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

Learning Session 5: Recipient Report Out

February 21, 2024

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

Vision: Healthy Communities, Healthy People

Agenda

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

Learning Objectives

Recipient Presentations

Health Services Center, Inc., Matthew 25, Central Carolina Health Network, Harris County Hospital District

Q & A

Recipient Presentations

University of Kansas School of Medicine – Wichita (UKSM-W) Medical Practice Association, AIDS Care Group, UPMC Presbyterian Shadyside, Callie Clinic

Q & A

Closeout

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WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Welcome & Opening Remarks

- RWHAP Part D CoP Team
- Bizzell CoP Team

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Learning Session #5 Learning Objectives

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

During Learning Session #5 CoP Participants will:

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

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Health Services Center, Inc.

Division of Community HIV/AIDS Programs
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Vision: Healthy Communities, Healthy People

Health Services Center, Inc.

Program Description (as it relates to PCC)

- Health Services Center, Inc. Ryan White Part D Program
- Continuum of Care Preconception Counseling

Core Team

- Director of HIV Care Services: Sonia Preston, CRNP
- HSC Administrative Director/RWD Coordinator: Kelly Turner, MS
- Case Management Coordinator: Paris Brock

CoP #1 PCC Initiatives Smart Goals

HRSA Evidence-Building and Evaluation Services

1. By the end of the CoP, we will provide education and training on preconception counseling, obtaining sexual history, and describing safe sex practices to providers and staff.
2. By the end of the CoP, we will develop a referral policy for linkage to existing preconception family planning programs.
3. By the end of the CoP, we will develop SMART text or EHR enhancements, such as best practice alerts to prompt providers to complete preconception family planning

Revised: SMART Goals for CoP Involvement

Revised SMART goals for CoP Involvement

1. Provide Preconception counseling training for at least 2 staff members
   - Create a training checklist on preconception counseling that will be checked quarterly to identify whether all current and new staff are comfortable using the required preconception counseling prompt to all identified patients of childbearing age that should be receiving preconception counseling.
2. Preconception counseling to be tracked by code
   - Utilize the EMR to identify all patients that should be receiving preconception counseling and add a standardized code in the electronic medical records system that all required staff must utilize to document preconception counseling discussions at intake to all patients of childbearing age within the next 12 months.
3. In house GYN exams for missing outside GYN appointments
   - Incorporate the preconception counseling prompt into in-house GYN exams so that 80% of identified patients will receive preconception counseling during their follow-up GYN appoinment.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

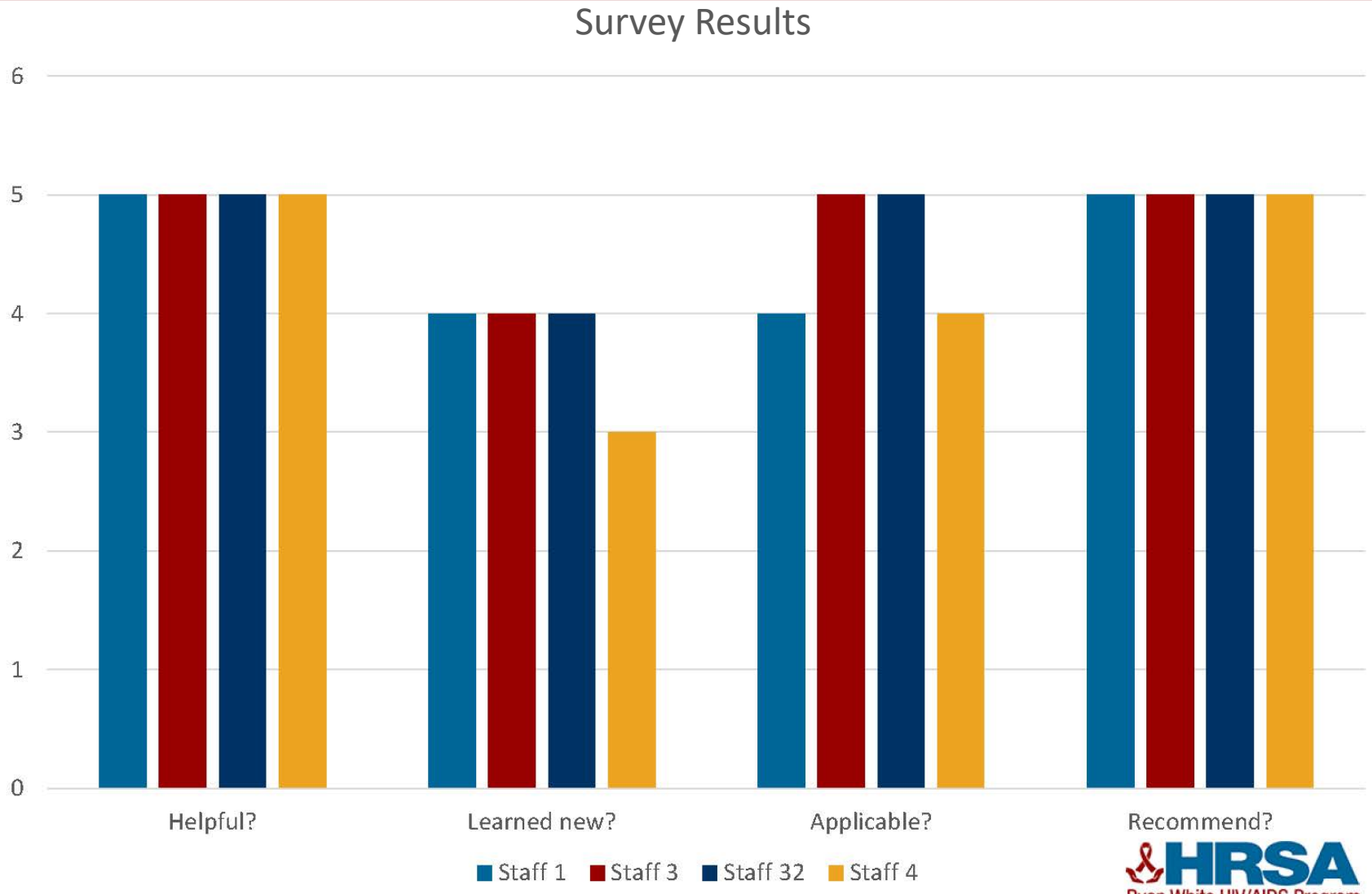
- Provide Preconception counseling training for at least 2 staff members

PDSA Cycle

- PLAN: Research and attend PCC training; evaluate the outcomes to promote best practices
- DO: Research PCC training appropriate for providers and case managers.
- STUDY: Basic understanding of PCC and why it is important to WICY health. Sessions 1 and 2 are recommended for remaining HSC case managers and providers to attend for best practice.
- ACT: HSC staff participated in Sessions 1 and 2 training and gave feedback

