



NATIONAL QUALITY CENTER *Improving HIV Care.*

### Quality Institute Session 3

## Using Data for Quality Improvement: *I Have My Performance Data, What's Next?*

Aug 26, 2008

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NQC Consultant  
Panel: Sarah A Kerr, Dan O'Shea

DOH STATE OF NEW YORK  
DEPARTMENT OF HEALTH

Funded by HRSA  
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### Learning Objectives:

- Provide a basic foundation and understanding of how to measure the quality of HIV care and services.
- Identify data sources to be used for quality improvement and analyze data points and data trends to identify key findings.
- Help grantees to foster the link between performance measurement and quality improvement activities, demonstrating how to take action beyond data collection.
- Share best practices from Part A, B, & C grantees on how to measure the quality of HIV care and how to link performance data to quality improvement activities.

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### What's wrong with this picture?



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## Lessons Learned

- There is too much data...
- Don't get distracted from all the noise – focus on the core findings
- Set priorities – you can not do everything!
- Communicate clearly – tell folks what is important!

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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!')
- Ongoing / periodic monitoring identifies problems as they emerge
- Determines whether changes lead to improvements
- Avoids slippage
- Allows for comparing performance across sites

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## Why Measure?

And....

- Linking performance Data to Quality Improvement Activities
  - "Performance measurement alone is not quality improvement. However, to do quality improvement, you need performance measurement!"

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## Information Into Action



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## Stages of Coping with Data

- Stage I: "The data are wrong..."
- Stage II: "The data are right, but it's not a problem..."
- Stage III: "The data are right, it's a problem, but it's not *my* problem..."
- Stage IV: "The data are right, it's a problem, it's *my* problem..."

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## Barriers To Putting Data Into Action

- Don't even know where to get data/info
- Paralysis by analysis
- No one is interested in it
- Defensiveness
- Too complex to understand
- Incorrect interpretation of data

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## 4 Steps

- **Data Gathering** – Where are the data?
- **Data Analysis** – What are the data telling us?
- **Data Sharing** – How can I best share the results with stakeholders?
- **Data Follow-up** – What should I do in response to the results?

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## Data Gathering

- **Where can I find the data?**

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## Data Sources

- **Where do the data come from?**
  - How much service or resources did we deliver?
  - What is our baseline?
  - Do we have historic data?



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## Data Source Suggestions

- HIVQUAL data
- RDR reports
- CAREWare
- ADAP Database
- HIV/AIDS Reporting System (HARS)
- Vital Statistics (mortality)
- Medicaid
- Surveillance Practice Management Systems/EMR
- Facility-wide utilization data
- Patient satisfaction surveys
- Unmet needs assessments

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## Data Analysis

- **What are your key results?**
- **What are your major findings based on generated data reports and your data analyses?**

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## Analyze Data\*

- Analyze data and review the results
- Identify areas where additional data are required
- If historical data are available, compare for trends
- Display and distribute data to communicate findings and results
- Identify areas for improvement and select a quality improvement project

\*Step 4 in HAB's Quality Management Technical Assistance Manual

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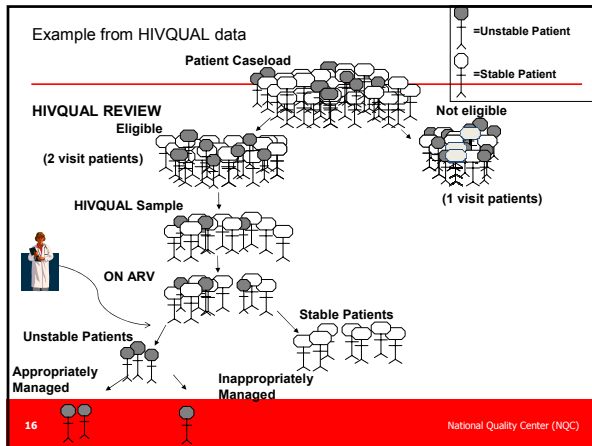
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## Common/Special Cause Variation

- **Common Cause Variation:**
  - Variability caused by unknown factors that result in a steady but random distribution of output around the average of the data.
  - Also called random variation, noise, noncontrollable variation, within-group variation, or inherent variation.
- **Special Cause Variation:**
  - Variability caused by a specific factor or known factors such as environmental conditions or process input parameters that result in a non-random distribution of output.
  - Also referred to as "exceptional" or "assignable" variation.

