Quality Institute #2:
How to Share Performance Data to Spur Improvement
Session 3

Clemens Steinbock
Wednesday, August 25; 3:30-5pm
Maryland B
RWA-0417

Disclosures

- I have no financial interest or relationships to disclose
- HRSA Education Committee Disclosures
  - HRSA Education Committee Staff have no financial interest or relationships to disclose
- CME Staff Disclosures
  - Professional Education Services Group staff have no financial interest or relationships to disclose

Learning Objectives

- Understand the importance of sharing performance data effectively with your target audience to generate momentum for quality improvement

- Learn strategies to prepare effective data reports and share data successfully

- Learn how peer grantees innovatively share data with their staff, providers, consumers, subcontractors, advisory bodies, etc.

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Agenda

- Introduction to data reporting
- Examples of grantee performance data reports and feedback by audience
- Development of recommendations/small group work
- QI resource overview

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4 Data 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?

Find a Balance between Measurement and Improvement

Options for Follow-up Activities

- **'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

Why Measuring?

- Strangers are asked to estimate the IQ of weathermen on TV they have never met before

- Question: Who can better estimate the IQ - you or strangers?

- Result: Strangers are 66% more accurate when predicting someone's IQ

- Conclusion: We are poor self evaluators based on the positive illusion effect

Convergence of Stranger Ratings of Personality and Intelligence With Self-Ratings, Partner Ratings, and Measured Intelligence

Peter Borkenau and Anette Liebler

Several studies have shown above-chance agreement of self-reports on extraversion and conscientiousness with ratings by strangers, indicating that ratings by strangers might be quite accurate. Because self-reports are a less-than-ideal criterion to evaluate the accuracy of stranger ratings, however, the present study compared them also with ratings by acquaintances and with targets' performance on an intelligence test. Ratings of extraversion, conscientiousness, and intelligence by strangers having been exposed to a videotape of targets were significantly related to self-reports of these traits as well as to ratings by acquaintances. Moreover, ratings of intelligence by strangers were related to targets' measured intelligence, provided that judges had been exposed to a sound film of the targets.

In daily life, individuals routinely form impressions of the personalities of other people. Sometimes, such impressions are based on minimal information, maybe the observation of others' visible behavior for a few seconds only. This raises the issue of whether impressions of strangers are illusory or whether they possess some validity (Ambady & Rosenthal, 1992). If they are illusory, they might nevertheless furnish the illusion of predictability and thus satisfy a need for perceived control. If they are accurate, however, they might also contribute to more appropriate and useful decisions concerning social interactions.

There are several studies that show some convergence, particularly for extraversion and conscientiousness, between self-ratings of personality and ratings by strangers who were exposed to minimal information on the targets (Albright, Kenny, & Malloy, 1988; Amelang, Köhler, & Gold, 1983; Berry 1991; Borkenau & Liebler, 1992; Gangestad, Simpson, DiGeronimo, & Biek, 1992; Norman & Goldberg, 1966; Paulhus & Bruce, 1992;

strangers to identify target personality (Borkenau & Liebler, 1992; Funder & Sneed, 1993; Gangestad et al., 1992). Although such a veridical impression view of self-stranger agreement is reasonable, alternative explanations of self-stranger agreement are conceivable, making self-reports a less-than-ideal criterion to evaluate the validity of stranger ratings of personality (Funder & Sneed, 1993).

A Self-Presentation Account of Self-Stranger Agreement

A reasonable alternative explanation of self-stranger agreement that differs from a veridical impression view might be a self-presentation account (Johnson, 1981). We distinguish here between two varieties of a self-presentation view. One view is that a person's actual personality is a latent quality apart from that person's observable behavior and that persons may usually present themselves in ways that are inconsistent with their ac-

[Peter Borkenau, Journal of Personality and Social Psychology, 65, 546-553]

20 Years of Leadership
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Why Measuring? We Are Unrealistically Optimistic

- 90% of all drivers think they are above average behind the wheel
- 94% of college professors report doing above average work
- Smokers are aware of the statistical risks but most believe that they are likely to be diagnosed with lung cancer and heart disease than non-smokers
- Gay man underestimate their chance to contract HIV, even though they know about HIV/AIDS in general
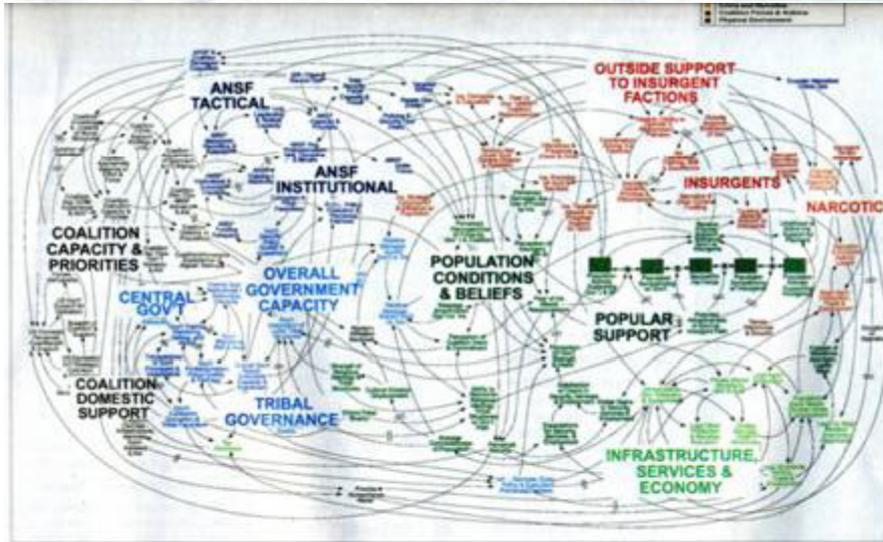
[Cass Sunstein, Journal of Legal Studies, 27, 1998, 799-823]

What's Wrong with this Picture?

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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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Quality Management should **NOT** look like:
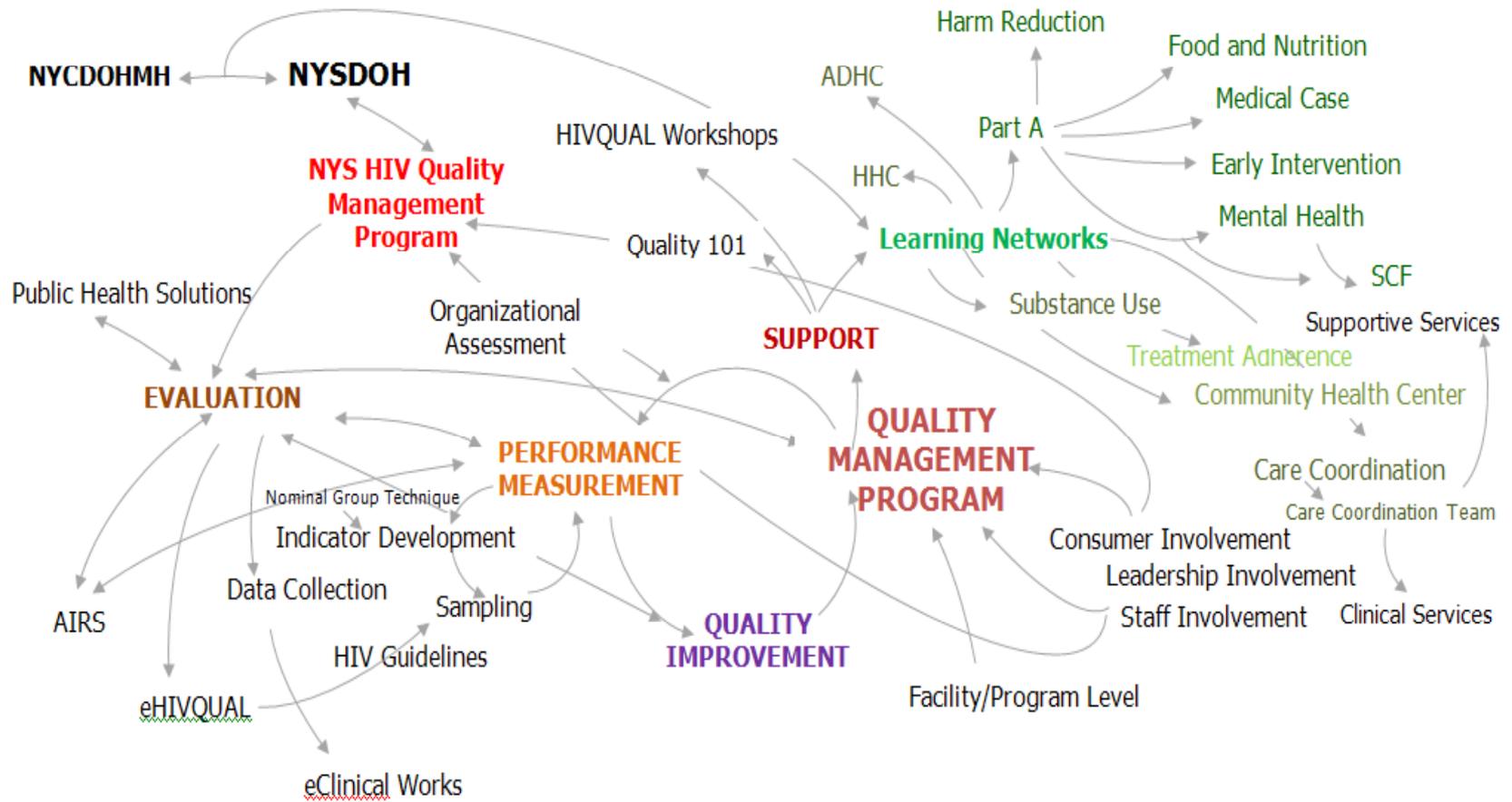
'Death by Slides' – Edward Tufte

