients should have one visit with their primary care provider *at least* every six months.
 - For those who don't, there should be documentation of referral to primary care.
 - For those with a referral, there should be documentation of follow up within 30 days.
 - For those with documented follow-up, there should be documentation that the client kept the appt.



Ex.: Related Indicators (ctd.)

Viral load and CD4 Counts

- Clients will have lab work completed (viral load and CD4 counts) *at least* once every six months.
 - For clients who do not, is there documentation of referral to primary care for these tests?
 - For clients with a referral to primary care, is there documentation of follow up within 30 days?
 - If documentation of follow up exists, is there documentation that the client received the viral load and/or CD4 tests?



Care Coordination Review

Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies

(Ellen Mooney's summary of AHRQ study + related HIV lit.)

- Care Coordination Definition
- Potential Frameworks
- Potential Measures
- Intervention Strategies
- Evidence Base in HIV Literature



Care Coordination Review (ctd.)

Conclusions from review (non-HIV-specific):

- Need agreement on definition of care coordination
- Coordination strategies are defined differently across reviews, making comparison difficult
- Frameworks from other disciplines (e.g., organizational theory) can inform care coordination efforts
- Evidence suggests that care coordination interventions can improve health outcomes (across chronic diseases)
- Through standardizing terminology, developing a framework and specifying outcomes and measures, the evidence base (particularly in HIV) could be expanded



Qualitative Study in EMA

Purpose: To describe current practices, gather info. on context of CM services, learn providers' perspectives on their programs, identify potential gaps in NYC Pt. A CM services, assess existing protocols

- Qualitative assessment of funded programs, focusing on intervention models and implementation
- Self-administered, open-ended questionnaire covered org. features, core services, client flow, and changes since startup
- Reviewed contract scopes, questionnaire responses, and any protocol-like documents provided



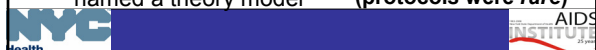
Qualitative Study in EMA (ctd.)

Findings

- Agencies are multi-service
- Providers aware of standards, guidance
- Client-centered services addressing barriers, strengths
- < 1/2 of programs named a theory model

Opaque Areas

- Means of coordination (e.g., few had electronic referral follow-up)
- Services conducted to ensure PC engagement
- How program models shape program activities
- What guidance case managers have for how to perform their jobs (**protocols were rare**)



Preparation for the Newer Model

- Westchester County DOH RW Program presented 2008 integrated model of Medical Case Management
- NYC DOHMH HIV Care, Treatment & Housing Program presented NYC's proposal for integration, accountability, coordination, and elimination of duplicative effort:
 - Comprehensive City-wide system ensuring access to varied services
 - Close relationship between medical providers and case management providers
 - Key support services accessible through one provider team, one case manager



Bringing it Home to the Network

Assessing Capacity & Drawing on What's Working

- Conducted surveys with network providers regarding:
 - current partnerships with PCPs (which ones) and coordination with those partners (level of success, method of coordination)
 - use of any electronic client records and potential for record-sharing with partners (what kind, how, shared with whom)
- Network provider presented on shared use of electronic client records within a healthcare system
- Next meeting: panel presentation by a multi-agency Brooklyn collaboration, on their model of coordination



Outcomes Within Reach

- Consistency within the EMA (NYC, TC) on service model (Medical Case Management)
- Creation of appropriate RFP guidance/protocols
- Targeting of TA to providers (need-based)
- Consistency of performance indicators with new service model
- Leveling of the playing field among providers
 - through increased care coord'n awareness, capacity
- Improved care coordination for PLWHA in EMA



Case Study 2: Tx Adherence

2007-08 emphasis on health literacy:

- Surveying and distributing the literature
- Inviting expert speakers
- Presentation of assessment tools
 - Regrouping (skepticism about available tools)
- Bringing it home
 - Surveying providers, presenting results
 - Reviewing tools and modules used in network



Surveying the Literature (ex.)

Article Type	Title	Cit.	Pop.	Study Design	Setting	Measures	Prev. of Lit. Levels	Results	Comments
Health Literacy and HIV Adherence	Health literacy: an overlooked factor in understanding HIV health disparities.	Osborn, C.Y., et al., 2007	N=204 patients infected with HIV were recruited from two clinics. Predominantly African-American	Clinic-recruited convenience sample	University hospital clinic, Midwest (large inner-city) & Southern (rural) US	REALM (literacy) & Patient Medication Adherence Questionnaire (adherence)	~1/3 had either low or marginal literacy skills (11.3% were reading at a 6th-grade level, and 20.1% were reading at a 7th to 8th-grade level).	When literacy is included in model, the effects of race diminish to nonsignificance. Literacy remains a significant independent predictor of nonadherence.	Having a less complex medication regimen was associated with a higher odds of adherence.

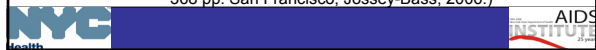


Expert Speakers

C. Zarcadoolas on *Domains of Health Literacy and Health Literacy Load Analysis: What does the material/message assume/require of the patient?*

- Fundamental literacy
- Science literacy
- Civic literacy
- Cultural literacy

(Zarcadoolas, Pleasant & Greer. *Advancing Health Literacy: A Framework for Understanding and Action*. 368 pp. San Francisco, Jossey-Bass, 2006.)



Presenting Results (ex.)

Q.1 Responses: Different Views on How to Assess

- Ask patients questions directly
- Use standardized instrument (e.g., REALM or Newest Vital Sign)
- Keep the instrument short (even 3-5 Qs)
- Client's own words
- Collect indirectly, via provider/chart
- Ensure assessment is related to patient's health care needs
- Ask NO additional questions
- Checkboxes



Collecting & Adapting Tools

- Online survey to ask about actual health literacy-related assessments and interventions already in use at participating programs
- Request for copies of health lit. or adherence data collection and communication tools
- Recommendations: types of questions providers can answer at the end of an adherence assessment, regimen review or education session (to integrate with other program work)



Outcomes Within Reach

- Network achievement of performance target
- Spread of process, recommendations to other learning networks (progress across categories)
- Improved ability of providers to target materials, communications to clients, which may promote:
 - improved health literacy (product of interaction)
 - improved adherence self-efficacy and/or adherence
- Opportunity to measure these changes over time, and (if successful) promote standards for assessment and intervention



Discussion/ Q. & A.



1983-2008
New York State Department of Health

AIDS
INSTITUTE
25 years