PCC Training for Staff

- Four staff trained
- Goal exceeded



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Action Period #2 Data & Progress

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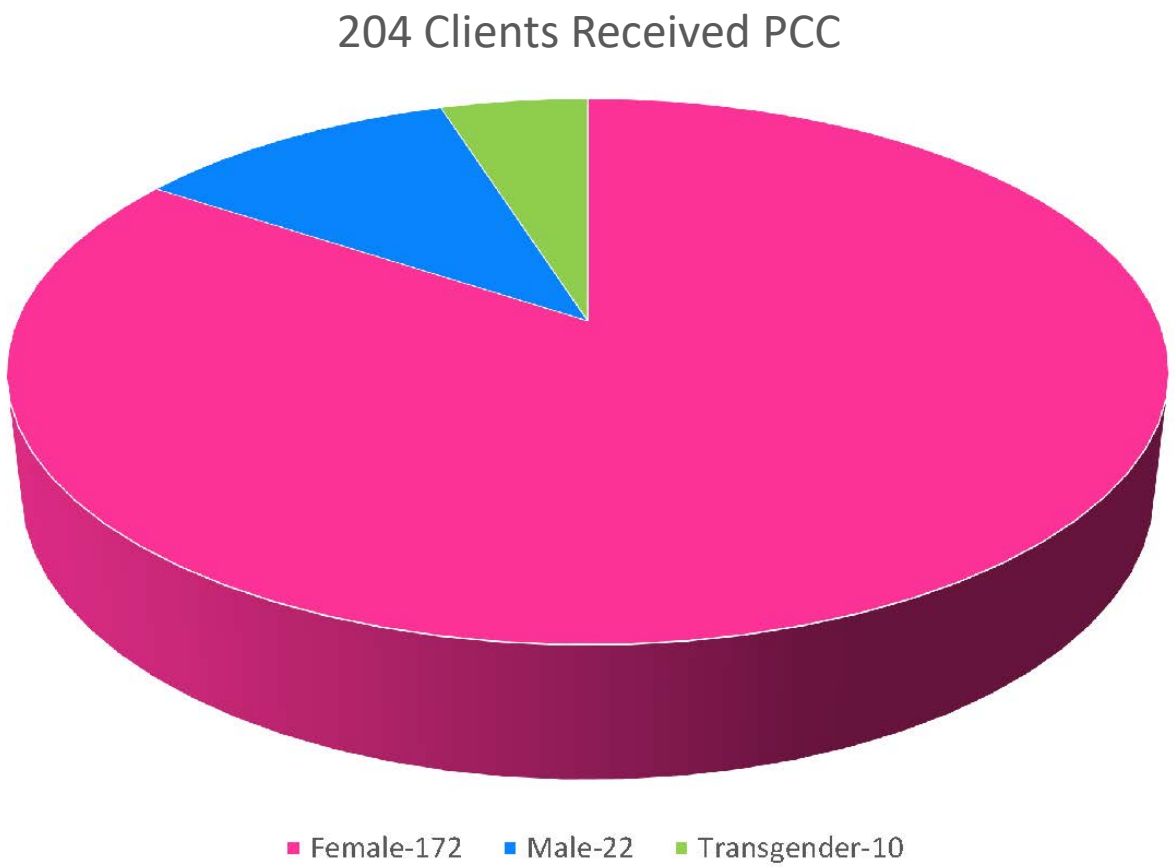
SMART Goal for Action Period #2

- Preconception counseling to be tracked by code

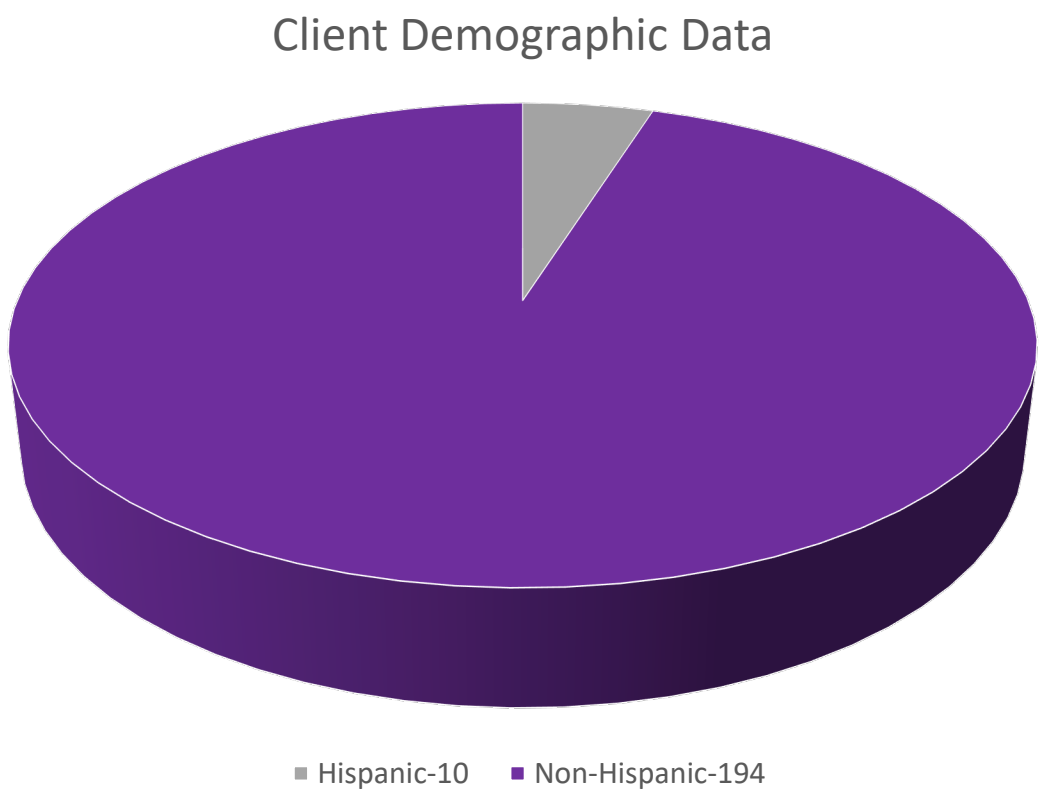
PDSA Cycle

- PLAN: Determine code in EMR to track data
- DO: Provider will use code when providing PCC
- STUDY: Collect data results regarding codes in EMR
- ACT: Make any necessary changes and proceed with documentation of PCC in system with clients