- Average data points/numbers per graph:
  - 120 in New York Times
  - 53 New England Journal of Medicine
  - 12 PowerPoint graph

- 100-160 spoken words per minute vs 15 words per slide

- To show content PowerPoint templates use only 30%-40% of the space available on a slide

Edward R. Tufte

The Cognitive Style of PowerPoint

Military parade, Stalin Square, Budapest, April 4, 1956.

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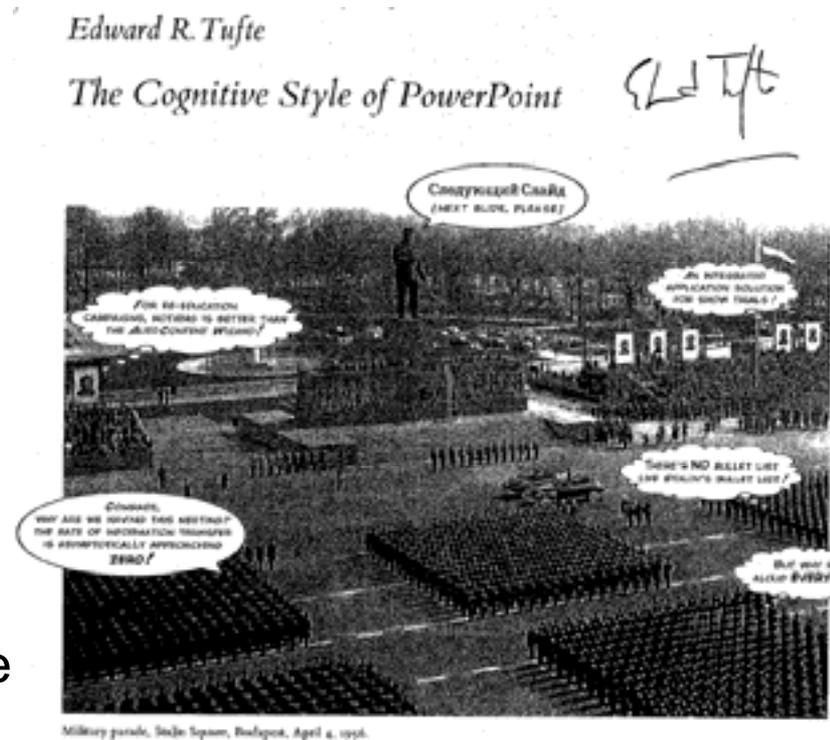
Lessons Learned about Data Reports

- **Tell a story – 'designer formats will not salvage weak content'**
  - Summarize major points you want to make
  - Use color to highlight key findings
  - Avoid technical jargon/define unfamiliar terms

- **Know your audiences and their data needs**
  - Plan data display with key stakeholders
  - Use different graphs for different audiences
  - Post graphic displays in hallways and waiting rooms for staff/patients

Lessons Learned about Data Reports

- **Be aware – we all have a different data literacy**
  - Define each indicator
  - Label charts and tables clearly (show 0% to 100%)
  - Identify data source(s) and dates
  - Stratify data by demographics/other characteristics
  - Note limitations

- **Find balance: simple messages vs complex data**
  - Begin analyses with questions/hypotheses
  - Limit the display to the points you need to make
  - Provide handouts with more data points
  - Provide comparisons over time, benchmarks, established targets

Examples from the Field…

Request to Audience

At the end of the presentation:

- Share one chart/graph that you like the most – remember the slide number!

- Share one improvement idea for your next data chart/graph that you have learned today

'Focus on how data are presented vs what the actual data points are telling you!'

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Lincoln Community Health Center Early Intervention Clinic - 5/1/08 through 12/31/09

