20 Years of Leadership
A LEGACY OF CARE

Using Quality Management to Measure and Improve Coordination between Supportive Services and Primary Care in the New York EMA

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AIDS INSTITUTE 25 years

NYC Health

Public Health Solutions
MERGING RESEARCH AND ACTION

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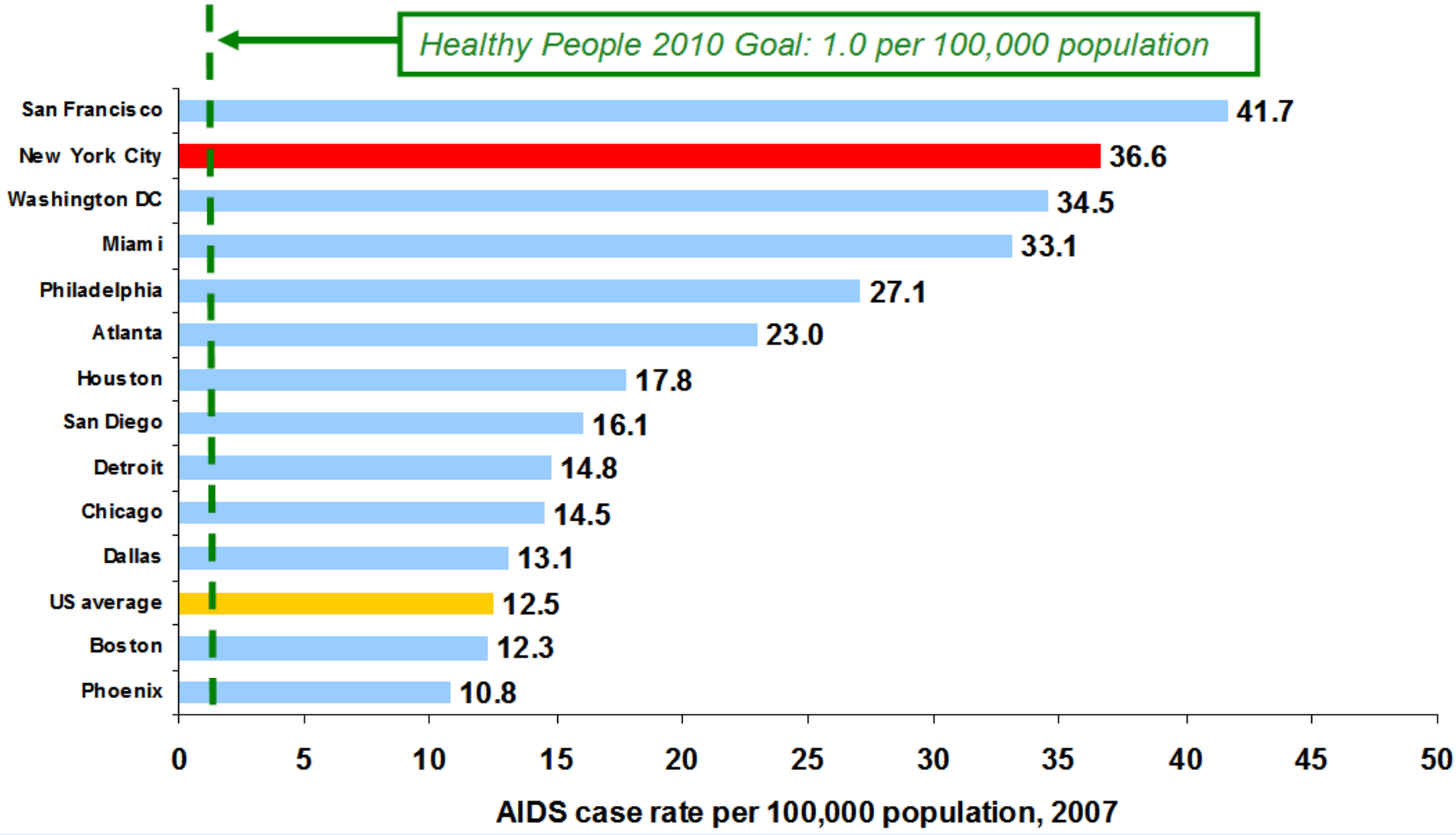
New York City Department of Health & Mental Hygiene

NYC Health

New York City has the 2nd Highest AIDS Case Rate in the US



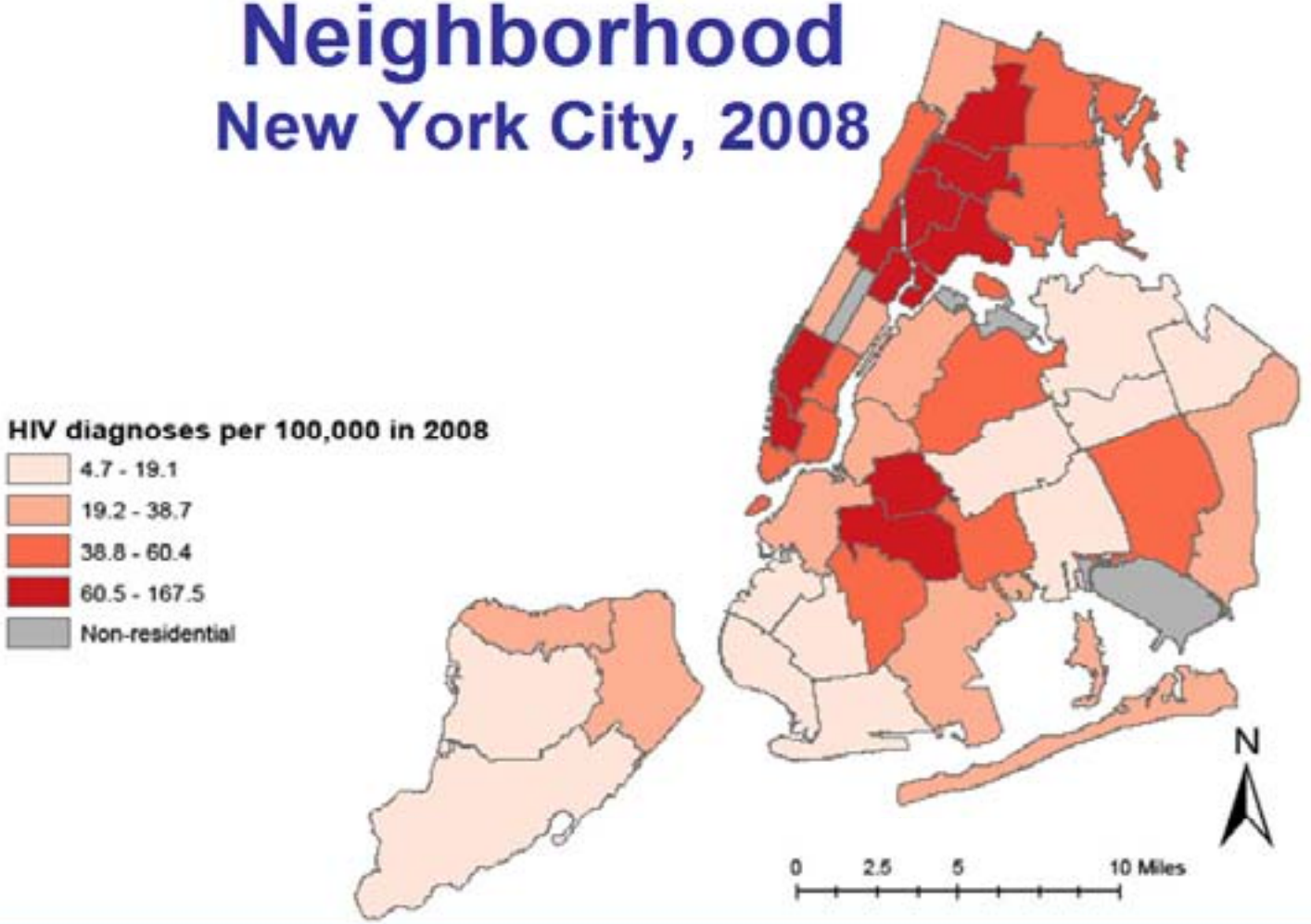
NYC's AIDS case rate is almost 3 times the US average, and nearly 37 times the Healthy People 2010 target.

Based on metropolitan statistical area of residence.

Source: CDC HIV/AIDS Surveillance Report, 2007, Table 17. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm

HIV Diagnosis Rates by UHF Neighborhood

New York City, 2008



UHF neighborhoods with the highest rates of HIV diagnoses are in the South Bronx, Central Brooklyn, lower Manhattan and Harlem.

Rate based on 2000 Census population.
UHF boundaries used in this map have been updated from previous maps.
As reported to the New York City Department of Health and Mental Hygiene by September 30, 2009.

NYC Health

Take Care New York 2012: A Policy for a Healthier NYC

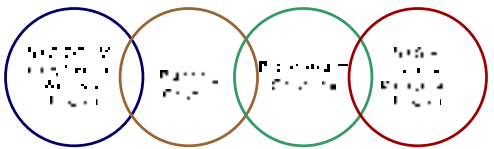
- ***Take Care New York*** is a comprehensive health policy that serves as the organizing principle for DOHMH plans to help all New Yorkers live longer and healthier lives.

- **New York City aims to:**

  1) Promote Quality Health Care for All
  2) Be Tobacco Free
  3) Promote Physical Activity and Healthy Eating
  4) Be Heart Healthy
  5) Stop the Spread of HIV and Other Sexually Transmitted Infections

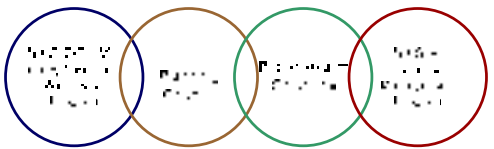
NY EMA Comprehensive Strategic Plan for HIV/AIDS Services

- Goal 1: Increase the number of individuals who are aware of their HIV status
- **Goal 2: Promote early entry into and continuity of HIV care**
  - **To increase the number of newly diagnosed individuals who enter into primary care within three months of diagnosis**
  - **To increase retention in HIV care and treatment**
- Goal 3: Promote optimal management of HIV infection
- Goal 4: Reduce HIV/AIDS health disparities