EMR Data



EMR Data



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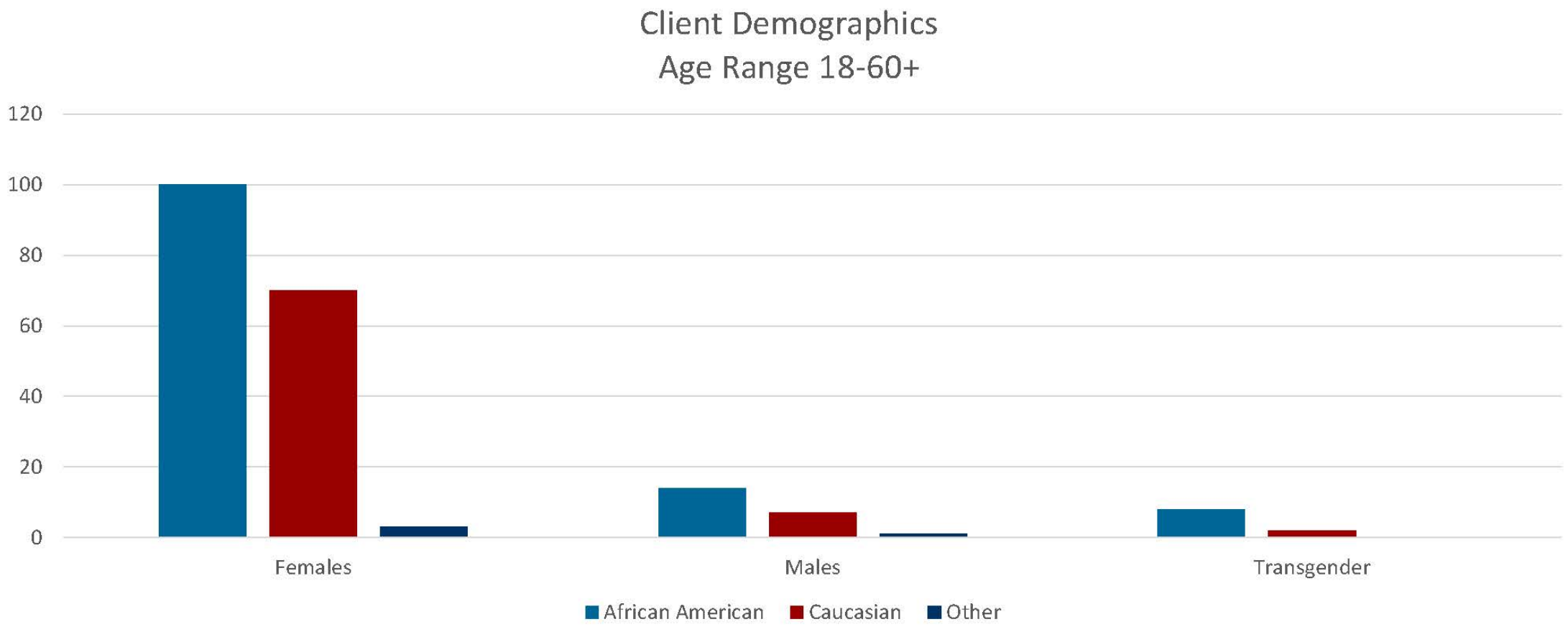
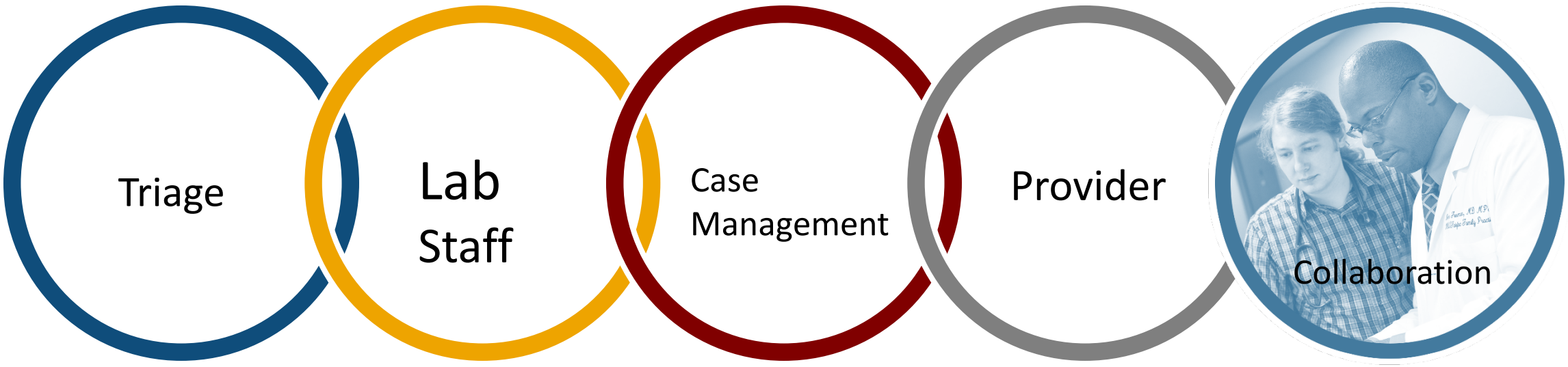

Client Demographics
Age Range 18-60+
120
100
80
60
40
20
0
Females
Males
Transgender
African American
Caucasian
Other

Clinic Flow and PCC



Action Period #3 Data & Progress

SMART Goal for Action Period #3

- In house GYN exams for missing outside GYN appointments

PDSA Cycle

- PLAN: Schedule follow up appointments
- DO: Provider will offer PCC at follow up appointments
- STUDY: Collect data results following appointments
- ACT: Make any necessary changes and proceed PCC at follow up appointments

Progress

- Action period 3 began on 1.2.24.
- Appointments are currently being scheduled

Key Takeaways & Next Steps

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WOMEN, INFANTS, CHILDREN, AND YOUTH (WICY)

Key Takeaways from Action Period 1 & 2

- PCC is needed for males and females
- Providers are the main source of consult; however, CM can be a wealth of knowledge and support for clients
- PCC received from more than one provider type
- Collaborations are key
- Training MUST be step 1!

Next Steps toward Achieving Goals

- Begin Goal 3 Implementation with Action Period 3 on 1.2.24
- Collect data and assess progress on Action Goal 3
- Expand collaborations
- Triage and lab staff trained for PCC
- PCC as an agency-wide CQM goal for 2024

Thank you!

Kelly Turner, MS

Administrative Director

Health Services Center, Inc.

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1-256-832-0100

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Matthew 25

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

Vision: Healthy Communities, Healthy People

Matthew 25

Matthew 25 is a rural, outpatient ambulatory clinic, Ryan White Part C and D Recipient as well as Part B subrecipient. Matthew 25 currently serves 157 Part D consumers and approximately 640 Part C.