PCP Prophylaxis

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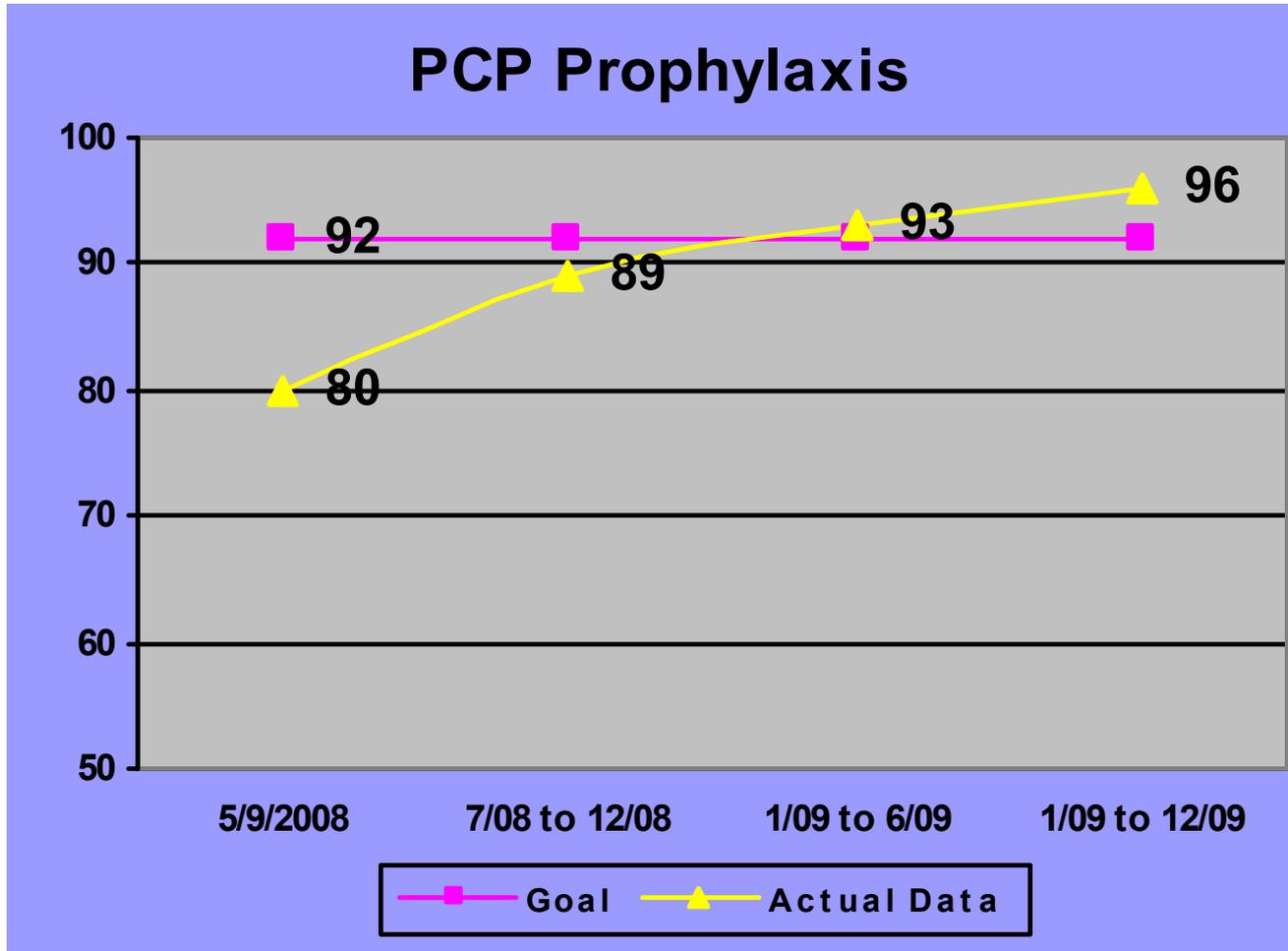
Pennsylvania HAB Performance Measure Data
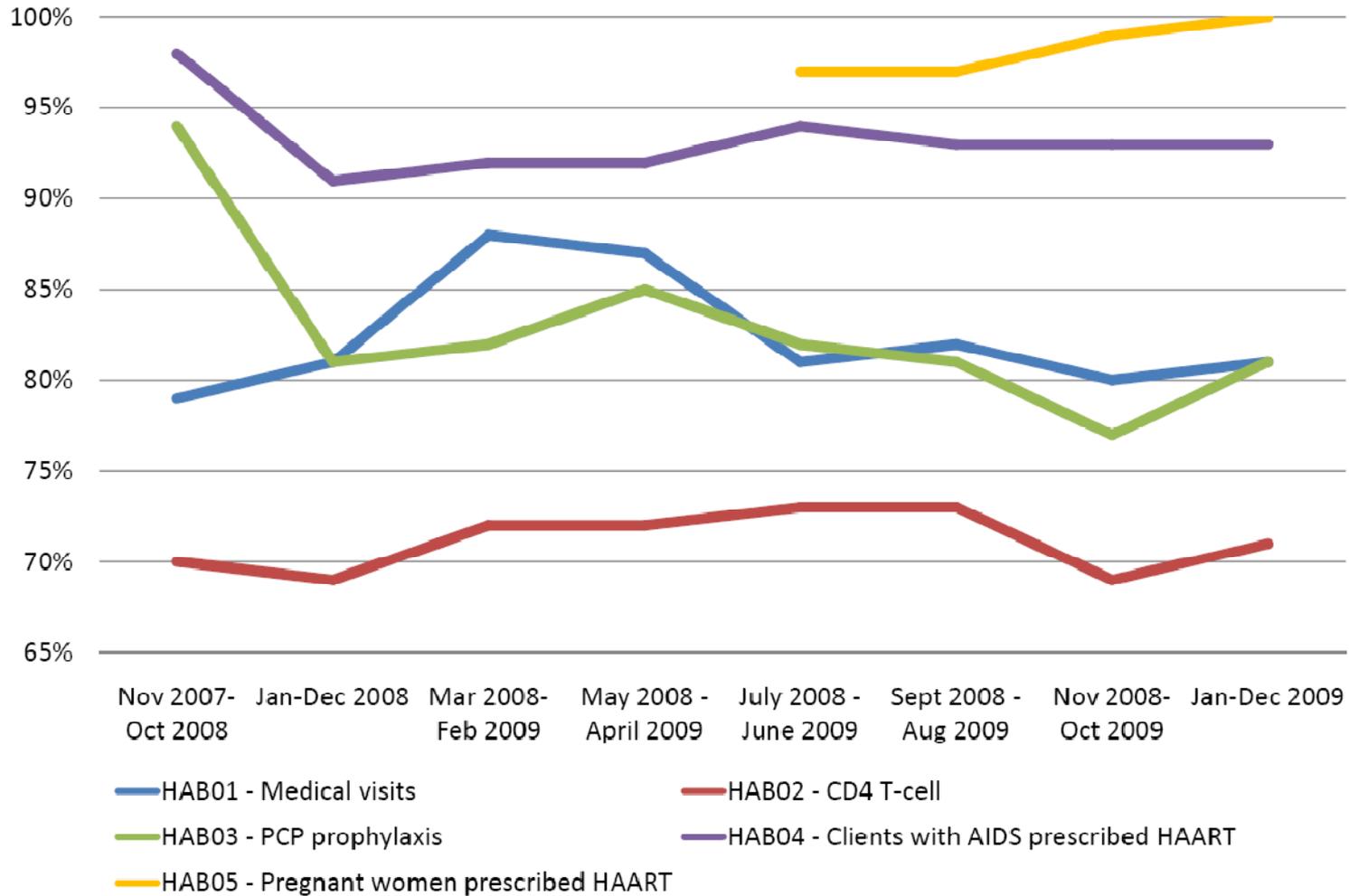
New Jersey Cycle 8 CPC Data
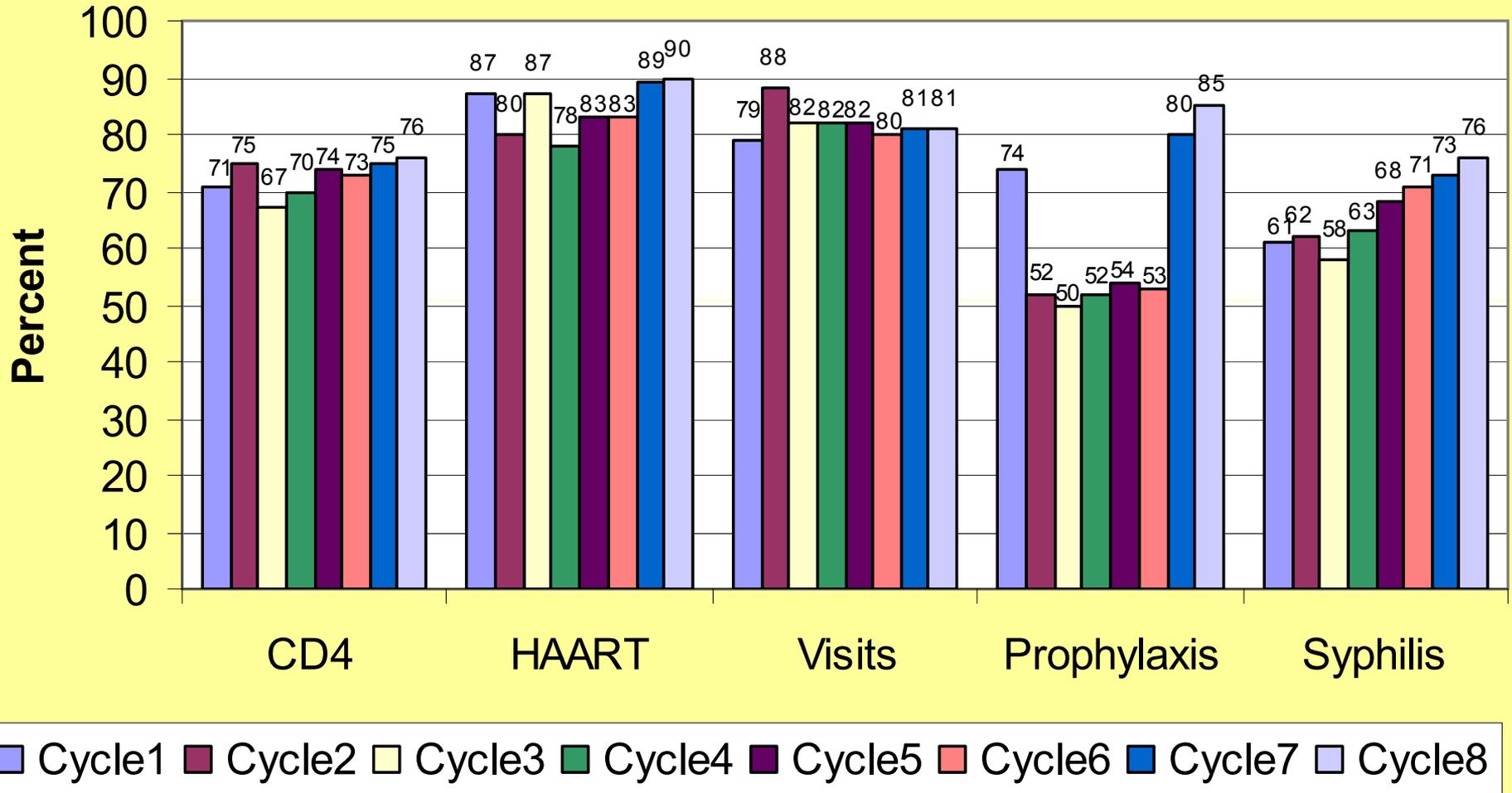
Viral Load Every 6 Months

Indicator Definition: Percentage of eligible patients who had a VL during each 6-month interval

(n = 11,131 eligible NYS patients in 2007)

Key Findings:

- Consistently high; no improvement since 2003
- Over 50% of NYS sites scored above 90%
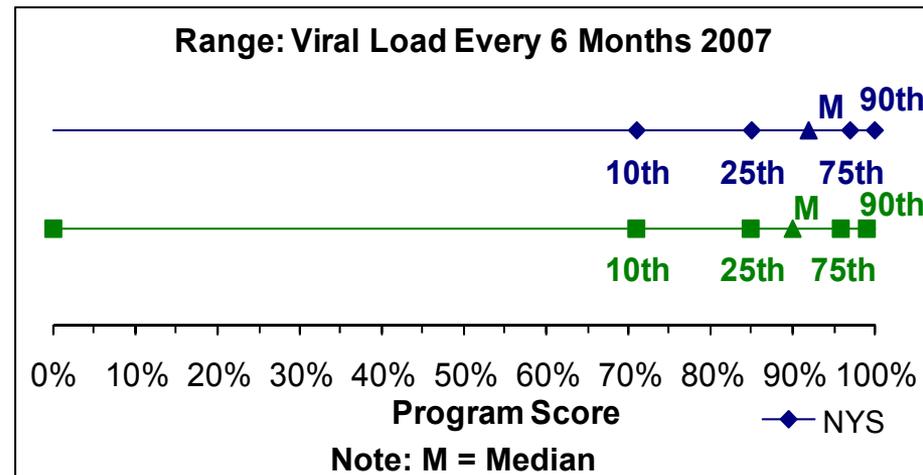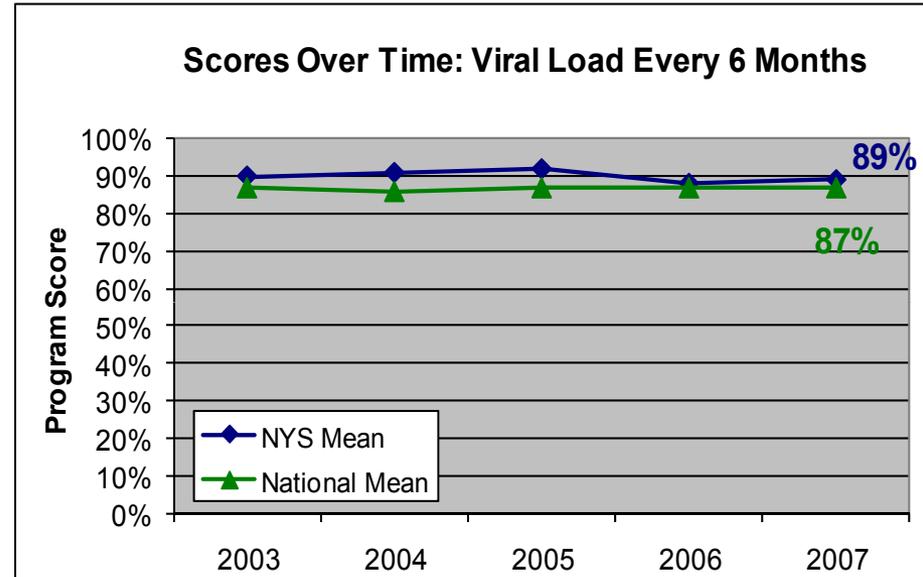
Frequency Distribution of Scores: Viral Load
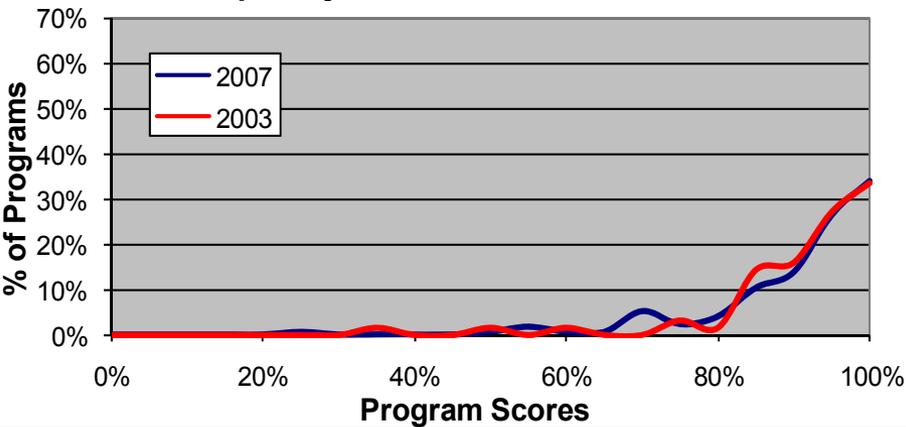
Scores Over Time: Viral Load Every 6 Months

Range: Viral Load Every 6 Months 2007

Note: M = Median

eHIVQUAL

Review Period: 1/1/2008 - 12/31/2008	CD4: ALL	VL: ALL	Gender: ALL
Sample: Eligible Only Age: ALL	State: ALL	Race: ALL	Risk: ALL
Program: ALL	On ARV: All Inclusive	Funding: ALL	Facility: ALL

Patients in Sample: 71

Not from 'Drug Treatment Center' and over 13 years old: 64

		Inj:
Heroin:	10	6
Cocaine:	5	3
Alcohol:	12	
Pills:	2	
Marijuana:	10	
Methamphetamine:	0	
Other:	2	

Substance Use Discussed
38   59.4 %

Intravenous Drug Users (IDU)
9   23.7 %

History of substance use identified
27   71.1 %

Past Users (> 6 months): 9   **Current Users (0-6 months): 18**

History of Substance Use
Within Last 7-24 Months
4   44.4 %

Currently in Treatment
4   22.2 %

Not in Treatment
11   61.1 %

Relapse Prevention or Ongoing
Treatment Discussed
3   75.0 %

Referral for Treatment
Made
4   36.4 %

1	Detoxification unit	2
2	Methadone	3
0	Residential treatment	3
0	Out-patient non-methadone	2

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TOT Participants by Zip Code (n=299)
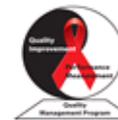
HIV Quality of Care Program
Dashboard

Printed on: 4/9/2010 6:45:46 AM

Review Period: 1/1/2008 - 12/31/2008 | CD4: ALL | VL: ALL | Gender: ALL
Sample: Eligible Only | Age: ALL | State: ALL | Race: ALL | Risk: ALL
Program: ALL | On ARV: All Inclusive | Funding: ALL | Facility: ALL

Patients in Sample: 71
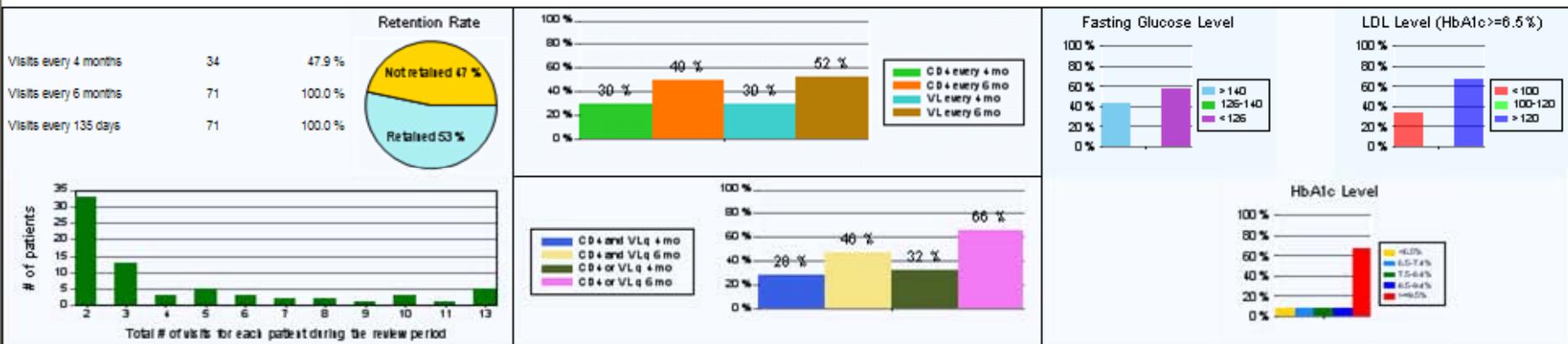
Visit Distribution

