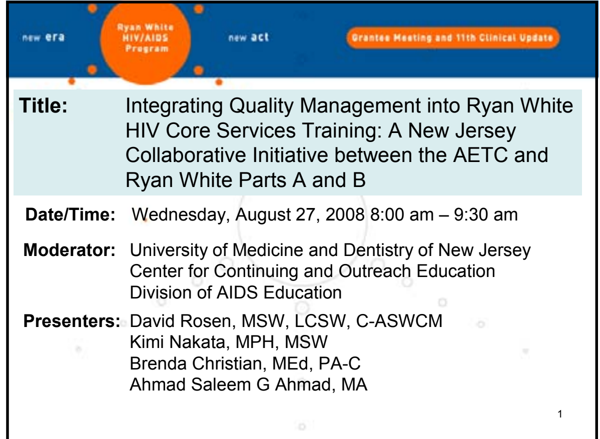
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Title: Integrating Quality Management into Ryan White HIV Core Services Training: A New Jersey Collaborative Initiative between the AETC and Ryan White Parts A and B
Date/Time: Wednesday, August 27, 2008 8:00 am – 9:30 am
Moderator: University of Medicine and Dentistry of New Jersey
Center for Continuing and Outreach Education
Division of AIDS Education
Presenters: David Rosen, MSW, LCSW, C-ASWCM
Kimi Nakata, MPH, MSW
Brenda Christian, MEd, PA-C
Ahmad Saleem G Ahmad, MA
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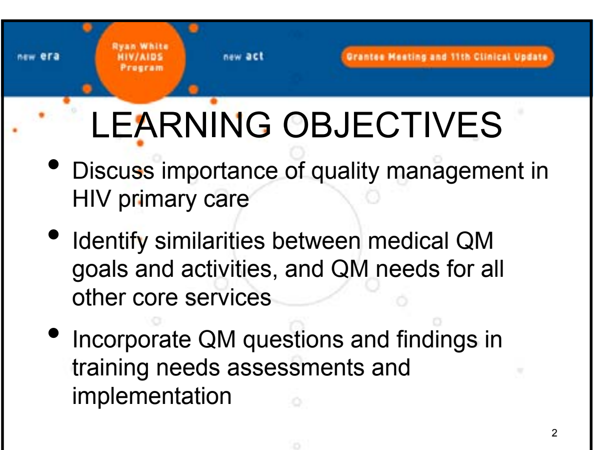
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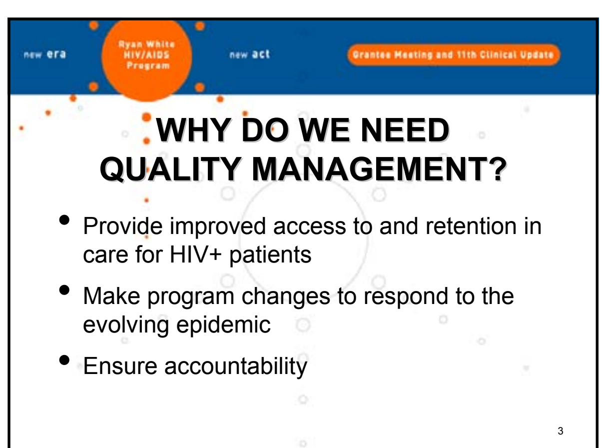
LEARNING OBJECTIVES
• Discuss importance of quality management in HIV primary care
• Identify similarities between medical QM goals and activities, and QM needs for all other core services
• Incorporate QM questions and findings in training needs assessments and implementation
2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WHY DO WE NEED QUALITY MANAGEMENT?
• Provide improved access to and retention in care for HIV+ patients
• Make program changes to respond to the evolving epidemic
• Ensure accountability
3

Ryan White HIV/AIDS Treatment Modernization Act 0f 2006

"The chief elected official/ grantee… *shall provide for the establishment of a* ***clinical*** *quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services"*