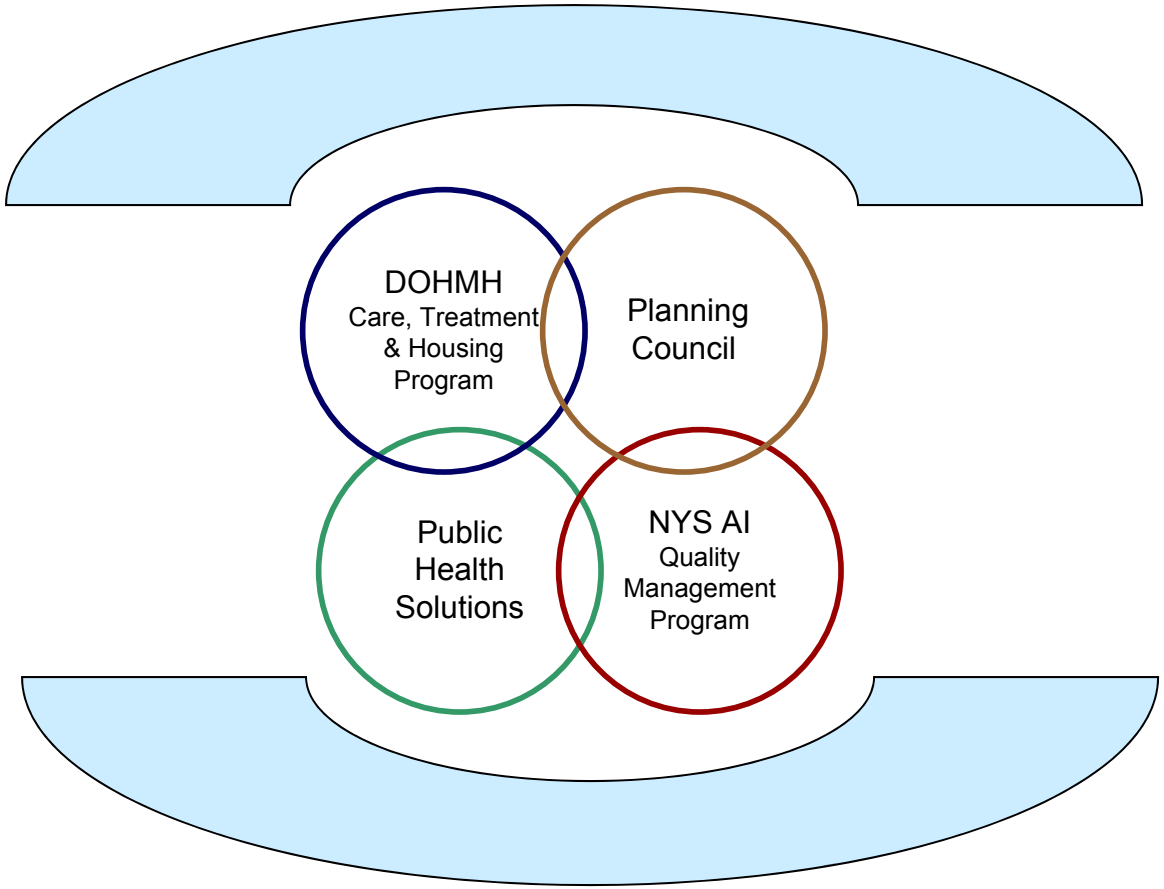


Part A Supportive Services:

- **Supportive Services**: services that support primary care including: substance abuse, mental health, case management and other HIV-related services.
- Services which assist PLWHA to engage and remain in medical care.
  - *Low adherence to visits and poor engagement in care predict higher mortality; patients with poor retention in care have been found to have ~50% higher mortality rate.* (Giordano et al. CID 2007;44:1493)

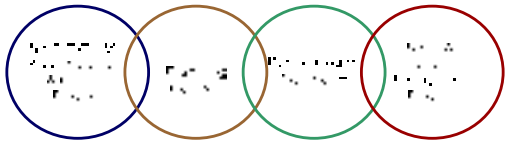


Partnership: New York City and New York State Health Departments



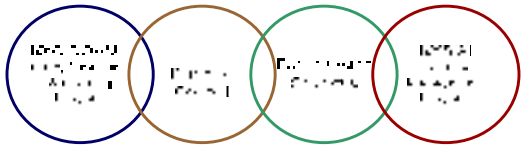
NYC DOHMH: Bureau of HIV/AIDS Prevention and Control

- **Prevention Program**
- **Epidemiology & Field Services**
- **Care, Treatment, and Housing Program (CTHP)**
  - Serves as the Ryan White Part A funds grantee in the NY EMA (five NYC boroughs, Westchester, Rockland, and Putnam Counties)
  - Under HRSA guidance, supports the Planning Council's process of resource allocation to target programs and interventions where most needed
  - Designates:
    - *Public Health Solutions (PHS) as its master contractor in NYC*
    - *NYS AIDS Institute (AI) to provide quality management*



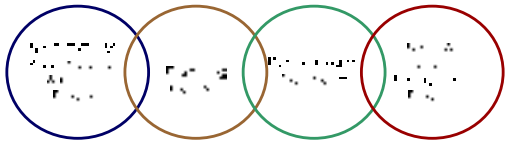
Planning Council

- *In 1991 the Mayor of New York City established the HIV Health and Human Services Planning Council of New York.*
- *The Council is charged with developing spending priorities and allocating for Ryan White CARE Act Part A funds based on the needs of HIV/AIDS epidemic.*
- *The 50 member Council is a coalition of persons living with HIV/AIDS, care givers, governmental representatives, and community members.*
- *The vision of the Planning Council is that people living with HIV disease in the New York EMA will have access to appropriate, quality services across the continuum of care, resulting in the best possible health and quality of life.*



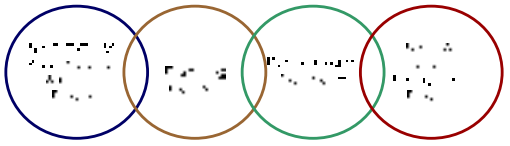
Public Health Solutions

- DOHMH designates Public Health Solutions (PHS) as its master contractor to administer subcontracts for the provision of Ryan White Part A HIV services throughout the five boroughs of NYC.
- In an effort to strengthen coordination between supportive services and primary care, PHS has been instrumental in working with providers on improving the assessment and reporting of primary care status measures (PCSM).

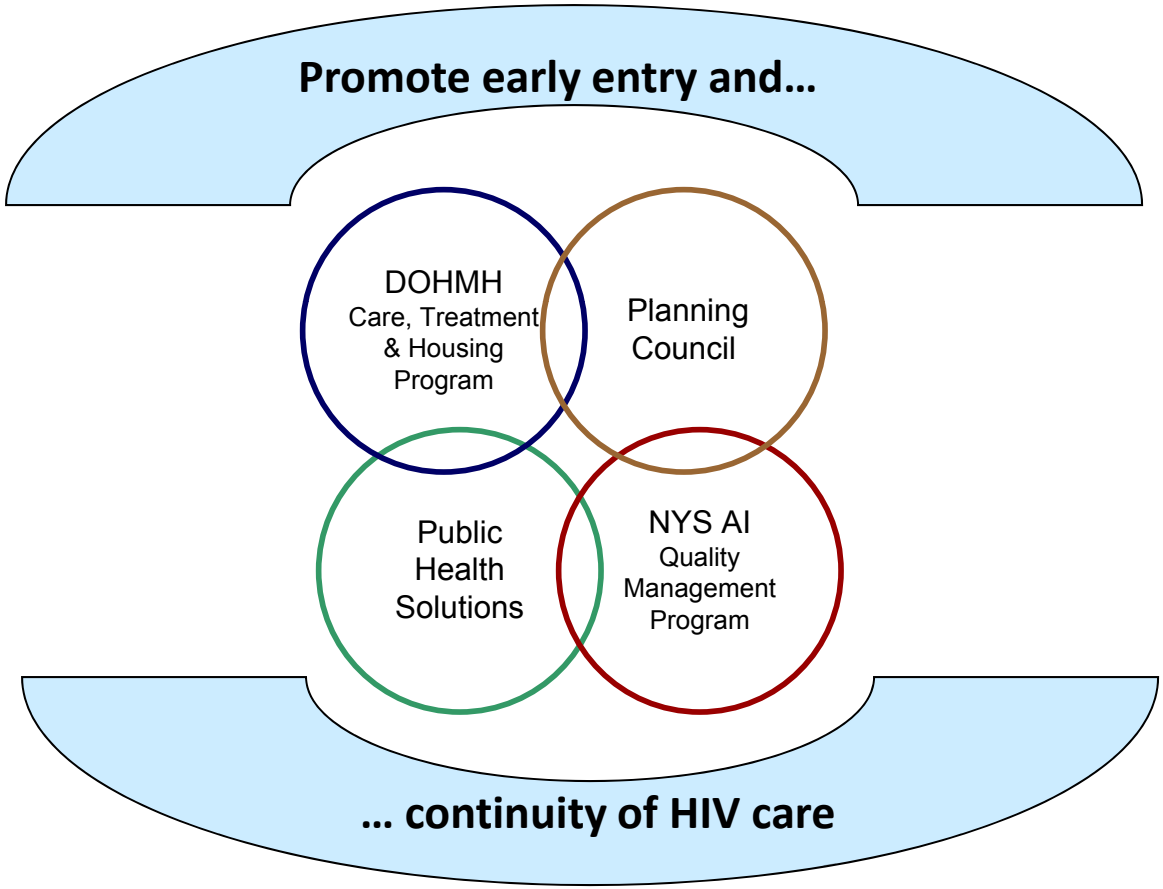


NYS DOH AIDS Institute

- The NYS AIDS Institute provides a multi-faceted quality management program to improve the quality of HIV services delivered in the Part A program
- Considerable experience in quality activities addressing program goals:
  - Promoting HIV quality activities throughout NYS
  - Importance of ensuring patients engaged and retained in primary medical care
  - Effective care coordination
  - Involving consumers in program efforts
  - Focus on clinical outcomes



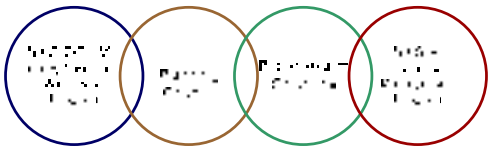
Partnership: NYC DOHMH



DOHMH Study– Delayed Initiation of Medical Care After HIV diagnosis

- NYC study* using 2003 HIV Surveillance data (n=1597), found that:
  - *64% of NYC patients initiated HIV care within 3 months of HIV diagnosis*
  - *19% initiated care more than 3 months after diagnosis*
  - ***17% never initiated care in NYC***

*Torian et al. Arch Inter Med. 2008;168 (11):1181-1187



HRSA Continuum of Engagement in HIV Care: NYC Data

Not in Care ⟷ **Fully Engaged in Care**

Unaware of HIV Status (not tested or never received results)	**Know HIV Status (not referred to care or didn't keep referral)**	**Receiving Other Medical Care but Not HIV Care**	**Entered HIV Primary Care But Dropped Out (lost to f/u ≥1 yrs)**	**In and Out of HIV Care or Infrequent User**	**Fully Engaged in HIV Primary Medical Care**
National rate	NYC – HARS data	NYC – CHAIN data	NYC- HARS data	NYC – HARS data	NYC – HARS data
21%	**17%**	**~26%**	***8.6 %***	***48% ****	***52% ****

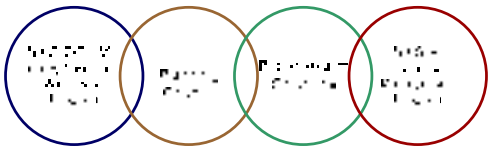
*Torian, et al. In advance of publication. 'Continuous care' definition: regularity of lab reports across 6 month intervals for 2.5 years for newly diagnosed July-Sept 2005.

