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Enhancing HIV Care Preconception Counseling, Including Sexual Health, Community of Practice (CoP)

Learning Session 4: Recipient Report Out

December 20, 2023

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Welcome and Ice Breaker

Welcome & Opening Remarks

- RWHAP Part D CoP Team
- Bizzell CoP Team

Ice Breaker

- Bizzell CoP Leads

Agenda

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Learning Objectives

Recipient Presentations – Enhancing Services to WICY

Johns Hopkins University, Sunshine Care (FL Health Department), Southeast Mississippi Rural Health Initiative (SeMRHI)

Q & A

Recipient Presentations

University of Toledo, Bond Community Health Center, East Carolina University HIV Program, Dallas Family Access Network

Q & A

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Ryan White HIV/AIDS Program

Learning Session #4 Learning Objectives

During Learning Session #4 CoP participants will:

- Describe the progress of their SMART goals and Action Period activities related to Preconception Counseling, including Sexual Health.
- Discuss lessons learned and key takeaways with other CoP participants.
- Engage in reflective discussion with other CoP participants on their experiences related to the PCC CoP.
- Outline plans for sustaining clinical practice improvements following completion of the CoP.

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Johns Hopkins University

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

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Johns Hopkins University

Program Description

Johns Hopkins HIV Women's Health Program provides comprehensive reproductive health and outreach services to persons with HIV since 1987 and is a RW funded provider since 1993. The Program offers routine and specialized gynecologic care and obstetrics, HIV counseling and testing, and referral and linkage to HIV care from a core group of faculty and staff. The program uses a multi-disciplinary collaborative approach with its HIV partners at Johns Hopkins including Infectious Disease, Pediatrics and Adolescent Medicine, and Psychiatry.

Core Team

- Project Director – Jean Keller
- Clinical Provider – Anna Powell
- Case Manager – Alison Livingston
- QI Lead – Aubrey Arteaga
- QI Team – JaToya McCrae, Marines Smith
- Part D WICY Participants – JH Youth Advisory Board

SMART Goals for CoP Involvement

- By February 29th, 2024, update current template to include PCC screening questions that primary care providers can utilize for clients who are identified as having a childbearing partner
- By February 29th, 2024, develop an SOP providing standards of care to gynecologic providers providing PCC to people with HIV
- By February 29th, 2024, update/educate primary care providers on PCC, standard practices, and the referral process
- Provide interdisciplinary updates to providers in the Johns Hopkins Adult/Adolescent HIV services.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

- Align PCC standards of care among multidisciplinary providers in Johns Hopkins Adult/Adolescent HIV services to routinize screenings during visits.

PDSA Cycle

- Cycle 1: Literature Review and Develop Educational Materials
- Cycle 2: Engage Youth Advisory Board and Collect Feedback
- Cycle 3: Incorporate YAB feedback and Measurement Tool for Educational Material
- Cycle 4: Distribute PCP acceptability/feasibility survey

Upcoming:

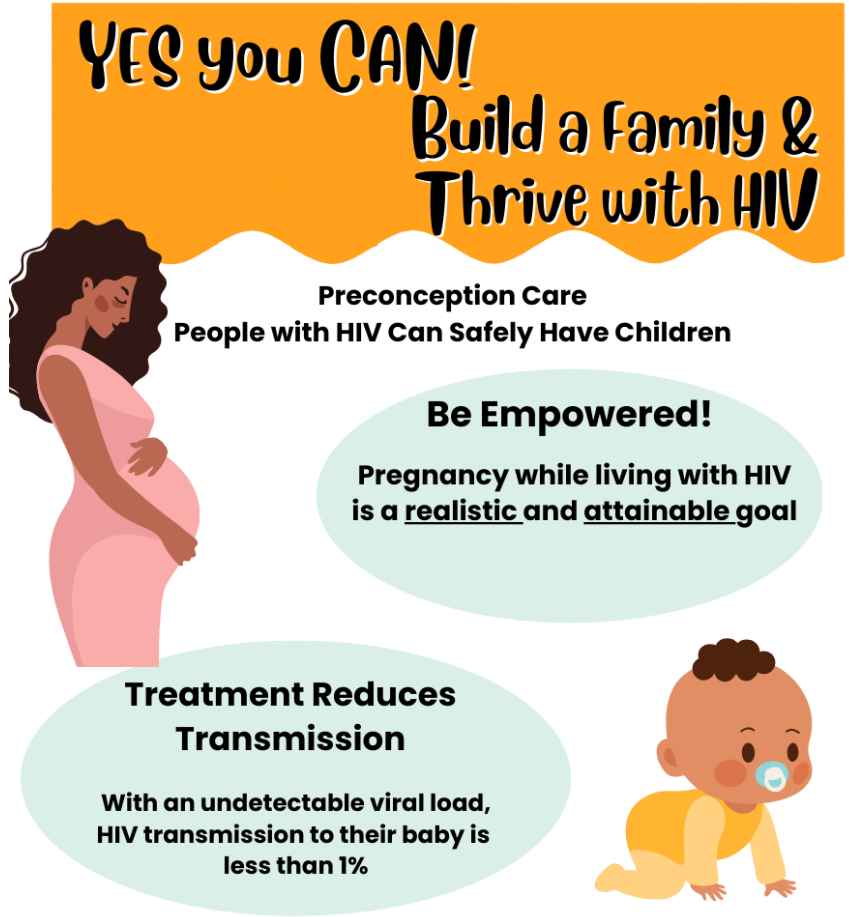
Cycle 5: Engage YAB/People with HIV to inform PCP education material

Action Period #1 Data & Progress

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

- Cycle 3: Incorporate YAB feedback and Measurement Tool for Educational Material

- Combat stigma
- Encourage treatment and Undetectable Viral Load



Action Period #1 Data & Progress

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

- Cycle 3: Incorporate YAB feedback and Measurement Tool for Educational Material

- Collaboration with Partner
- Using QR code Analytics as metric for flyer impact
- Tracking number of flyers and locations distributed

Data Collection In Progress.

Preconception Care is for Everyone!

Everyone is entitled to high quality preconception care.

Get Started!

Get connected to a Virtual Health Navigator

& Get help setting up an appointment

www.OurVOISES.org

Johns Hopkins HIV/AIDS Women's Program
JH-WICY Partnership for Excellence in HIV Care
Funded by the Health Resources and Services Administration
Ryan White Part D Women, Infants, Children, and Youth

Action Period #2 Data & Progress

SMART Goal for Action Period #2

- By February 29th, 2024, update current template to include PCC screening questions that primary care providers can utilize for clients, to identify childbearing intentions

PDSA Cycle

- Cycle 1: Identify PCP serving People with HIV and Develop Assessment Tools
- Cycle 2: Distribute pregnancy intention feasibility/acceptability survey
- Cycle 3: Collect survey results and current PCC billing code data

Action Period #2 Data & Progress

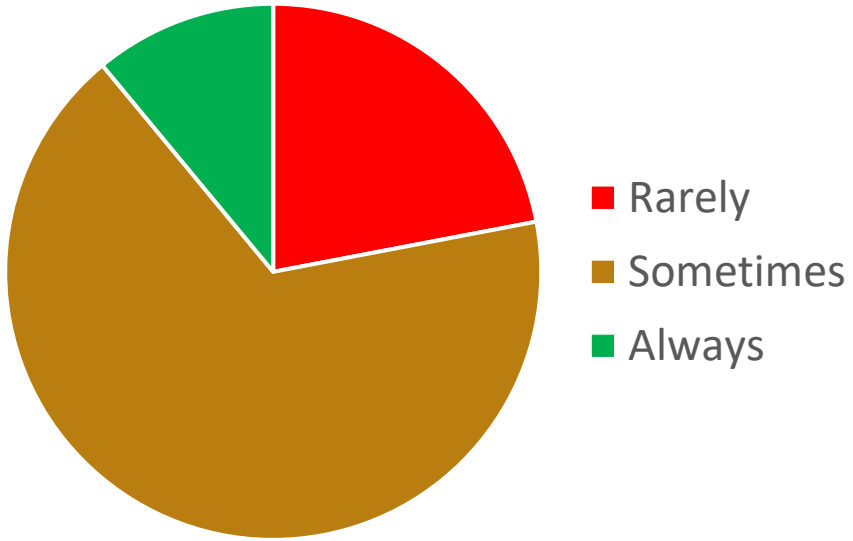
- Cycle 3: Collect survey results
  - ~85 providers contacted to complete survey
  - 27 providers responded

Action Period #2 Data & Progress

- Cycle 3: Collect survey results

How often do you discuss pregnancy intention/contraception with your patients with HIV?

