HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

create equity collaborative

create+equity Collaborative:

Kick-Off Webinar

Project ECHO®
HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Mon, November 9, 2020
1:00 pm ET

NEW YORK STATE | Department of Health

HRSA Ryan White HIV/AIDS Program
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Before we start…

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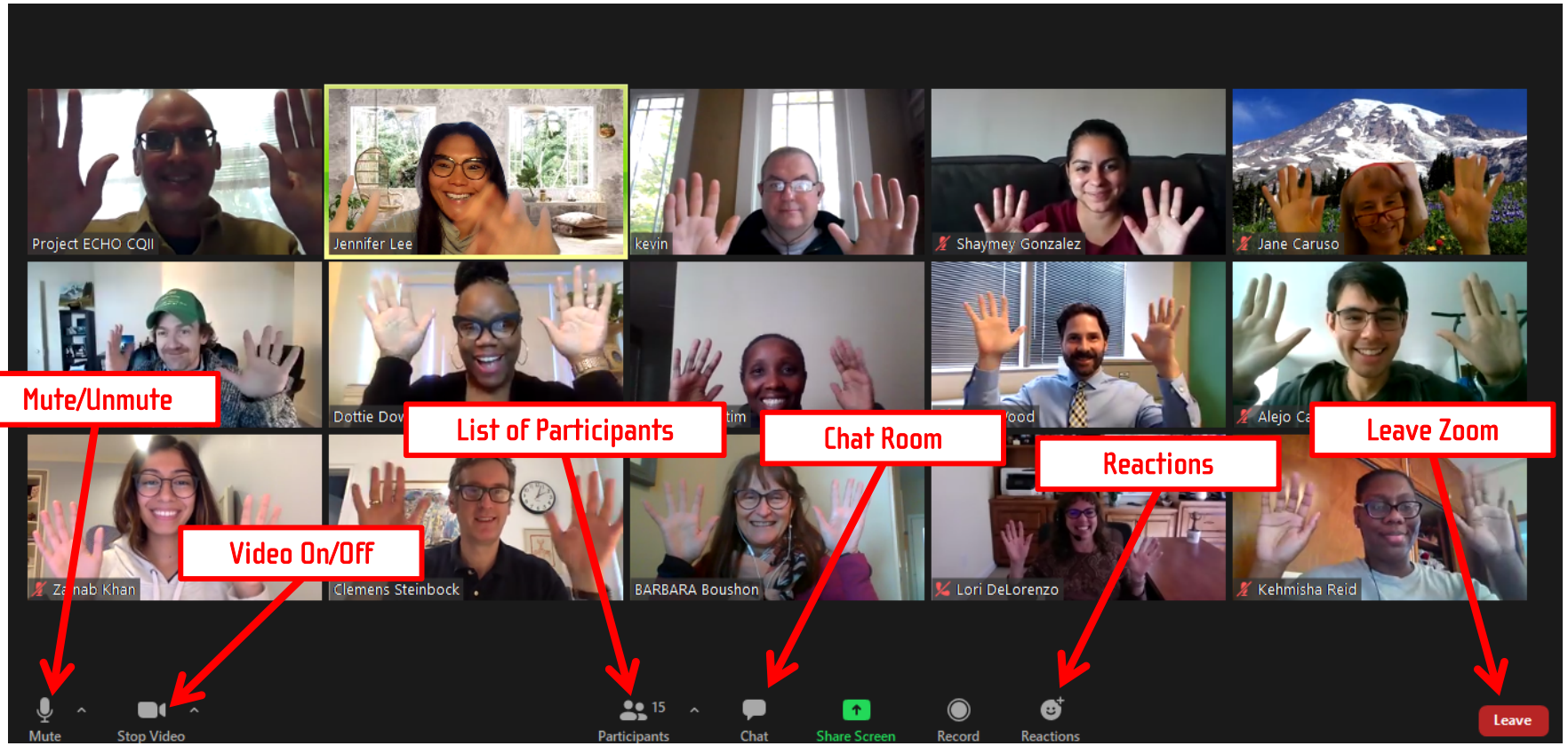
Zoom Introduction

Zoom Functionalities | "All teach, all learn, all improve"

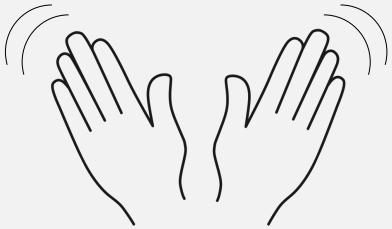
Use Your Camera | Use Our Signs | Mute/Unmute Your Line | Actively Participate



Our Zoom Hand Gestures

Applause

I enjoy and/or support what you are saying



Can't Hear You

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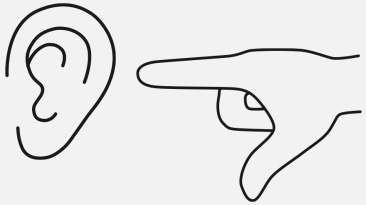
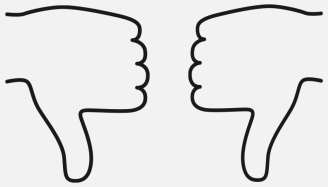


Want to Share

I have a question or want to speak next

Technical Problem

I need some technical support



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- Include name and location on Zoom label
- Keep video on and mute your line when needed
- Use our hand signals
- Use the chat room to ask for clarifications, post questions, or share your wisdom
- Eliminate personal/private health information
- Create a "brave space of learning" - don't assume or be silent
- We will record the Zoom sessions to allow others to learn

Please be reminded that we will record our session for later replay!

Opening Remarks

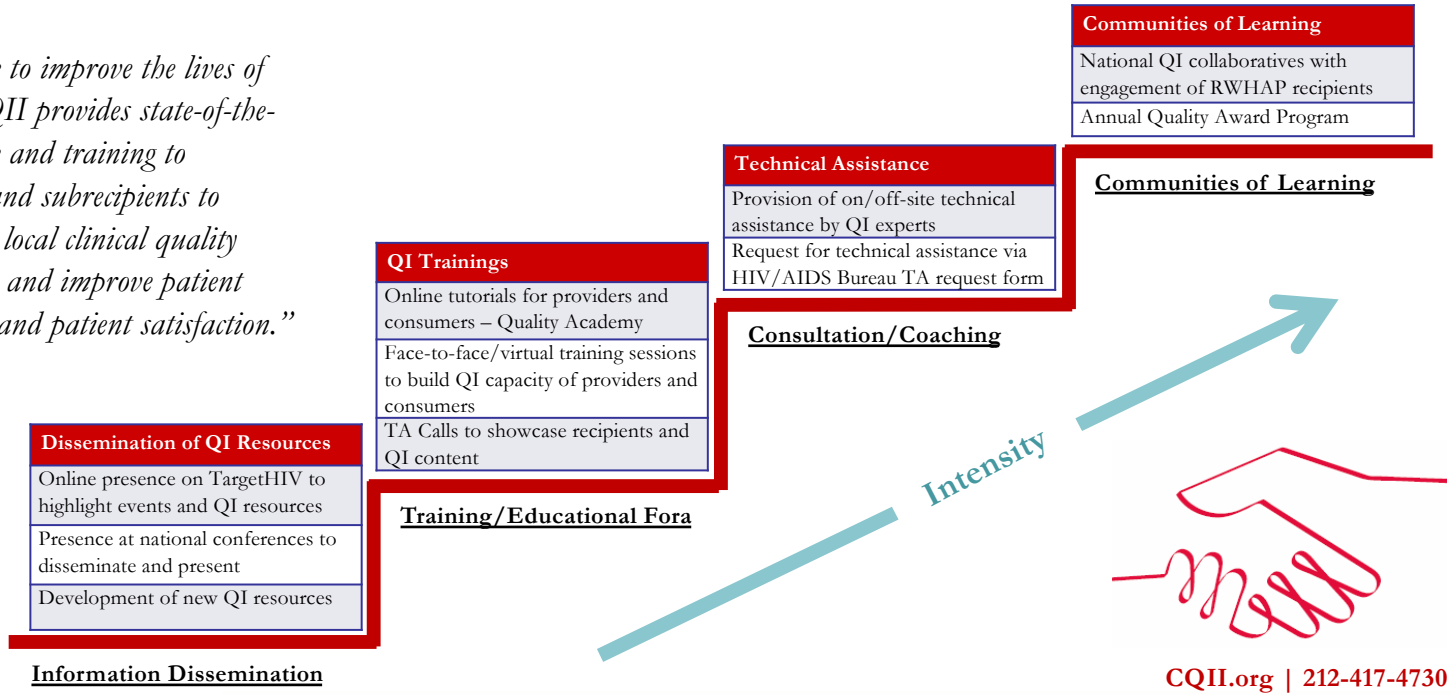
Laura W. Cheever, MD, ScM
HAB Associate Administrator