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## Run Chart

- **Definition**
  - A line graph of data plotted over time
- **Creating a Run Chart**
  - Time increments on the horizontal axis
  - Measurement increments, e.g., percentages on the left vertical axis
  - Marked point indicates the measurement or quantity observed at one point in time
  - Data points are connected to help display upward or downward trends in performance

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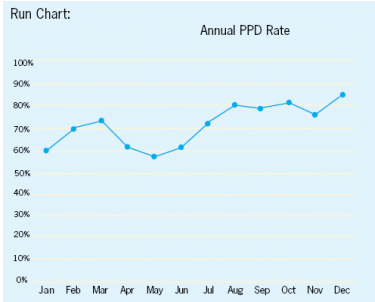
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## Run Chart



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## Control Chart

- **Definition**
  - A Control Chart is a run chart which control limits above and below the median/mean. Control limits are computed from the data to distinguish between variation in a process resulting from common causes and variation resulting from special causes.
- **Creating a Control Chart**
  - Create Run Chart
  - Calculate upper/lower control limits, plus or minus 3 standard deviations (3 sigma) of the centerline
  - Add the upper/lower control limits to the Run Chart

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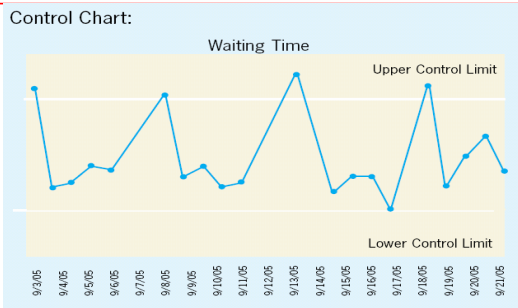
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## Control Chart



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## Histogram

- **Definition**
  - A Histogram is a frequency table in a tabular form to increase knowledge about a process.
- **Creating a HISTOGRAM**
  - Construct a frequency table based on available values
  - Sort the frequencies from highest to lowest
  - Display in a tabular form

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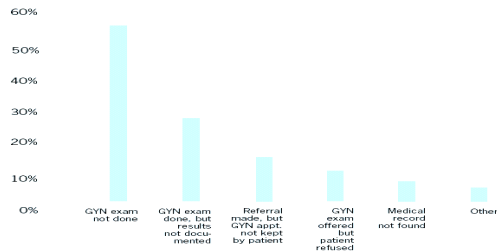
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## Histogram

Histogram:  
Reasons for No GYN Exam in Medical Record



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## Pareto Chart

- **Definition**
  - A simple bar chart which ranks related categories in decreasing order of occurrence, helping focus problem-solving efforts (80% of effects come from 20% of potential causes)
- **Creating a Pareto Chart**
  - Response categories on the horizontal axis in order of decreasing frequency
  - "Raw data", e.g., percentages are recorded on the left vertical axis
  - Each bar's height represents the frequency of the corresponding category
  - Line at top from left to right shows cumulative percentages

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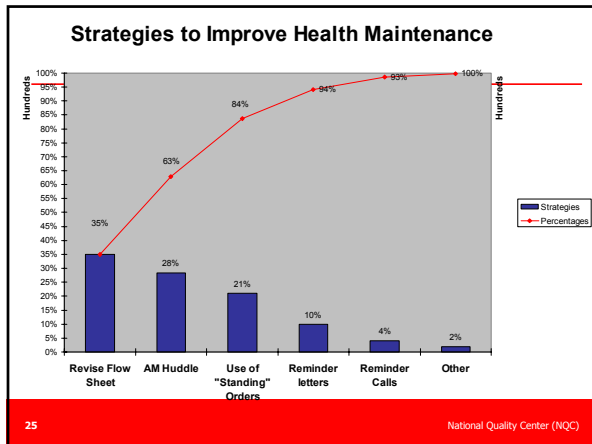
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### Analyze This Data

Indicator	Site A-06	Site A-07	Site B-06	Site B-07
PPD placed but not read	12.9%	5.4%	0%	10.9%
PPD not done	35.5%	21.6%	55.2%	47.8%
PPD Done	51.6%	73%	44.8%	41.3%

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### Answer the questions:

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- Which change from 06 to 07 is the most positive?
- Which change from 06 to 07 is the most negative?
- For which site would you make TB screening a priority for improvement?
- What other information would you like to know?