Rarely	22%
Sometimes	67%
Always	11%

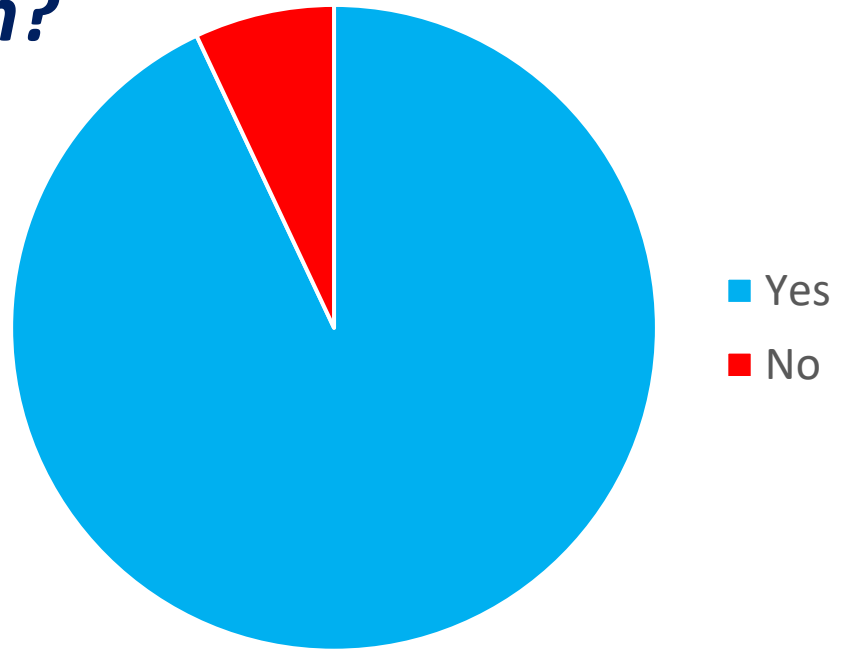


Action Period #2 Data & Progress

- Cycle 3: Collect survey results

Are you willing to discuss pregnancy intentions with your patients if it was a simple screen?

Yes	93%
No	7%



Action Period #2 Data & Progress

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- Cycle 3: Collect survey results

How comfortable are you discussing pregnancy intention/contraception with your patients?

Extremely or Somewhat Uncomfortable	**14%**
Somewhat Comfortable	**22%**
Extremely Comfortable	**63%**

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Action Period #2 Data & Progress

- Cycle 3: Collect survey results

What are your perceived barriers with discussing pregnancy intentions with your patients with HIV?

Privacy	5%
Time	73%
Patient Comfort Level	14%
Other	41%

Action Period #2 Data & Progress

- Cycle 3: Collect survey results

What are your perceived barriers with discussing pregnancy intentions with your patients with HIV?

Privacy	5%
Time	73%
Patient Comfort Level	14%
Other	41%

"Most of my patients are male or older women (menopausal)"

"So very many other pressing medical issues to cover"

"Provider comfort level, biases about pregnancy intention"

Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2

- Collaborating with People with HIV and community partners to make effective flyers
- Providers may benefit from education that addresses comfortability with assessing pregnancy intentions
- Client involvement in education materials will be key

Next Steps toward Achieving Goals

- Develop educational materials for providers and assess impact on comfortability
- Implement Epic Screening tools and measure usage

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Sunshine Care Center Prenatal & Perinatal Program
Florida Department of Health

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Sunshine Care Center Prenatal & Perinatal Program

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Program Description (as it relates to PCC)

Sunshine Care Center, in partnership with a high-risk Obstetrics group, provides HIV prenatal and perinatal care in Central Florida (encompassing five counties) to women and adolescents (18-24 years of age) who are uninsured and underinsured with low-socioeconomic status and high STI risk.

Core Team

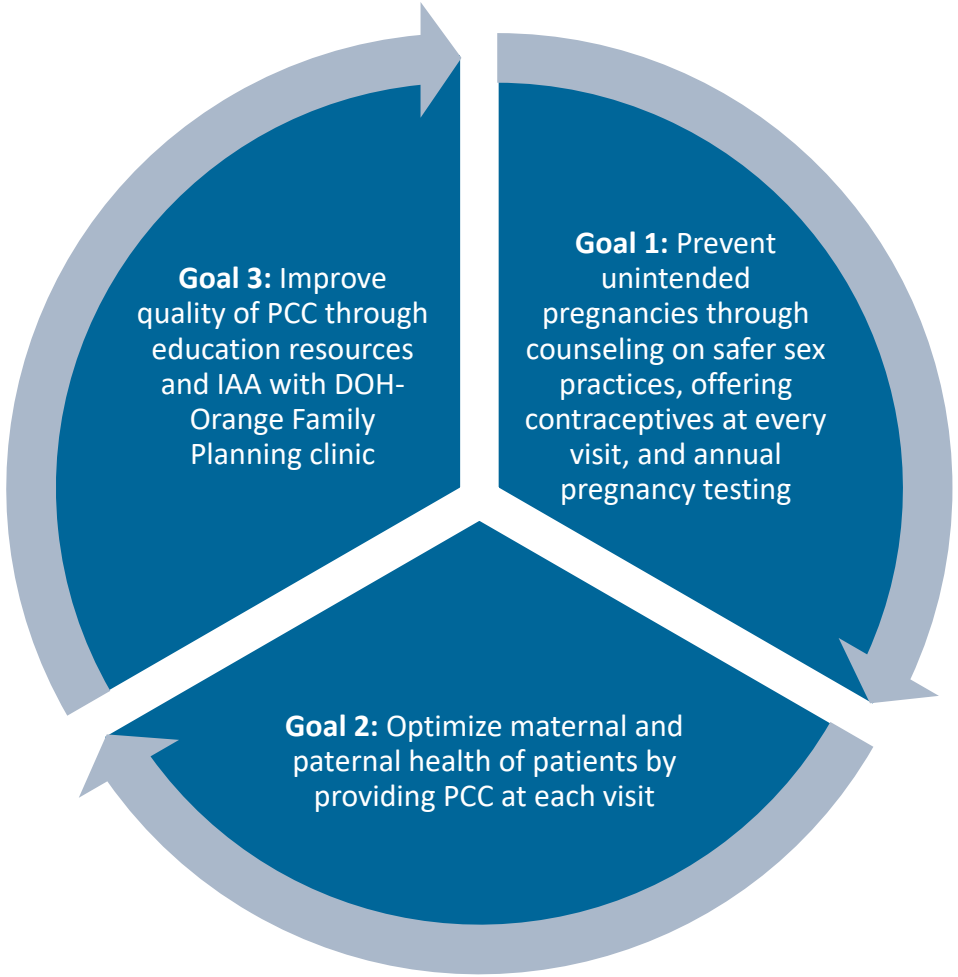
- Project Manager – Alelia Munroe, RWHAP Manager
- Quality Manager – Kelly Bastien, SCC Quality Manager
- HIV Case Manager – Jossie Roman-Marrero, ICM Part D
- Clinical Provider – Tameka Browne, APRN Part D Provider
- QI Lead – Rosarito Rivera-Sanchez, Nurse Supervisor
- Part D WICY Participants – In Progress

SMART Goals for CoP Involvement

- Prevent unintended pregnancies by counseling all patients of childbearing age on safer sex practices, offering contraceptives at every visit, and ensuring that 90% of female patients of childbearing age complete an annual pregnancy test by February 29, 2024.
- Optimize maternal and paternal health of 90% of patients of childbearing age by providing PCC at each visit by February 29, 2024. This will include sexual partners, management of comorbidities, ART adherence, and achieving viral suppression to prevent vertical transmission and decrease potential risk to mother and fetus during the perinatal period.
- Improve the quality of PCC by distributing education resources to 90% of patients of childbearing age and by establishing an Inter-Agency Agreement (IAA) with the DOH-Orange Family Planning clinic by September 2023.