Part A Service Categories
Emphasize Linkage & Maintenance in Care

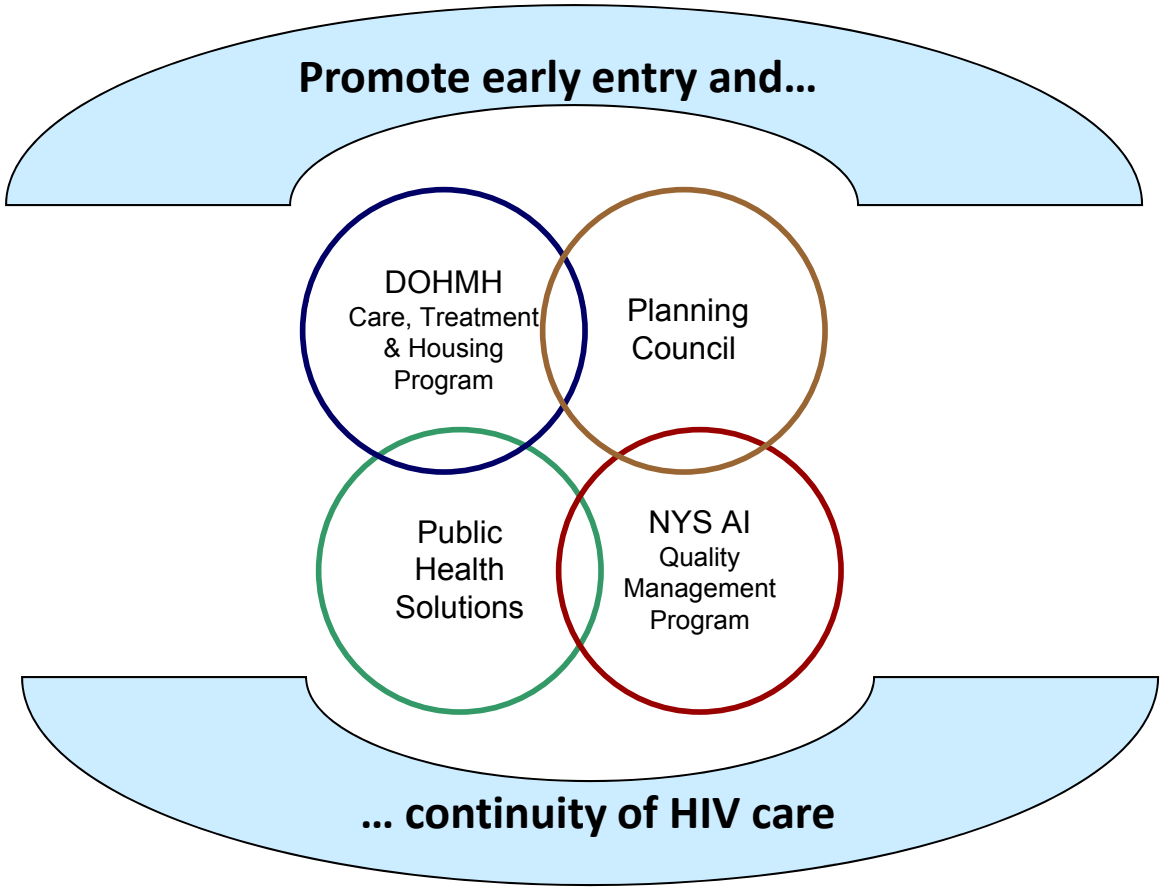
- **Early Intervention Services**
  - Provide rapid HIV testing and linkage to care
- **Case Management / Maintenance in Care**
  - Services target out-of-care individuals or those at risk for dropping out of care
- **Mental Health**
  - Provide assistance to PLWHA with mental illness to reduce barriers to access and engagement in primary care
- **Harm Reduction**
  - Provide harm reduction to PLWHA with substance use issues to minimize barriers to engagement in primary care
- **Food & Nutrition**
  - Provide food and nutrition services and linkage to primary care

Part A Service Categories Emphasize Linkage & Maintenance in Care

- New Program Models:
  - **Ryan White Part A HIV Care Coordination** (2009)
    - Provides an expanded form of HIV medical case management including treatment adherence support.
      - Ensure that PLWHA are linked to care in an timely manner
      - Maintain patients in care via medical care/social service navigation
      - Teach and support treatment adherence, including DOT
      - Provide ongoing health education
      - Support and coach patients to achieve self-sufficiency
  - **Outreach to Homeless and/or Street Youth** (2011)
  - **Transitional Care Coordination for Homeless or Unstably-Housed** (2011)



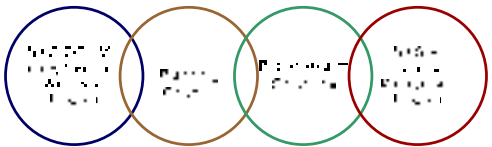
Partnership: HIV Health and Human Services Planning Council



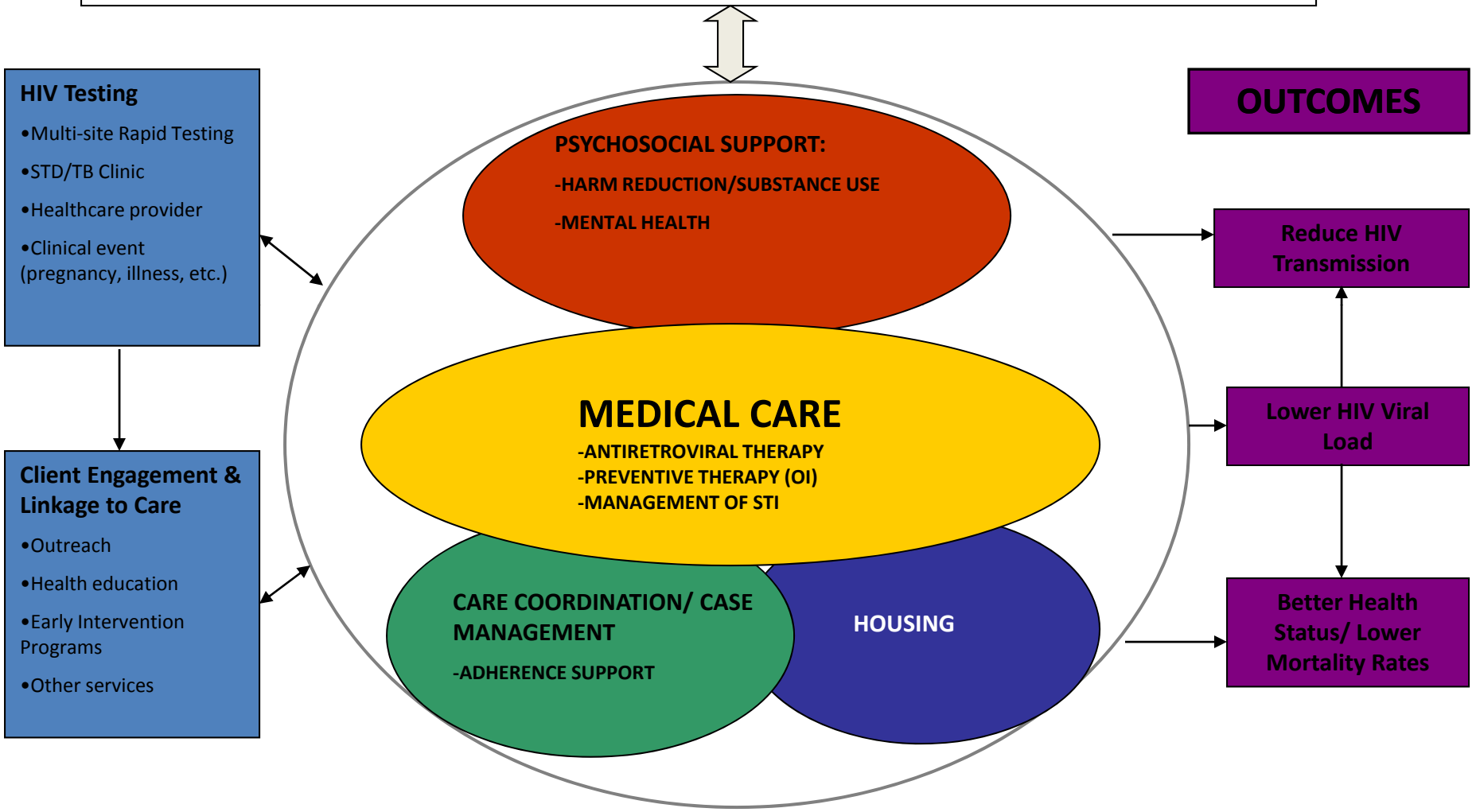
Planning Council

- Beginning in 2004, the Planning Council, undertook 3 major initiatives to plan and organize the delivery of HIV Supportive Services:
  - Develop a comprehensive model →

    "HIV Continuum of Care"
  - Updated the Comprehensive Strategic Plans prioritized services that support primary care
  - Allocated resources to address access and linkage to medical care

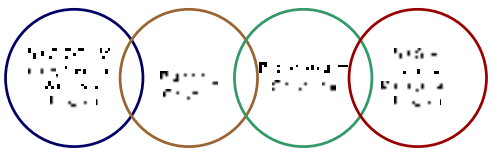


HIV Continuum of Care: Oversight, Management, Quality Improvement, & Capacity Development

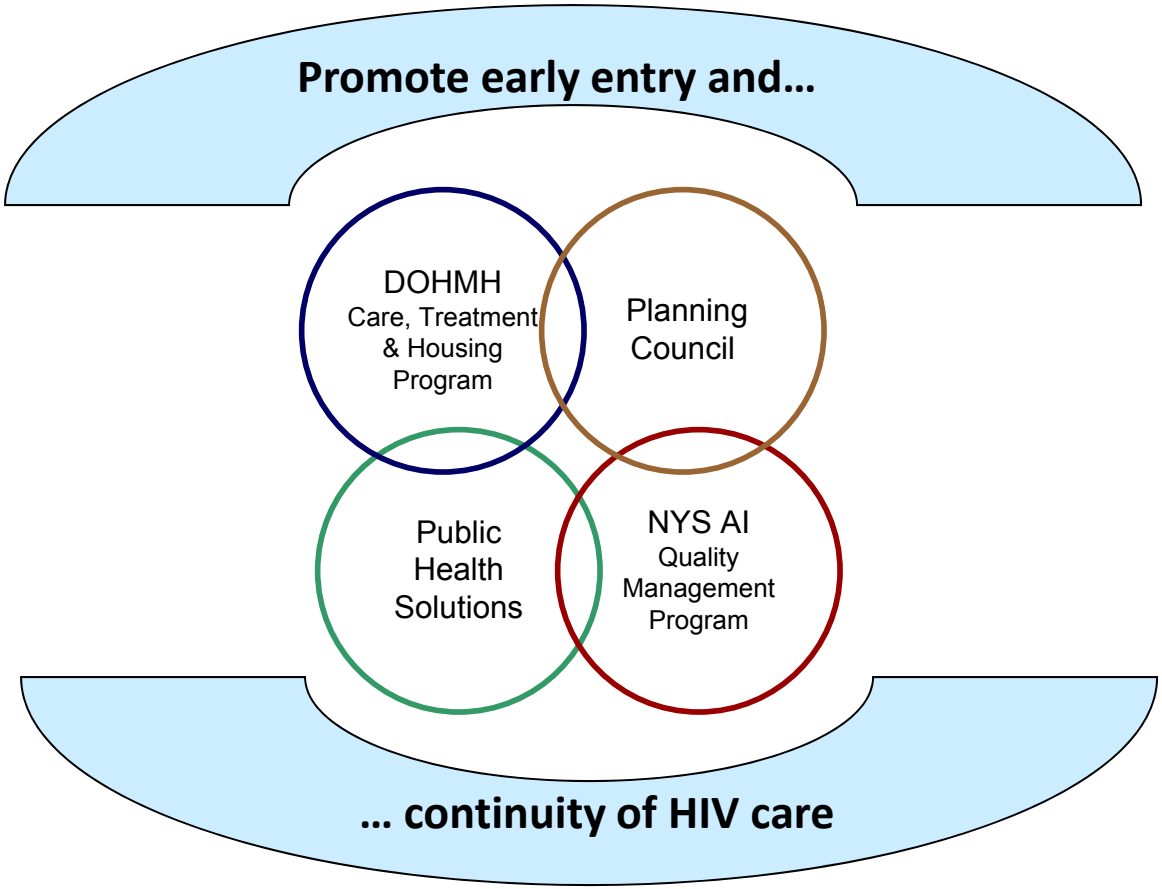


HIV Continuum of Care Model

- All HIV-positive patients to receive services that:
  - Promote state-of-the-art medical care
  - Facilitate access to medical care
    - HIV Testing
    - Ensure access and linkage to care (within 90-days)
    - Follow-up on PCP visit & Referrals
    - Care Coordination/ Case Management
    - Treatment Adherence Assessment
    - Psychosocial Services
    - Housing