CD4 / Viral Load Monitoring

Diabetes Management
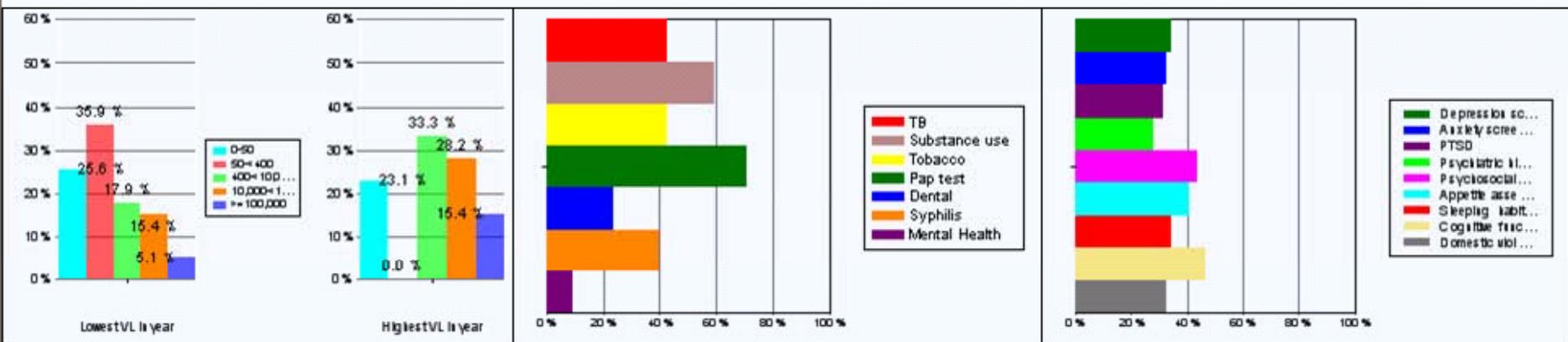
Viral Load Suppression

Screening Indicators

Mental Health Components

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Top Scoring Performance in 4 Categories (Viral Load, Adherence, TB, Pelvic)

In 2007, how many of the 174 NYS HIVQUAL facilities were in the top 25% statewide on all four indicators (Viral Load Every 6 Months, Tx Adherence, TB Screening, Pelvic Exam)? n = 174

Bar chart:
- Top 25% 0x: 48%, n = 82
- Top 25% 1x: 30%, n = 52
- Top 25% 2x: 11%, n = 19
- Top 25% 3x: 7%, n = 12
- Top 25% 4x: 5%, n = 8

Sample size > 40: Nassau Health Care, Westbury; APICHA; Wyckoff Heights Medical Center

First Regional Workshops

First Onsite TA Consultation

First Exhibit

First Steering Meeting

2005

Sept

2006

Initial Meeting with HAB in DC

Initiation of IHI/NQC website

First Consumer Advisory Meeting

Initiation of National TA Calls

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74% of all Ryan White grantees participated in TA Calls
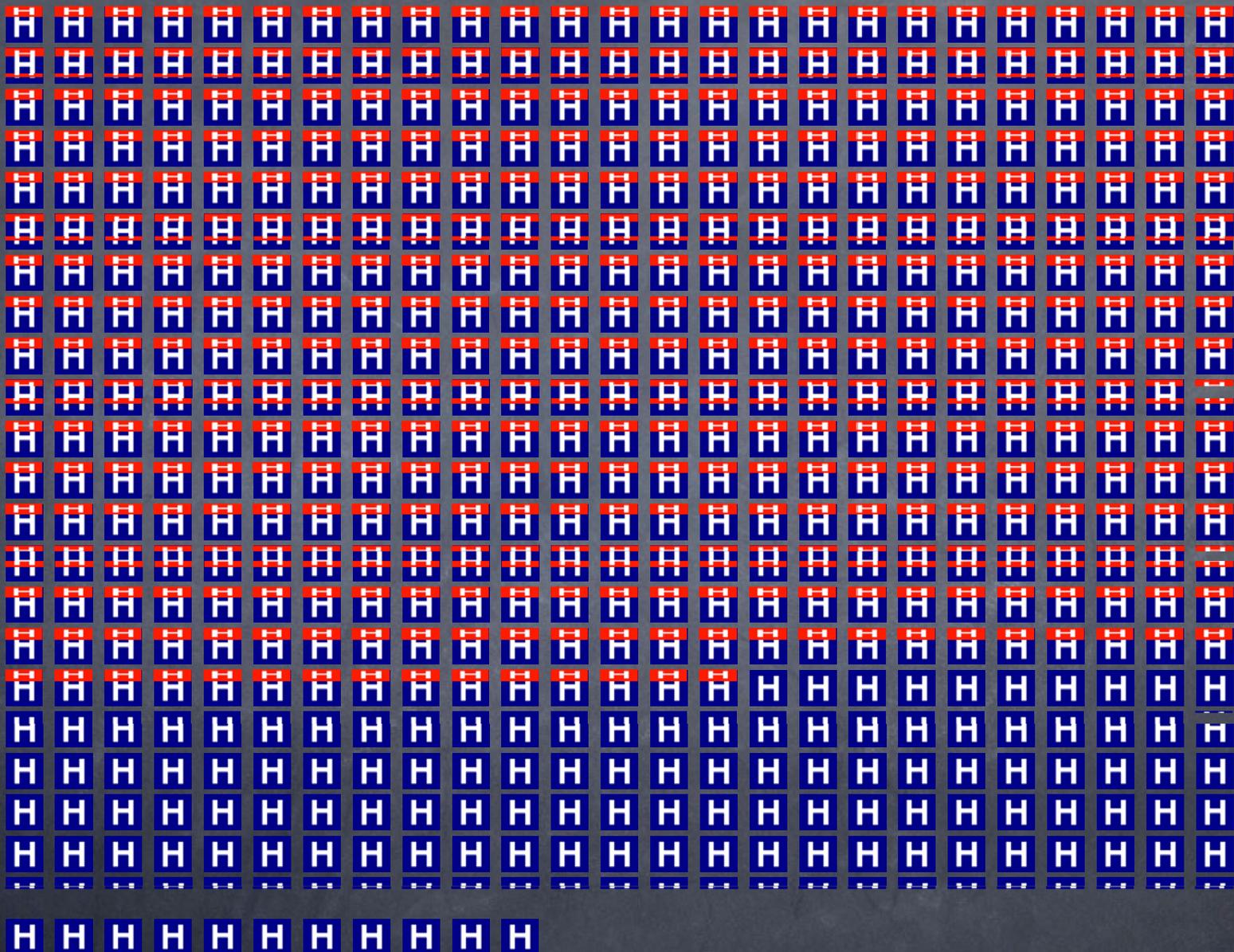
	San Juan Part A		Ponce Part A		Caguas Part A		Puerto Rico Part B	
	April 05	June 09	May 05	June 09	May 05	June 09	May 05	Jun 09
Written Quality Management Plan	−	+	−	+	−	+	−	+
QI Committee	−	+	+	+	−	+	−	+
Consumer on Committee	−	+	−	+	−	+	−	+
Quality Indicators	−	+	−	+	−	+	−	+
QM Required in Subcontracts	−	+	−	+	−	+	−	−
Organizational Assessments Conducted	−	+	−	+	−	+	−	+
Participation in QM Workshops	−	+	−	+	−	+	−	+
QM Trainings for subcontractors	−	+	−	+	−	+	−	+
Participation in NQC TOT	−	+	−	+	−	+	−	+
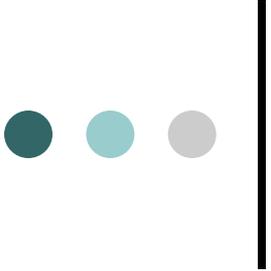
Data, the other way… (2007)

- Out of 11,131 pts with 2 or more annual medical visits, 614 pts did **NOT** have a documented VL during the last 6 months of the year (5.5%)

- Based on a sample of 2,209 pts with a CD4 count less than 200, 246 pts were **NOT** on PCP prophylaxis (11.1%)

- 1,313 out of 4,269 female patients did **NOT** receive a GYN exam last year (30.8%)

Spidercharts

CHFP 2005

Spider chart with axes: HEP A Vaccination (0.63), HAART Adherence (0.35), OH (0.09), PAP (0.38), Social Assessment (0.31), PPD Screening (0.33), Undetct VL, pts on HAART (0.41). Scale 0 to 0.7.

CHFP 2006

Spider chart with axes: HEP A Vaccination (0.82), HAART Adherence (0.92), OH (0.21), PAP (0.84), Social Assessment (0.74), PPD Screening (0.31), Undetct VL, pts on HAART (0.61). Scale 0 to 1.