CoP #1 PCC Initiatives

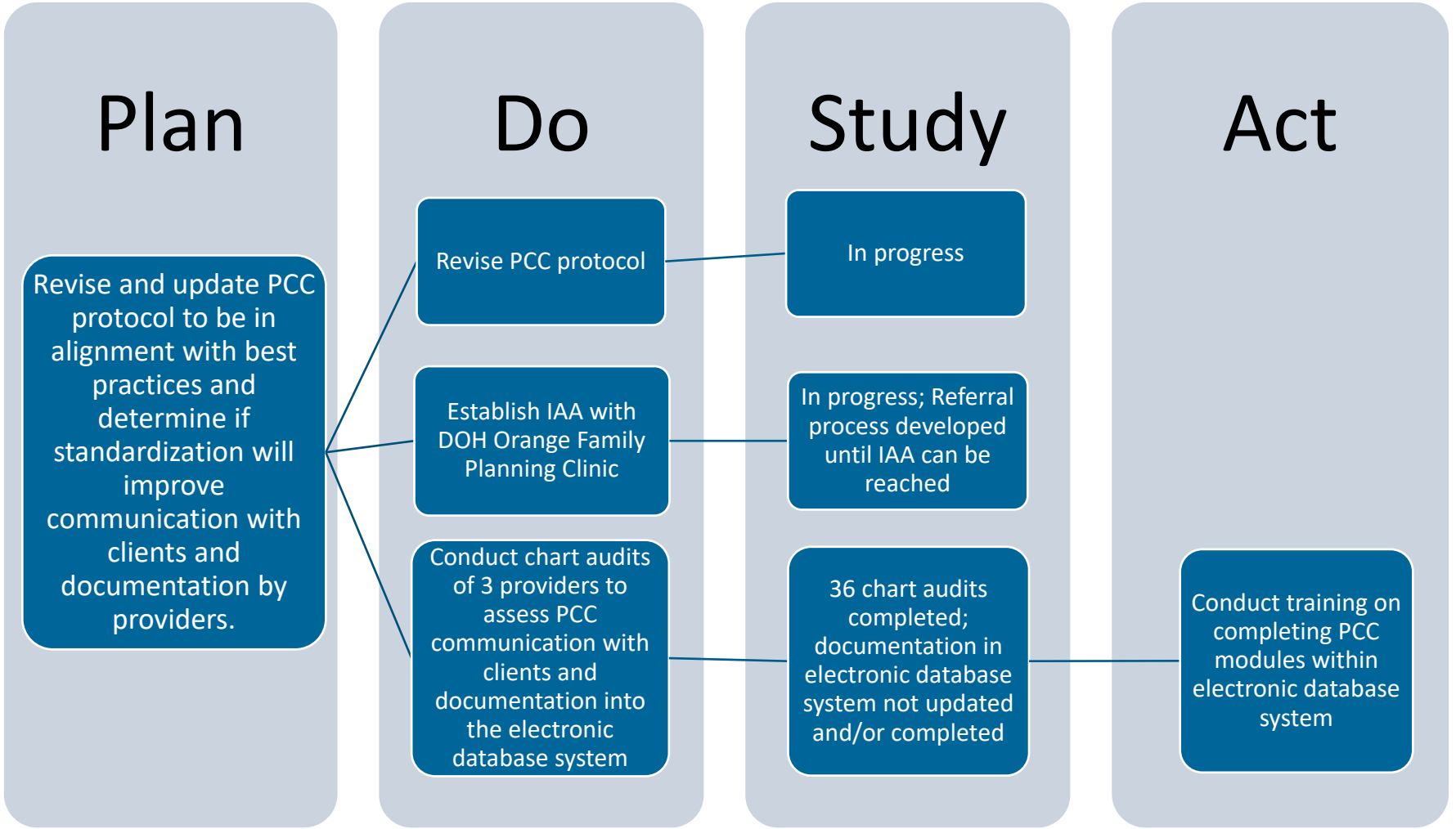
- 3 interconnected SMART goals still functioning within PDSA Cycle 1
- No major changes to report besides minor modifications within target dates originally set



Action Period #1 Data & Progress

SMART Goal for Action Period #1

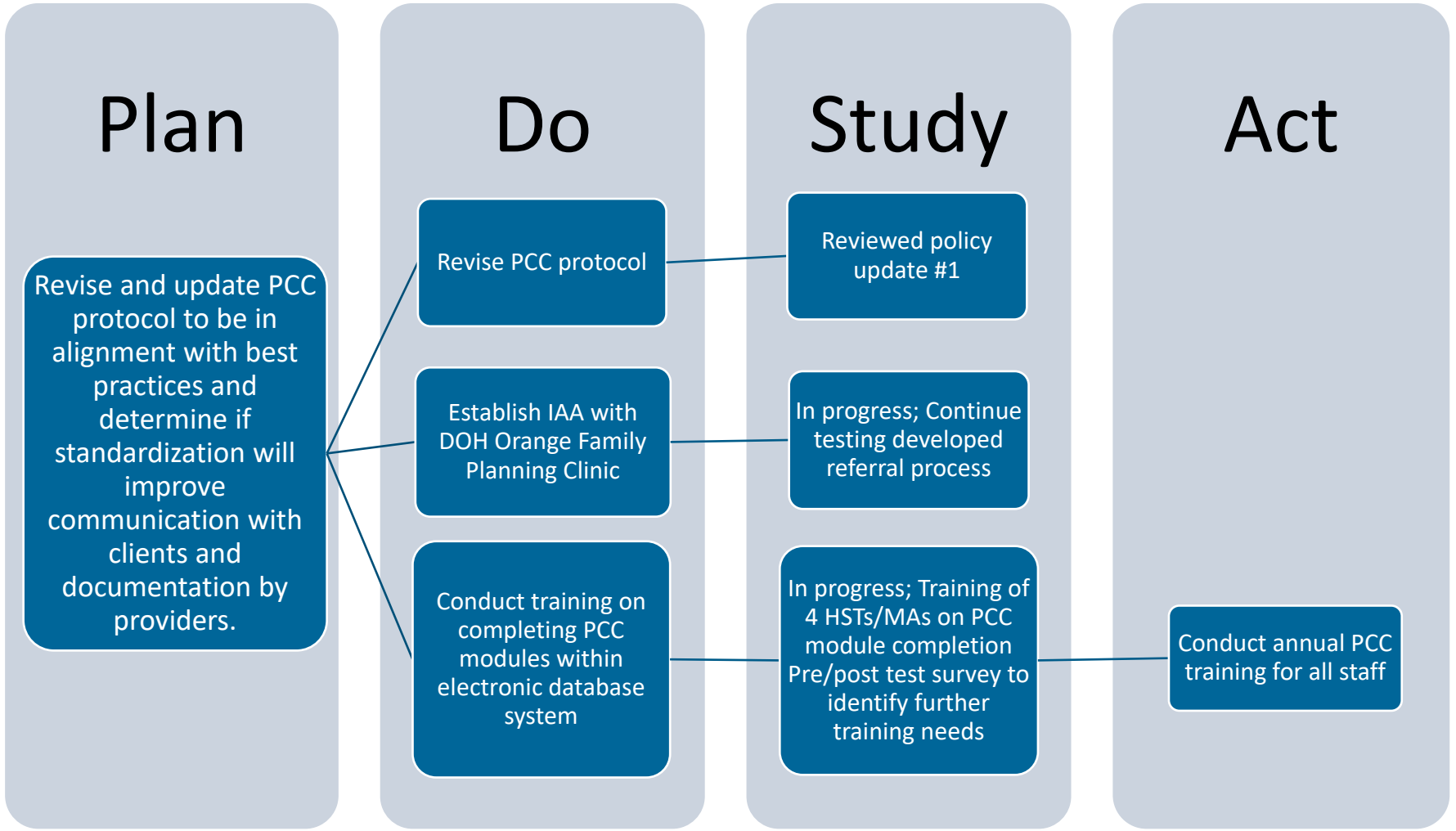
- Optimize maternal and paternal health of 90% of patients of childbearing age by providing PCC at each visit by February 29, 2024.