4

Ryan White HIV/AIDS Treatment Modernization Act 0f 2006

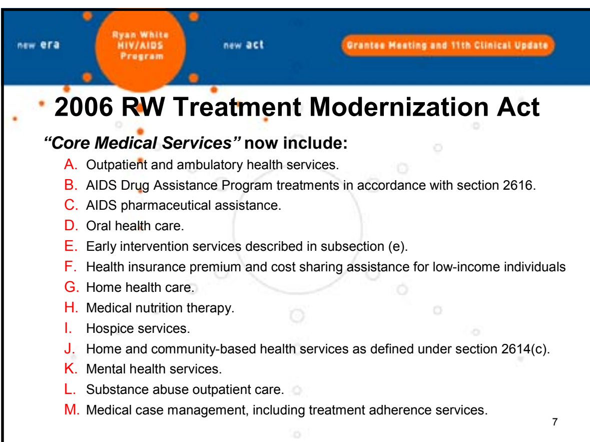
- "RWCA grantees are directed to establish **clinical** quality management programs to …"
  - "assess the extent to which HIV health services are consistent with the most recent Public Health Service (PHS) guidelines…"
  - "develop strategies for ensuring that such services are consistent with the guidelines for improvement in access to and quality of HIV health services"

5

What do we measure?

- **QUALITY**
  - Accessibility
  - Appropriateness
  - Continuity
  - Effectiveness
  - Efficacy
  - Efficiency
  - Patient Satisfaction
  - Safety of environment
  - Timeliness of care
  - Demographic characteristics