32
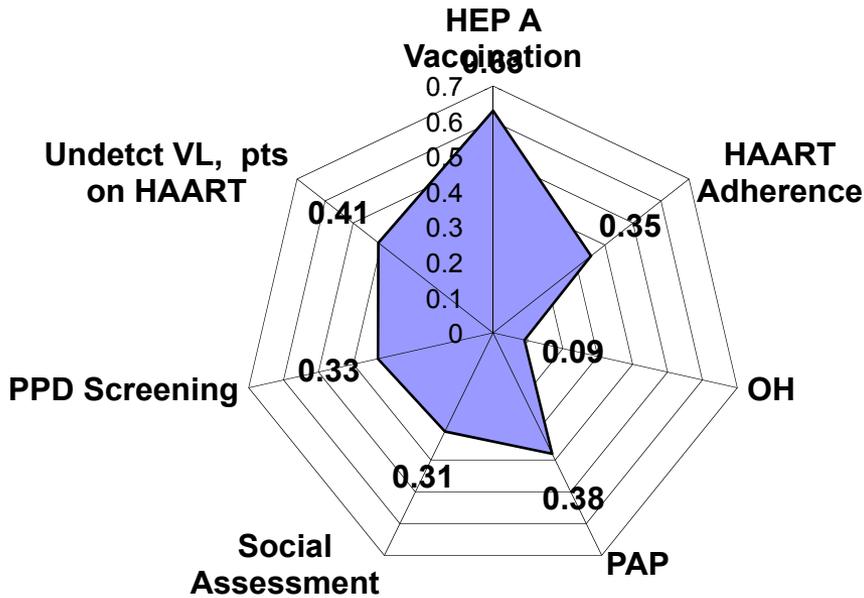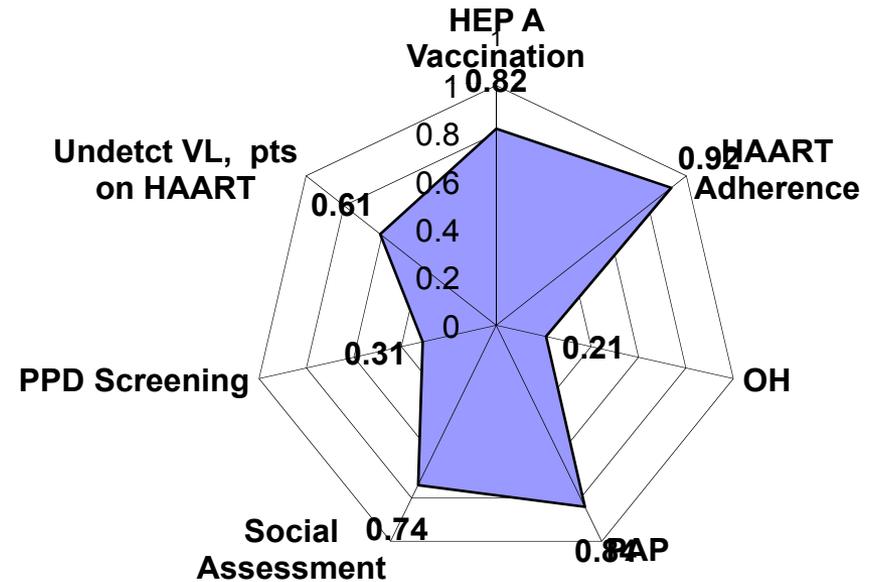
Management of Antiretroviral Therapy (ARV)

Background

Antiretroviral therapy management for people with HIV has become increasingly complex. The AIDS Institute's Medical Care Criteria Committee, a group of HIV clinical experts, routinely updates guidelines regarding appropriate ARV management. These standards of care provide guidance for when therapy should be initiated and/or changed, as well as guidance for appropriate monitoring and management of stable and unstable patients. The guidelines are posted on the AIDS Institute website located at www.hivguidelines.org.

The Measure

The New York State Department of Health AIDS Institute quality of care indicator measures the percentage of patients receiving ARV who know had their antiretroviral therapy managed appropriately during each 4-month review period.

The indicator, management of antiretroviral therapy, was adopted in 1999 and is based on a standard of care developed by the Medical Care Criteria Committee in conjunction with the HIV Quality of Care Advisory Committee.

When patients are on antiretroviral medication, the virus can be well-controlled and is called "stable"; or the patient is called ...

Clinically stable p... defined as those w...

- Viral load is und...
- Viral load has dr... 4-month review p...
- Viral load has inc... lowest value in 6... AND there is a su... cian that patient ...

Clinically unstable patients receiving ARV therapy are defined as those who meet the following criteria:

- Viral load is increasing by more than 1 log and absolute value is over 1,000; or
- CD4 is dropping by 50% since last 4-month review period; or
- Patient deemed unstable by physician; or
- Opportunistic infection in the last 4-month review period (new or recurrent).

The HIV Quality of Care Advisory Committee has defined specific expectations regarding appropriate monitoring and management for clinically stable and unstable patients, as follows:

Management of Clinically Stable Patients

- Viral load measurement every four months

Management of Clinically Unstable Patients (3 options)

- Regimen was changed and viral load assay performed within 8 weeks of decision; or
- Justification provided not to change therapy because of intercurrent illness, recent vaccination, adherence intervention documented, viral load ...

In 2001, the Quality of Care Advisory Committee changed the indicator for management of unstable patients to include appropriate follow-up. Specifically, unstable patients whose regimen was either changed or for whom justification was provided not to change therapy were from that point on expected to have a follow-up viral load test performed within eight weeks, in order for therapy to have been considered to have been appropriately managed. Similarly, patients whose therapy was discontinued were expected to have clinical follow-up documented within three months. As a result, some reports received by facilities in 2000 included scores that were higher than data used in calculating the combined ARV scores for this report.

Comparative Rates

The 2001 median statewide performance rate for appropriate management of antiretroviral therapy was 80%, which was unchanged from 2000. Performance rates for ARV ranged from a high score of 98% to a low score of 49%. The following chart shows the percentage of facilities scoring in the following percentile ranges in 2001: 90-100%, 80-89%, 70-79%, 60-69%, or less than 60%.

Appropriate Management of ARV
Percentage of facilities scoring in the following groups

- 90-100% — 46%
- 80-39% — 37%
- 70-79% — 4%
- 60-59% — 6%
- Less than 60% — 7%

Performance Data (2000 – 2001)

The table beginning on the next page provides performance data for health care facilities reviewed through the Quality of Care Program for management of antiretroviral therapy for clinically stable and unstable patients. This information includes the statistically derived score the facility received for this particular indicator. Performance measurement data are provided for 2000 and 2001, and are adjusted based on past performance. Readers of the table below are able to see whether performance scores reflect an upward or downward trend in performance, or if the trend over two years has been relatively stable.

After each facility's name, the city or borough, and region in which the facility is located, is listed. The regions have been assigned the following codes:

- NYC (Manhattan, Bronx, Brooklyn, Queens, Staten Island)
- LI (Long Island)
- LMH (Lower and Mid-Hudson Valley)
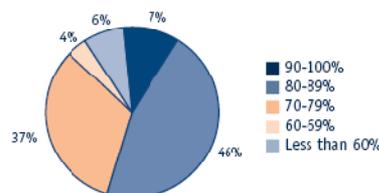- NE (Northeast New York)
- CW (Central and Western New York)

Facilities are also identified by facility type. Facility types have been given the following codes:

- DTC (Drug Treatment Centers)
- CHC (Community Health Centers)
- HOSP (Hospital)

Management of Antiretroviral Therapy (ARV)

Health Care Facility	Facility Type	2000 Score	2001 Score
Addiction Research & Treatment Corporation, Brooklyn, NYC	DTC	90	82
AIDS Community Services of Western New York, Buffalo, CW	CHC	82	81
Albany Medical Center, Albany, NE	HOSP	78	83
Albany Medical Center - Mid Hudson Care Center, Kingston, LMH	CHC	73	76
Albert Einstein College of Medicine - Division of Substance Abuse, Bronx, NYC	DTC	90	90
Anthony L. Jordan Health Center, Rochester, CW	CHC	67	57
Amot Ogden Medical Center, Elmira, CW	HOSP	75	65
Bedford Stuyvesant Family Health Center, Brooklyn, NYC	CHC	63	60
Bellevue Hospital Center, Manhattan, NYC	HOSP	85	85
Betances Health Center, Manhattan, NYC	CHC	83	77
Beth Israel Medical Center, Manhattan, NYC	HOSP	86	84
Beth Israel Medical Center - MMTP, Manhattan, NYC	DTC	75	83
Brookton Neighborhood Health Center, Manhattan, NYC	CHC	86	87
Bronx Community Health Network, Bronx, NYC	CHC	86	89
Bronx-Lebanon Hospital Center, Bronx, NYC	DTC	76	79
Bronx-Lebanon - MMTP, Bronx, NYC	HOSP	92	86
Brookdale Hospital Medical Center, Brooklyn, NYC	HOSP	74	82
Brooklyn Hospital Center, Brooklyn, NYC	HOSP	95	83
Brooklyn Plaza Medical Center, Brooklyn, NYC	CHC	84	77
Brownsville Multi-Service Center for Family Health, Brooklyn, NYC	CHC	82	85
Cabrini Medical Center, Manhattan, NYC	HOSP	65	80
Callen-Lorde Community Health Center, Manhattan, NYC	CHC	82	86
Catskill Regional Medical Center, Harris, LMH	HOSP	75	69
Champlain Valley Physicians Hospital Medical Center, Plattsburgh, NE	HOSP	72	77
Community Health Network, Inc., Rochester, CW	CHC	95	94
Community Healthcare Network, Inc., Manhattan, NYC	CHC	81	84
Coney Island Hospital, Brooklyn, NYC	HOSP	83	77
Cumberland Diagnostic and Treatment Center, Brooklyn, NYC	CHC	75	73
Daytop Village, Inc. of New York, Manhattan, NYC	DTC	94	92
East New York Diagnostic and Treatment Center, Brooklyn, NYC	CHC	80	73
Elmhurst Hospital Center, Queens, NYC	HOSP	76	79
Erie County Medical Center, Buffalo, CW	HOSP	86	85
Family Health Center of Newburgh, LMH	CHC	66	58
Geneva B. Scruggs Community Health Care Center, Buffalo, CW	CHC	65	73
Government Diagnostic and Treatment Center, Manhattan, NYC	CHC	89	87
Greenwich House - MMTP, Manhattan, NYC	DTC	93	92