Action Period #2 Data & Progress

SMART Goal for Action Period #2

- Optimize maternal and paternal health of 90% of patients of childbearing age by providing PCC at each visit by February 29, 2024.



Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2

- Driver diagram essential in identifying the 'influencers' throughout our PDSA cycle and action periods
- Identification of a practitioner champion to drive change within the clinical team

Next Steps toward Achieving Goals

- Continue working toward IAA with DOH-Orange Family Planning Clinic

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Southeast Mississippi Rural Health Initiative (SeMRHI)

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Southeast Mississippi Rural Health Initiative (SeMRHI)

Program Description (as it relates to PCC)

- Assess patient's sexual activity, sexual orientation, birth control method, and barriers used during sexual intercourse.

- Educate patients about STI prevention, assist with family planning, and provide STI prevention methods (i.e., PEP/PrEP).

Core Team

- Project Director – Tonya Green
- Project Manager – Aspen Hardges
- Clinical Provider – Dr. Echols-Williams
- Quality Improvement Lead – Tonya Green & Tiffany Gholar
- Community Outreach – Tosha Satcher
- HIV Case Manager – Sandra Baker & Tosha Satcher

SMART Goals for CoP Involvement

- Provide preconception counseling (PCC) trainings to 80% of Ryan White clinical staff by February 2024.
- 80% of people with HIV who complete a medical visit starting November, 2023, will receive documented PCC in EHR and CAREware.
- 80% of people with HIV will receive case management services to promote optimal sexual health/wellness outcomes by providing patients with educational materials, STI barriers, specialty referrals, and other needed services/resources.

Action Period #1 Data & Progress

SMART Goal for Action Period #1: People with HIV who complete a medical visit starting November 2023, will receive documented PCC in EHR and CAREWare.

Objective: A total of at least 20 women with HIV will complete a PCC survey to promote sexual health/wellness and improve PCC documentation in EHR.

PDSA Cycle:

- **Action Period**: July 26- August 31, 2023
- A total of 26 women completed the PCC survey accurately
  - **Results:** **3** women requested PCC brochures; 1 woman was referred to OB-GYN for birth control options; **5** women received STI prevention counseling by RN Case Managers
  - **Staff Feedback:** The survey was helpful with guiding discussions about sexual wellness/health and majority of the patients answered the questions without complaints.

CoP #1 PCC Initiatives

Past Smart Goal #1: Provide PCC trainings to 80% of SeMRHI's clinical staff by February 2024.

Current Smart Goal #1: **Provide preconception counseling (PCC) trainings to 80% of Ryan White clinical staff by February 2024.**

Progress:

- Obtained in-house PCC educational pamphlets, flyers, and other resources
- PCC trainings will be completed during staff development/ meetings
- Identify WICY patients who need PCC during huddle

Past Smart Goal #2: Provide PCC to 80% of People with HIV, who received a medical visit, within one year.

Current Smart Goal #2: **People with HIV who complete a medical visit starting November 2023, will receive documented PCC in EHR and CAREWare.**

Progress:

- Evaluated PCC documentation in EHR
- Updated Smart Text in EHR
- Added PCC screening tab in CAREWare

Past Smart Goal #3: People with HIV who received PCC will report a 70% satisfaction rate, via survey.

Current Smart Goal #3: **80% of People with HIV will receive case management services to promote optimal sexual health/wellness outcomes by providing patients with educational materials, STI barriers, specialty referrals, and other needed services/resources.**

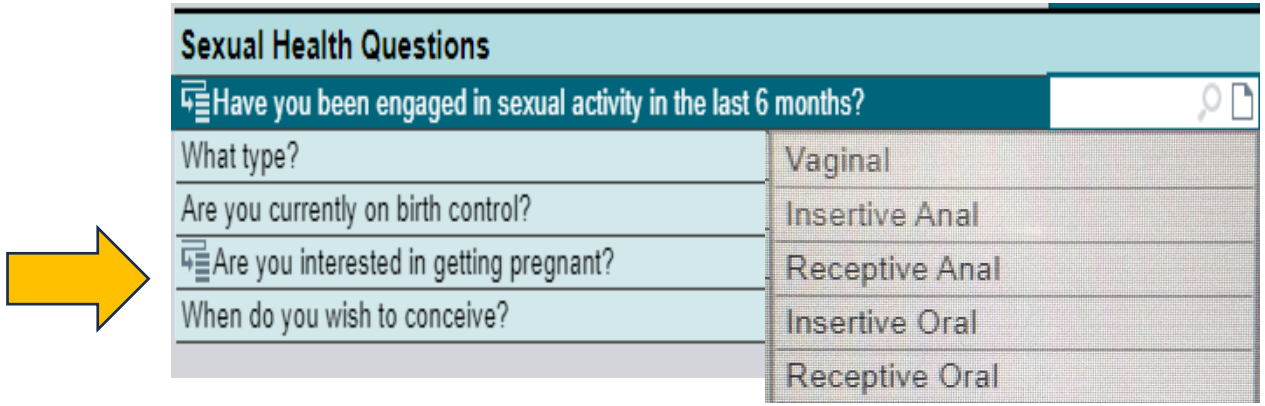
Progress :

- Obtained in-house PCC educational pamphlets, flyers, and other resources for patients
- Sexual Health Flowsheet has been added to EHR

Action Period #2 Data & Progress

SMART Goal for Action Period #1: People with HIV who complete a medical visit starting November 2023, will receive documented PCC in EHR and CAREWare.

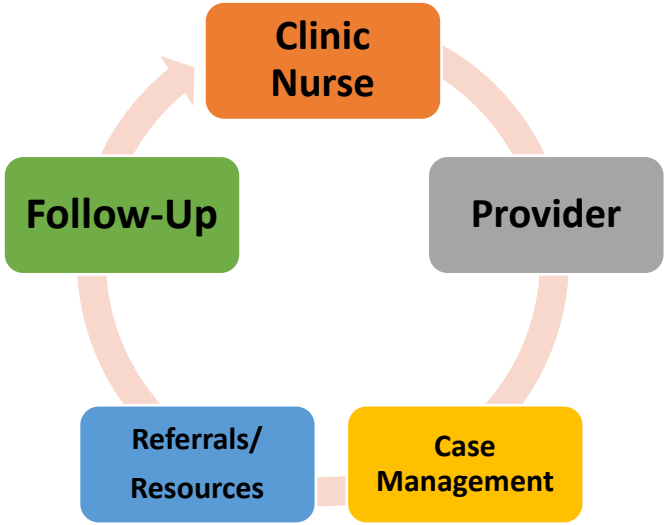
Objective: PCC template will be used by Ryan White clinical staff to guide PCC and improve documentation of PCC in EHR/CAREWare by November 30, 2023.