Partnership: Public Health Solutions



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Director for Programs and Contract Management
Public Health Solutions

Public Health Solutions
MERGING RESEARCH AND ACTION

Public Health Solutions

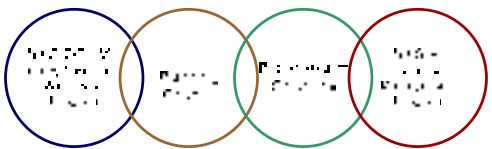
- **Founded in 1957 – provides dynamic solutions to prevent disease and improve community health**
  - conducts comprehensive research providing insight on public health issues
  - creates and manages community health programs
  - provides services to organizations to address public health challenges
  - partners with government agencies and nonprofit organizations to enhance their effectiveness and strengthen their capacity to have an impact and efficiently manage funds
- **Master Contractor for the New York City Department of Health and Mental Hygiene (DOHMH) for HIV/AIDS Contract Administration since 1991**
- **HIV Care Services, a program of Public Health Solutions, manages a portfolio of approximately $150 million in Ryan White Part A and CDC HIV Prevention and City Council contracts**

Introduction

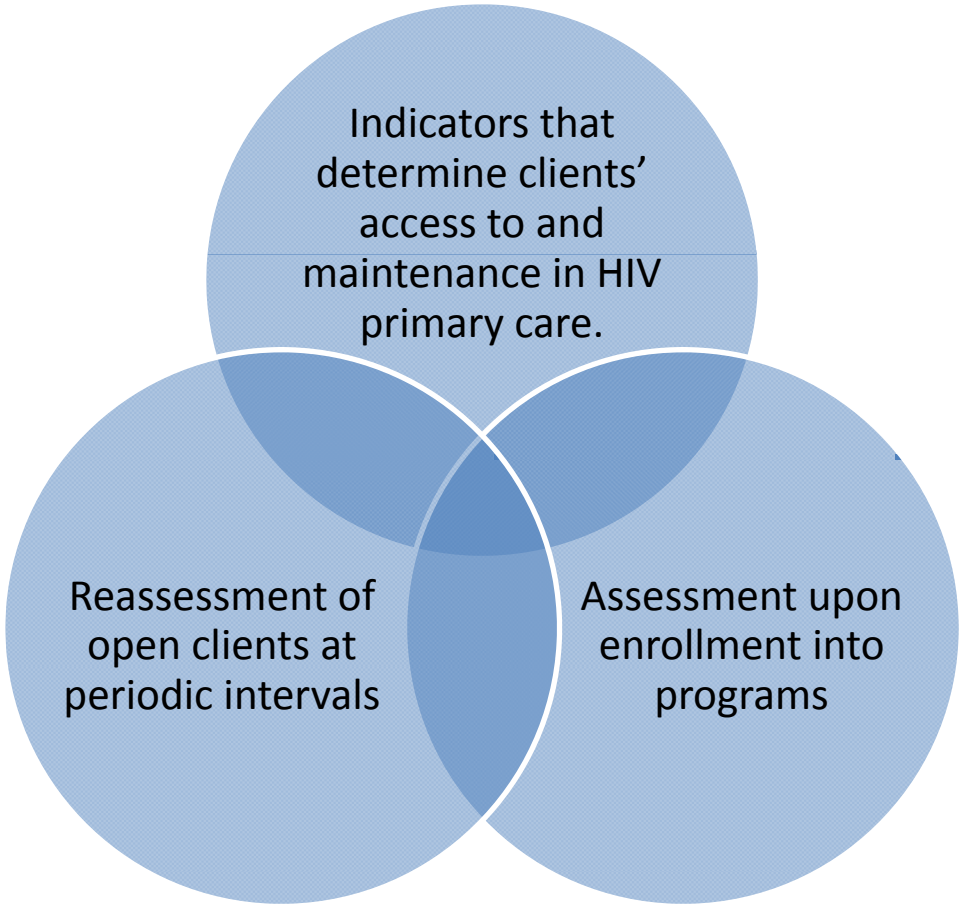
- DOHMH, the HIV Health and Human Services Planning Council (the PC) and Public Health Solutions wished to ensure that the NY EMA provided RW-funded services that are responsive to the core mission of Ryan White legislation.

- We selected data elements that assist in program planning and evaluation

- Beginning in FY 2006 RW contractors were required to report on Primary Care Status Measures (PCSMs).



What are PCSMs?



Service Categories with reporting requirements

All new contracts (rebid), Clinical programs and Select renewed programs

FY 2006 –initiated reporting with 4 new and rebid service categories and a cohort of clinical services contracts

- Supportive Counseling
- Legal Advocacy
- Treatment Adherence
- Out-stationed Medical Teams

FY 2007 – 5 rebid categories and the Prison Transitional Case Management contracts were added to cohort

- Mental Health Services
- Early Intervention
- Maintenance In Care
- Harm Reduction
- Housing Placement Assistance

FY 2008 – added 3 service categories of renewed contracts to cohort reporting

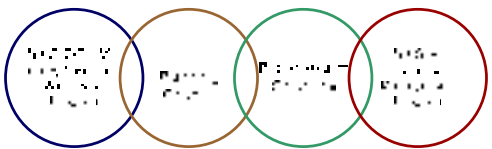
- Case Management
- Transitional Housing
- Housing Placement Coordination

FY 2009 – transitioned 2 new categories and added 1 new category of rebid contracts to those reporting on PCSMs

- Adolescent Outreach
- Harm Reduction Outreach
- Care Coordination (Medical Case Management)

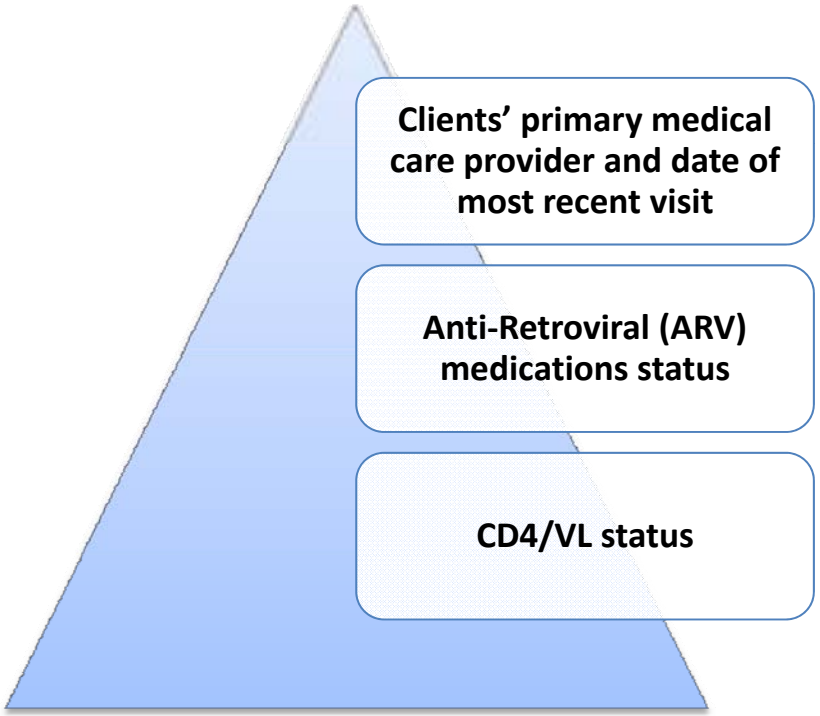
FY 2011 – 3 rebid categories will be added to those reporting on PCSMs

- Food and Nutrition
- Transitional Care Coordination for Homeless and Unstably Housed
- Outreach to Homeless and Unstably Housed Youth



What is assessed?

In general, three major areas are assessed:

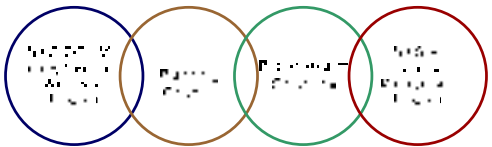


What is assessed?

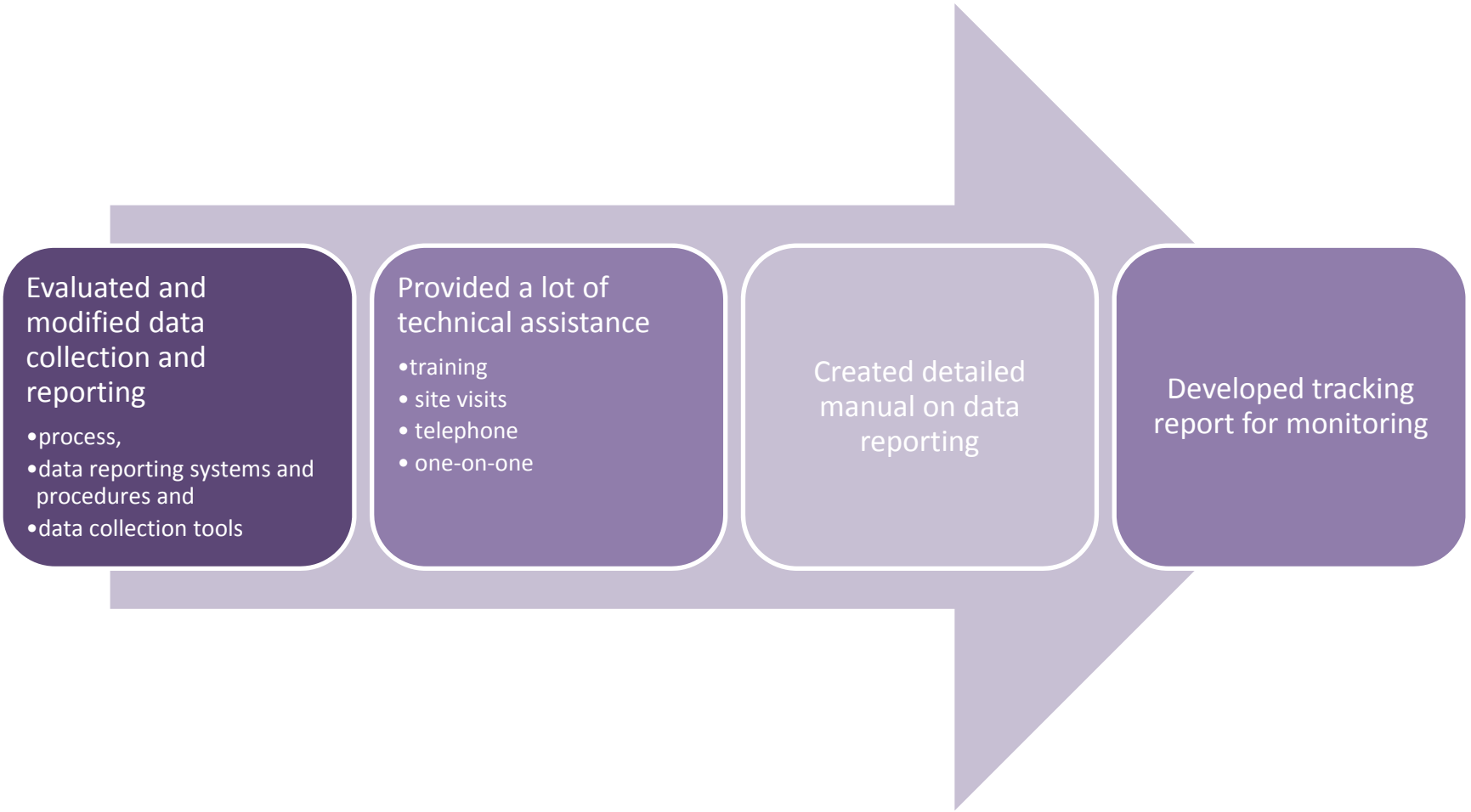
(cont'd)