Agenda

- Welcome
- Opening Remarks by HRSA HIV/AIDS Bureau
- Overview of Literature Review (10min)
- Collaborative Overview, Framework, and Timeline (30min)
- Introduction to Tools & Resources (5min)
- Q&A Session (10min)

HRSA Ryan White HIV/AIDS Program
Center for Quality Improvement & Innovation (CQII)

"Together, we continue to improve the lives of people with HIV. CQII provides state-of-the-art technical assistance and training to RWHAP recipients and subrecipients to measurably strengthen local clinical quality management programs and improve patient care, health outcomes, and patient satisfaction."



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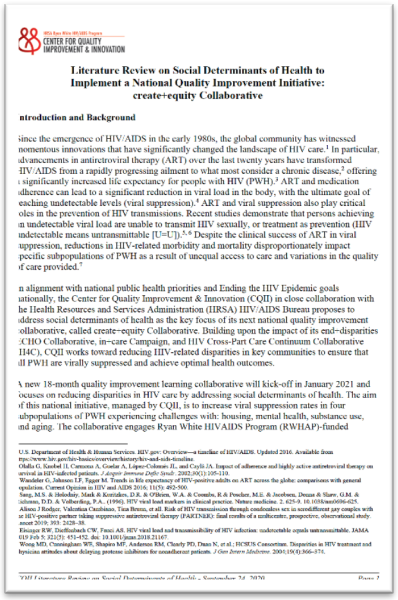
Creating equity will end the HIV epidemic.

create+equity Video

Literature Review – Key Findings

Literature Review

Literature Review



Literature Review on Social Determinants of Health to Implement a National Quality Improvement Initiative: create+equity Collaborative

ntroduction and Background

ince the emergence of HIV/AIDS in the early 1980s, the global community has witnessed nomentous innovations that have significantly changed the landscape of HIV care.[1] In particular, dvancements in antiretroviral therapy (ART) over the last twenty years have transformed HIV/AIDS from a rapidly progressing ailment to what most consider a chronic disease,[2] offering significantly increased life expectancy for people with HIV (PWH).[3] ART and medication dherence can lead to a significant reduction in viral load in the body, with the ultimate goal of eaching undetectable levels (viral suppression).[4] ART and viral suppression also play critical oles in the prevention of HIV transmissions. Recent studies demonstrate that persons achieving n undetectable viral load are unable to transmit HIV sexually, or treatment as prevention (HIV undetectable means untransmittable [U=U]).[5, 6] Despite the clinical success of ART in viral uppression, reductions in HIV-related morbidity and mortality disproportionately impact pecific subpopulations of PWH as a result of unequal access to care and variations in the quality f care provided.[7]

n alignment with national public health priorities and Ending the HIV Epidemic goals ationally, the Center for Quality Improvement & Innovation (CQII) in close collaboration with he Health Resources and Services Administration (HRSA) HIV/AIDS Bureau proposes to ddress social determinants of health as the key focus of its next national quality improvement ollaborative, called create+equity Collaborative. Building upon the impact of its end+disparities CHO Collaborative, in+care Campaign, and HIV Cross-Part Care Continuum Collaborative IHC), CQII works toward reducing HIV-related disparities in key communities to ensure that ll PWH are virally suppressed and achieve optimal health outcomes.

A new 18-month quality improvement learning collaborative will kick-off in January 2021 and ocuses on reducing disparities in HIV care by addressing social determinants of health. The aim f this national initiative, managed by CQII, is to increase viral suppression rates in four ubpopulations of PWH experiencing challenges with: housing, mental health, substance use, nd aging. The collaborative engages Ryan White HIV/AIDS Program (RWHAP)-funded

- A detailed Literature Review has been developed to make a case about the importance of addressing social determinants of health to end the HIV epidemic in the United States
- A corresponding PowerPoint slide set with information related to the four priority areas of the Collaborative is available

Link

What is a Social Determinant of Health?

"Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes."

– Centers for Disease Control (CDC)

CENTERS FOR DISEASE CONTROL AND PREVENTION

https://www.cdc.gov/socialdeterminants/index.htm

"I diagnosed 'abdominal pain' when the real problem was hunger.
I mislabeled the hopelessness of long-term unemployment as depression.
I misdiagnosed poverty that causes patients to miss pills or appointments as noncompliance.
I mistook the inability of one older patient to read for dementia."

- Dr. Laura Gottlieb, Professor and Author

Did You Know?

- **People with unstable housing** have a **16% lower** viral suppression rate compared to those with stable housing
- **People with mental illness** have a lower viral suppression rate, on average by **8.5%**
- **People who inject drugs** make up of **1 in 10** new HIV diagnoses
- **People ages 13 to 24** make up **21%** of new HIV diagnoses, while **people ages 50 and older** make up **17%** of new HIV diagnoses in the United States

Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports
https://www.cdc.gov/hiv/group/age/olderamericans/index.html
https://www.cdc.gov/hiv/group/hiv-idu.html
https://www.cdc.gov/hiv/group/age/youth/index.html

Disparities in Housing

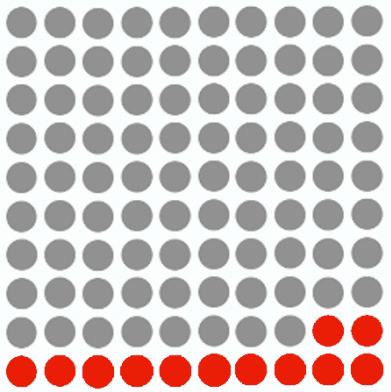
Housing

"It is hard to argue that housing is not a fundamental human need. Decent, affordable housing should be a basic right for everybody in this country. The reason is simple: without stable shelter, everything falls apart."