PDSA Cycle

Action Period: October 1 – November 30, 2023

- **Results:** PCC template has been created and added to EHR (EPIC) and PCC Screening Tab has been added to CAREWare for metrics.
- **Staff Feedback:** The Sexual Health Flowsheet has been helpful with guiding PCC with patients.



Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2:

- Educating staff about PCC and using guided questions improved staff's confidence with implementing PCC with their patients.
- Teamwork makes the dream work.
- Reviewing and updating templates helps with optimal patient outcomes.

Next Steps toward Achieving Goals

- Continue PCC training with RW clinical staff.
- Measure the amount of PCC screenings completed during People with HIV medical visits.
- Measure the benefits of PCC by calculating the numbers of STI barriers, pamphlets, specialty referrals, and other services/resources given to People with HIV.

Questions?

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University of Toledo – HSC Ryan White Part D

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

University of Toledo-HSC Ryan White Part D

Preconception Counseling Initiatives:

- Medical director guidance and input on service
- Provider champion to guide service documentation through education and chart review
- Building service into the new EMR template

Core Team

- Katie Himich – Program Director
- Erin Durante – Lead Case Manager
- Danielle Warren – Nurse Practitioner
- Tiffany Morgillo – Quality Supervisor
- Kristin Huntsman – Clinical Supervisor
- Ginny York – Behavioral Health Manager
- Christina Williams – Billing/Claims Supervisor; Outreach

Action Period #1 Data & Progress

SMART Goal for Action Period #1

100% of all providers/staff affiliated with the Ryan White Part D Program will complete annual expanded preconception counseling education by 12/31/2023.

PDSA Cycle

- Identified 12 training/educational opportunities.
- Each training reviewed and “scored” by the appropriate discipline.
- 5 Discipline categories identified: learners, all staff, clinical staff, non-clinical staff, providers.
- 5 final trainings selected and assigned to applicable category.

CoP #1 PCC Initiatives

- 100% of all providers/staff affiliated with the Ryan White Part D Program will complete annual expanded preconception counseling education by 12/31/2023.

- Expand the EMR template for preconception counseling to include reportable fields ~~provider checklist, a patient questionnaire,~~ and gender inclusive opportunities by 9/30/2023.

- 100% of Ryan White Part D patients (not specific to childbearing potential) seen for a routine Outpatient Ambulatory Health Service between 9/30/2023-12/31/2023 will have the updated EMR template on preconception counseling completed by their provider. (Gender Inclusive Healthcare)

Action Period #1 Data & Progress

SMART Goal for Action Period #1

Expand the EMR template for preconception counseling to include reportable fields ~~provider checklist, a patient questionnaire,~~ and gender inclusive opportunities by 9/30/2023.

PDSA Cycle

- Educate CoP team on PCC criteria, definition, etc.
- Create PCC template in EHR based on PCC criteria.
- Engage IT and EHR specialist on reporting from template criteria.
- Build education for providers on the use of EHR template.
- Small scale test with 1 provider over 2-5 days.
- Numerator = patients who receive PCC documented in new EHR template; Denominator = total number of eligible patients with completed visits scheduled with testing provider. 0/0, unable to complete test, provider on FMLA.

Action Period #2 Data & Progress

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

SMART Goal for Action Period #1

100% of all providers/staff affiliated with the Ryan White Part D Program will complete annual expanded preconception counseling education by 12/31/2023.

PDSA Cycle

- Develop 3 competencies associated with gender inclusive healthcare from current best practice training opportunities.
- Load competencies into annual training module for the institution based on categories (clinical, non-clinical, all staff).
- Assign training to 100% of staff (numerator = # of staff assigned; denominator = # of staff in category)
  - Clinical Staff 32/32
  - Non-clinical Staff 3/3
  - All Staff 35/35

Action Period #2 Data & Progress

SMART Goal for Action Period #1

Expand the EMR template for preconception counseling to include reportable fields ~~provider checklist, a patient questionnaire,~~ and gender inclusive opportunities by 9/30/2023.

PDSA Cycle

- Small scale testing:
  - Opportunity 1:
    - 1 provider over 2-5 days.
    - Numerator = patients who receive PCC documented in new EHR template; Denominator = total number of eligible patients with completed visits scheduled with testing provider.
    - 5/11, 3 days.
    - Identified necessary updates and completed. (PCC)
  - Opportunity 2:
    - 2 providers over 2-4 weeks.
    - Numerator = patients who receive PCC documented in new EHR template; Denominator = total number of eligible patients with completed visits scheduled with testing provider.
    - 22/24, 30 days, sex at birth = female.
    - Identified necessary updates and completed. (PCC2)
- PCC3 updates in progress for gender inclusive documentation.

Key Takeaways & Next Steps

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Key Takeaways from Action Period 1 & 2

- The schedules for integrating functionalities and reporting within the electronic health record are extensive and intricate.
- Transitioning preconception counseling services from being focused solely on individuals with a uterus to encompassing all individuals presents significant complexities.
- Implementing gender inclusive preconception counseling has challenges in the face of ongoing staffing shortages.

Next Steps toward Achieving Goals

- Extend the reach of our training programs and competencies to widen the impact of education.
- Examine, refine, and apply practices and policies for clinical care that are inclusive and gender neutral.
- Continuously update and maintain electronic health records to reflect the latest best practices in gender inclusive healthcare.

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Bond Community Health Center

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Program Description

- Bond Community Health Center is in Leon County in the Tallahassee Metropolitan area, the Capital City of Florida, a college town in the panhandle.
- Leon County has an estimated population of 299,357 residents.
- Our Ryan White Part D Program serves 138 WICY and approximately 200 non-part D patients from diverse backgrounds who are low-income with HIV.
- We provide preconception counseling and sexual health education for women of childbearing age and youth.
- We created an Athena based preconception and sexual health template for clinical staff use for patient education at every visit.

Core Team

- Damon McMillan, HIV Specialist & Program Medical Director
- Faye Tinson, Program Director / QI Lead
- Cynthia Evans, HIV Specialist Nurse Practitioner
- Ajebu Okeke, HIV Specialty Pharmacist
- Anastacia Kizer, Medical Case Manager
- Kyla Shillington, OB/ GYN Nurse Practitioner
- DaShaneka Wright, Consumer Advocacy Coordinator
- Tamika Leland, CQM & Data Entry Specialist
- Reginald Hamilton, Transportation Specialist


I AM

CoP #1 PCC Initiatives

Original SMART goals

- Use Athena to run reports to confirm 100% of patients aged 13 to 48 are receiving preconception counseling at every visit from staff using the preconception counseling template by September 30, 2023.
- Measure efficacy of PCC education by September 30, 2023 through a printed patient survey. Once the patient has seen the provider, this survey would be delivered by clinical staff.
- Use Athena to run reports to confirm 100% of patients aged 13 to 48 are receiving sexual health education at every visit from clinical staff by February 1, 2024.