Sharing of Data with Consumers

A CONSUMER'S GUIDE TO QUALITY OF HIV CARE IN NEW YORK STATE

New York State Department of Health AIDS Institute

Overall Comparison of Clinical Performance – Manhattan				
Health Care Facility	ARV 2001 Score	Viral Load 2001 Score	PPD 2000 Score	Pelvic Exam 2000 Score
Bellevue Hospital Center	85%	84%	77%	82%
Betances Health Center	77%	83%	46%	67%
Beth Israel Medical Center	84%	85%	48%	81%
Beth Israel Medical Center - MMTP	83%	89%	89%	89%
Boriken Neighborhood Health Center	87%	81%	56%	79%
Cabrini Medical Center	80%	73%	36%	52%
Callen-Lorde Community Health Center	86%	81%	48%	51%
Community Healthcare Network, Inc.	84%	84%	39%	93%
Daytop Village, Inc. of New York	92%	93%	83%	88%
Gouverneur Diagnostic and Treatment Center	87%	89%	73%	74%
Greenwich House - MMTP	92%	84%	86%	81%
Harlem Hospital Center	72%	78%	70%	86%
Lenox Hill Hospital	84%	88%	48%	73%
Lower East Side Service Center	84%	87%	92%	78%
Metropolitan Hospital Center	78%	84%	32%	64%
Mount Sinai Medical Center	82%	80%	54%	74%
New York-Presbyterian (Columbia Presbyterian)	89%	88%	62%	83%
New York-Presbyterian (Weill Cornell)	86%	88%	17%	62%
New York-Presbyterian (Weill Cornell), Rogers Clinic	95%	92%	66%	78%
North General Hospital	66%	73%	56%	73%
Phoenix House	96%	94%	99%	97%
Renaissance Health Care Network	59%	69%	67%	66%
Ryan-NENA Community Health Center	82%	79%	63%	NA
Settlement Health and Medical Services	86%	82%	58%	74%
St. Clare's Hospital and Health Center	69%	69%	57%	87%
St. Luke's Roosevelt Hospital (Roosevelt Hospital)	77%	70%	56%	86%
St. Luke's Roosevelt Hospital (St. Luke's Hospital)	81%	78%	51%	71%
SWCHC - St. Vincent's Hospital and Medical Center	80%	86%	47%	87%
William F. Ryan Community Health Center	82%	83%	75%	83%

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HOME   ABOUT THE D5   **VIEW CLINICS**   WHO WE ARE

HOW ARE CLINICS SCORED?

Clinics are given a D5 score by MN Community Measurement based on the percentage of their patients achieving the D5.

The following data is based on patients with Type 1 or Type 2 diabetes, aged 18-75, who were treated in participating Minnesota or neighboring clinics. Only patients who met all of the following 5 goals are counted toward a clinic's D5 score:

1) Control blood pressure less than 130/80
2) Lower LDL or "bad" cholesterol to less than 100 mg/dl
3) Maintain blood sugar so that A1c level is less than 7%
4) Don't smoke
5) Take an aspirin daily, for those ages 40 and older

WHAT DO THESE NUMBERS MEAN?

19%: The average percentage of patients who achieved the D5 among all clinics reported

Percentage of a clinic's patients who achieved the D5 (all five goals)

Number of a clinic's patients who achieved the D5 (all five goals)

Fairview Oxboro Clinic
Group: Fairview Health Services, County: Hennepin
600 W 98th St Bloomington MN 55420
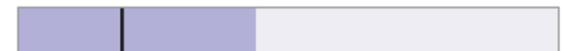
45%

546 of 1219 records reviewed

view historical data

Apple Valley Medical Clinic
Group: Apple Valley Medical Clinic, County: Dakota
14655 Galaxie Ave. Apple Valley MN 55124

44%

388 of 876 records reviewed

view historical data

20 Years of Leadership
A LEGACY OF CARE
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COUNTY OF LOS ANGELES
Public Health
Office of AIDS Programs & Policy

Cost of Food Pantry Selection Using the USDA 2005 Dietary Guidelines for Americans for a Los Angeles County Food Pantry System Serving Low Income People with HIV Infection

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[1]Office of AIDS Programs & Policy, Los Angeles County Department of Public Health, Los Angeles, CA, [2]Necessities of Life Program, AIDS Project Los Angeles, Los Angeles, CA, [3]Consulting Dietitian, North Hollywood, CA, [4]Department of Nutrition, Case Western Reserve University, Cleveland, OH

APLA AIDS Project Los Angeles

BACKGROUND

Documenting the nutritional value of emergency food is necessary in the initial stage of food system change.[1]

In 2006, the Los Angeles County Commission on HIV approved Standards of Care (SOC) to establish minimum quality expectations for food pantries funded by the Office of AIDS Programs and Policy serving people with HIV infection (PWHI). One standard specified that food provided meet at least 50% of the 2005 USDA Dietary Guidelines for Americans (DGA) at the 2,000-calorie level. Adjustments were made for increased protein and for A/C rich fruits.

AIDS Project Los Angeles (APLA), providing groceries to PWHI for over 20 years, adopted the SOC in 2006. APLA pre-bags groceries for over 2300 eligible clients at nine food pantry sites in Los Angeles County. Clients may receive food once a week, four weeks a month. APLA procures donated and purchased food via:

- Food drives
- Los Angeles Regional Food Bank
- Emergency Food Assistance Program
- USDA commodities
- Local food purveyors

OBJECTIVES

Identify if APLA met the SOC that food provided meet at least 50% of the 2000 USDA Dietary Guidelines for Americans (DGA) at the 2,000-calorie level and at what food cost.

METHODS

- Microsoft Excel spreadsheets were developed to catalog
  - Monthly food lists according to DGA food groups, subgroups, & selected nutrients
  - Costs of purchased food

- Three food lists were determined to be evaluated:
  - A: one month in 2005, randomly selected before the SOC was adopted
  - B: two months in 2008 randomly selected after the SOC was adopted and averaged
  - C: adjustment of B to better meet the SOC

- The USDA Food Buying Guide for Child Nutrition Programs was used to determine the edible portion of foods provided.

- Food lists were analyzed using The Food Processor SQL version 10.5 (ESHA Research).

- Costs of food purchased by APLA were collected from computerized inventory and invoice records. Food cost was assigned zero dollars if donated.