6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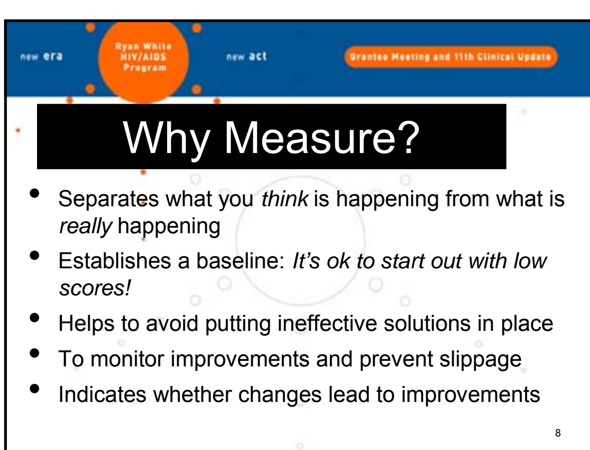
2006 RW Treatment Modernization Act
"Core Medical Services" now include:
A. Outpatient and ambulatory health services.
B. AIDS Drug Assistance Program treatments in accordance with section 2616.
C. AIDS pharmaceutical assistance.
D. Oral health care.
E. Early intervention services described in subsection (e).
F. Health insurance premium and cost sharing assistance for low-income individuals
G. Home health care.
H. Medical nutrition therapy.
I. Hospice services.
J. Home and community-based health services as defined under section 2614(c).
K. Mental health services.
L. Substance abuse outpatient care.
M. Medical case management, including treatment adherence services.
7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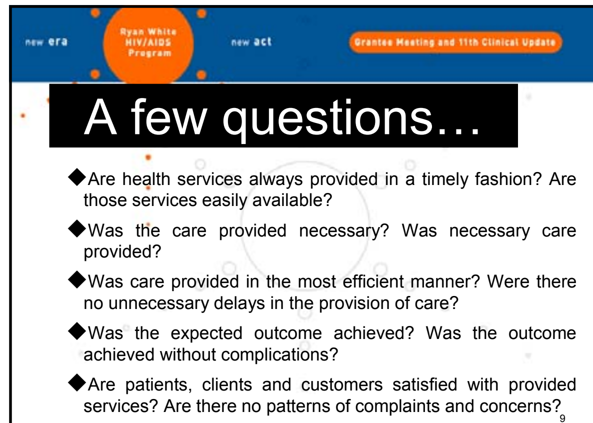
Why Measure?
Separates what you think is happening from what is really happening
Establishes a baseline: It's ok to start out with low scores!
Helps to avoid putting ineffective solutions in place
To monitor improvements and prevent slippage
Indicates whether changes lead to improvements
8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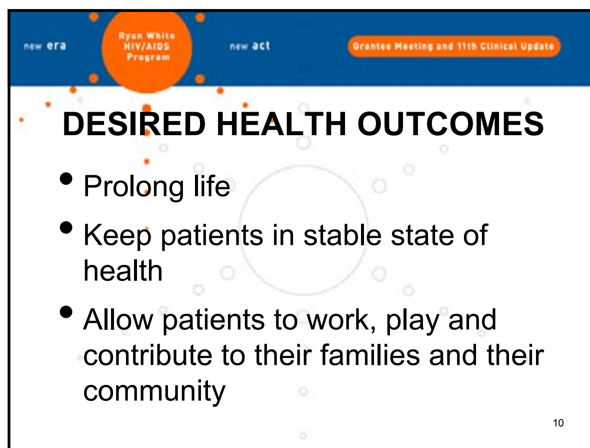
A few questions…
Are health services always provided in a timely fashion? Are those services easily available?
Was the care provided necessary? Was necessary care provided?
Was care provided in the most efficient manner? Were there no unnecessary delays in the provision of care?
Was the expected outcome achieved? Was the outcome achieved without complications?
Are patients, clients and customers satisfied with provided services? Are there no patterns of complaints and concerns?
9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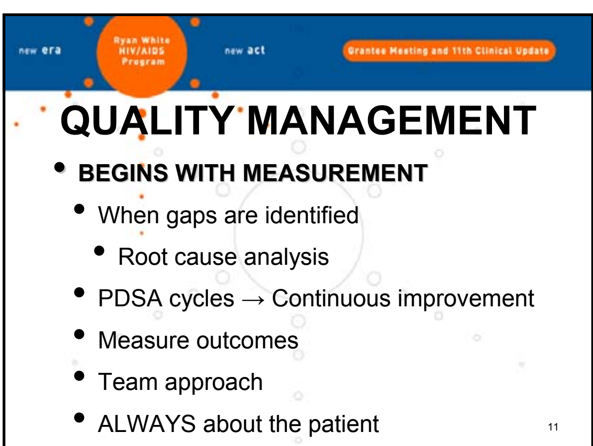
DESIRED HEALTH OUTCOMES
Prolong life
Keep patients in stable state of health
Allow patients to work, play and contribute to their families and their community
10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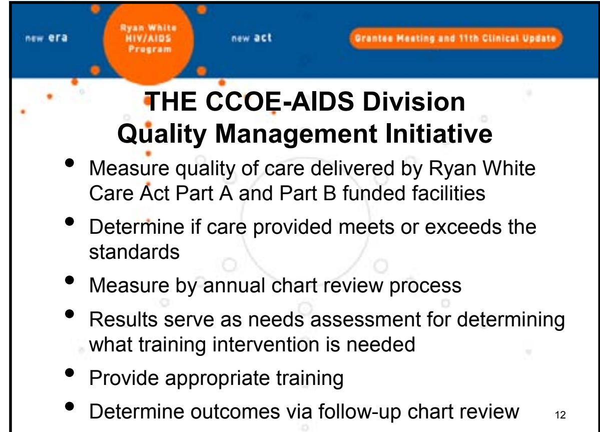
QUALITY MANAGEMENT
BEGINS WITH MEASUREMENT
When gaps are identified
Root cause analysis
PDSA cycles → Continuous improvement
Measure outcomes
Team approach
ALWAYS about the patient
11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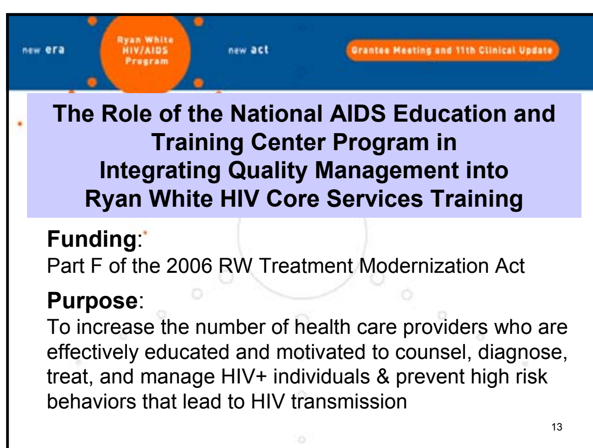