Changes made to SMART Goals

- We did not measure the efficacy of patient education as it relates to preconception counseling.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

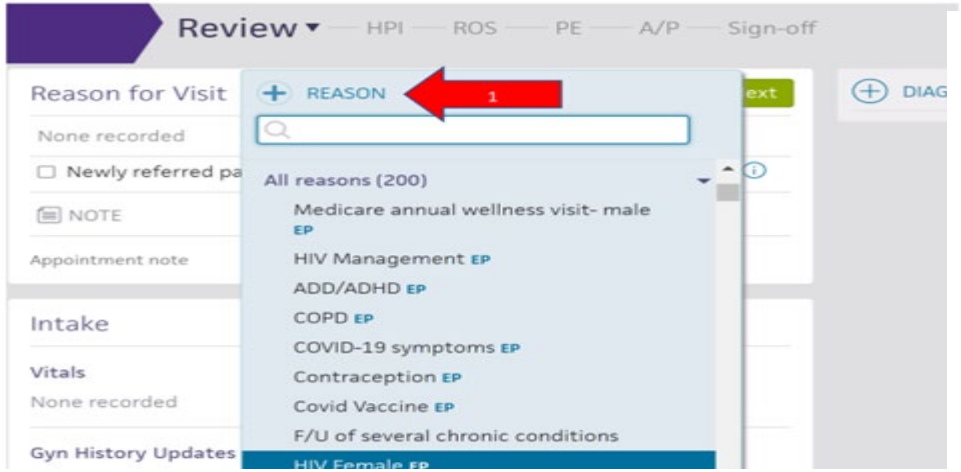
- Use Athena to run reports to confirm 100% of patients aged 13 to 48 are receiving preconception counseling at every visit from staff using the preconception counseling template by September 30, 2023.

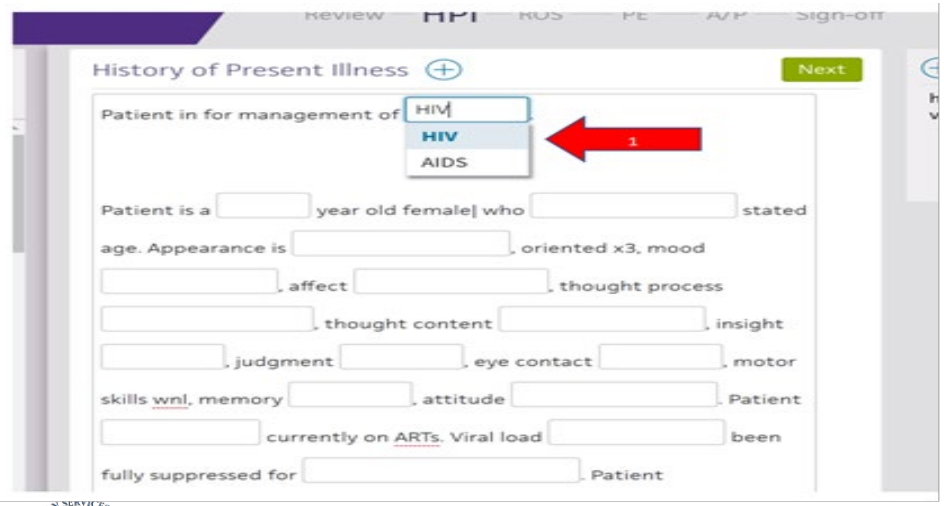
- Use Athena to run reports to confirm 100% of patients aged 13 to 48 are receiving sexual health education at every visit from clinical staff by February 1, 2024.

PDSA Cycle

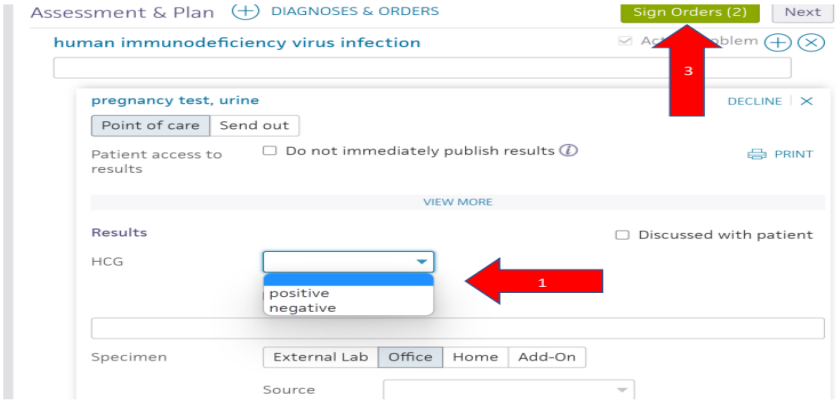
- PLAN: Identified patients who were aged 13 to 48, childbearing age, and we identified key staff who needed training.
- DO: Each visit we provided education on PCC and sexual health. Each visit offered open dialog for more discussion on PCC for patients who wanted to conceive.
- STUDY: June: 12/21 (57%) of goal was met; August: 15/21 (71%) of goal was met.
- ACT: We adopted that the age should increase to 50 for Action Period 2 and we continued PCC & sexual health counseling.

SMART Goals

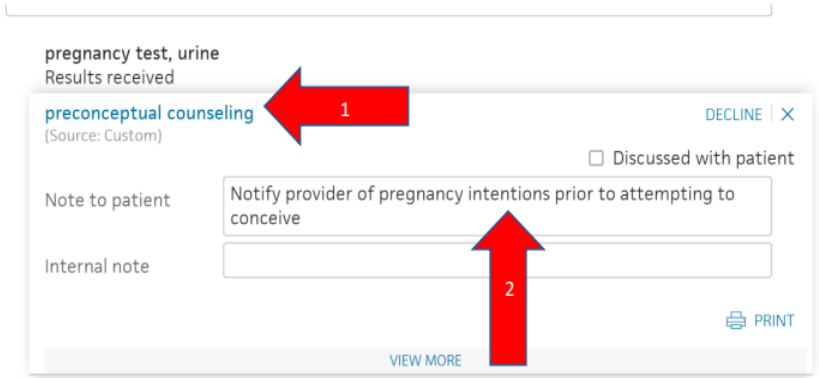




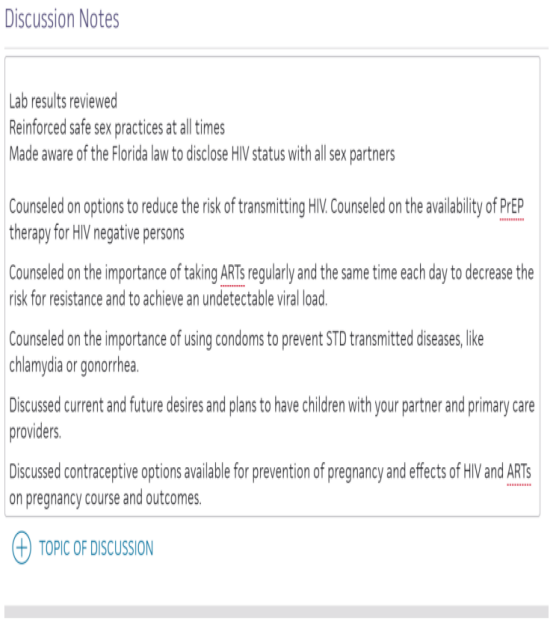
Step#3: Complete the A/P section for urine pregnancy test (test will automatically load in this section as part of encounter type)



Step#4: Click on "preconceptual counseling" and edit the note section as needed.