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## Data Sharing

- Did you discuss the data results and analysis with your QI committee?
- How did you share the data results with your staff and consumers (CAB, etc.)?
- How do you generate ownership among staff and consumers?

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## Formatting a Report\*



- Keep it simple - Don't crowd too much on a page...
- Include a summary of major points
- Avoid technical jargon & define unfamiliar terms
- Define each indicator
- Highlight point of interest on tables with bold type, circles, or arrows

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## Formatting a Report\*



- Use color to help highlight & distinguish key findings
- Label charts and tables clearly
- Identify source and date of the data presented and note limitations
- Provide comparisons over time and benchmarks

\* Using Outcome Information—Making Data Pay Off, The Urban Institute, p. xiv, 2004.

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## What's Wrong With This Report?

Specific Indicator	Site A 2006	Site A 2007	% Change 2007 Site A	Specific	Site B 2006	Site B 2007	% Change 2007 Site B
PPD Screening placed but not read	12.9%	5.40%	-7.55%	PPD Screening placed but not read	0.0%	10.90%	10.90%
PPD Screening not done	35.5%	21.60%	-13.90%	PPD Screening not done	55.2%	47.80%	-7.40%

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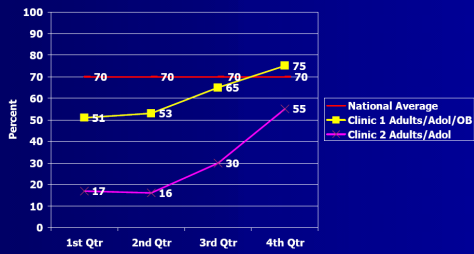
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## Pelvic Exam

Percentage of patients who had a pelvic exam within the last 12 months



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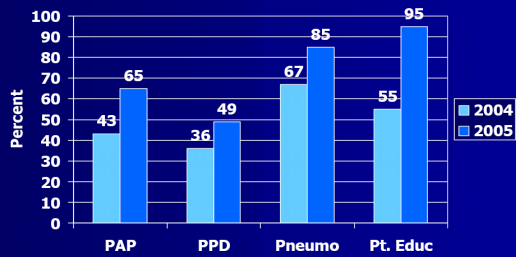
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## Clinic Performance 2004-2005



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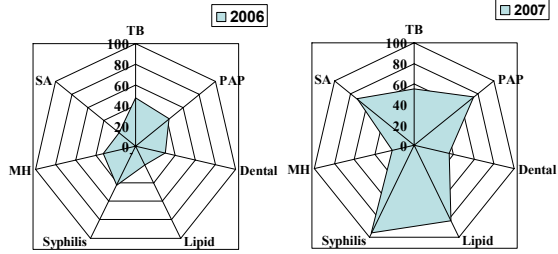
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## All HIV Indicators Combined



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## STORYBOARDS

- Construct the storyboard as a logical progression of 'boxed information'
- Lead the reader through the main points and steps of the improvement project
- Communicate with descriptive pictures and graphics more than words
- Use color and keep any text simple
- Following the HIV committee's review of the storyboard, post it in a visible location to share the team's results with consumers and staff



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## Data Display Tips

- Begin analyses with questions/hypotheses before 'digging' through data
- Plan data display with key stakeholders early in the process
- Limit the display to the points you need to make
- Format charts and graphs so that others can plug in data
- Show 100% as the upper range to avoid misrepresenting of data
- If possible, show benchmark data (internal/external)
- Publicize the results; post graphic displays in hallways and waiting rooms for staff/patients
- Compare outcomes to established targets/goals
- When appropriate, compare results grouped by demographics or other characteristics

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## Creating Data Ownership

- Share and discuss all data reports with QM Committee
- Share reports with staff at staff meetings or just send everyone the data reports
- Share data with sub-grantees and providers
- Share reports with consumers (display in waiting room, discussion at Consumer Advisory Committee, etc.)

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## Tips to Create Data Ownership

- Involve staff in setting the goals each year
- View Performance Improvement as a management tool
  - Do not use results for punishment
  - Include outcomes achieved when evaluating staff
- Share reports with staff promptly & listen to variance explanations
- Establish roles & responsibilities for staff to participate
- Watch out for defensiveness
- Watch out for paralysis by analysis

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## Data Follow-up

- What immediate changes will you make based on the key findings?
- Are you considering initiating a QI project to address the data findings? Who will be responsible and what are the next steps?