- Matthew Desmond, Sociologist and Author at Princeton University

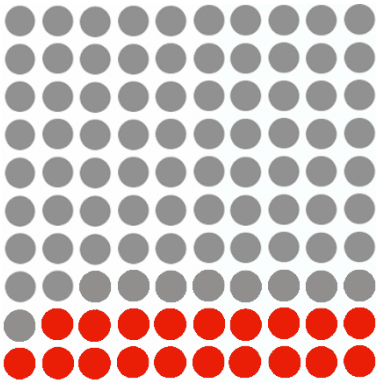
Disparities in Housing

12% of **stably housed** clients have not reached viral suppression



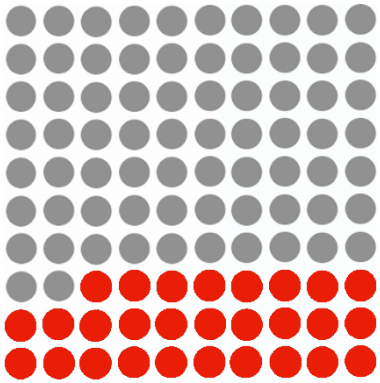
Not Virally Suppressed

19% of **temporarily housed** clients have not reached viral suppression



Not Virally Suppressed

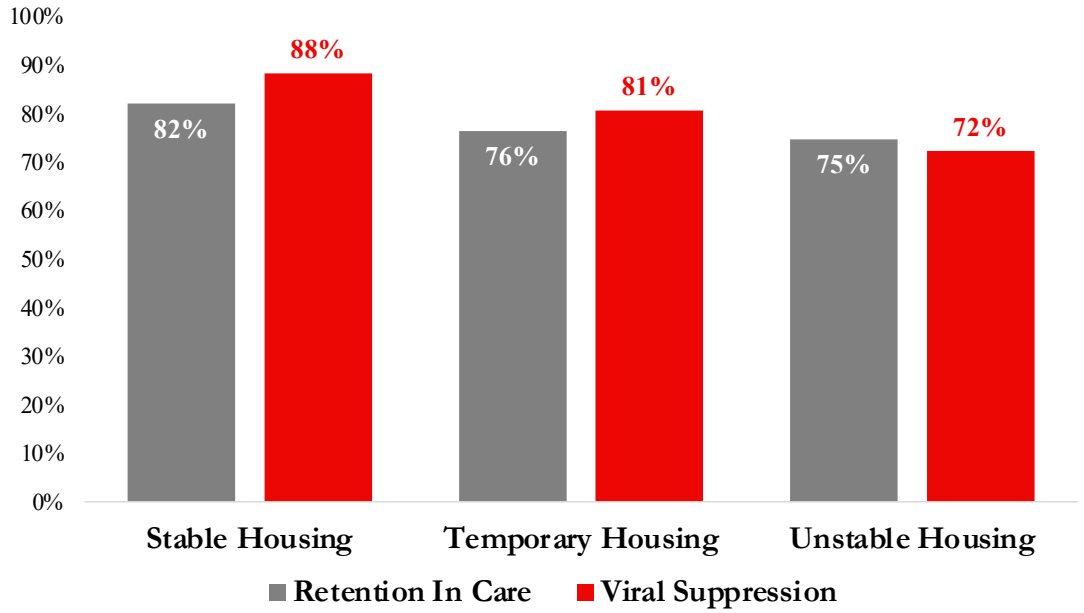
28% of **unstably housed** clients have not reached viral suppression



Not Virally Suppressed

Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports.

Viral Suppression and Retention in HIV Care by Housing Status



Those experiencing unstable housing face the **lowest rates** of retention in care (75% vs. 82%), as well as viral suppression (72% vs. 88%) rates, compared to those with stable housing.

Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports.

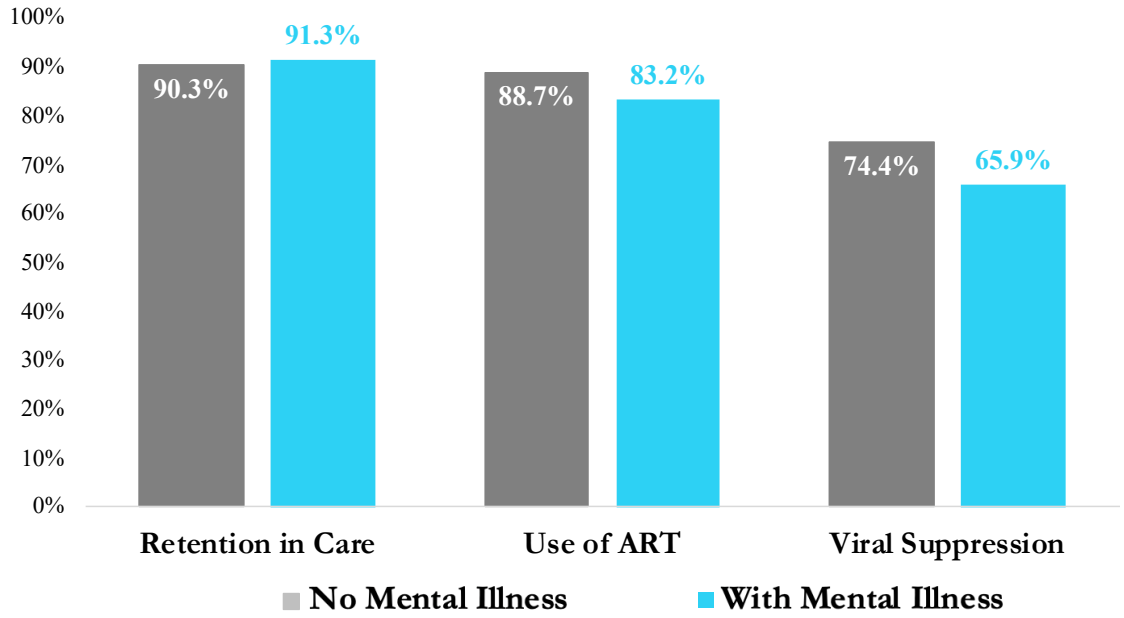
Disparities in Mental Health

Mental Health

"There is no health without mental health."

- Former United States Surgeon General, Dr. David Satcher

Health Outcomes of People with HIV and Mental Illness

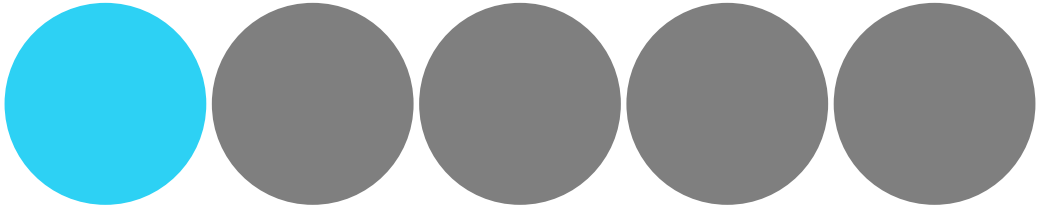


The viral suppression rate for individuals living with mental health diagnoses is **8.5% lower** than those without a mental health diagnosis.