The nature of the service category drives reporting requirements and differs from category to category

Important exceptions are made at the service category level. For example, some contractors don't assess all three and some assess additional category-specific measures

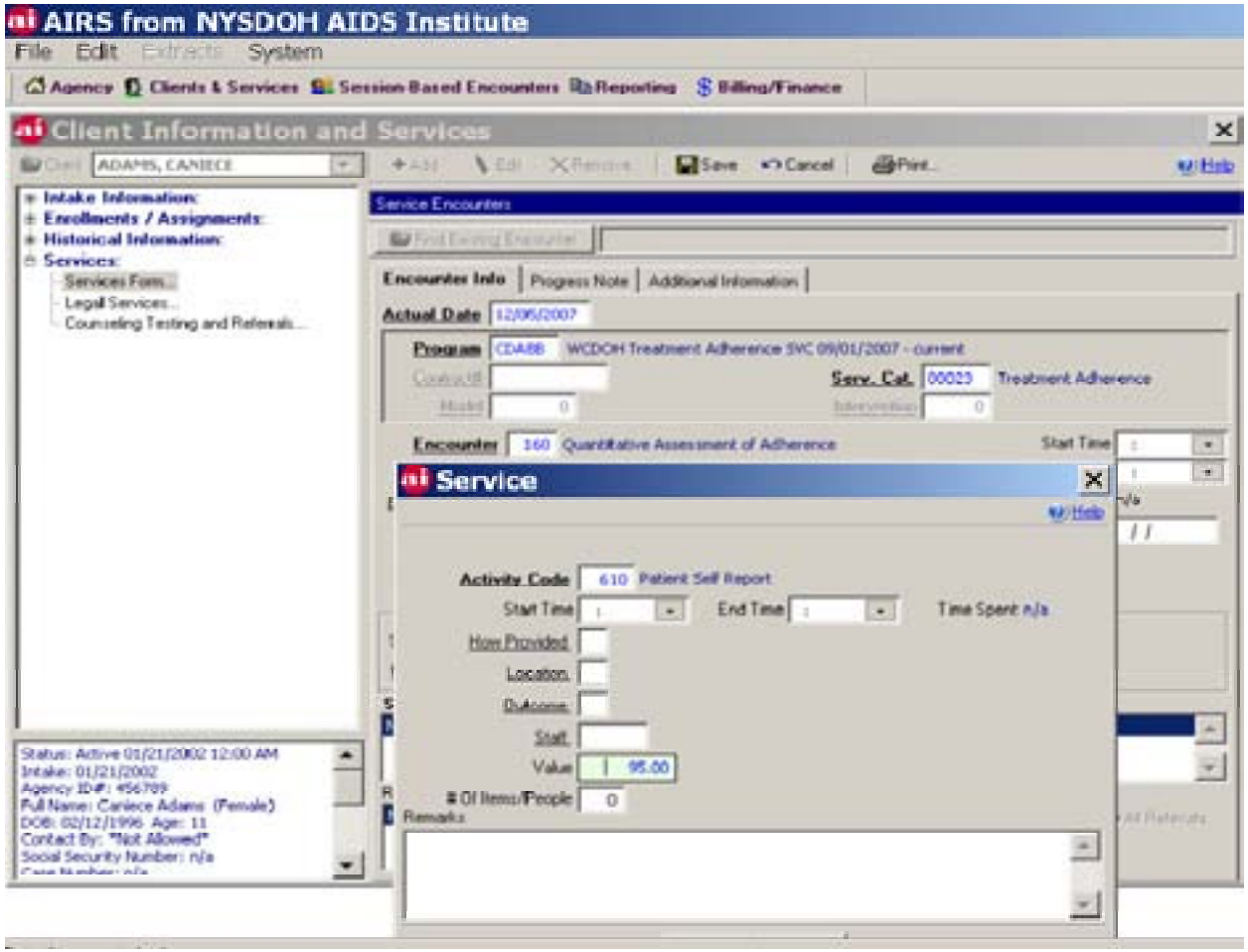


Start-up Phase



Tools and Technical Assistance

(excerpted from Manual provided to contractors)



Sample Data Collection Tool

Primary Care Status Measures

Client Name: _____ (LAST) _____ (FIRST) _____ (Middle) **Client ID:** _____

Staff Completing Form: _____

Section I – **PCP Visit Information**

Date of most recent primary care/outpatient visit:
__ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Date Asked: __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Primary Care Physician:
_____

If a client has not had a PCP visit within the six preceding months, do NOT proceed to Section II and III. Refer client to a HIV Primary Care Provider. Complete the referral information below.

Name of primary care physician/provider client referred to:
_____

Date of Referral: __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Status of Referral:
_____
_____

Primary care physician appointment date:
__ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Section II - **Laboratory Test Information**

05 HIV Detection / Antigen / Viral Load Test
Test Code: 03 PCR 12 Quant PCR 13 bDNA 88 Other

Test Date:
__ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Test Result: 5 Detectable 6 Undetectable
Count: _____

06 CD4 (T-Helper) Tests
Test Date:
__ __ / __ __ / __ __ __ __
MONTH DAY YEAR

Range: 01 < 200 02 200-499 03 500-749 04 750-999 05 1000-1499 06 >=1500
--range is acceptable without count but count is preferred.

Count: _____ *Percentage:* ___ ___ ___ %

Section III - **ARV Therapy History**

Client on ARV Therapy Y/N?_____

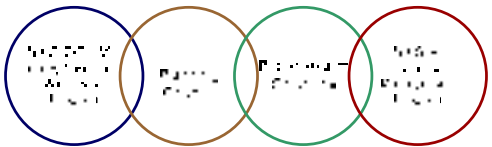
Date Asked: __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

ARV Therapy Type: Check One
02- HAART_____
04- MONO THERAPY_____
05- DUAL THERAPY_____
06- UNKNOWN/ UNREPORTED_____

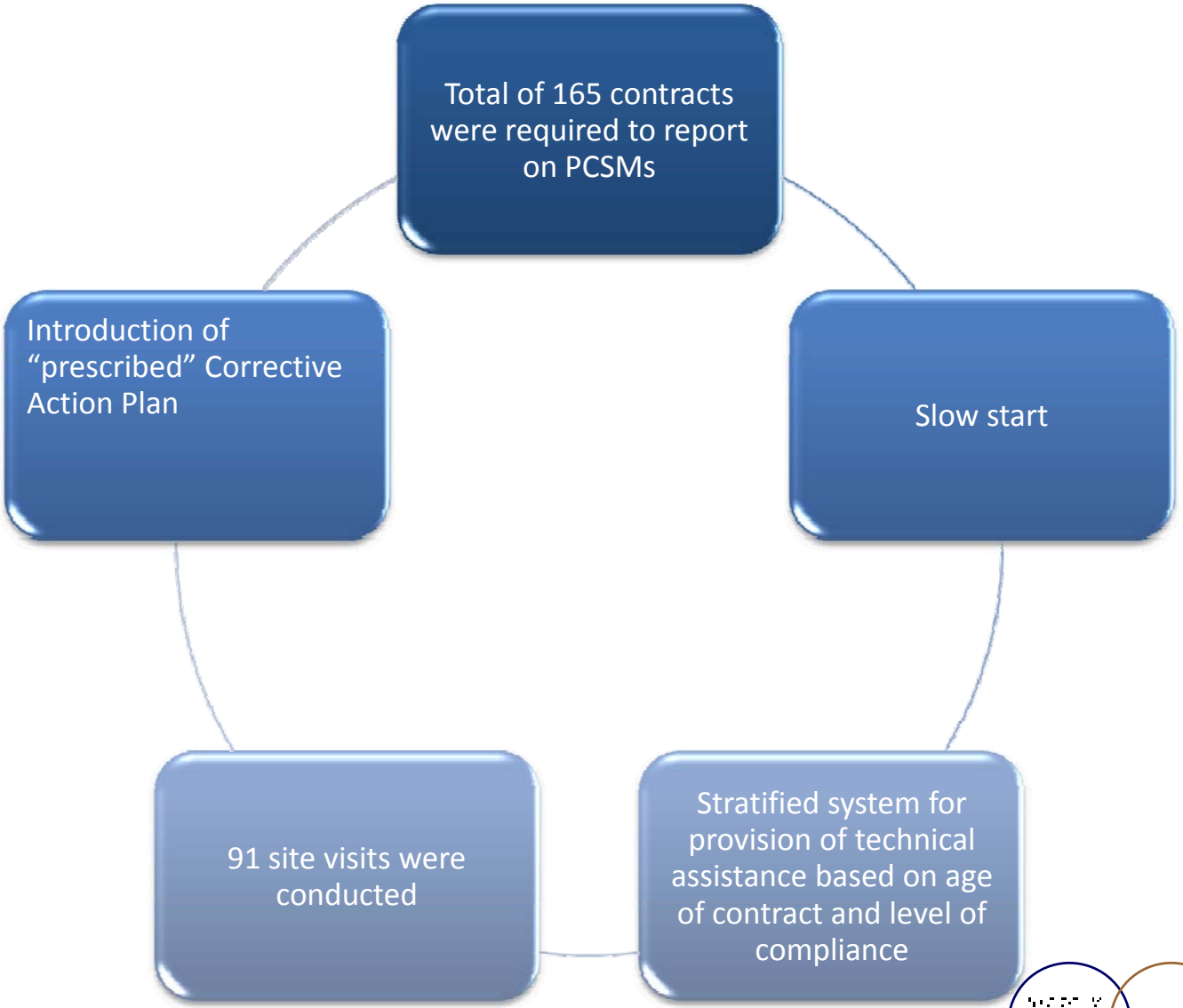
ARV Start Date:
__ __ / __ __ / __ __ __ __
MONTH DAY YEAR

If not on medication please state why: ***(Not required by HIVCS; however, is required by AIRS to save record)***
_____
_____

AIRS Data Entry Key:
Current PCP: Clients & Services -> Historical Information -> Primary Care Physician Information
Referral to PCP: Enter an Encounter/Service following contract mapping then enter referral information in the referral section of the Encounter/Service screen
Viral Load & CD4 Tests: Clients & Services -> Historical Information -> Laboratory & Psychological Tests
ARV Therapy: Clients & Services -> Historical Information -> Medication History -> ARV Therapy Type