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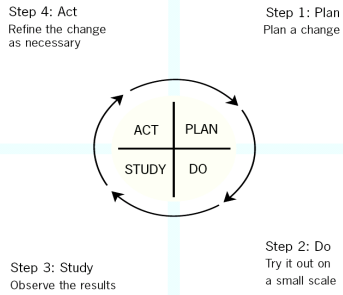
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## PDSA includes: DO and ACT!!



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## Options for Actions

- **‘Do nothing!’** – if scores are within expected ranges and goals, frequently repeat measurement
- **‘Take Immediate Individual Action’** – follow-up on individual pts (missed appointments, pts not on PCP prophylaxis, etc) and/or provider
- **‘Quick PDSA’** – develop a quick pilot test
- **‘Launch QI Project!’** – set up a cross-functional team to address identified aspects of HIV care

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## “How Are We Doing” Meetings\*

- **Who should participate?** - Include managers, clinicians, staff
- **When should the meetings be held?** - Soon after the latest data become available; Coordinate with data collection schedule
- **How should the data be used?** - Provide reports in advance; highlight successes & concerns
- **What if there are poor results?** - Establish priorities for further study
- **What if there are good results?** - Identify “successful practices”; Recognize staff contributing to successes
- **What are the next steps?** - Establish performance improvement teams to establish causes, brainstorm improvements & develop PDSA cycles

\*Adapted from the Urban Institute’s Series on Outcome Management for Nonprofit Organizations, pg. 14

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## Data Follow-up with Consumers

- Ask consumers about Next Steps
  - Engage Consumer Advisory Committee
  - Invite consumer (who is informed and supported) to join QM committee
  - Engage consumer in a QI team activity

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## AND NOW .....

- **Open Door Community Health Center**
  - Sarah Kerr, CQI Coordinator/Needle Exchange Program Director
- **County of San Diego - Public Health Services HIV, STD & Hepatitis Branch**
  - Daniel O'Shea  
Assistant Medical Services Administrator

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**Open Door Community Health Centers**

**HIV/AIDS Primary Care Program**

Ryan White Part B and C grantee

 STATE OF NEW YORK  
DEPARTMENT OF HEALTH

Funded by HRSA  
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### Open Door Community Health Centers

- Started as one storefront clinic in 1971
- Currently employs 330 staff
- 73 (50 FTE) providers (medical, dental and behavioral health)
- 40,000 patients
- 160,000 visits in 2007
- 165 active HIV patients in 2007
- Staff include:
  - 3 Providers (2 HIV Specialists)
  - 3 RN Medical Case Managers
  - Registered Dietitian
  - Mental Health providers
  - Dentists
  - Project Director
  - CQI Coordinator
  - HIV Screening Coordinator




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### Challenges in Using Data

- LOTS and LOTS and LOTS of data!
  - Allergies noted
  - Papers organized and attached
  - Forms are complete
  - Initial visit documentation complete
  - Pertinent history complete
  - Difficulties with analyzing data?
  - Problems sharing data?
  - Documentation each subsequent visit complete
  - Medication documentation complete
  - Record entries dated and signed
  - Record entries legible/black ink

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### Challenges in Using Data

- And that's not all.....
  - Patient offered Treatment (HAART)
  - Patient offered Opportunistic Infection Prophylaxis
  - CD4 T-Cell counts/Viral loads
  - Chemistry Profiles/Genotype testing
  - Hepatitis Serology A,B,C, performed at least once a year
  - Vaccinations
  - STD testing
  - TB testing
  - Pap smears
  - Patient Education/Risk Reduction

The list goes on and on and on.....

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## Challenges in Using Data

- How were we analyzing all this data?
  - Who's in the denominator?
    - Including EVERYONE was short-changing our program
  - Confusion about sample sizes
    - 10% is not enough to make generalizations
  - Exclusions to certain measures
    - Pap smears, TB testing, flu vaccine
  - What about services received by other providers?