- Additional comparison were derived from:
  - Retail costs for food lists B & C collected and averaged of 2 to 3 stores commonly used by APLA clients in 2009
  - Monthly cost using the Thrifty plan for males (20-50 years) in Official USDA Food Plans: Cost of Food at Home Four levels, US Average, June 2008 & June 2009
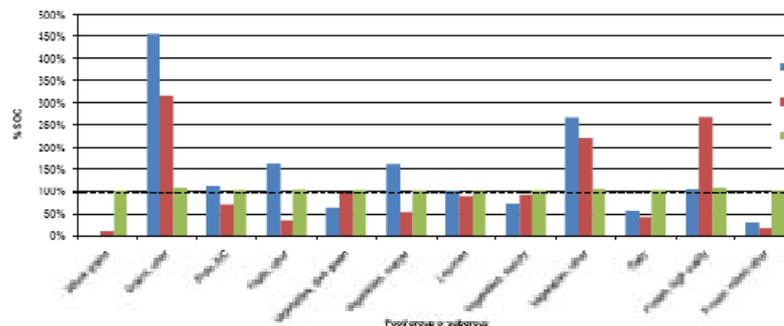
RESULTS

Figure 1. % SOC met for food groups and subgroups, A, B, & C
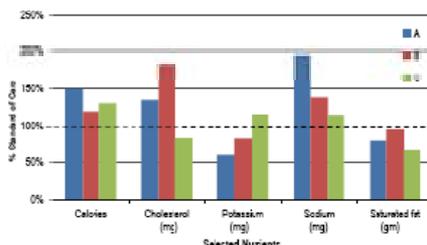Meeting goals for food lists A & B was inconsistent and better met for food list C

Figure 2. % SOC met for calories and selected nutrients, A, B, & C

- Calories remained relatively equal
- Higher amounts of cholesterol, sodium, and saturated fat were found in A & B compared to C
- A & B contained protein exceeding the SOC, and included more convenience and processed foods
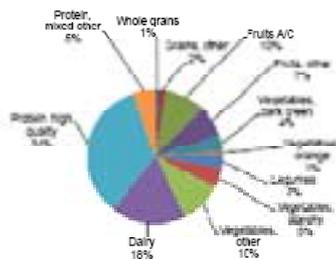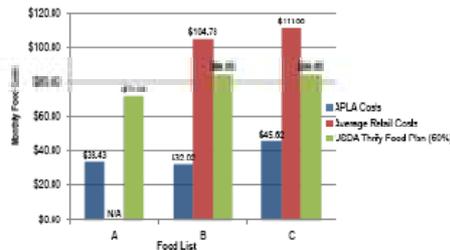

Figure 3. Monthly estimated costs of food for APLA, retail in 2009 dollars, and 50% Thrifty Food Plan for males 20-50 years, June 2005 for males 19-50, June 2008

Yearly estimated food costs to APLA are
- B: $384.24 per individual and $883,752 for 2,300 clients
- C: $847.44 per individual and $1,239,112 for 2,300 clients, an additional $375,360 per year
- At maximum food expenditure of $883,752 per year, only 1614 clients (70%) could receive food meeting SOC

Figure 4. Percent of food dollars spent, B
Largest expenditures in 2008 were for (1) high quality protein, $10.96; (2) dairy, $5.75, (3) other vegetables, $3.24; and (4) fruits that are excellent sources of vitamin A and/or C, $3.16.

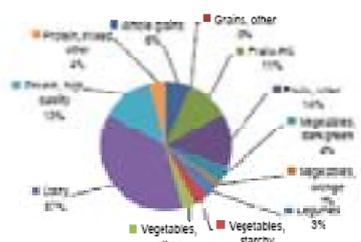Figure 5. Percent of food dollars spent, C
Largest expenditures to better meet the SOC would be for (1) dairy $17.02; (2) other fruits, $6.10; (3) high quality protein, $5.81; and (4) fruits that were excellent sources of vitamin A and/or C, $4.76

Table 1. Percent SOC met for A, B, & C by food category, and percent of total food dollars spent by food category for B & C.

	A % SOC	B % SOC	C % SOC	B % cost	C % cost
Whole grains	0%	9%	100%	1%	6%
Grains, other	453%	315%	108%	2%	0%
Fruits A/C	115%	70%	101%	10%	11%
Fruits, other	102%	30%	102%	0%	14%
Vegetables, dark green	64%	97%	101%	4%	4%
Vegetables, orange	61%	54%	101%	1%	1%
Legumes	100%	88%	98%	3%	3%
Vegetables, starchy	72%	91%	101%	5%	4%
Vegetables, other	266%	221%	104%	11%	3%
Dairy	100%	40%	100%	19%	27%
Protein, high quality	100%	90%	100%	19%	19%
Protein, mixed other	100%	90%	100%	6%	4%

CONCLUSION

- APLA did not meet SOC goals for all categories both nutrients and food groups and subgroups after adopting it
- APLA provides its clients economical value and nutrition support through its ability to procure food through various means
- The SOC reflects quality of food provided and not just the quantity of food provided
- Barriers in purchasing and procuring food to meet SOC include:
  - Budget constraints
  - Changes in prices, i.e., sharp increase in the cost of milk in 2008
  - Changes in availability of foods
  - Clientele with limited cooking capability and personal preferences for convenience items
- Menu planning may increase ability to better meet SOC within budget constraints
- The SOC can guide APLA to focus time, money and energy to procure foods that meet the SOC and assist PWHI to meet the DGA

RECOMMENDATIONS

- Contrast percent of SOC with current spending by food category to redistribute spending from categories that exceed the SOC to the categories that are below the SOC.
- Monitor that foods provided meet the SOC through ongoing nutritional analysis
- Incorporate best practices to purchase, receive, store, inventory, distribute, and monitor a consistent menu planning

CONTACT INFORMATION

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[1] McCullum et al. Evidence-based strategies to build community food security. J Amer Diet Assoc. 2005

Key Lessons Learned

- Allow audience to absorb data and graphs
- Watch out for defensiveness
- Watch out for paralysis by analysis
- Rotate the functions of data reporting among staff
- Share reports at QM committees and at staff, provider and consumer meetings
- Share detailed data report, if needed

National Quality Center (NQC)

Key Lessons Learned

- Stratify statewide data by race/ethnicity, region, etc.
- Develop individual provider reports to share data and compare with aggregate statewide data
- Show not only mean/median, but top 25%, bottom 25%, etc.
- Use maps and other pictorial strategies
- Consider blinded vs. unblinded data reports

National Quality Center (NQC)

Request to Audience

- Which chart/graph did you like the most?

- Share one improvement idea for your next data chart/graph that you have learned today

Quality Improvement Resources

National Quality Center (NQC)

Quality Academy

C) Measurement and Data

TUTORIAL 7	TUTORIAL 8	TUTORIAL 9	TUTORIAL 21
Acting on Measurement – Overview	**Choosing Quality Measures for HIV Care and Services**	**Collecting Performance Data**	**Statistics 101 and Making Graphs in Microsoft Excel**
Beginner	Intermediate	Intermediate	Intermediate

NQC Technical Assistance Calls

One Hour a Month...

National Technical Assistance Calls

Wondering how others do it? Give NQC just one hour a month.

National Quality Center (NQC)

Development of Recommendations: Small Group Discussions

- Select one of the following 4 topic areas based on your personal interest

- Move towards the assigned meeting area

- Select a group facilitator(s) and select a reporter

- Discuss your topic and report back to the larger group

National Quality Center (NQC)

Topic Areas

- How can we best share agency-wide **performance data with consumers**? How can consumers 'understand' your data'? How can you overcome the resistance by your staff to openly share 'bad' data?

- What are the steps necessary to openly **share 'unblinded' performance data** across your agency, network or region? How can we link high performers with 'poor' performers?

- How can you best **prioritize your performance data** and take action based on the most important indicator? What are the selection criteria? Who should be involved?

- How can you effectively report your quality performance data to your agency-wide **senior leaders**? What reporting format is most effective?

National Quality Center (NQC)

Aha Moment and Action Planning

- What have you learned from this workshop?
- What will you do differently in response to this workshop?

- Complete the Action Planning Form on your chair

National Quality Center (NQC)

NQC Activities at the AGM 2010 – Join Us!

Monday, August 23, 2010

- 11am: Improve Your Care and Services with Consumer Input (Quality Institute 1) - Delaware A
- 2:30pm: Creating a Culture for Quality Improvement (Quality Institute 1) - Delaware A

Tuesday, August 24, 2010

- 8:30am: Quality in Hard Times (Quality Institute 1) - Delaware A

Wednesday, August 25, 2010

- 8:30am: Quality Improvement 101/HAB Quality Expectations (Quality Institute 2) - Maryland B
- 11am: An Introduction to Performance Measurement (Quality Institute 2) - Maryland B
- 3:30pm: How to Share Performance Data to Spur Improvement (Quality Institute 2) - Maryland B

Thursday, August 26, 2010

- 8am: Strategies to Measure and Improve Patient Retention Rates - Washington 2
- 10am: Aligning Quality Initiatives: Lessons Learned from Cross-Part Collaborative - Washington 4
- 10am: Quality Management for Non-Clinical Care - Washington 1

Visit our NQC/HIVQUAL Exhibit Booth in the Exhibit Area

- Pick up hard copies of QI Publications and meet your staff and consultants

NATIONAL QUALITY CENTER

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