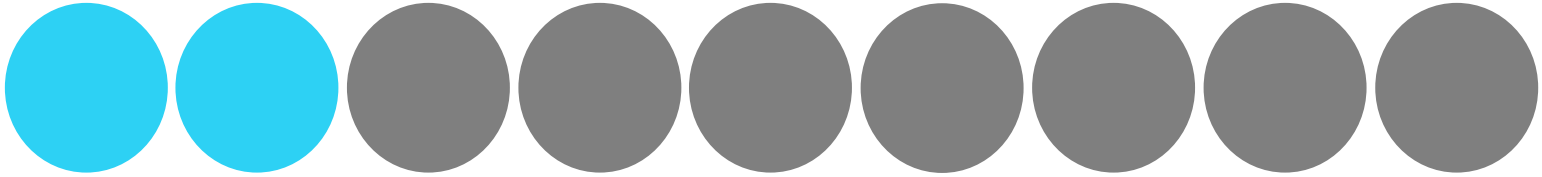
Yehia BR, Stephens-Shield AJ, Momplaisir F, et al. Health Outcomes of HIV-Infected People with Mental Illness. AIDS Behav. 2015;19(8):1491-1500. doi:10.1007/s10461-015-1080-4.

Disparities in Mental Health

One in five people diagnosed with HIV in the U.S. live with **depression**



Two in nine people diagnosed with HIV in the U.S. live with **anxiety**



CDC. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection, United States, 2018 Cycle (June 2018–May 2019). HIV Surveillance Special Report 25.

Disparities in Substance Use

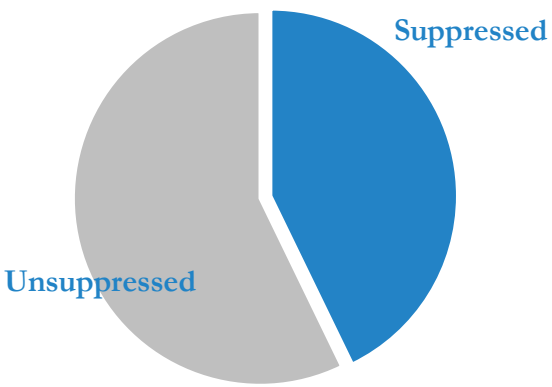
Substance Use

"The mentality and behavior of people who use substances is wholly irrational until you understand that they are completely powerless over their addiction and unless they have structured help, they have no hope."

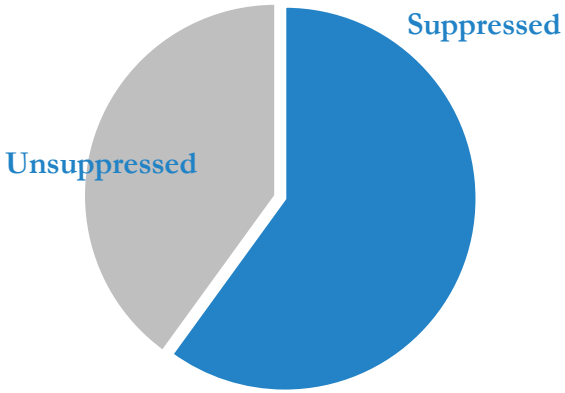
- Russell Brand, Actor & Author

Disparities in Substance Use

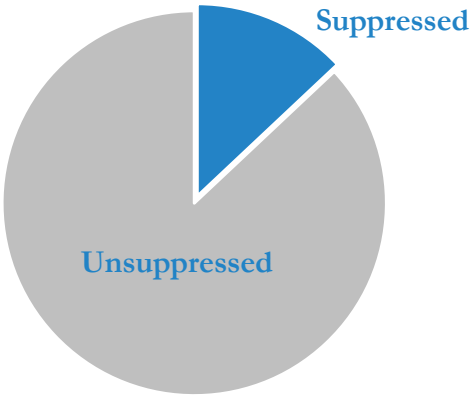
43% of PWH who **inject drugs** are virally suppressed



60% of PWH who engage in **binge drinking** are virally suppressed

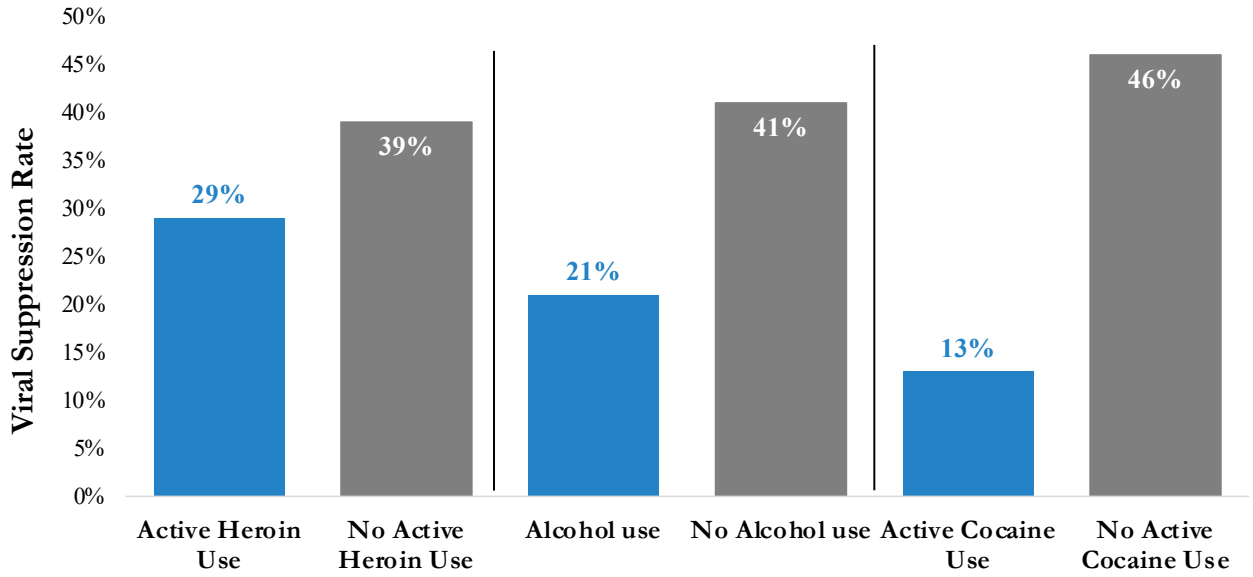


13% of PWH active **cocaine** users are virally suppressed



Karch DL. HIV Infection Care and Viral Suppression Among People Who Inject Drugs, 28 U.S. Jurisdictions, 2012-2013. Open AIDS J. 2016;10:127-135.

Viral Suppression Rates among HIV Patients who Use Substances



The viral suppression rate of non-substance users is significantly **higher**, with an average rate of 18% more across all substances.

Yehia BR, et al. Health Outcomes of HIV-Infected People with Mental Illness. AIDS Behav. 2015;19(8):1491-1500