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## Challenges in Using Data

- How were we sharing data?
  - Quarterly reports to HIV Reengineering Team
  - Project Director reported to Corporate QI Committee quarterly
  - Lack of meaningful data sharing with consumers
  - Tables of data
    - Difficult to compare across time

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## Challenges in Using Data

Quality Indicators	Total # of charts			% of charts	
	A	N	N/A	Appropriate	N/A
Allergies noted	32	0	0	100%	0
Forms are complete	30	0	0	100%	0
Pertinent history complete	15	1	16	94%	6%
Documentation each visit complete	32	0	0	100%	0
Medication documentation complete	31	1	0	97%	3%
Record entries dated and signed	30	1	1	97%	3%
Record entries legible/black ink	31	0	1	100%	0
Errors corrected properly	6	0	25	100%	0

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## Solutions tried

- It was time to prioritize
  - Chose annual goals based on data
  - Revamped our CQI Committee to include a variety of staff
  - Stepped up consumer involvement
  - Defined our indicators
  - Rethink methods of data sharing
- Annual data collection cycle (HIVQUAL)
  - Re-measure annual goals and improvement specific measures frequently

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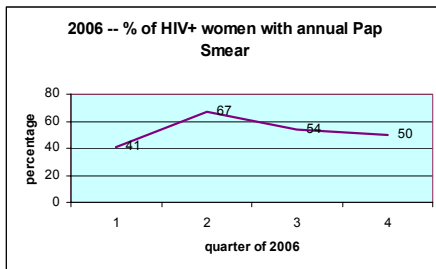
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## Sharing data

- Reorganized data...



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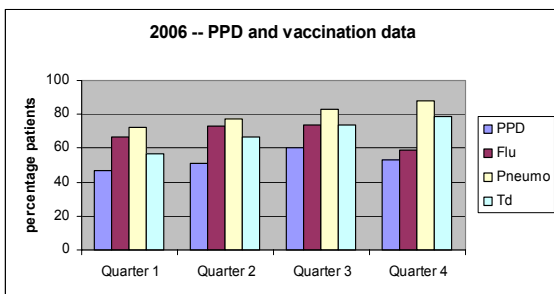
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## Sharing data



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## Improvement Project Example

- Develop and systematize the use of an annual Mental Health Screening Tool
  - Gathered examples of MH screening forms
  - Revised as a committee
    - Implemented use w/ one provider for 2 weeks
    - Discussed successes, failures, revised
    - Re-tested w/ one provider for 2 weeks
    - Expanded to all 3 provider for 4 weeks
    - Made final changes to form
  - Re-measure every quarter
  - Plan to revisit and analyze at close of year.

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## Improvement Project Example

- Increase the percentage of HIV+ patients receiving annual dental exams by 20%.
    - In 2006 26% of our HIV patients received a dental exam in the past year.
- Improvement strategies included:
- patient education via newsletter and workshops
  - refining the dental fast track system
  - asking dental director to join our HIV CQI Committee
- At the end of 2007 our data showed us that only **6%** of our HIV patients received a dental exam in the last year!
    - What happened?
  - Analyzed the data.... Compared billing info to appointment info
    - In reality over 40% of the HIV patients had an annual dental exam

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## Lessons learned

- Think big but start small.
- Find a CQI Champion, alter job descriptions.
- Validate your data.
- Make the data accessible.

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### San Diego County Public Health Services HIV, STD and Hepatitis Branch Ryan White Part A Grantee

Presented by  
Dan O'Shea  
Assistant Medical Services Administrator

DOH STATE OF NEW YORK  
DEPARTMENT OF HEALTH

Funded by HRSA  
HIV/AIDS Bureau

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### About the San Diego EMA

- 4,200 square miles (2<sup>nd</sup> largest California county)
  - City of San Diego, 17 other cities, large urban and rural areas
  - Borders Mexico – world's most active border crossing
- Est. population 2007: 3,098,269
  - 52% Caucasian, 5% AA, 29% Latino, 10% A/PI, 0.5% NA
- Est. PLWH/A 12/07: 17,310
  - 57% Caucasian, 13% AA, 27% Latino, 3% A/PI, 0.7% NA, 10% female
- AIDS incidence 1/06-12/07: 43% Caucasian, 14% AA, 39% Latino, 4% A/PI, 0.7% N/A, 11% female
- Est. PLWH/A who know status 7/06 (unmet need estimate): 15,086
  - Of these, estimated # **not using** HIV primary care in past 12 months: 5,579 (37%) (upper bound estimate)