Early Experience 2007



Corrective Action Plan

Corrective Action Plan

1. Identify the area of concern. Complete a separate table for each concern.	
Area of concern:	☐ PCSMs data not entered in URS and not reported to HIV Care Services ☐ Primary Care Physician visit data not reported/inadequately reported ☐ Absent or inadequate documentation of PCSMs in client records ☐ No or inadequate referrals for clients without a PCP visit within 6 months ☐ No CAP needed at this time
2. Identify the issue(s) that have contributed to the area of concern listed above.	
Issue A:	☐ Lack of clarity regarding PCSMs reporting process
Issue B:	☐ Data entry not conducted ☐ Data entry not coordinated ☐ Data entry training needed ☐ Data entry not possible due to technological problems (URS/AIRS)
Issue C:	☐ Staff vacancies ☐ Other_____(specify)
3. Formulate solution(s) to address the issues identified above. For each solution, list the action step(s) necessary to achieve the solution, staff responsible, and time frame for completion.	
Solution A:	

Actions Steps:	**Staff Responsible:**	**Time frame for Completion:**	**Related Issues:**

Early Challenges

EMA's data reporting

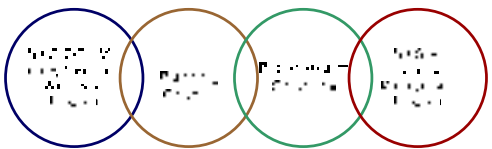
- database system replaced – technical training, data export problems

Introduction of PBC

- concerns about non-reimbursable reporting requirements

Tracking report

- revealed ambiguity in interpreting PCSMs



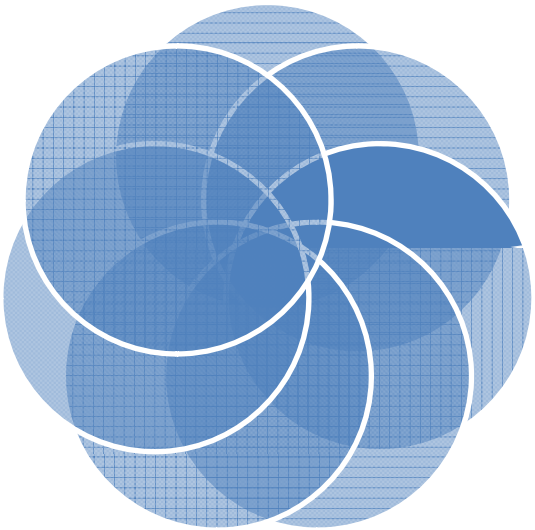
Operational Mandates

Intensive site visits

Technical assistance

(data collection, reporting protocols, QA, organizational culture, interdepartmental communication)

Need for clear, logical tracking tools

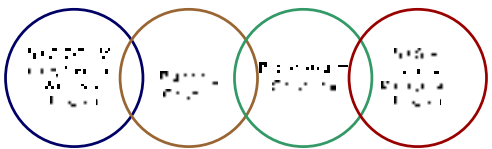


Acceleration of corrective action: Conditional status

Best practices sharing

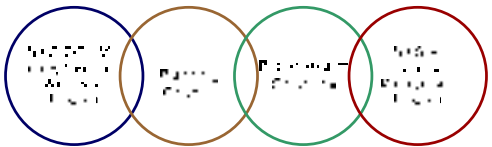
Need for disciplinary process in place

Dedicated staff

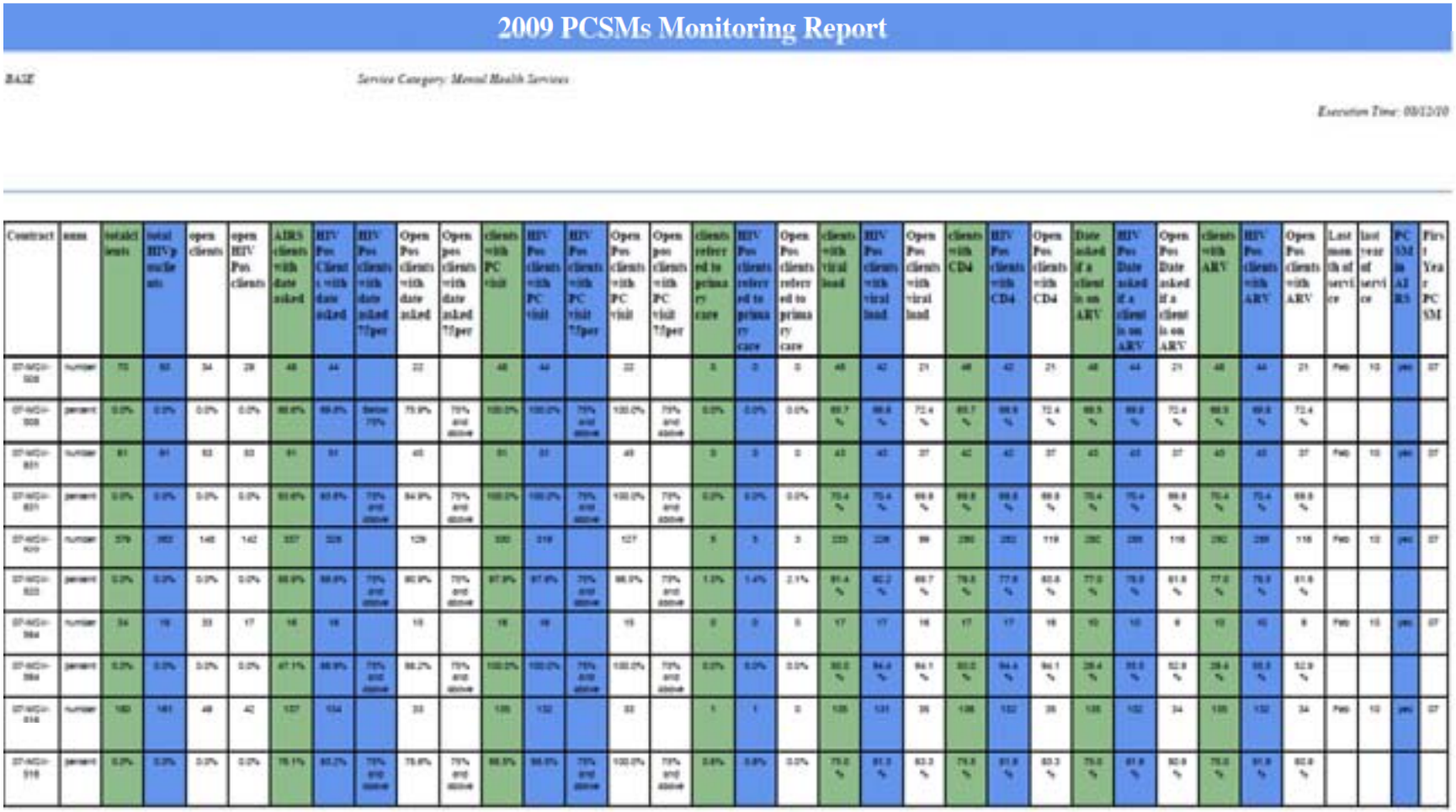


Tracking Report Elements
(partial list)

- Total number of enrolled clients
- HIV status (PCSMs only for index HIV+ client)
- Level of contract compliance with PCSM reporting requirements
  - Status of engagement in care
  - ARV status
  - Labs conducted