Disparities Across the Lifespan

Age

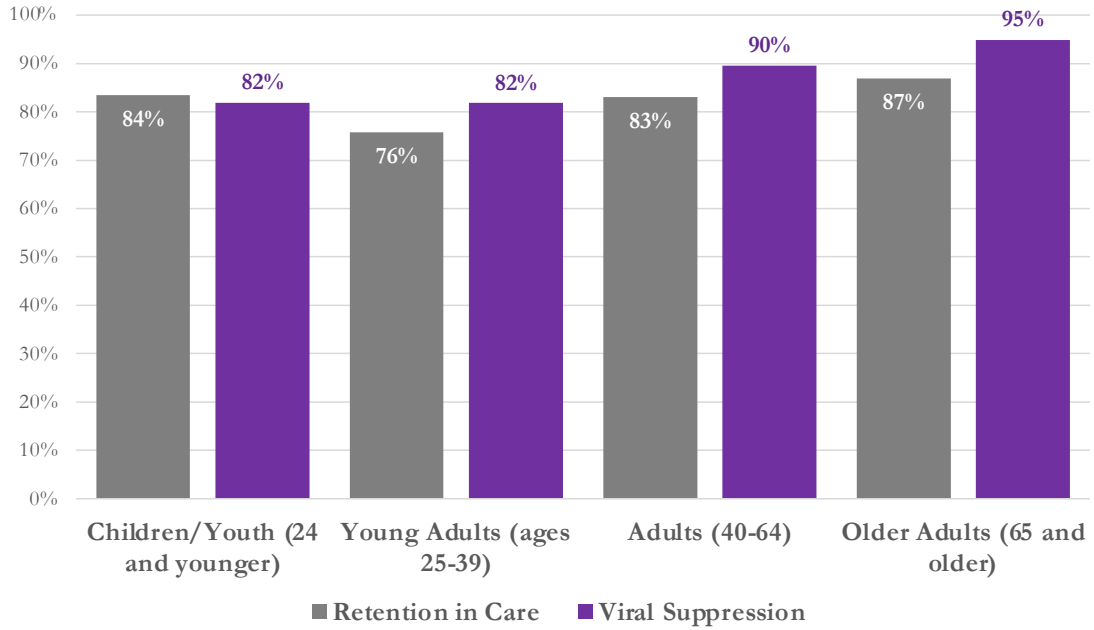
"It's not the years in your life that count. It's the life in your years."

- Abraham Lincoln

Disparities Across the Lifespan

Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports.

Disparities Across the Lifespan



While the overall viral suppression rate is 87%, the rate for individuals under the age of 39 is 82% and for individuals above the age of 65 is 95%.

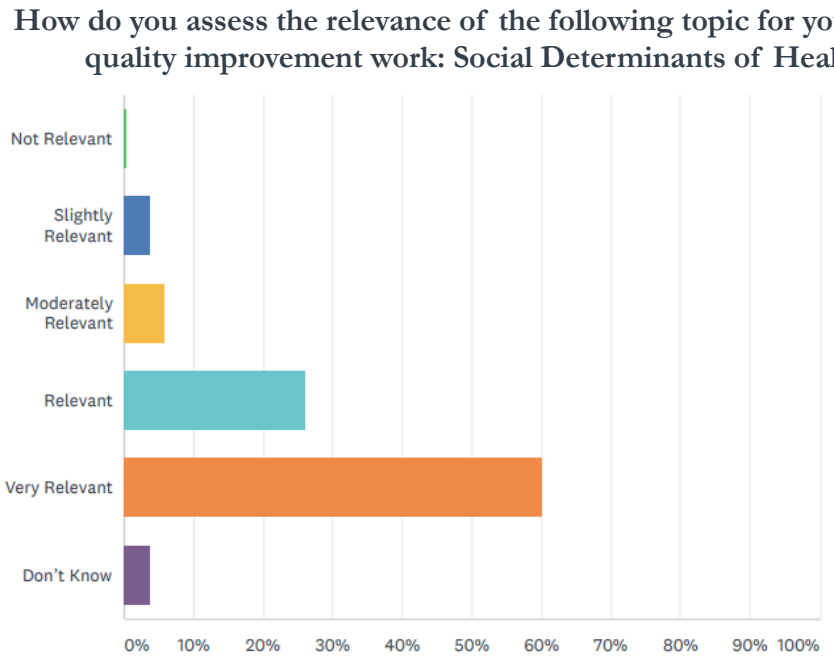
Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. http://hab.hrsa.gov/data/data-reports.

2019 CQII Online Survey (n=241)

86% viewed the topic of social determinants of health as relevant/very relevant

96% were interested/very interested in creating QI projects that address social determinants of health

94% indicated that they would participate in a social determinants of health collaborative



Retrieved from 2019 CQII National QI Survey and Results

create+equity Collaborative Overview

Mission of the create+equity Collaborative

"To promote the application of quality improvement interventions to measurably increase viral suppression rates for people with HIV experiencing the impact of social determinants of health related to housing instabilities, substance use, mental health, and age across Ryan White HIV/AIDS Program-funded recipients and subrecipients."

create+equity Collaborative: Big Picture

- This national QI initiative promotes the application of evidence-informed interventions and emerging practices to measurably increase viral suppression rates for people with HIV experiencing social determinants of health related to
  - Housing
  - Mental Health
  - Substance Use
  - Age Across the Lifespan
- The 18-month Collaborative (starting Jan 2021) combines the IHI Breakthrough Series model with the Project ECHO at the University of New Mexico

2018: end+disparities ECHO Collaborative

create+equity Collaborative: Big Picture

- Each Community Partner is asked to focus their improvement efforts on one population of focus: housing, substance use, mental health, or age across the lifespan
- Community Partner join virtual special interest groups based on their population of focus twice a month (Affinity Group)
- Learning Sessions with all Community Partners are held every five months, starting Feb 2021 and ending May 2022
- Online reporting of population-specific measures (every 2 months) and QI intervention updates (every 3 months)
- A faculty of experts and QI coaches are available for assistance
- Key resources and tools are shared to maximize local use, i.e., driver diagrams, listing of evidence informed- interventions

Goals of the create+equity Collaborative

Reach:

- One in six Ryan White HIV/AIDS Program-funded recipients across the United States actively participate in the create+equity Collaborative

Impact:

- Reduce the viral suppression gap between the entire caseload and the selected subpopulations of focus by 20%

Sustainability:

- 90% of active Community Partners have conducted, documented, and sustained their quality improvement efforts using the knowledge gained in the Collaborative and remain active six months after the formal end of the Collaborative (June 2022)

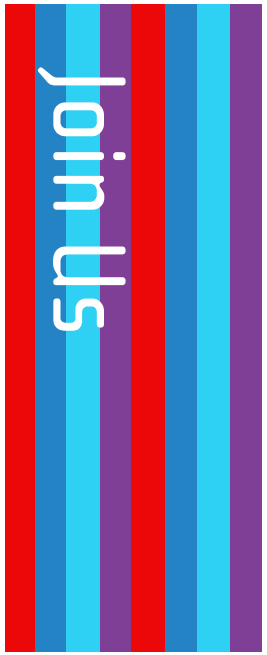
Pre-Work Expectations for Community Partner

- Select one population focus for your improvement efforts using the provided Disparity Calculator
- Connect with your assigned QI Coach
- Create an aim statement with measurable improvement goals for your selected population of focus
- Set up your local QI team with multidisciplinary membership
- Complete other pre-work assignments (submit key staff contacts, information on current data systems, patient caseload, etc.)