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### San Diego EMA Ryan White HIV Primary Care Network

- UCSD teaching hospital and 6 nonprofit community health centers (part of safety net for indigent)
- 11 clinic sites geographically dispersed
  - Familiarity of each clinic with surrounding community fosters client trust and culturally appropriate service delivery
- Active HIV primary care caseload of ~2,200 PLWH/A
- 41% of Ryan White Part A/B service budget funds for medical and dental care
- 19% for medical case management, 11% for early intervention services, 8% for outpatient mental health and substance abuse treatment, 21% for support services

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## About SD HIV, STD and Hepatitis Branch

- HSHB Programs
- RW Part A/B QM Program (Plan, Staffing, Committees)
  - Standards of Care Committee; Evaluation Committee
    - Co-sponsored by Planning Council & Part A Grantee
  - SD Regional Quality Group participant (Parts A/B, C & D)
- Data Reviewed/Used:
  - Contractor process and outcome data
  - ARIES
  - Contractor QM plans
  - Client satisfaction processes
  - Core medical service chart reviews

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## Challenges in Collecting and Using Data

- 7 different clinic providers geographically dispersed
- Varying size and structure of clinic programs
- Each clinic has different data management systems; import into countywide electronic client level data collection system (ARIES) in process
- Charts sometimes disorganized; documentation not always clear, sometimes difficult to find and interpret
  - Most facilities have flow sheet but not all are well maintained
  - Form developed and approved by Standards of Care Committee used in only two programs
- Countywide v. individual clinic needs

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## Collecting Data: Primary Care Chart Review

- Client registration database - eligibility for inclusion:
  - Enrolled in the program consecutively from 10/05
  - Minimum one medical visit in the following 12 mos.
  - *Excluded:* entries without a home address
- Eligible list sorted by primary care clinic provider (7)
  - 10% of eligible enrollees, but no fewer than ten patients, selected as sample for each clinic
  - Percentage sampled by clinic ranged from 10% to 53%
- Resulting sample = 154 (12% of eligible clients)
  - Gender selection biased; reviewed 23% eligible females and 11% eligible males
  - Years in care: 1-2 (39%); 3-5 (29%); 6-10 (19%); >10 (6%)
  - Average annual visits = 5 (range of 4 to 8 per clinic program)
- Each record reviewed for all services provided 10/05-10/06:
  - Medical encounters, lab tests, medications, compliance, screening tests for STDs and TB, PAP smears for females, dental referrals

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## Primary Care Chart Review Summary of Findings March 07

- Overall improvement from previous review in both documentation and compliance with the standards of care
- **ARV therapy:** 91% of charts documented ARV discussed with patient
  - Documentation of compliance with medication in 73% of records
- **Frequency and outcome of T-cell and viral load:** On average, each patient received 3.3 T-cell tests and 3.2 viral load tests during 12-month period
- **Resistance testing:** 68% were exempt; 10% not eligible; 10% tested; and 12% of patients eligible for resistance testing not tested
- **Infectious disease screening:** 38% documented for minimum standard of 3 risk assessments; 29% were not screened
  - **STDs:** VDRL/RPR documented in 79%; 46% GC and Chlamydia screening
  - **TB testing:** 88% documented TB status; test results documented in 46%; 31% recorded as known positive; of those, 95% documented prophylactic treatment
  - **Pap test:** documented in 84% of 31 female charts reviewed
- **Dental referrals:** 20% documented referral/advice re: annual exam

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## Solutions Tried: Countywide data

- **Standards of Care Committee:**
  - Reviewed aggregate and anonymous data by clinic program for comparison
  - Clinicians had opportunity to review successes and challenges together and preview what they might expect in individual reports
- Identified overall/system-wide areas of strength:
  - Antiretroviral therapy discussed with patients, frequency and outcome of T-cell, viral load and pap tests
- Identified overall/system-wide areas for improvement:
  - Documentation of dental referrals and STD screening
  - Noted that charts were not screened to determine whether clients were in a monogamous relationship or not