THE CCOE-AIDS Division
Quality Management Initiative
Measure quality of care delivered by Ryan White Care Act Part A and Part B funded facilities
Determine if care provided meets or exceeds the standards
Measure by annual chart review process
Results serve as needs assessment for determining what training intervention is needed
Provide appropriate training
Determine outcomes via follow-up chart review
12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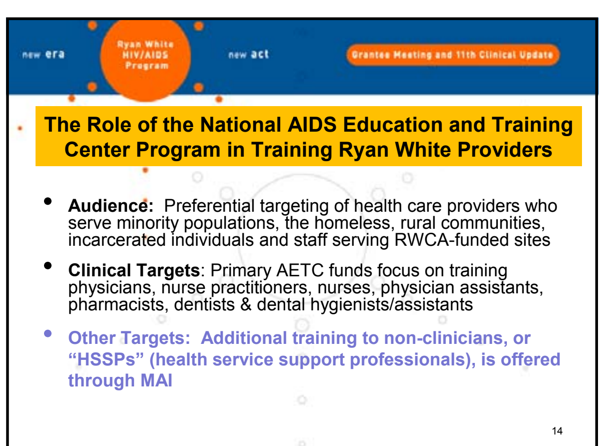
The Role of the National AIDS Education and Training Center Program in Integrating Quality Management into Ryan White HIV Core Services Training
Funding:
Part F of the 2006 RW Treatment Modernization Act
Purpose:
To increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat, and manage HIV+ individuals & prevent high risk behaviors that lead to HIV transmission
13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The Role of the National AIDS Education and Training Center Program in Training Ryan White Providers
Audience: Preferential targeting of health care providers who serve minority populations, the homeless, rural communities, incarcerated individuals and staff serving RWCA-funded sites
Clinical Targets: Primary AETC funds focus on training physicians, nurse practitioners, nurses, physician assistants, pharmacists, dentists & dental hygienists/assistants
Other Targets: Additional training to non-clinicians, or "HSSPs" (health service support professionals), is offered through MAI
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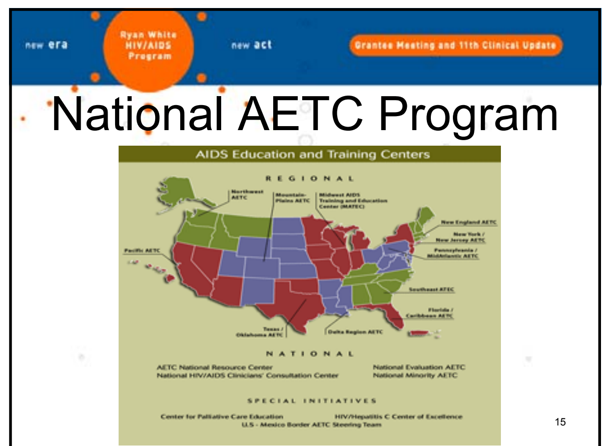
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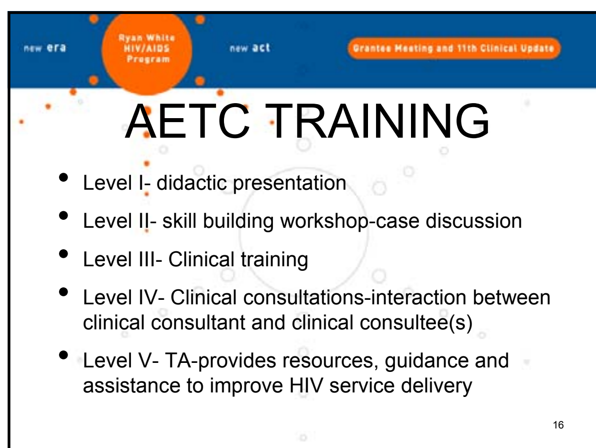
National AETC Program
AIDS Education and Training Centers
REGIONAL
Northwest AETC
Mountain-Plains AETC
Midwest AIDS Training and Education Center (MATEC)
New England AETC
New York / New Jersey AETC
Pacific AETC
Pennsylvania / MidAtlantic AETC
Southeast AETC
Florida / Caribbean AETC
Texas / Oklahoma AETC
Delta Region AETC
NATIONAL
AETC National Resource Center
National HIV/AIDS Clinicians' Consultation Center
National Evaluation AETC
National Minority AETC
SPECIAL INITIATIVES
Center for Palliative Care Education
HIV/Hepatitis C Center of Excellence
U.S - Mexico Border AETC Steering Team
15