Matthew 25 has 4 clinic locations in 2 states:

- Indiana: Evansville
- Kentucky: Henderson, Owensboro and Bowling Green

The Core Team for this project are located in Matthew 25's Bowling Green clinic

Project Director/QI Lead: Sarah Phillips
Co-Project Director: Angela Pendragon
Clinical Provider: Charlie Rose, APRN
HIV Case Manager: Michelle Hall

CoP #1 PCC Initiatives

Initial SMART Goals for CoP Involvement

1. Determine the current PCC process through mapping and identify population(s) receiving PCC through Careware by February 2024.

2. Create a trauma informed PCC and sexual health interview and documentation in EHR by February 2024.

3. Train office staff initially and annually on utilizing trauma informed interview approach to sexual health and PCC by February 2024.

CoP #1 PCC Initiatives

Revised SMART Goals

1. Implement a SOP that addresses PCC through a uniformed person-centered approach for all staff (part B case managers, Part D provider, etc.) that interact with persons with HIV of childbearing potential by 2/2024.

2. Implement efficient client-centered script on preconception counseling for engaging clients of childbearing age in a conversation on their reproductive goals and needs by end of 2/2024.

3. Documentation of PCC during medical visits will be completed in EClinical works and Careware starting January 2024.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

- Implement a SOP that addresses PCC through a uniformed person-centered approach for all staff (part B case managers, Part D providers, etc.) that interact with persons with HIV of childbearing potential by 2/2024

PDSA Cycle

- Collected data that included role-based access, who had access to what systems, and reasoning behind.
- Discovered case managers can access and chart in both Eclinical Works and CareWare. Clinical staff only have access to Eclinical Work.

Outcome

- Goal could not be accomplished in timeframe.

Key Takeaways & Next Steps Action
Action Period #1

Key Takeaways from Action Period #1

- Goal Involved unrealistic access to role-based software, and limitation due to medical privacy laws.
- Learned from the process despite not being able to accomplish in time frame.

Next Steps toward Achieving Goals

- Continue to communicate the identified need to other upper management.
- Work with other department heads in creating foreword action.

Action Period #2 Data & Progress

SMART Goal for Action Period #2

- Implement efficient client-centered script on preconception counseling for engaging clients of childbearing age in a conversation on their reproductive goals and needs by end of 2/2024.

PDSA

- Cycle 1: Distribute preconception counseling survey to providers and collect results
- Cycle 2: Chose preconception counseling script: FPNTC provided PATH approach
- Cycle 3: Educated medical providers on new script and integrating it into their appointments
- Cycle 4: Medical providers utilize the script on 2 patients during time period 12/1/23-1/5/2024
- Cycle 5: Re-Distribute preconception counseling survey to medical providers and collect survey results

FPNTC Script

Efficient Questions for Client-Centered Contraceptive Counseling

Asking about **P**arenthood/**P**regnancy **A**ttitude, **T**iming, and **H**ow important is pregnancy prevention (PATH) is an efficient approach for engaging clients in a conversation to help clarify their reproductive goals and needs.

CLARIFY YOUR CLIENT'S REPRODUCTIVE GOALS AND NEEDS, ASK THEM:

"Do you think you might like to have (more) children at some point?"

"When do you think that might be?"

"How important is it to you to prevent pregnancy (until then)?"

IF YOUR CLIENT IS INTERESTED IN PREGNANCY PREVENTION, ASK THEM:

"Do you have a sense of what is important to you about your birth control method?"

"Some methods of birth control _____. How important is that to you?"

"In addition to preventing pregnancy, there are birth control methods that _____. Would you like to know more about that?"

"I hear you saying that you are interested in a method that is _____. Do you have a sense of what else is important to you?"

Learn more about PATH at **envisionsrh.com**
Find more resources at **FPNTC.org**

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FPNTC Script

Efficient Questions for Client-Centered Contraceptive Counseling *(cont.)*

QUESTIONS TO ASK ALL YOUR CLIENTS...

"Since you've said _____, would you like to talk about ways to be prepared for a healthy pregnancy?"

"What questions do you have about _____?"

"We covered a lot of information. What do we need to go over again?"

TRY THESE FACILITATION SKILLS...

Start with "YES" (agreement, empathy, or validation) before offering clarifying information:

"YES, you're absolutely right, AND…"

"Wow! I think most people would find that hard to deal with AND..."

"YES, I can absolutely see how you would think that, AND…"

Uncover misconceptions with:

"Many of my clients say _____. Is that something you think about?"

Offer follow-up questions after giving a piece of relevant information:

"How would that be for you?"

"Has that ever happened to you before?"

"How do you see yourself managing this?"

Learn more about PATH at **envisionsrh.com**
Find more resources at **FPNTC.org**

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Action Period #2 Data & Progress

Pre PCC script

How comfortable are you talking to patients about their sexual health and reproductive goals?

- 0% Not comfortable
- 75% Somewhat Comfortable
- 25% Extremely Comfortable

Post PCC script

How comfortable are you talking to patients about their sexual health and reproductive goals after learning and utilizing the Preconception Counseling script?

- 0% Not comfortable
- 25% Somewhat Comfortable
- 75% Extremely Comfortable

How likely are you to use the script in your everyday practice?

- 0% Not likely
- 0% Likely
- 100% Very Likely

Action Period #2 Data & Progress

Medical Provider feedback after using new PCC script:

"She shared more than she usually does- it wasn't just yes or no answers. I think more importantly it was a great opportunity to add her husband into the discussion as far as him testing and staying healthy also. She did share her past pregnancies we planned so we discussed her letting me know when they are trying so that we could also come up with a plan for her to stay healthy, start folic acid and stay virally suppressed."

"We talked about several methods of contraception, prompted by the script and she also had questions; does she need to change her ART Regimen now or when she is trying to conceive? So, we talked about the guidelines. She asked about breastfeeding, we talked about the studies, she was so excited about the findings. We agreed at the end of the conversation she would think about a contraception method to start at the next visit, in the meantime she will use condoms religiously."

Key Takeaways & Next Steps

Action Period 2

- Learned that small incremental changes are preferred
- Initial Smart goals will /can evolve
- A script for Case Management and would be useful when discussing PCC as it relates to CM.

Next Steps toward Achieving Goals

- Facilitate the discussion of a PCC script with other service departments that support/enhance the one adopted in this action period
- Measure benefits of PCC script by monitoring # of specialty referrals as a result.

Action Period #3 Data & Progress

SMART Goal for Action Period #3

90% of Part D patients who have a medical visit will receive PCC and have it documented in EClinical works(EHR) and CAREWare starting January 2024.