Tracking Report - sample



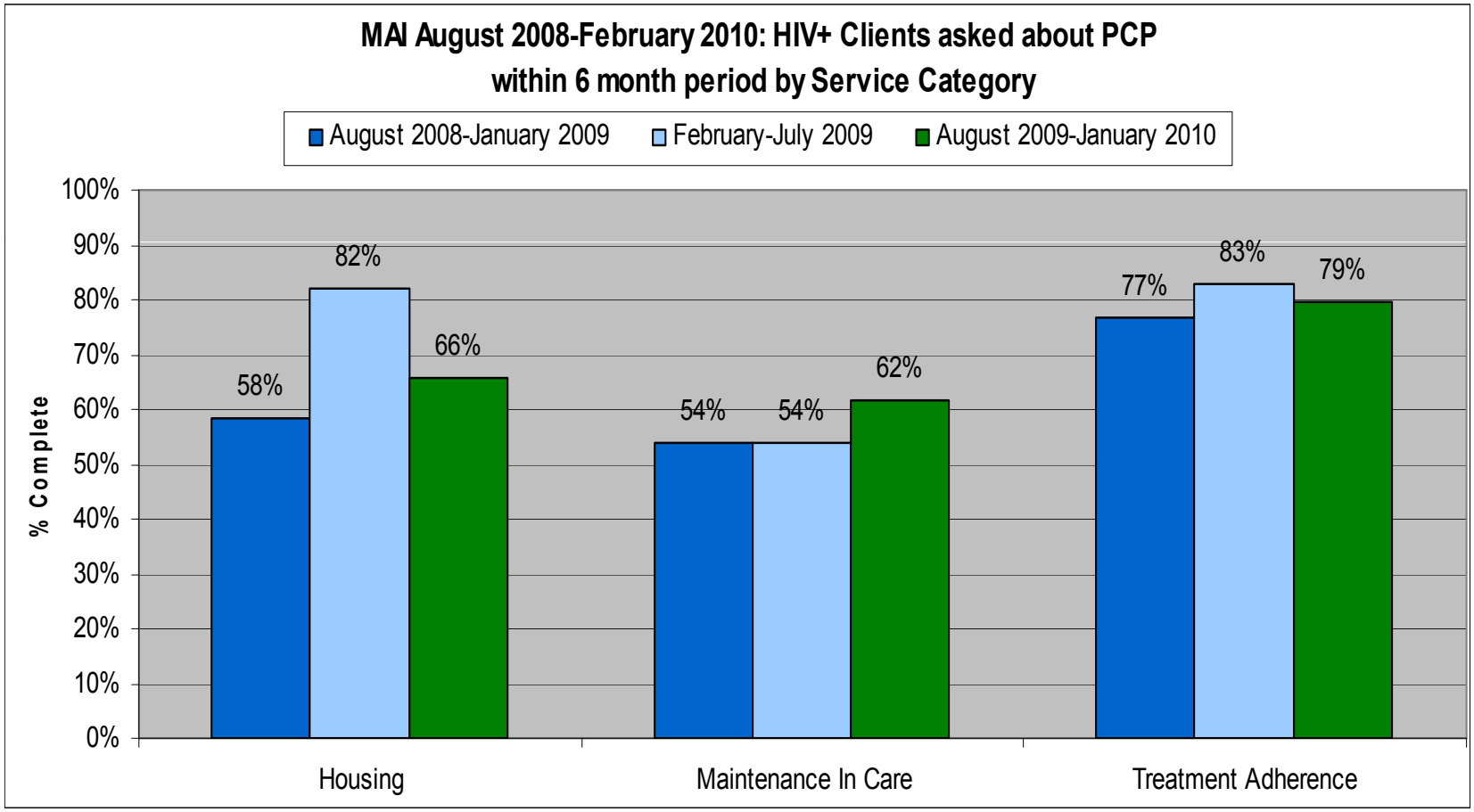
2009 PCSMs Monitoring Report

BASE — *Service Category: Mental Health Services*

Execution Time: 08/12/10

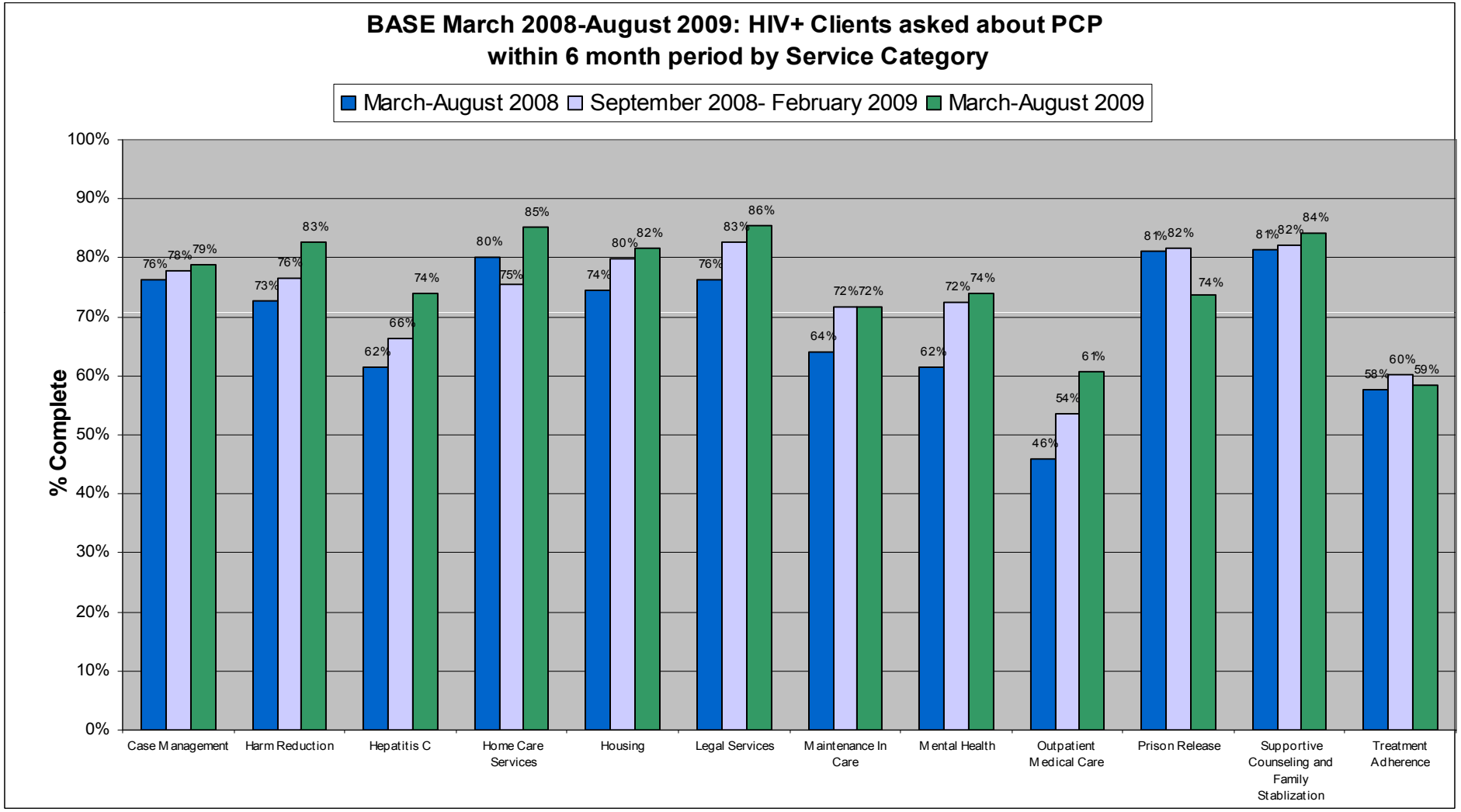
Contract	enns	totalcl ients	total HIV p ositie nts	open clients	open HIV Pos clients	AIRS clients with date asked	HIV Pos Client s with date asked	HIV Pos clients with date asked ??per	Open Pos clients with date asked	Open pos clients with date asked ??per	clients with PC visit	HIV Pos clients with PC visit	HIV Pos clients with PC visit ??per	Open Pos clients with PC visit	Open pos clients with PC visit ??per	clients referr ed to prima ry care	HIV Pos clients referr ed to prima ry care	Open Pos clients referr ed to prima ry care	clients with viral load	HIV Pos clients with viral load	Open Pos clients with viral load	clients with CD4	HIV Pos clients with CD4	Open Pos clients with CD4	Date asked if a client is on ARV	HIV Pos Date asked if a client is on ARV	Open Pos Date asked if a client is on ARV	clients with ARV	HIV Pos clients with ARV	Open Pos clients with ARV	Last mon th of servi ce	last year of servi ce	PC SM in AI RS	Firs t Yea r PC SM
07-WCI-508	number	75	83	34	29	48	44		22		48	44		22		5	5	0	48	42	21	48	42	21	48	44	21	48	44	21	Feb	10	yes	07
07-WCI-508	percent	0.0%	0.0%	0.0%	0.0%	88.8%	88.8%	Below 75%	75.9%	75% and above	100.0%	100.0%	75% and above	100.0%	75% and above	0.0%	0.0%	0.0%	88.7 %	88.8 %	72.4 %	88.7 %	88.8 %	72.4 %	88.5 %	88.8 %	72.4 %	88.5 %	88.8 %	72.4 %				
07-WCI-851	number	81	84	53	53	91	91		45		91	91		45		3	3	0	43	43	37	42	42	37	43	43	37	43	43	37	Feb	10	yes	07
07-WCI-851	percent	0.0%	0.0%	0.0%	0.0%	88.8%	88.8%	75% and above	84.9%	75% and above	100.0%	100.0%	75% and above	100.0%	75% and above	0.0%	0.0%	0.0%	79.4 %	79.4 %	68.8 %	88.8 %	88.8 %	68.8 %	79.4 %	79.4 %	68.8 %	79.4 %	79.4 %	68.8 %				
07-WCI-509	number	279	302	148	142	257	228		129		220	218		127		5	5	3	223	228	99	280	282	118	282	288	118	282	288	118	Feb	10	yes	07
07-WCI-833	percent	0.0%	0.0%	0.0%	0.0%	88.8%	88.8%	75% and above	90.9%	75% and above	97.8%	97.8%	75% and above	98.5%	75% and above	1.5%	1.4%	2.1%	85.4 %	82.2 %	68.7 %	78.8 %	77.8 %	63.8 %	77.8 %	78.8 %	61.8 %	77.8 %	78.8 %	61.8 %				
07-WCI-564	number	34	19	33	17	18	18		15		18	18		15		0	0	0	17	17	16	17	17	16	10	10	8	10	10	8	Feb	10	yes	07
07-WCI-564	percent	0.0%	0.0%	0.0%	0.0%	47.1%	38.9%	75% and above	86.2%	75% and above	100.0%	100.0%	75% and above	100.0%	75% and above	0.0%	0.0%	0.0%	88.8 %	84.4 %	84.1 %	88.8 %	84.4 %	84.1 %	28.4 %	55.5 %	52.9 %	28.4 %	55.5 %	52.9 %				
07-WCI-516	number	180	181	48	42	137	134		33		135	132		33		1	1	0	135	131	35	136	132	35	135	132	34	135	132	34	Feb	10	yes	07
07-WCI-516	percent	0.0%	0.0%	0.0%	0.0%	76.1%	82.2%	75% and above	75.8%	75% and above	88.8%	88.8%	75% and above	100.0%	75% and above	0.8%	0.8%	0.0%	75.0 %	81.3 %	83.3 %	75.8 %	81.8 %	83.3 %	75.0 %	81.8 %	82.9 %	75.0 %	81.8 %	82.9 %				

Achievements



*All data is based on distinct urn_no (unique identifier)
*Includes all clients enrolled for the entire 6 month period with at least one activity in the period and any clients enrolled during the period
*Does not include HHC Bellvue or the Institute for Family Health

Achievements



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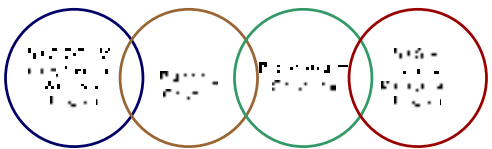
Feedback to Contractors

Development/distribution of the “report card”

- **Frequency**
- **Target audience**
- **Response**



Program Report Cards

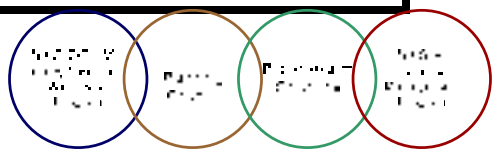
2008 PCSMs Monitoring by Contracts

HIV-positive Clients who received Services

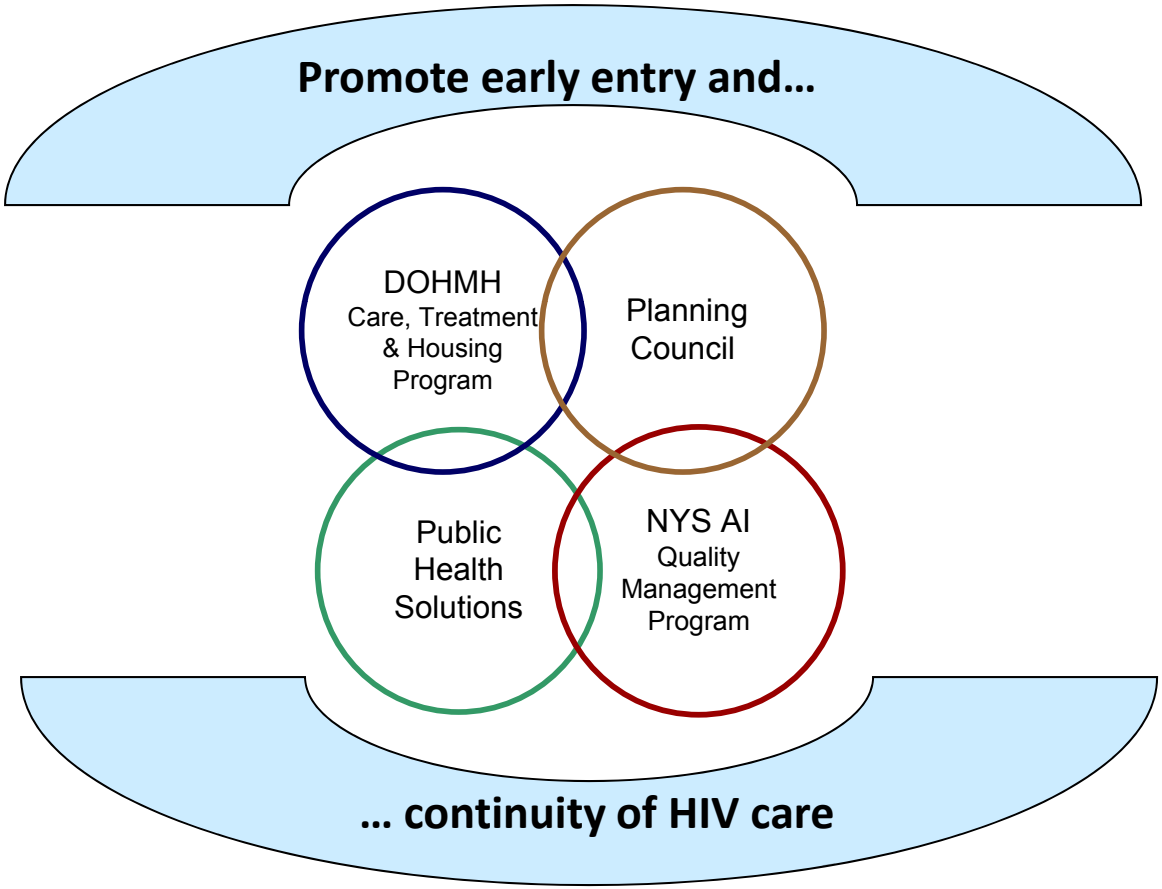
Execution Time: 06/17/00

ABC AGENCY

Contract Numbers	00-HCS-130		
	Number	Percent	
Total Clients	136		
Total HIV-positive Clients	133		
Asked if They have a PCP	104	78.2%	75% and above
with a PCP Visit Date	103	99.04%	75% and above
Referred to Primary Care	1	0.75%	
with a Viral Load Result	126	94.74%	
with a CD4 Count	128	96.24%	
Asked if They Are on ARV	132	99.25%	
with an ARV Status	132	99.25%	
Last Month and Year of Service			February 2009
Report PCSM via AIRS?			yes