Step# 5: Review the discussion section and edit documentation as needed



Action Period #2 Data & Progress

SMART Goal for Action Period #2

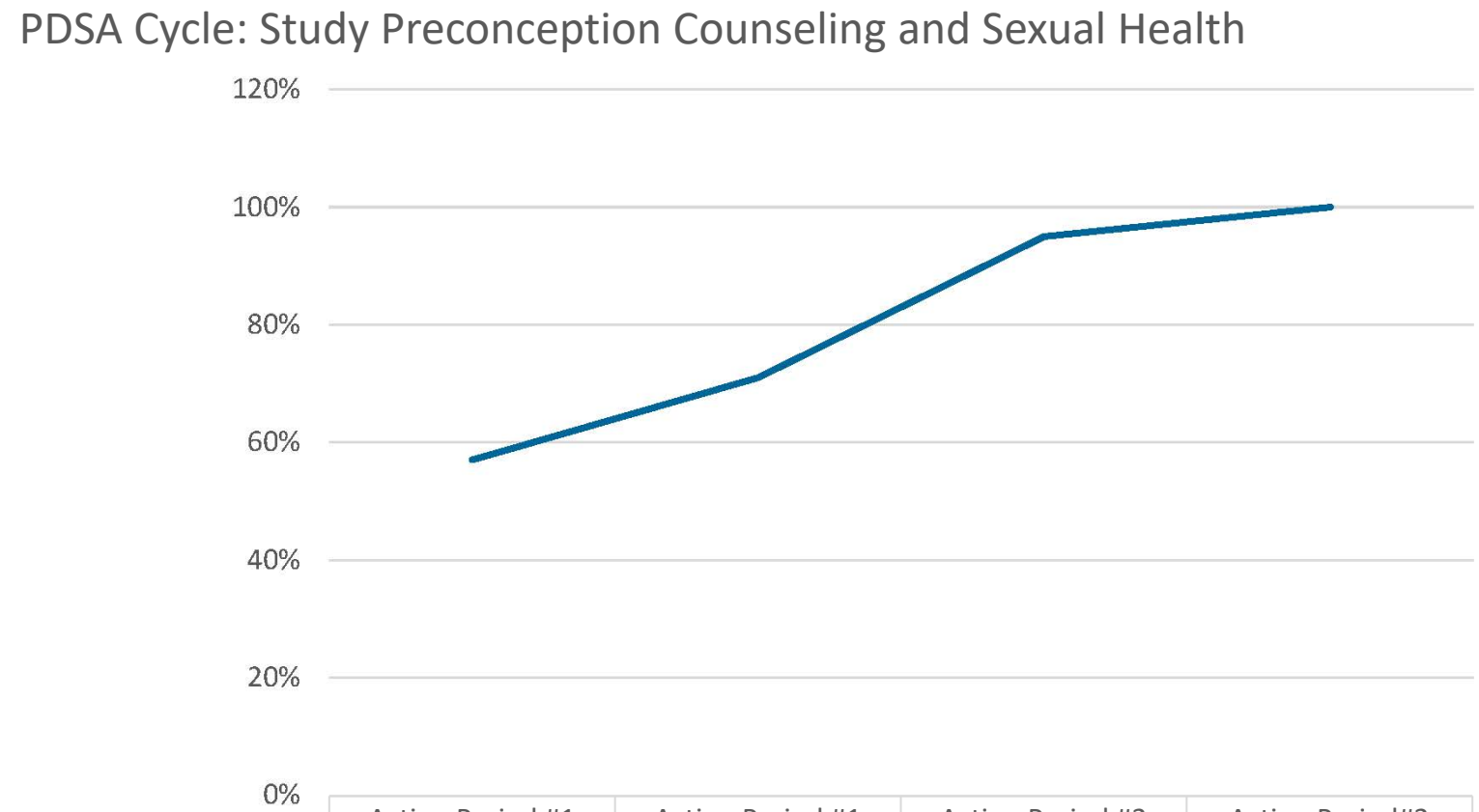
- Use Athena to run reports to confirm 100% of patients aged 13 to 50 are receiving preconception counseling at every visit from staff using the preconception counseling template by September 30, 2023.

- Use Athena to run reports to confirm 100% of patients aged 13 to 50 are receiving sexual health education at every visit from clinical staff by February 1, 2024.

PDSA Cycle

- PLAN: Reinforced training to improve preconception counseling and sexual health at each visit for patients aged 13 to 48, childbearing age, and identified new staff who needed the training.
- DO: Each visit offered open dialog for more discussion on PCC for patients who wanted to conceive. We observed that women up to 50 years were still able to conceive and some of them tested positive for STI's.
- STUDY: September: 20/21 women (95 %) of goal met; November: 21/21 (100%) of goal met.
- ACT: Providers reinforced PCC and sexual health counseling at each visit.

Action Period #2 Data & Progress



	Action Period #1	Action Period #1	Action Period #2	Action Period#2
Preconception Counseling and Sexual Health	57%	71%	95%	100%
Total Patients	12/21	15/21	20/21	21/21

Key Takeaways & Next Steps

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Key Takeaways from Action Period 1 & 2

1. Preconception (PCC) and sexual health counseling is a vital part of routine care for Ryan White WICY patients and their families to encourage a patient-centered approach.

2. All staff should receive PCC and sexual health education and the importance of this education for people with HIV.

3. Patient-centered documentation is a key component toward capturing PCC with our patient population.

Key Takeaways & Next Steps

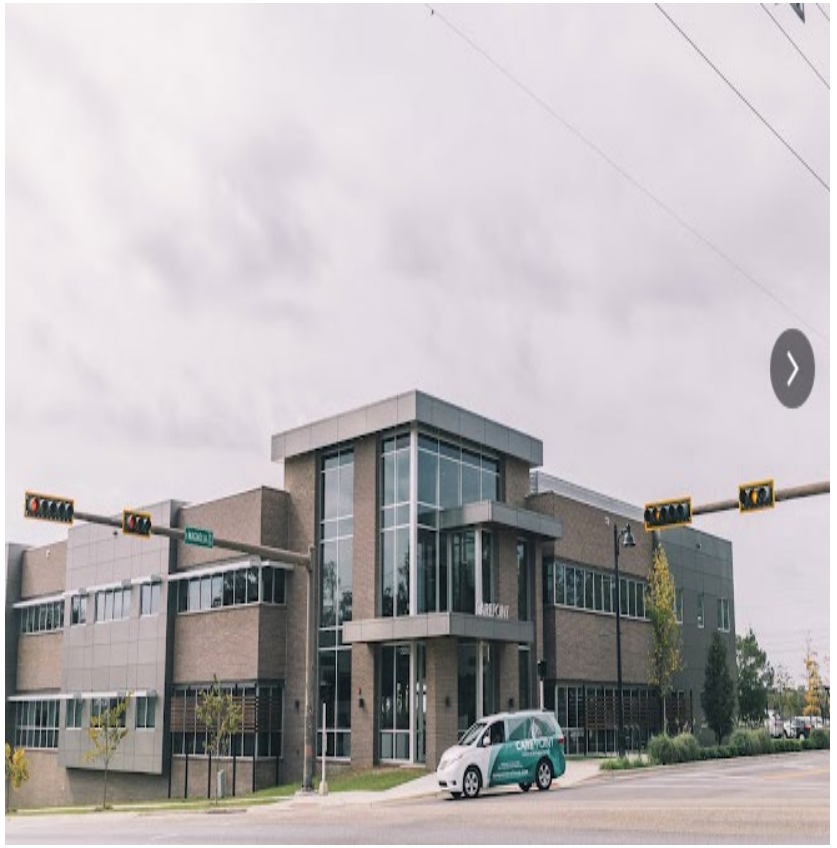
Next Steps toward Achieving Goals

- Allow team discussion on if developing PCC scripts for our population would be beneficial.
- Adopt the BeSafe Model or another model.
- Train key staff on the Model.
- Create a template with educational scripts for the Model on PCC and sexual health education in the EHR.

Thank You

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Locations



DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

HRSA
Health Resources & Services Administration

HRSA
Health Resources & Services Administration

East Carolina University HIV Program (ECUHIVP)

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

ECU HIV Program (ECUHIVP)

ECUHIVP Preconception Counseling (PCC) & Sexual Health Program

ECUHIVP is the only RWPD funded program in ENC providing HIV care and support services to HIV-positive women 25 years and older, infants up to 2 years old, children between 2 and 12 years old, and youth ages 13-24.