PDSA

- Cycle 1: Assessed PCC documentation in Eclinical Works and CareWare
  * Updated Structured data in Eclinical Works
- Cycle 2: Adding PCC screening in CAREWare
- Cycle 3: Introduce PCC performance measure to M25 CQM meetings and add to 2024 CQM plan to be measured quarterly

Key Takeaways & Next Steps Action Action Period #3

Key Takeaways from Action Period 3

- Training is necessary for all parties on new documentation requirement and data collection

Next Steps toward Achieving Goals

- Add the PCC performance measure to Matthew 25 quarterly data review to ensure the completion of PCC
- Review Performance Measure Quarterly
- Implement quality improvement projects as needed to maintain target goal

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Central Carolina Health Network

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

Vision: Healthy Communities, Healthy People

Central Carolina Health Network

CCHN, a private non-profit 501(c)3, currently serves 7 counties in central North Carolina. CCHN distributes the Part D WICY Grant to 3 HIV clinics in Region 4. Our represented clinic within this COP is Cone Health's Regional Center for Infectious Diseases (RCID) in Greensboro, NC.

RCID provides comprehensive services for people living with HIV/AIDS. Our integrated care team includes physicians, nurse practitioners, Pharm D's, nurses, CMA's, case managers, bridge counselors, financial counselors, behavioral health counselors, and a dental clinic. CCHN funds all medical and support staff in this care team including 4 agencies outside of RCID stationed within the clinic for one-stop ongoing education, HIV prevention and care, and research studies.

Core Team

- Project Director/Manager –Meagan Patillo
- HIV Case Manager –Connie Holt
- Clinical Providers –Shaquenia Staley, Sabina Manandhar, Stephanie Dixon
- QI Lead –Megan Burroughs

CoP #1 PCC Initiatives

Initial SMART Goals for CoP Involvement

- Develop PCC tracking tool and begin tracking progress quarterly.
- Develop a PCC recording for patients to be placed in Mychart prior/post visit by February 2024.
- Develop a training tool and identify resources for staff and providers on PCC by February 2024.

Revised SMART Goals

- Removed the PCC recording in MyChart and added PCC to the rooming process to ensure that patients were engaged and document the activity in Epic.
- Developing training and resources for staff became part of action period 2 and 3.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

- Develop PCC tracking tool and begin tracking progress quarterly.

Aim

By February 2024 RCID will have an established CQI to improve documentation and tracking of PCC focused conversation to 80% of patients.

We used a PDSA Cycle to identify areas for improving our PCC process.

Primary Drivers

1. PCC resources
2. Staff/Provider training
3. Tracking tool for patients who received PCC.

Secondary Drivers

1. Identify PCC population – all patients 18-50 years of age.
2. Develop resource guide for patients
3. Create report in Epic to track how many patients were screened in the rooming process.

Action Period #1 Activities

Activities:

- Added a screening tool in the “rooming process” while clinical staff prepares the patient for their provider visit.
- In August 2023, created a report in EPIC to assess the use of the Pregnancy Intention Screening Questionnaire (PISQ) annual screening tool.

Outcome

- By September 21st, we had 35% completion for patients 18-50 years.

Action Period #2 Data & Progress

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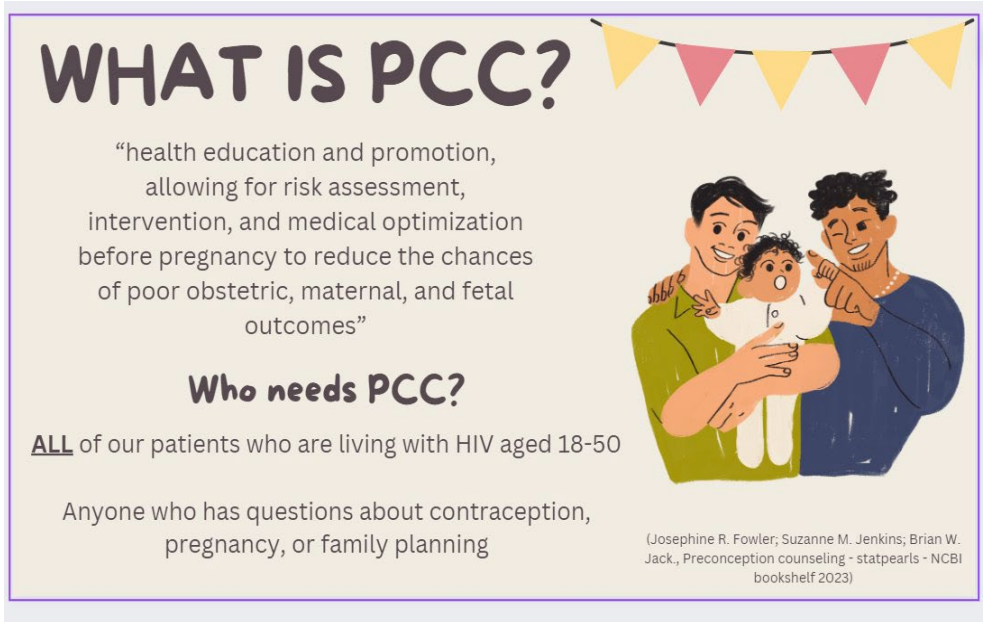
SMART Goal for Action Period #2

Develop a training tool and identify resources for staff and providers on PCC by February 2024.

- In December 2023, created a brochure for providers who needed additional support in integrating PCC into their practice.
- In January 2024, we created a PowerPoint for training clinical staff. As of January 3rd, we are at 50.3% completion rate.



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Examples of Resources for Staff

REGIONAL VASECTOMY PROGRAM

Open to any male who is 21 years of age or older. The cost is on a sliding fee scale, based on family size and income.

336-641-4718

CENTERING PREGNANCY™

Prenatal care that includes health assessment, education and support.

336-641-3245

Free Family Planning/ Birth Control Services (for Eligible Individuals)

Planned Parenthood
Greensboro Health Center
336-373-0678

Guilford County Health Department
336-641-3245

Who Can Apply for Be Smart?

- U.S. citizens or documented immigrants
- North Carolina residents who:
  - ✔ Are not pregnant;
  - ✔ Are not incarcerated; or
  - ✔ Have an income at or below 195% of the federal poverty level.
- Not currently on Medicaid
- Other requirements may apply

How Do I Apply for Be Smart?

Applications are available at:

- Your county Department of Social Services office;
- Local health departments;
- Many community health centers; and
- Online at https://dma.ncdhhs.gov.

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Examples of Resources for Staff

Ask your provider about contraception today! Find contraception , safe sex supplies and STI testing at the following locations:

Regional Center for Infectious Disease
301 E Wendover Suite 111
Greensboro, NC 27401
336-832-7840

Triad Health Project
801 Summit Ave
Greensboro NC 27405
336-275-1654
501 W Westwood Ave
High Point. NC 27262
336-884-4116

Guilford County Health Department
1100E Wendover
Greensboro, NC 27401
336-832-7840

Adoption Resources

Friends in Adoption
www.friendsinadoption.org
800-982-3678

Human Rights Campaign
www.hrc.org/resources

Lifelong Adoptions
www.lifelongadoptions.com/lgbt-adoption

Paths for Families
www.pathsforfamilies.org

Key Takeaways & Next Steps

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

Key Takeaways from Action Period 1 & 2

- Recognizing the need for PCC within the clinic, we had many patients who reported not realizing that they could have children while living with HIV.