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Why the AETC?

- AETCs maintain relationships with RW-funded HIV care facilities across multi-Part funded regions
- AETCs are responsible for assessing clinical training needs in their assigned regions
- AETCs can focus needs-based and targeted HSSP trainings on standardizing knowledge, skills and activities across agencies within a set region

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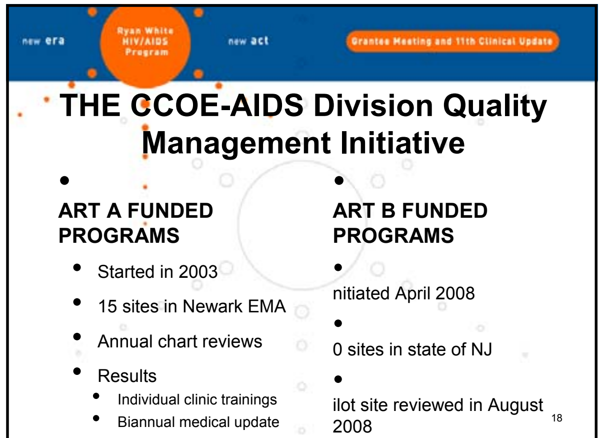

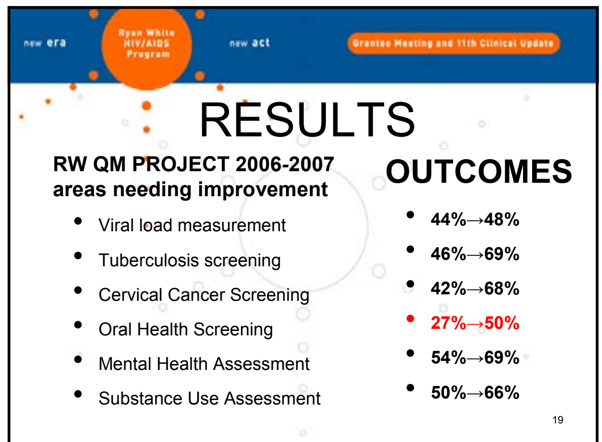
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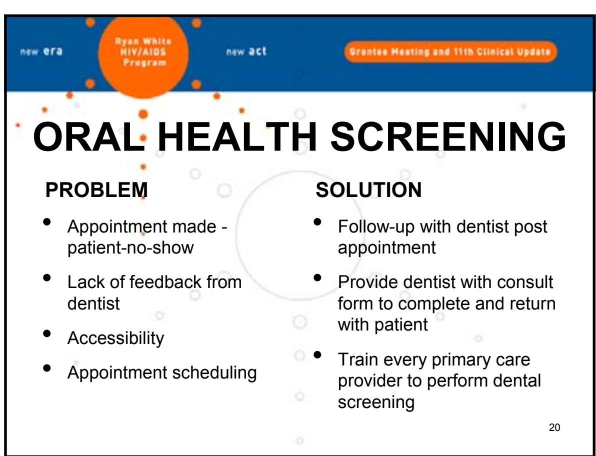
RESULTS
RW QM PROJECT 2006-2007
areas needing improvement
Viral load measurement
Tuberculosis screening
Cervical Cancer Screening
Oral Health Screening
Mental Health Assessment
Substance Use Assessment
OUTCOMES
44%→48%
46%→69%
42%→68%
27%→50%
54%→69%
50%→66%
19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ORAL HEALTH SCREENING
PROBLEM
Appointment made - patient-no-show
Lack of feedback from dentist
Accessibility
Appointment scheduling
SOLUTION
Follow-up with dentist post appointment
Provide dentist with consult form to complete and return with patient
Train every primary care provider to perform dental screening
20

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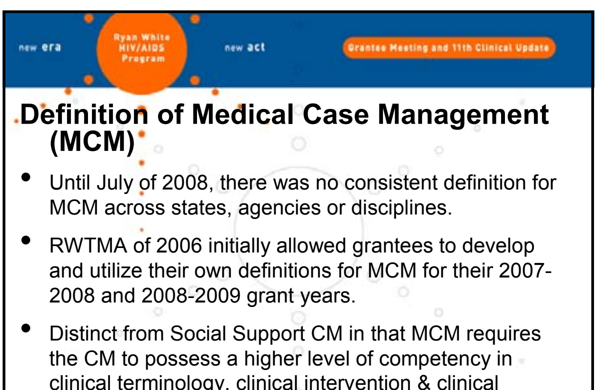
MEDICAL CASE MANAGEMENT



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In July of 2008, HRSA/HAB provided a <u>definition</u> for MCM within their 2009-2010 Part A guidance

Medical Case Management services (including tx adherence):

- are a range of client-centered services that link clients with health care, psychosocial, and other services.
- include the coordination and follow-up of medical treatments
- ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- provide on-going assessment of the client's and other key family members' needs ands personal support systems.
- include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments.
- include client-specific advocacy and/or review of utilization of services