Core Team

- Jared Carter-Davis AGNP-C, MSN, AAHIVS – RW Program Director/Medical Director/PI
- Jerome Garner MPA, MPH, MCHES, RHEd, CHC – RW Grant Administrator
- Chaundra Wiggins RN – Nurse Manager/Director of Clinical Operations
- Camilya Taylor RN – RN Case Manager
- Michael Robinson MD – Physician
- Shakea Riddick – Medical Case Manager (MCM)
- Courtney Kirchner – Social-Clinical Research Assistant

CoP #1 PCC Initiatives

Original SMART Goals

- Increase patients' preconception knowledge via standardized clinical PCC procedures using a multidisciplinary team approach that includes nursing, physicians, who will provide said counseling at first available appointment within CoP timeframe, and medical case managers

- Measure patients' preconception knowledge using a pre-test (i.e., administered by nursing during PCC) with monthly analysis conducted by the social-clinical research team

- A minimum of 80% of the identified patient census of child-bearing women will have engaged in PCC by the conclusion of the CoP in Winter 2024

Changes

- The second goal has been changed to improve patients' preconception knowledge by attaching the PCC handout to after-visit summaries. Pre-charting will be done on identified patients to add the handout to After Visit Summary (AVS).

Action Period #2 Data & Progress

SMART Goal for Action Period #1

Increase patients' preconception knowledge via standardized clinical PCC procedures using a multidisciplinary team approach that includes nursing, physicians, who will provide said counseling at first available appointment within CoP timeframe, and medical case managers

PDSA Cycle

- Plan
  - Patients of childbearing age (18-49) will be given PCC information during appointment by provider, and nursing staff will give patients take-home handout with same information.
  - Data to be tracked – MRN, name, age, race, ethnicity, identified for PCC (yes/no), provider, # of pregnancies, PCC given (yes/no), appointment date, showed for appointment (yes/no), ICD10 code present (yes/no), and any relevant notes
- Do
  - One provider had 46 eligible patients, 22 were no-shows.
  - 40 of the 46 were identified for PCC. Of the 6 not identified, two patients were transgender females and four reported tubal ligation. 5 patients were currently pregnant, and the three of those who attended appointments were given PCC.
  - Of the 40 identified patients, 21 showed for appointments.

Action Period #2 Data & Progress

- Study
  - Patients who did not show up to appointments were a major deterrent.
  - 12 of the 21 identified patients who attended appointments had the PCC Smart Phrase documented in their EHR, and all 12 had the ICD10 code documented.

- Act
  - Consistency of documentation within EHRs needs improvement.
  - A video or slideshow sent as a MyChart blast could prove more effective in distributing information to eligible patients. Attaching the handout to after-visit summaries could also improve distribution of information.

Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2

- Documentation improvement is necessary.
- Patients are more likely to take home handouts if given at the end of the appointment with the AVS.

Next Steps toward Achieving Goals

- The PCC handout will be attached to eligible patients' AVS.
- A slideshow containing PCC information will be sent as a MyChart blast to eligible patients.
- All providers in the clinic will train with Dr. Robinson on PCC and begin providing information to eligible patients and documenting in EHRs with the appropriate Smart Phrase and ICD10 code.

HRSA
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UT Southwestern Medical Center's Dallas Family Access Network (DFAN)

Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

UT Southwestern DFAN

Program Description

UT Southwestern Medical Center's Dallas Family Access Network (DFAN), a program within the Community Prevention and Intervention Unit (CPIU), has been in operation for over 30 years serving WICY, both cis and transgender, across Dallas and 8 surrounding rural counties. In addition to providing medical and support services directly, DFAN subcontracts with 3 clinical, a dental, and transportation providers.

Core Team

- Jeremy Chow, MD – CPIU Medical Director/PI DFAN
- Tracee Belzle – Interim DFAN Program Director
- Bendu Coleman – Prev. CQM Coordinator New DFAN Program Director

CoP #1 PCC Initiatives – SMART Goals

ENHANCING HIV CARE
WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

- By June 30, 2023, increase the reach of DFAN and its clinical partners by developing a marketing campaign, including social media, outreach and public health detailing to increase community members' and clinical providers' awareness of the importance of PCC for individuals of childbearing potential with HIV as measured through analytics, evaluation, and outreach and public health detailing reports.

- Deliver two PCC skills trainings based on the ARVT Guidelines by July 31, 2023. Identify existing training, modify, and deliver two online trainings to enhance DFAN and its clinical providers' skills to provide PCC based on the ARVT Guidelines for individuals with childbearing potential with HIV as measured by pre- and post-evaluations.

- Document PCC to reach 80% Performance Measure standard. By December 31, 2023, improve documentation of PCC to reach the 80% Performance Measure standard for DFAN and its clinical partners by ensuring partners' contracts reflect this standard, and Care Ware and intake forms capture this data for individuals with childbearing potential with HIV as measured through data and chart reviews for each entity and implement quality management projects, as needed to reach this performance measure.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

By June 30, 2023, increase the reach of DFAN and its clinical partners by developing a marketing campaign, including social media, outreach and public health detailing to increase community members' and clinical providers' awareness of the importance of PCC for individuals of childbearing potential with HIV as measured through analytics, evaluation, and outreach and public health detailing reports.

PDSA Cycle

- Plan: Develop marketing plan, define audience, create content, and define metrics.
- Do: Developed marketing plan. Implementation was delayed due to staff changes, A content creator has been hired and we've shared our first post.
- Study: Refined the marketing plan. Will analyze the metrics and engagement.
- Act: Will refine strategies based on feedback.

Action Period #1 Data & Progress

Action Period #1 Data & Progress Cont.

SMART Goal

Document PCC to reach 80% Performance Measure standard. By December 31, 2023, improve documentation of PCC to reach the 80% Performance Measure standard for DFAN and its clinical partners by ensuring partners' contracts reflect this standard and Care Ware and intake forms capture this data for individuals with childbearing potential with HIV as measured through data and chart reviews for each entity and implement quality management projects, as needed to reach this performance measure.

PDSA Cycle

- Plan: Improve documentation of PCC.
- Do: Added PCC to Care Ware and intake forms.
- Study: Will analyze the metrics. Using CAREWare reporting feature.
- Act: Will refine strategies based on feedback.

Action Period #2 Data & Progress

SMART Goal for Action Period #2

Deliver two PCC skills trainings based on the ARVT Guidelines by July 31, 2023. Identify existing training, modify, and deliver two online trainings to enhance DFAN and its clinical providers' skills to provide PCC based on the ARVT Guidelines for individuals with childbearing potential with HIV as measured by pre- and post-evaluations.

PDSA Cycle

- **Plan:** Develop a short course covering the need for PCC and how it can be implemented in our partner clinics.
- **Do:** Ms. Giddens is revising existing trainings to deliver to our clinical providers. Trainings are expected to be attended by all contracted staff. All three of our subrecipients that provide medical services had representation on PCC Learning Session 2. Share training through social media channels to reach a broader audience.
- **Study:** Analyze results of retroactive evaluation of the training.
- **Act:** Make refinements based on participant feedback.

Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2

- Content creators are important
- Dedicated time for objectives
- Buy-in from partners

Next Steps toward Achieving Goals

- Post on social media consistently
- Host training sessions for clinicians

Questions?

Upcoming Events

CoP Learning Sessions and Action Periods

- **January 2024** – Action Period #3 (PDSA-specific activities, data collection, and analysis)
- **January 24, 2024** – Technical Assistance Session – E H R
- **February 21, 2024** – **Learning Session #5** - Final presentations from remaining CoP Core Teams

Leadership Check-in Calls with the Bizzell Team will be scheduled and occur monthly.