Collaborative Expectations for Community Partners

- Attend Affinity Sessions twice a month (60min) with other Community Partners focusing on same subpopulation
- Present at least one Case Presentation during these Affinity Sessions using the provided template and a Report Back
- Conduct local improvement efforts to mitigate the impact of social determinants of health
- Participate in the Collaborative-wide Learning Sessions
- Routinely submit performance data (every other month) and QI intervention updates (quarterly)
- Create a Storyboard to capture your improvement efforts

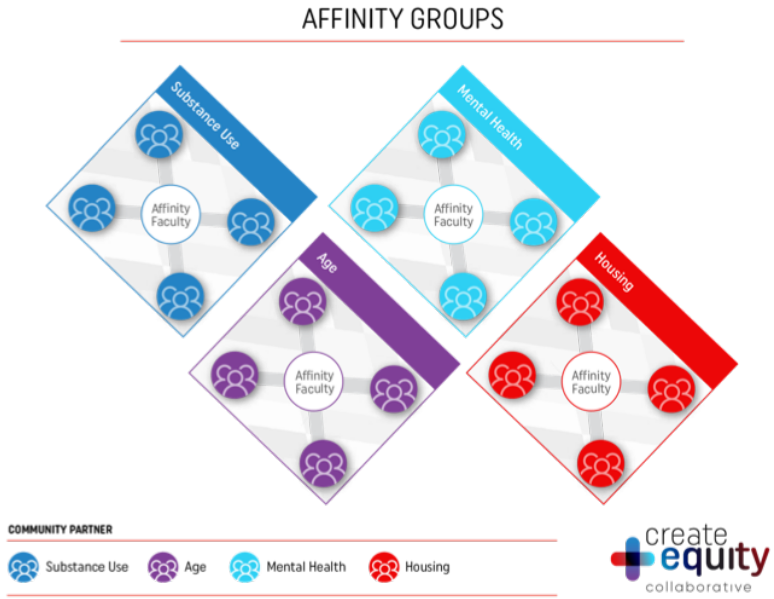
Benefits of Participation for Community Partners



- Increased capacity to conduct effective QI projects that address the impact of social determinants of health
- Improved viral suppression rates for the selected population of focus
- Increased access to QI Coaches, content experts, and other Community Partners to advance local improvement efforts
- Access to evidence-informed and emerging practices for each Affinity Group population of focus
- Strengthened partnerships with internal/external providers focusing on key services related to social determinants of health
- Increased performance measurement capacity to routinely detect and track disparate HIV-related health outcomes for HIV subpopulations

Collaborative Framework

Affinity Sessions



- Bi-weekly virtual Affinity Sessions for each Affinity Group: housing, mental health, substance use, and age across the lifespan
  - Enable teams to create a community of learning while eliminating barriers to meeting in-person
  - Each participating agency present at least one Case Presentation and one Report-Back 6 months afterwards
- Each Affinity Group is supported by a dedicated faculty, which includes content experts, including individuals with lived experiences, to provide ongoing expertise and facilitate support by peer providers

Affinity Groups Focus

Housing

- Assist HIV clients who are temporarily or unstably housed to reach viral suppression
- Increase access to the appropriate and ongoing (internal or external) housing services
- Increase the annual housing status screening rates for all HIV clients served by the agency

Substance Use

- Assist active or recent substance users to reach viral suppression
- Increase annual substance use screening rates for all HIV clients served by the agency
- Affinity Faculty will focus on specific substance use disorders, such as opioids, methamphetamine, stimulants, or alcohol, , while each Community Partner can determine their own mental health improvement focus

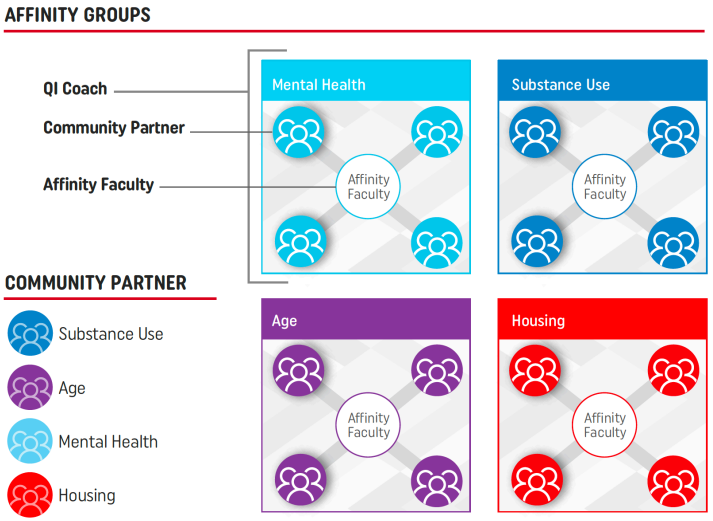
Mental Health

- Help HIV clients who have a documented mental health diagnosis/es to reach viral suppression
- Increase annual mental health screening rates for all HIV clients
- Affinity Faculty will focus on specific mental health diagnoses, such as depression, anxiety, psychotic disorders, and post-traumatic stress disorder, while each Community Partner can determine their own mental health improvement focus

Age Across the Lifespan

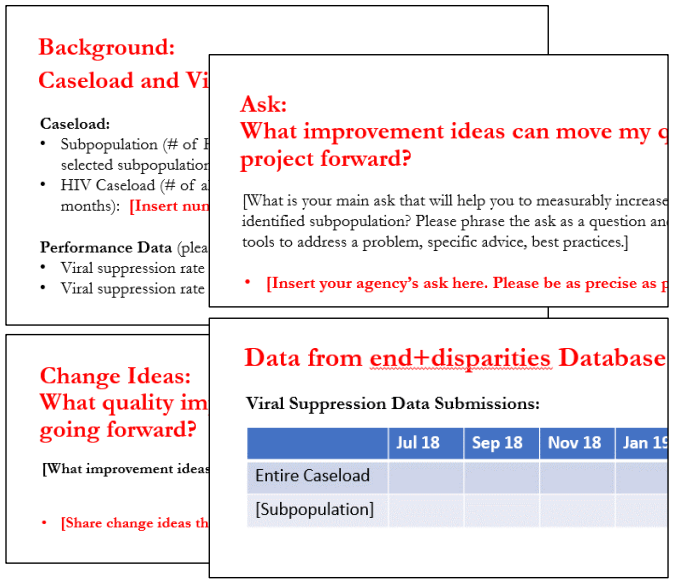
- Community Partners select one of following age groups based on their local performance data and interest:
  children/youth (24 and younger); young adults (25-39); adults (40-64); and older adults (65 and older)
- Improve the viral suppression rate for the selected age group

QI Coach Support



- Two nationally recognized quality improvement experts – CQII QI Coaches – are assigned to each Affinity Group to support participants to meet the collaborative milestones and expectations
- QI Coaches provide support via monthly QI Group sessions and individualized coaching sessions to provide additional support
- QI Coaches focus on guiding Community Partners through each step of their QI project, prepare for their Case Presentations, and provide feedback after reporting cycles, and the preparation of your Storyboard

Case Presentations

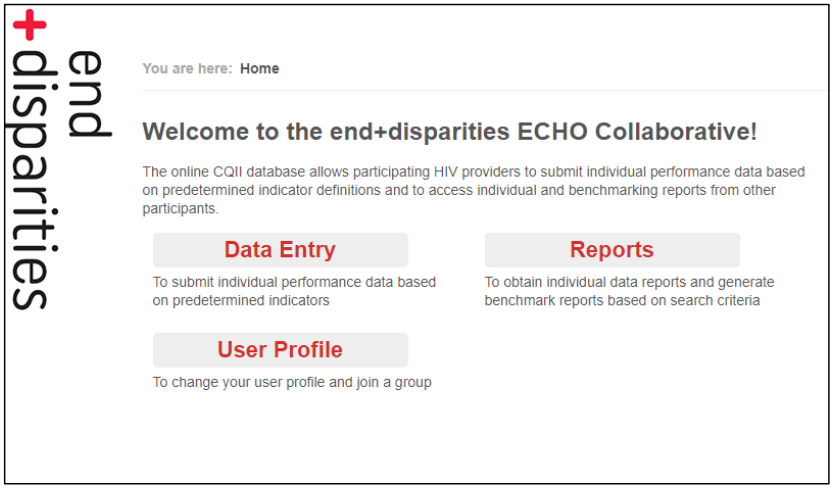


- Case Presentations are designed to promote peer sharing, build capacity, learn from real-life situations, and allow participants to improve their work
- Community Partners focus on one of the following areas related to their selected Affinity Group
  - One system-wide challenge or barrier
  - A current or planned quality improvement intervention
  - Best practices or lessons learned based on current or recent QI efforts
  - Single patient experience (no patient identifiers) to illustrate the effects of a system issue