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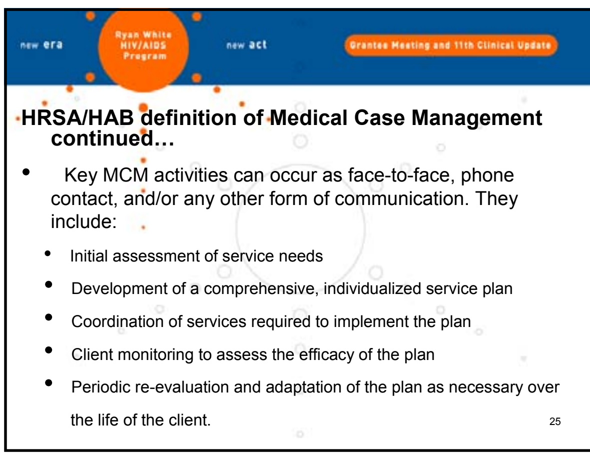
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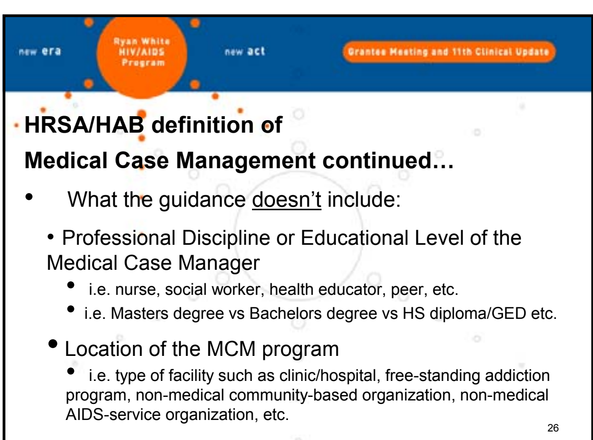
HRSA/HAB definition of Medical Case Management continued…
• Key MCM activities can occur as face-to-face, phone contact, and/or any other form of communication. They include:
• Initial assessment of service needs
• Development of a comprehensive, individualized service plan
• Coordination of services required to implement the plan
• Client monitoring to assess the efficacy of the plan
• Periodic re-evaluation and adaptation of the plan as necessary over the life of the client.
25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HRSA/HAB definition of
Medical Case Management continued…
• What the guidance doesn't include:
• Professional Discipline or Educational Level of the Medical Case Manager
• i.e. nurse, social worker, health educator, peer, etc.
• i.e. Masters degree vs Bachelors degree vs HS diploma/GED etc.
• Location of the MCM program
• i.e. type of facility such as clinic/hospital, free-standing addiction program, non-medical community-based organization, non-medical AIDS-service organization, etc.
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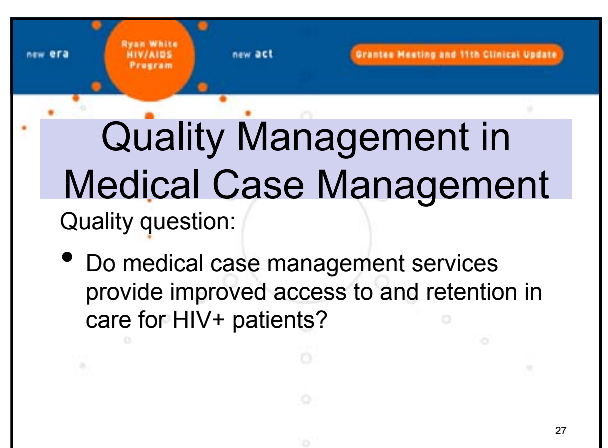
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Quality Management in Medical Case Management
Quality question:
• Do medical case management services provide improved access to and retention in care for HIV+ patients?
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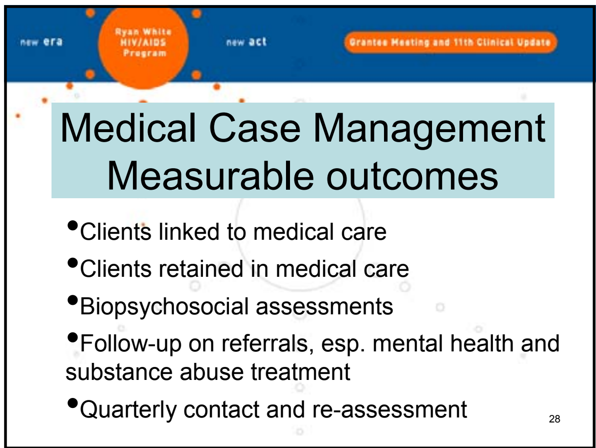
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Medical Case Management
Measurable outcomes
•Clients linked to medical care
•Clients retained in medical care
•Biopsychosocial assessments
•Follow-up on referrals, esp. mental health and substance abuse treatment
•Quarterly contact and re-assessment
28