- Providing basic education for patients has been a game changer for our clinic population.

- Clinic staff adapted well to the process. However, we saw challenges with changing our provider's practice which led to creating a resource brochure and training.

During Action period #3 (in progress)

- Continue to work on our resource brochure for providers to provide to patients when they express interest in family planning, contraception, sterilization, and adoption.
- Create training slides and education on Preconception Counseling for all staff to review in the clinic.

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Harris Health System
Thomas Street @ Quentin Mease Health Center

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

Vision: Healthy Communities, Healthy People

Program Name

Program Description (as it relates to PCC)

- Harris Health System's Thomas Street @ Quentin Mease Health Center has been providing care to people living with HIV since the early 1980's and continues to serve approximately 5,000 PLWH annually. Our HIV program was the first free-standing HIV clinic in the U.S. We provide a complete continuum of primary and specialty care as well as a wide range of supportive services in our HIV clinics, and we work with the two large general hospitals in our system to ensure effective transitions between inpatient and outpatient care for our patients. Harris Health is one of few providers that offer prenatal and labor and delivery services for pregnant PLWH.

Core Team

- Carin Martin – Grants Project Manager
- Anny Abraham - Quality Improvement Manager RN
- Niki Hamlin – OB HIV Medical Case Manager
- Dr. Jose Serpa-Alvarez – Thomas Street @ Quentin Mease Medical Director
- Dr. Jenny McKinney – Maternal-Fetal Medicine OB/GYN Physician
- Dr. Jess Gerard – OB/GYN Physician

SMART Goals for CoP Involvement

- By the end of the CoP develop SMART text or EMR enhancements, such as best practice alerts to prompt providers to complete preconception family planning.

- By the end of the CoP we will develop a referral policy for linkage to existing preconception family planning program.

- By the end of the CoP we will provide education and training on preconception counseling, obtaining sexual history, and describing safe sex practices to providers and staff.

CoP #1 PCC Initiatives

- Development of PCC Screening Tool.

- Integration of PCC Resources into Clinic EMR:
  - Smartphrase PCC screening tool
  - PCC visit referral code

- Clinician training on new PCC clinic practices and workflows.

Action Period #1 Data & Progress

SMART Goal for Action Period #1

- By the end of the CoP develop SMART text or EMR enhancements, such as best practice alerts to prompt providers to complete preconception family planning.

Action Period #1 Activities:

- Integrate new PCC Smart Phrase screening tool into Epic.
- Have one medical provider assess female patients age 18-50 using the smart phrase screening tool for patients on their regular schedule, and make GYN referrals as appropriate.
- Preform chart review of all completed visits for female patients age 18-50 on participating provider schedule to determine: 1) was preconception screening documented; 2) was patient interested in Gyn referral for conception counseling or contraception; 3) was gyn referral provided to interested patients.

Action Period #1 Data & Progress

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

Harris Health Epic Preconception Counseling Smart Phrase Screening Tool

1. Are you or your partner interested in having a child in the next year? {YES/NO:11432}
2. If yes, are you interested in speaking to an OB/GYN about trying to conceive? {YES/ NO N/A:22436}
3. If no, are you using any form of birth control? {YES/NO:11432} {CONTRACEPTION:706}
4. If no, are you interested in speaking to a gynecologist about birth control? {YES/ NO N/A:22436}

Outcomes:

- During July's first PDSA 4 females of child bearing age had completed visits
- Only one patient needed gyn referral but referral process needed vetting.
- There was positive feedback on the ease of screening questions.
- Chart reviewer reported that the screening information was easily identified in the progress notes.

Action Period #2 Data & Progress

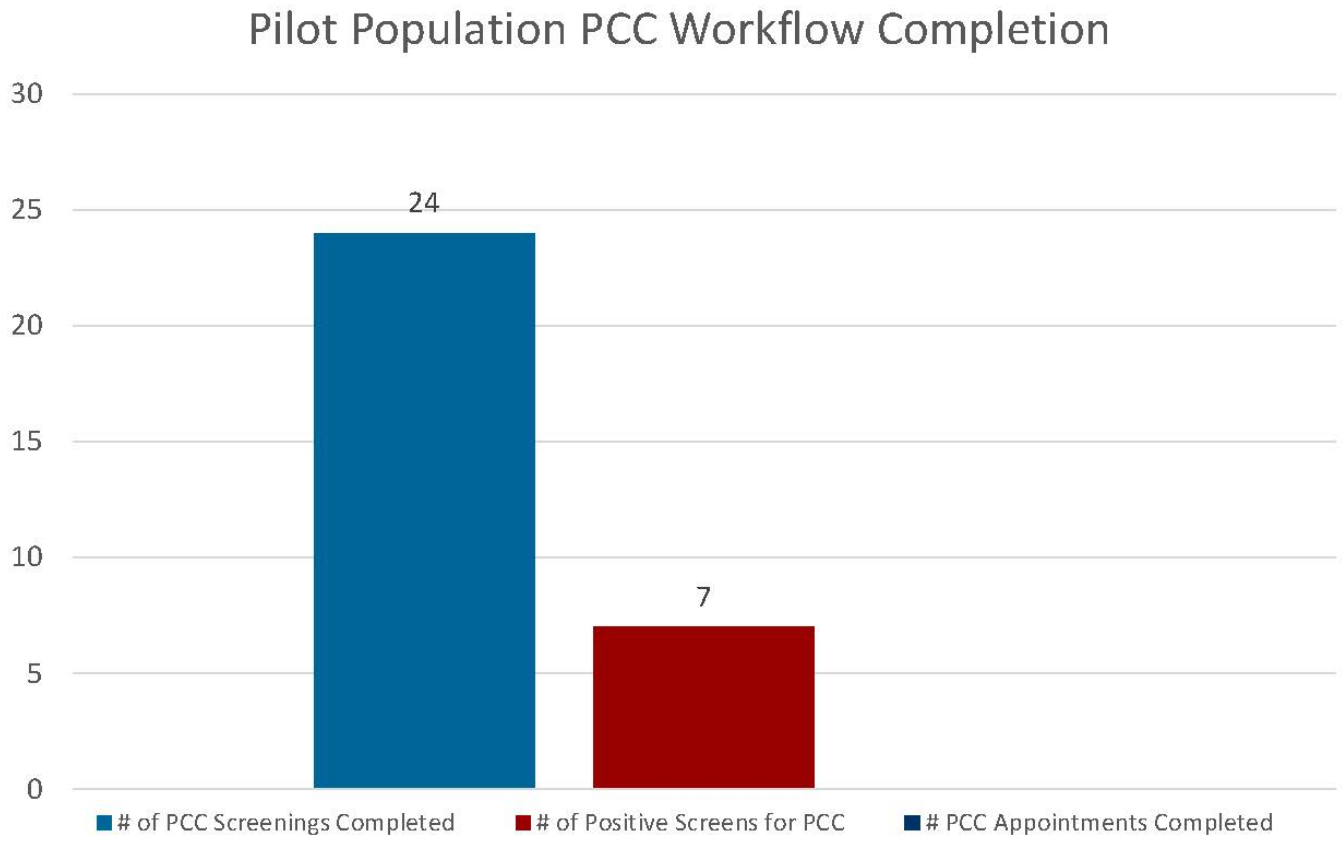
SMART Goal for Action Period #2

- By the end of the CoP we will develop a referral policy for linkage to existing preconception family planning program.