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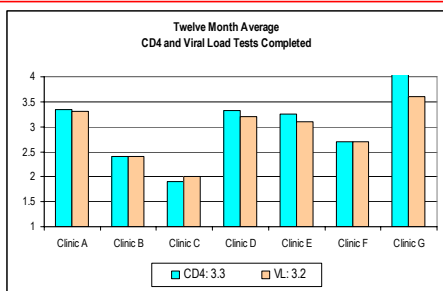
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## Example of Aggregate/Unspecified Clinic Data Frequency of T-Cell and Viral Load



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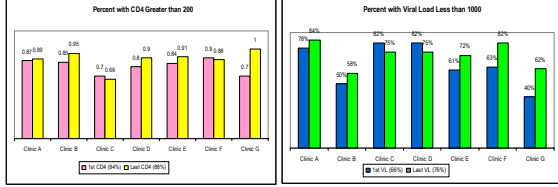
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### Example of Aggregate/Unspecified Clinic Data Outcome of T-Cell and Viral Load



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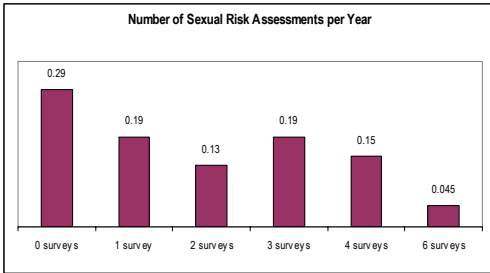
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### Infectious Disease Screening: Sexually Transmitted Diseases



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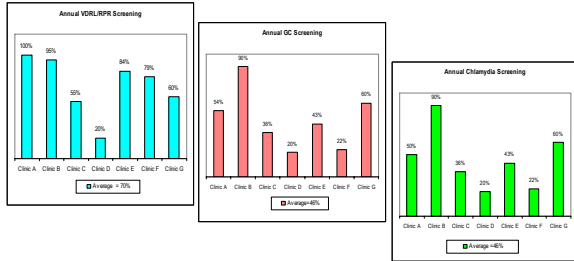
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### Infectious Disease Screening: Sexually Transmitted Diseases



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## Solutions Tried: Individual Program Data

- Each clinic provided individual program results:
  - Overview of process, enrollee demographics from clinic, results and observations
  - Compared clinic program results to average results for all clinics for major screening tests, and disease status indicators
  - Identified individual strengths and areas for improvement
  - Charged to use this data in program QM plan
- Physician members of the Standards of Care Committee implemented standards at their facilities
- Facilities that serve the majority of the HIV population show a commitment to broad based quality of care by their high scores with screening and outcomes
- Smaller clinics, many without SOCC representative, appear to be operate on periphery of quality care

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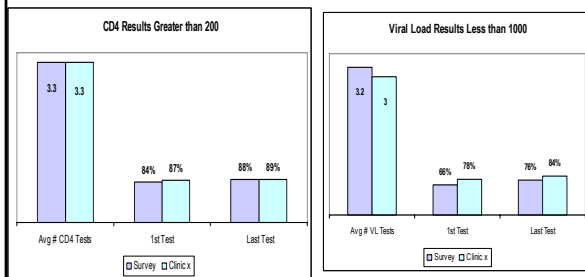
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## Example of Provider-Specific Data



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## Countywide Improvement Projects

- Conduct annual HIV primary care chart reviews
- Increase STD Screening:
  - New Sexual Risk Assessment Form fully implemented
  - Effectively communicate standards and emphasize importance for screening with all RW primary care providers
    - Syphilis epidemic linked to HIV: number of syphilis cases continuing to increase
  - Coordinate with the STD Control Officer to develop and implement a strategy to increase screening of high risk persons, including education and outreach to all community physicians who treat PLWH/A
  - Establish appropriate benchmarks to measure increased STD screening among RW providers
- Increase dental referrals:
  - Only 30% of enrollees receive dental prophylaxis
  - Create Dental Services Working Group of dental providers and consumers
- Improve communication:
  - Distribute Standards of Care Committee meeting minutes to all RW practitioners
  - Develop a semi-annual newsletter for providers and staff to inform them of program goals, operational changes, outcomes, and celebrations.

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## Lessons learned

- Involve medical providers (Standards of Care)
- Define specific terms for each indicator measured
- Countywide and mandated individual program QM plans = major influence on on-going improvement
- Teamwork:
  - Standards of Care Committee
  - Grantee
  - Planning Council
  - Providers
  - Consumers

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