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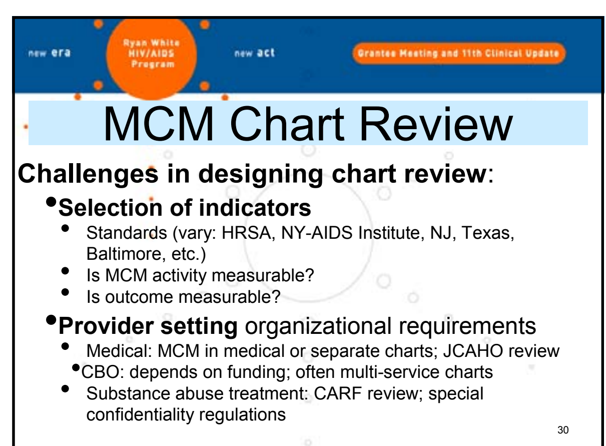
Measuring Case Management
Quality
•Chart review
•Service statistics
•Client surveys
•Which is most reliable?
•What does each measure?
29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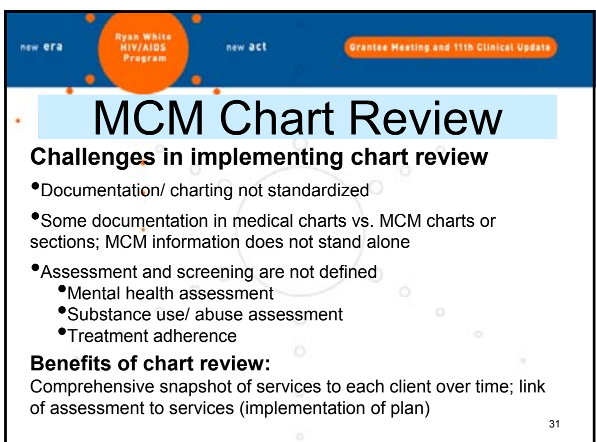
MCM Chart Review
Challenges in designing chart review:
•Selection of indicators
• Standards (vary: HRSA, NY-AIDS Institute, NJ, Texas, Baltimore, etc.)
• Is MCM activity measurable?
• Is outcome measurable?
•Provider setting organizational requirements
• Medical: MCM in medical or separate charts; JCAHO review
•CBO: depends on funding; often multi-service charts
• Substance abuse treatment: CARF review; special confidentiality regulations
30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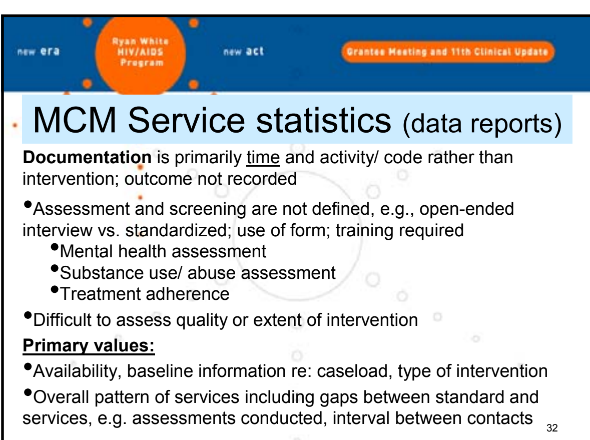
MCM Chart Review
Challenges in implementing chart review
•Documentation/ charting not standardized
•Some documentation in medical charts vs. MCM charts or sections; MCM information does not stand alone
•Assessment and screening are not defined
•Mental health assessment
•Substance use/ abuse assessment
•Treatment adherence
Benefits of chart review:
Comprehensive snapshot of services to each client over time; link of assessment to services (implementation of plan)
31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MCM Service statistics (data reports)
Documentation is primarily time and activity/ code rather than intervention; outcome not recorded
•Assessment and screening are not defined, e.g., open-ended interview vs. standardized; use of form; training required
•Mental health assessment
•Substance use/ abuse assessment
•Treatment adherence
•Difficult to assess quality or extent of intervention
Primary values:
•Availability, baseline information re: caseload, type of intervention