Action Period #2 Activities:

- Two additional medical providers assess female patients age 18-50 using the smart phrase screening tool for patients on their regular schedule, and make GYN referrals as appropriate.
- Work with Nursing Staff to ensure PCC referral is integrated into after visit workflow.
- Preform chart review of all completed visits for female patients age 18-50 on participating provider schedule to determine: 1) was preconception screening documented; 2) was patient interested in Gyn referral for conception counseling or contraception; 3) was gyn referral provided to interested patients; *4) was PCC referral visits scheduled and/or completed.*

Action Period #2 Data & Progress



PCC Appointment Completion Challenges

- Cancellations
- Provider Availability
- Multiple Reasons for GYN Referral

Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2

- Ensure team members from across clinic departments have active representation workflow feedback.

Next Steps toward Achieving Goals

- Continue sample populations until referral linkage is reliable
- Expand to male patient population
- Develop standardized PCC tool

Action Period #3 Data & Progress

SMART Goal for Action Period #3

- By the end of the CoP we will develop a referral policy for linkage to existing preconception family planning program. (Continued)

Action Period #3 Activities:

- Create new PCC referral order in Epic
  - Systems IT has created new order
  - Testing Completed
  - In Production and available to piloting providers 1/8/23

Questions?

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University of Kansas School of Medicine-Wichita (UKSM-W) Medical Practice Association

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

Vision: Healthy Communities, Healthy People

University of Kansas School of Medicine-Wichita (UKSM-W) Medical Practice Association

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

Program Description

UKSM-W is a program that provides care to ~1500 people living with HIV with 4 delivery sites across Kansas. As part of HIV primary care, 200 people of childbearing potential are seen annually and will be advised on conception and safer sex topics.

Core Team (March 2023)

- Michael Madecky, Project Manager
- Mary Gonzales, Clinical Provider
- Kayla Del Rio, Clinical Provider
- Paulette Phipps, QI Lead
- Lamberto Gonzalez, Case Manager
- Tonya Sims, Case Manager

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UKSM-W MPA Core Team – January 2024

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

- *Michelle Scheuring, Program Manager
- Mary Gonzales, Clinical Provider
- Kayla Del Rio, Clinical Provider
- *Jennifer Priller, Quality Coordinator
- *Rachelle Feuillerat, Case Manager
- *Lynnea Johnson, Case Manager

* Denotes new team member, three of whom have been here less than 60 days

We are thankful for Mary and Kayla, and the consistency they provide – both to our patients, our staff, and the program as a whole!

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UKSM-W MPA *Original* SMART Goals

- Core team will develop a **policy** defining patient population and activities required for PCC service by 06/01/2023.
- By the February 29, 2024, clinicians and QI staff will have the Z31.69 ICD-10 code and associated assessments added to the **EMR** problem list for 75% of PCC eligible individuals.
- By 07/31/2023, Quality lead, HIM staff, and clinical supervisor will have completed **EMR** customization to monitor PCC care at initial visit and annually.

UKSM-W MPA *Revised* SMART Goals

- By February 29, 2024, 75% of clients with childbearing potential will receive documented PCC. Reflected by adding the ICD-10 code and associated assessments added to the **EMR** problem list.
    - By 07/31/2023, Quality lead, HIM staff, and clinical supervisor will identify the ICD-10 code that will enable documentation of PCC.
- By February 29, 2024, develop a user guide for WICY who are considering pregnancy including resources available to their **community** and specifics of HIV and pregnancy.
- By January 30, 2024, gather examples of how other grantees disseminate community resources for WICY with reproduction potential to inform our delivery of PCC.

Action Period #1 Progress

SMART Goals for Action Period #1

- By February 29, 2024, clinicians and QI staff will have the Z31.69 ICD-10 code and associated assessments added to the **EMR** problem list for 75% of PCC eligible individuals.
    - By 07/31/2023, Quality lead, HIM staff, and clinical supervisor will have identify the ICD-10 code that will enable documentation of PCC.

PDSA Cycle

- P: Identify ICD-10 code for documentation of PCC
- D: Identified the ICD-10 code and began using it
- S: Running reports is the next step, however this is a work in progress
- A: Once we can run the reports, we will know if we have met the goal

Action Period #2 Data & Progress

SMART Goals for Action Period #2

- Develop user guide for WICY who are considering pregnancy including resources available to their community and specifics of HIV and pregnancy.

PDSA Cycle

- P: Review resources utilized by other organizations
- D: Compile the content and write the user guide. Kayla and Mary created an informational booklet to hand out to patients with childbearing potential
- S: Piloted user guide with one pregnant client to gauge response
- A: Next steps are to finalize the document and provide to 75% of individuals eligible for PCC

Action Period #3 Data & Progress

SMART Goal for Action Period #3

- By January 30, 2024, gather examples of how other grantees disseminate community resources for WICY with reproduction potential to inform our delivery of PCC.

PDSA Cycle

- P: Wrote email to Part D grantees requesting information
- D: As it is received, we are putting answers in a spreadsheet
- S: Review information received
- A: Incorporate best practices into our PCC policy

Action Periods Data & Progress

- From what I can tell, our original team did not break the goals out by action period when they were getting started.

- Nor have I been able to find good documentation on the PDSA cycles, with regard to the specifics of each phase.

Despite the challenges,
Mary and Kayla accomplished several significant tasks

Key Takeaways & Next Steps

Key Takeaways from Action Period 1 & 2 &3

- Keep the goals small, breaking down each component into its own goal
- Keep better documentation – assign one person on the team to document all aspects of the project

Next Steps toward Achieving Goals

- Compile responses from other Part D programs
- Up our nerd game – learn how to work the EMR reporting features to monitor progress
- Send information booklet to printshop
- Update and train all staff

HRSA
Health Resources & Services Administration

AIDS Care Group

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

Vision: Healthy Communities, Healthy People

AIDS Care Group

Program Description

AIDS Care Group is a community-based organization that provides testing and treatment for HIV/AIDS, Hepatitis C, STIs, Opioid Use Disorders. We are based in S.E. PA serving over 1,000 clients annually from the Philadelphia EMA, as well as Berks and Dauphin counties.