Partnership: NYS DOH AIDS Institute



20 Years of Leadership
A LEGACY OF CARE

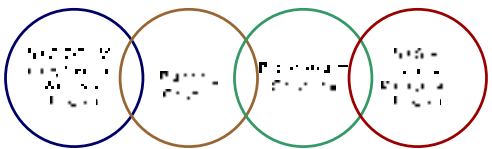
Using Quality Management to Measure and Improve Coordination between Supportive Services and Primary Care in the New York EMA

Tracy Hatton
Part A Quality Management Program
New York State Department of Health AIDS Institute

AIDS INSTITUTE 25 years

NY EMA Quality Management Program

- Established in 2001 based on RWCA
- Builds upon NYS AIDS Institute program standards and statewide expectations
- Focus on quality needs specific to the EMA consumers and providers

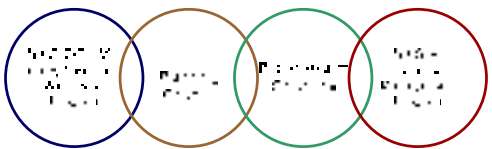


Quality Management Framework

Performance Measurement
Quality Improvement Efforts
HIV Quality Learning Networks

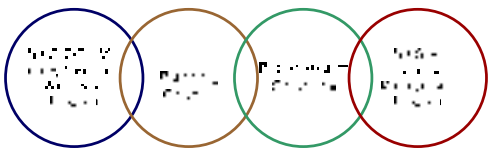
Using Performance Measurement

- Prioritizing areas for improvement
- Identification of common issues through performance data
- Measuring progress
- Benchmarking and goal setting



Primary Care Priorities

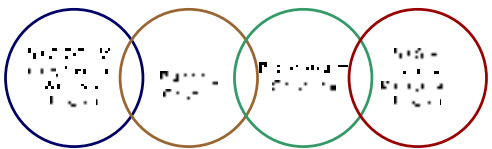
- Increase the number of patients who are linked to a Primary Care Provider
- Improve documentation of rates of viral load and CD4 testing
- Improve documentation that referral to PCP occurred and follow-up that appointment was kept for those clients who have not had a visit or are newly diagnosed



Primary Care Indicators

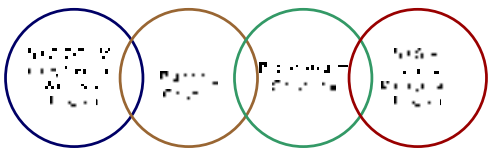
- Emphasize the goals and priorities of the EMA in the area of primary care and coordination of care

- Establish priority areas for the Quality Management Program provider and be responsive to these goals



Rationale for Review of Primary Care Data Elements

- Emphasize engagement in primary care as a quality priority
- Create identity in supportive service providers of their role in HIV continuum of care
- To address primary care access on a wide scale-as a goal of the EMA
- Establish a priority area for the quality management program



Primary Care Access Indicators

(Reviewed for the first time in 2004)

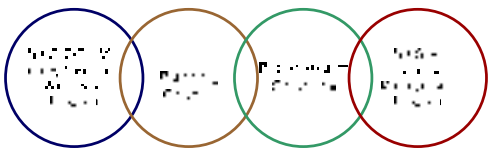
- Measure:

  One visit at least every 6 months

  Or, annual assessment that patient has primary care provider, name of provider and visits dates

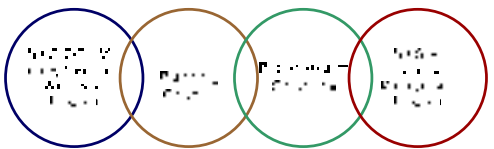
  – If no visit, documentation of referral to primary care provider

  – Follow-up to determine appointment was kept



What Does this Measure and Who Benefits?

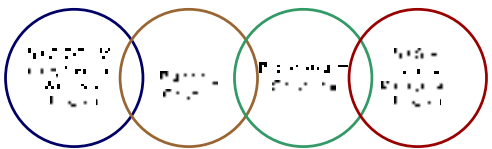
- For service providers-ensure that supportive services and medical care complement each other
- For patients-HIV care providers are communicating about cases
- For EMA-RW patients engaged and retained in medical care



Primary Care Review Data

Primary care access reviewed for these services (begun in many cases prior to contractual requirement)

- Mental Health (2005-2009)
- Case Management (2004-2006)
- Food and Nutrition (2004, 2008)
- Harm Reduction (2006, 2008)



Primary Care Performance Review Data
Case Management, Harm Reduction, Food & Nutrition

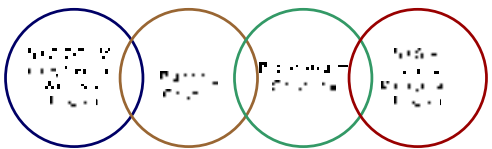
	Assessed for Primary Care	
CM 2004 n=479 (33 programs)	55%	
CM 2006 n=623 (31 programs)	91%	
HR 2006 n=909 (18 programs)	58%	
HR 2008 n=596 (24 programs)	88.6%	
F&N 2004 n=412 (14 programs)	14%	
F&N 2008 n=511 (13 programs)	97.3%	Of those assessed, over 99% have regular PCP

Improvement Strategies

In the HIV Quality Learning Networks:

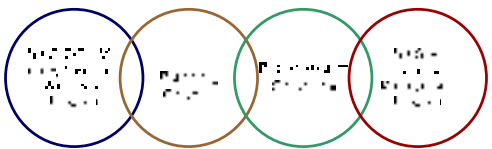
- Stress care continuum and emphasize role and responsibility supportive services have in ensure patients are in medical care
- Share forms, methods, best practices

  e.g. add primary care assessment to 'intake' or 'enrollment' form
- Emphasize documentation in charts
- Increase involvement with clinical services



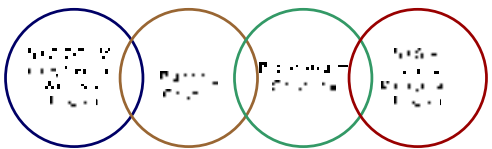
Continuing Steps in Learning Networks

- Increase the number of patients out of care who are linked to a primary care provider
- Develop and implement referral methods
- Improve documentation that referral to and appointment with primary care provider occurred for those not in care
- Promote integration and information sharing between supportive and clinical programs



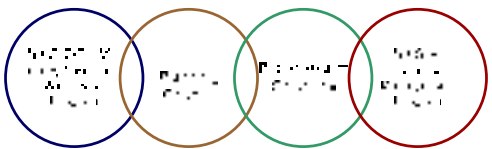
Successes and Continued Challenges

- Improvement in many but not all programs
- Focus on linking data reviews to quality improvement activities
- Working together in Learning Network to identify performance priorities

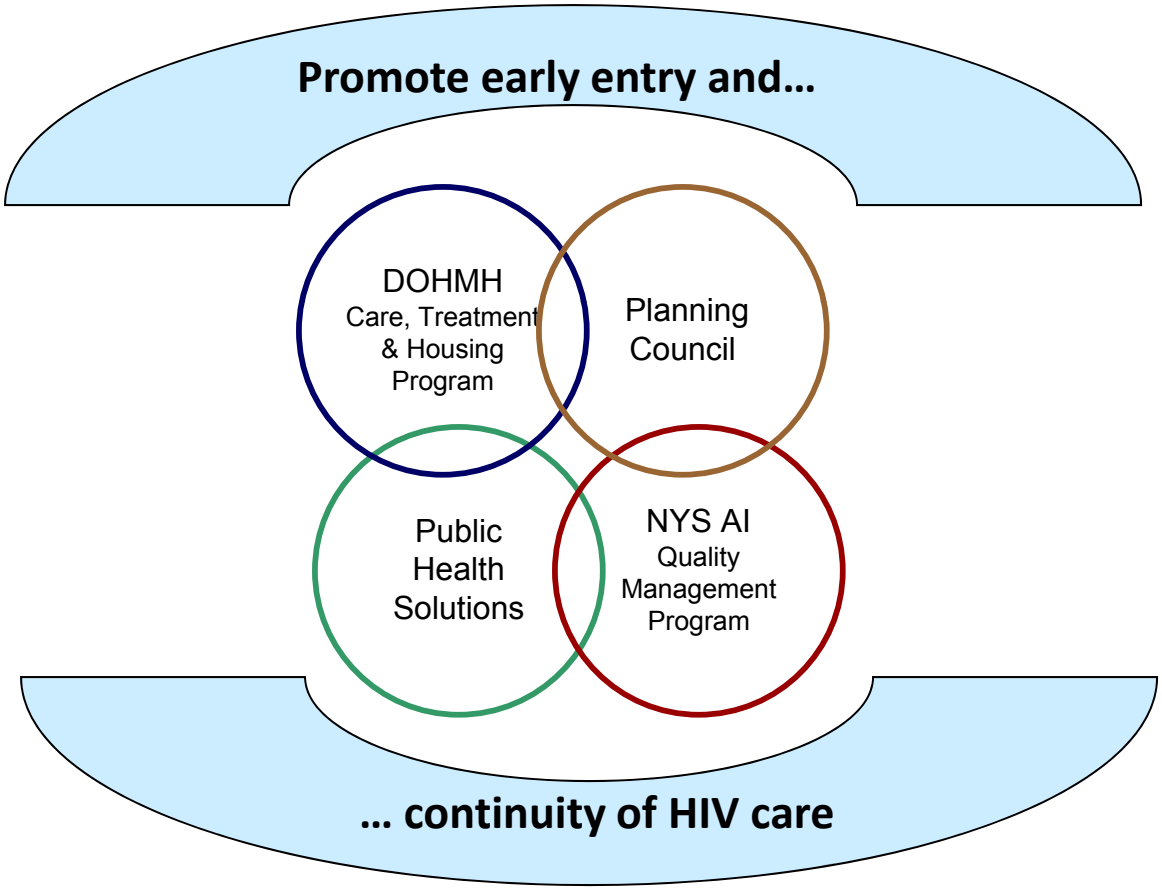


Conclusions

- Programs have made strides in assessing clients' primary care information –a majority are now reported as being in care
- Lack of referrals for those *not* in care remains issue across all program categories, whether hospital-based or CBO



Partnership



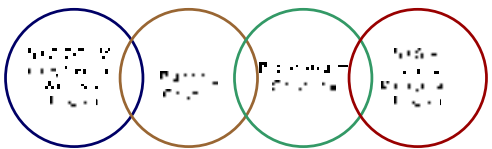
Public Health Solutions
MERGING RESEARCH AND ACTION

AIDS INSTITUTE 25 years

NYC Health

Lessons Learned

- For EMA wide initiatives, flexible approach possible if goals are aligned
- Importance of engagement with providers
- Okay to push providers but it takes time to achieve results



Questions and Answers

Thank you

Contact Us For More Info!

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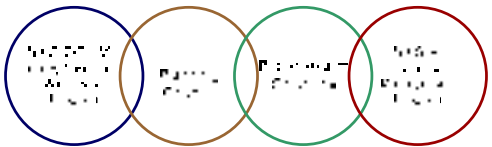

Acknowledgments

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