•Overall pattern of services including gaps between standard and services, e.g. assessments conducted, interval between contacts
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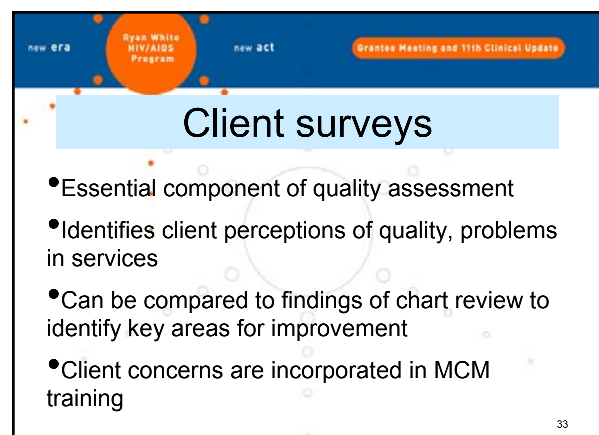
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Client surveys
•Essential component of quality assessment
•Identifies client perceptions of quality, problems in services
•Can be compared to findings of chart review to identify key areas for improvement
•Client concerns are incorporated in MCM training
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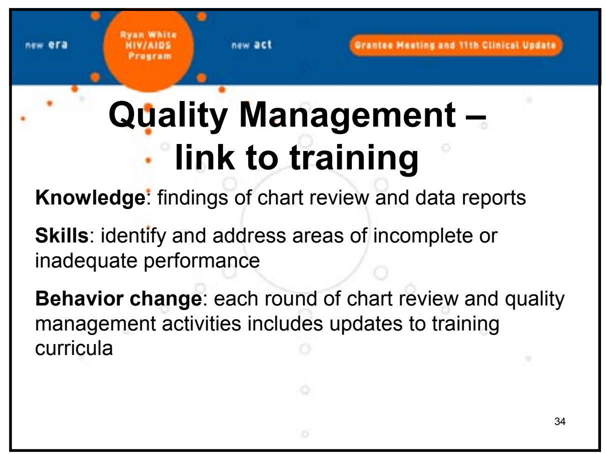
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Quality Management – link to training
Knowledge: findings of chart review and data reports
Skills: identify and address areas of incomplete or inadequate performance
Behavior change: each round of chart review and quality management activities includes updates to training curricula
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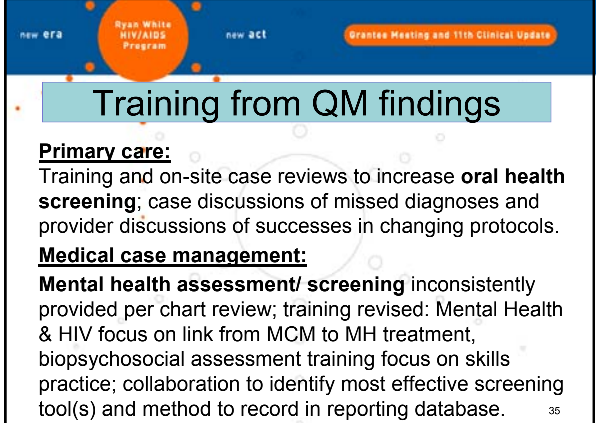
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Training from QM findings
Primary care:
Training and on-site case reviews to increase **oral health screening**; case discussions of missed diagnoses and provider discussions of successes in changing protocols.
Medical case management:
Mental health assessment/ screening inconsistently provided per chart review; training revised: Mental Health & HIV focus on link from MCM to MH treatment, biopsychosocial assessment training focus on skills practice; collaboration to identify most effective screening tool(s) and method to record in reporting database.
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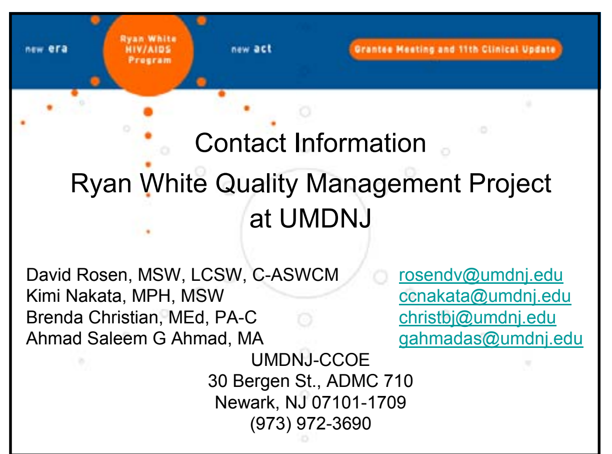
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