Reporting Elements

Reporting of Performance Data and QI Interventions

- All Community Partners report on the HAB Viral Suppression Measure definition for all patients and their Affinity Group-specific measures
- Community Partners enter their aggregated data (no individual patient data) every 2 months allowing them to benchmark their progress with their peers
- Participants enter their QI interventions every 3 months to share and inspire other participants to improve their quality of care
- Previously used online database is being re-programmed to allow for routine reporting



2018: end+disparities Database

Affinity Groups Measures

Housing

- Housing Stability : % of HIV pts who are temporarily or unstably housed with a viral load less than 200 copies/mL at last viral load test during the measurement year
- Housing Screening : % of HIV pts with a housing status screening during the measurement year
- Housing Intervention: % of HIV pts who are temporarily or unstably housed at the most recent housing screening with at least one relevant housing intervention

Substance Use

- Substance Use: % of HIV pts who have a documented substance use disorder or a substance use service with a viral load less than 200 copies/mL at last viral load test during the measurement year
- Substance Use Screening: % of HIV pts with a substance use screening during the measurement year

Mental Health

- Mental Health: % of HIV pts who have received one or more of the mental health diagnoses OR received one or more mental health services during the same measurement period with a viral load less than 200 copies/mL at last viral load test during the measurement year
- Mental Health Screening: % of HIV pts with a mental health status screening during the measurement year

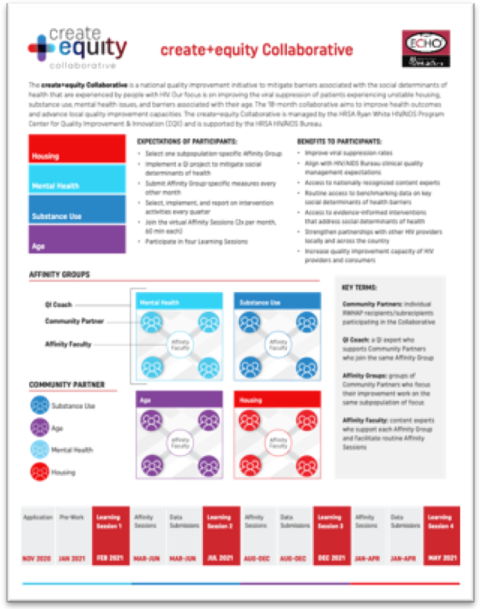
Age Across the Lifespan

- Age Across the Lifespan: % of HIV pts with the site-selected age group [children/youth (24 and younger); young adults (25-39); adults (40-64); or older adults (65 and older)] with a viral load less than 200 copies/mL at last viral load test during the measurement year
- [Other measures for each age group to be developed]

Tools and Resources

Collaborative Tools

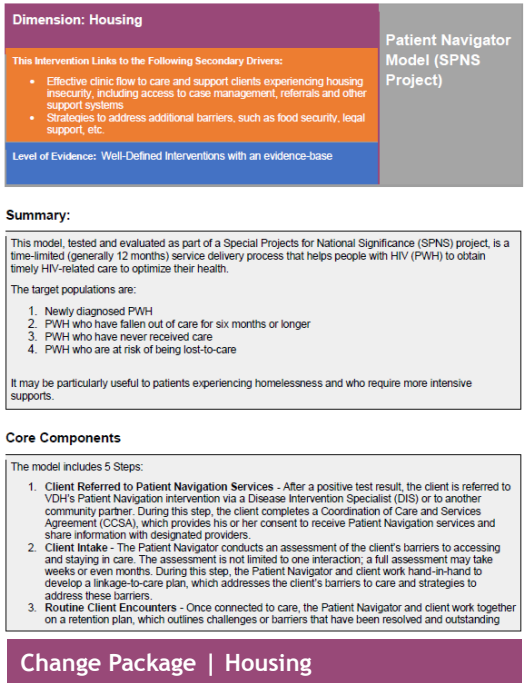
One-Page Flyer



Collaborative Toolkit

To access all Collaborative tools and resources | CQII.org

Change Packages: Listing of Key Interventions



Dimension: Housing

This Intervention Links to the Following Secondary Drivers:

- Effective clinic flow to care and support clients experiencing housing insecurity, including access to case management, referrals and other support systems
- Strategies to address additional barriers, such as food security, legal support, etc.

Level of Evidence: Well-Defined Interventions with an evidence-base

Patient Navigator Model (SPNS Project)

Summary:

This model, tested and evaluated as part of a Special Projects for National Significance (SPNS) project, is a time-limited (generally 12 months) service delivery process that helps people with HIV (PWH) to obtain timely HIV-related care to optimize their health.

The target populations are:

1. Newly diagnosed PWH
2. PWH who have fallen out of care for six months or longer
3. PWH who have never received care
4. PWH who are at risk of being lost-to-care

It may be particularly useful to patients experiencing homelessness and who require more intensive supports.

Core Components

The model includes 5 Steps:

1. **Client Referred to Patient Navigation Services** - After a positive test result, the client is referred to VDH's Patient Navigation intervention via a Disease Intervention Specialist (DIS) or to another community partner. During this step, the client completes a Coordination of Care and Services Agreement (CCSA), which provides his or her consent to receive Patient Navigation services and share information with designated providers.
2. **Client Intake** - The Patient Navigator conducts an assessment of the client's barriers to accessing and staying in care. The assessment is not limited to one interaction; a full assessment may take weeks or even months. During this step, the Patient Navigator and client work hand-in-hand to develop a linkage-to-care plan, which addresses the client's barriers to care and strategies to address these barriers.
3. **Routine Client Encounters** - Once connected to care, the Patient Navigator and client work together on a retention plan, which outlines challenges or barriers that have been resolved and outstanding

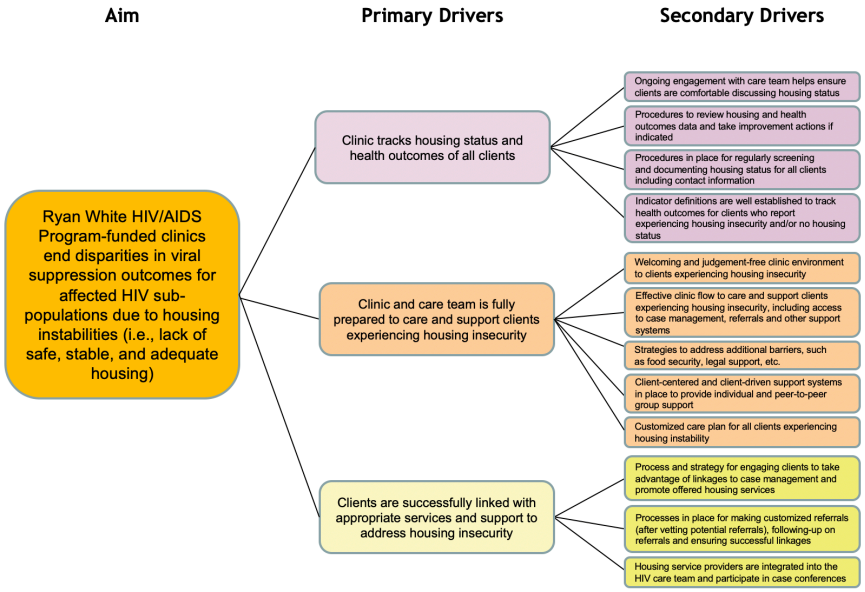
Change Package | Housing

- A Change Package is a set of evidence-informed interventions and emerging practices that are critical to the improvement of an identified process and generate ideas for tests of change
- An extensive Change Package are available for : housing, mental health, substance use, and age across the lifespan
- Each Community Partner should review the appropriate Change Package and the related interventions, and prioritize those that are most relevant for their organization
- CQII partnered with IHI to develop Change Packages for each Affinity Group with content experts and stakeholders

Link

Institute *for* Healthcare Improvement

Driver Diagrams



Driver Diagram | Housing

- Driver Diagrams present a graphical representation of drivers (factors) that have an impact on achieving the preferred outcomes
  - Primary Drivers are the major factors driving the outcomes
  - Secondary Drivers are the detailed activates and structures that make up the primary divers
- CQII partnered with IHI to develop Driver Diagrams for each Affinity Group with content experts and stakeholders

Link

Institute *for* Healthcare Improvement

Application Process

Application Process

Kick-Off Webinars	[Nov 2020] Zoom sessions to introduce RWHAP recipients/subrecipients to the Collaborative, purpose, and benefits of participation
Individual Application	[Nov 2020] Individual recipients/subrecipients apply online as Community Partners and indicate their Affinity Group of choice
Selection Process	[Dec 2020] CQII and HIV/AIDS Bureau review all applications and select the Community Partners; final announcements are made and Pre-Work activities start

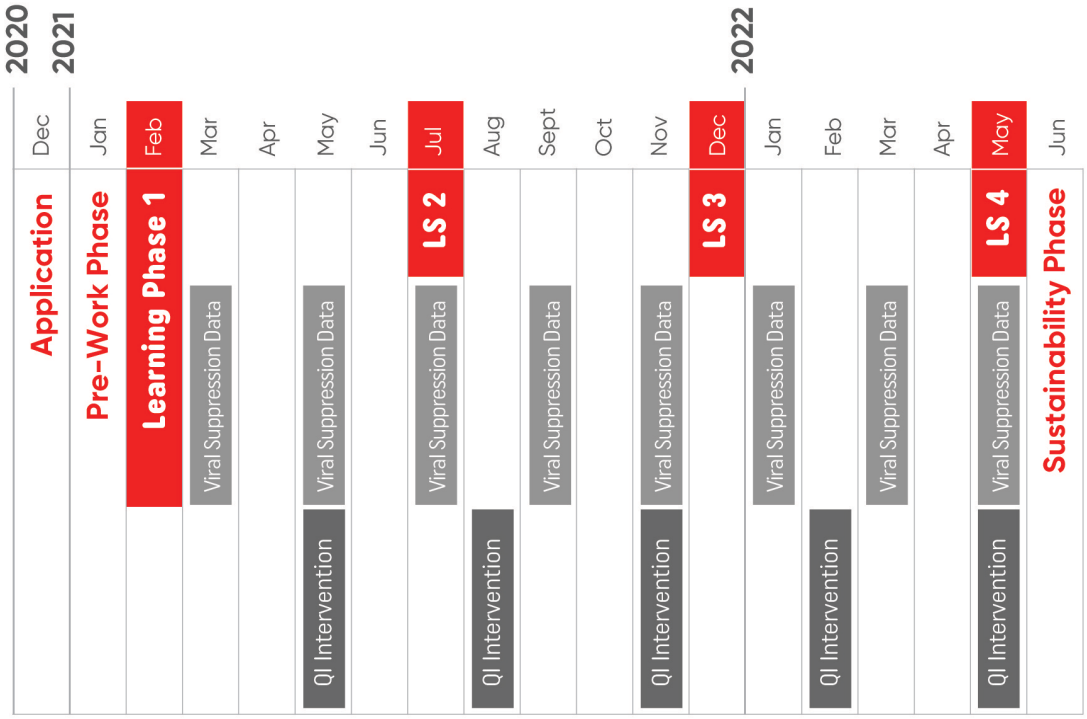
Selection Criteria

A max of 100 Community Partners - 25 per Affinity Group - can join the Collaborative; CQII and HAB will assess all applications using the following selection criteria:

- Geographic representation vs prevalence
- RWHAP Part funding diversity
- QI competency level
- New recipients vs those who have participated in a prior CQII collaborative
- Ability to draw performance data from EMR
- Performance gap between overall vs subpopulation
- Number of patients reported to increase Collaborative impact

Timeline and Next Steps

Reporting Calendar



Collaborative Timeline

Next Steps

- **Apply to Participate**: Application Deadline: Mon, Nov 30, 2020
- **Get Ready**: Community Partners are selected, join introductory webinars, and connect with assigned QI Coach [Dec-Jan 2021]
- **Prepare for Learning Session 1**: Participate in our first Learning Session [Feb 2021]
- **Learn From Each Other**: Attend the first Affinity Sessions [Mar 2021] and start submitting your performance data [Mar 2021]

Apply Here

Submit your application for review by CQII and the HIV/AIDS Bureau:
www.surveymonkey.com/r/collaborativeapplication

Health equity benefits everyone.

Q &A

To learn more about the create+equity Collaborative | CQII.org

FAQs

Where can you find the literature review slides and more resources?

To find our literature review slides and many other resources please visit the create+equity Collaborative Recourses page (CQII.org).

Will the create+equity Collaborative involve Regional Groups?

No. The create+equity Collaborative will not support Regional Groups, but we encourage members from previous collaborative Regional Groups to apply.

When is the application deadline?

The deadline for the create+equity Collaborative is **November 30th, 2020**, we encourage you to apply before the deadline. You can apply using the following application link. Application Site

What Ryan White Funding recipients are you targeting?

We are recruiting from Parts A, B, C, D.

FAQs

Does a Part A or B recipient have to apply or does each subrecipient have to submit an application?

You have two options to choose your level of participation.

Option A: The Part A or Part B network recipient can be the lead agency and conduct QI efforts across your network of subrecipients. In this scenario, all participating subrecipients focus on the same Affinity Group (Housing, Mental Health, Substance Use, or Age Across the Lifespan), lead all improvement activities across all participating subrecipients, and submit their data. We encourage that as many subrecipients as possible join.

Option B: The Part A or Part B network recipient supports the subrecipient and the subrecipient improvement project as a local QI team member. In this scenario, the subrecipient enrolls in the Collaborative, is the team lead, and submits all data and QI updates.

Is the application for an individual person or per agency/Community Partner?

Each Community Partner/agency will fill out one application for participating in the create+equity Collaborative. Individual Community Partner staff who wish to participate may do so as part of the agencies' QI team.

Will agencies receive guidance and assistance when pulling their data?

Yes, agencies/Community Partners will receive guidance throughout the Collaborative from other collaborative participants as well as QI Coaches and Faculty members.

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HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

create equity collaborative

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Improve HIV Care. Ask Me How!

Learn More | create+equity Collaborative

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