Core Team

- Ann Ferguson, MSN, COO – Project Director
- Gwen Verlinghieri, CRNP – Clinical Provider
- Dev'ri Cashe, CRNP – Clinical Provider
- Monica Johnson, RN – Patient Education
- Michelle Scamuffa, HIV Program Manager – QI Lead
- Rebecca Ferguson, Data Coordinator – Data Lead
- Allison Byrd, Peer Navigator – Consumer Representative

CoP #1 PCC Initiatives

SMART Goals for CoP Involvement (original)

- By November 1, 2023, staff will be trained on preconception counseling. This training will occur annually.
- A preconception counseling handout will be developed by July 1, 2023
- A CareWare report for tracking preconception counseling data will be developed by December 1, 2023.

Revised SMART Goals for CoP Involvement

- Revise PCC EMR template to meet all RWHAP Part D PCC including Sexual Health Expectations by August 1, 2023
- Train staff on preconception counseling, and billing. Initial learning session to be completed by November 30, 2023 . Training annually after that.
  - *Revision - to be completed by December 6, 2023*
- Create EMR Report for tracking preconception counseling encounters by December 1, 2023

Action Period #1 Data & Progress

SMART Goal for Action Period #1
Revise PCC EMR template to meet all RWHAP Part D PCC including Sexual Health Expectations by September 1, 2023

PDSA Cycle

- Does the current PCC EMR template align with the RWHAP Part D guidelines? The review will identify areas where the current template needs improvement.

- During the review of the PCC EMR template, we determined that there were specific gaps in collecting partner history, a specific lab testing plan for PCC, and documentation at every visit. Consequently, we expanded the template to include these essential items, ensuring that it aligns with RWHAP Part D guidelines.

Action Period #2 Data & Progress

SMART Goal for Action Period #2

Train staff on preconception counseling, and billing. Initial learning session to be completed by November 30, 2023 . Training annually after that.

PDSA Cycle

During this cycle we hosted a comprehensive training for all providers and staff on PCC. The training session was attended by 7 providers and 9 support staff. The session included training on use of the new templates and the plan for data collection through billing for counseling sessions.

Action Period #3 Data & Progress

SMART Goal for Action Period # 3

Create EMR Report for tracking preconception counseling encounters by December 1, 2023.

PDSA Cycle

We have created the report template in the EMR (Practice Fusion). The template incudes 2 Dx criteria Z31.69 (Encounter for other general counseling and advice on procreation), and B20/Z21. The report breaks down counseling sessions by patient and contains 9 elements such as counseling date, age, sex.

Key Takeaways & Next Steps

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

Key Takeaways from Action Period 1 & 2

- Identified the need for multiple approaches to PCC
- Unexpected implementation delay- impact on schedule
- Recognized a disparity in delivering PCC to men
- “Lessons Learned” The significance of proactive planning and ensuring equitable delivery of healthcare services.

Next Steps toward Achieving Goals

- Training triage staff on documenting the desire for PCC counseling.
- Using report data to inform progress on documentation of PCC.

HRSA
Health Resources & Services Administration

UPMC Presbyterian Shadyside, Pittsburgh

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

Vision: Healthy Communities, Healthy People

UPMC Presbyterian Shadyside, Pittsburgh

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

Program Description (as it relates to PCC)

- Comprehensive HIV primary care hospital-based clinic, part of academic medical center
- RW Parts C, D, F recipient; integrated women's healthcare including preconception counseling

UPMC
LIFE CHANGING MEDICINE

Core Team

- Deb McMahon, MD; Clinical Director;
- Katie Bunge, MD, MPH; OB/GYN
- Maja Sarac, MHA; RW Program Coordinator
- Tamara Shank, MBA, MSN, CPC; Quality Coordinator
- Kate Codd-Palmer, CRNP; Unit Manager, Women's Health
- Ella Kaplan, MSW, LCSW; Lead Social Worker

CoP #1 PCC Initiatives

SMART Goals for CoP Involvement (original)

- Promote culturally competent preconception counseling to men, women and gender diverse persons of childbearing potential over the next year; develop visit template for PWH<50 years of age; assess by random sample of 50 charts
- Recommend STI screening include PCC for persons of childbearing potential; add drop-down prompts in EMR over the next year; assess by random sample of 50 charts.
- Conduct culturally competent PCC virtual training session for providers and relevant staff over the next year; 75% participation either real-time or view recorded session.

Revised SMART Goals for CoP Involvement

- Promote culturally competent preconception counseling to men, women and gender diverse persons of childbearing potential over the next year; assess by random sample of 100 charts.
  - Routinize preconception counseling utilizing a standard template in EMR
- Ensure STI screenings include preconception counseling for persons of childbearing potential; assess by random sample of 50 charts.
- Conduct culturally competent preconception counseling training session for providers and relevant staff over the next year; record attendance.

The main change to our SMART goals is that timelines have been extended for the EMR template

Action Period #1 Data & Progress

SMART Goal for Action Period #1

- Promote culturally competent preconception counseling to men, women and gender diverse persons of childbearing potential over the next year; assess by random sample of 50 charts.
  - Develop visit template for PWH < 50 yrs. of age

PDSA Cycle

- P: Developed a template, completed first review with providers, initiated template use in November 2023 (Action Period #2)
- D: CoP members will assess early compliance by reviewing 10 randomly selected charts; ongoing.
- S: Collate and analyze results from 10 selected charts and obtain provider feedback in February 2024.
- A: Revise visit template if utilization reveals opportunities for improvement and re-educated clinicians, when warranted.

Our Template Revisions

PRECONCEPTION COUNSELING

- Would you like to become pregnant, have children or add to your family in the next year? If yes, refer to GYN MD – reason: preconception counseling.
  - If no, are you or your partner at risk of getting pregnant?
  - If planning a pregnancy in the next year, are you taking Folic Acid 400mcg daily?
- Are you interested in STI screening?

RELATED TO PCC

- Within the past 12 months, did the food you buy just not last and you didn't have money to get more?
- Within the past 12 months, have you ever stayed: outside in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch surfing)?
  - Are you worried about losing your housing?
  - Do you want a referral to see a social worker today?

Key Takeaways & Next Steps

Key Takeaways from Action Period 1

- Building an EMR template requires attention to detail
- Inserting pre-conception questions into larger visit template
- Getting feedback and buy-in from providers is essential
- Working with Hospital EMR team to execute takes time

Next Steps toward Achieving Goals

- Visit template in use; providers have been reminded and encouraged to use it
- Work with EpicCare team to insert automatic referral in Epic template to OB/GYN for more detailed and specific preconception counseling (pregnancy management, initial infertility evaluations, available REI services, LARC contraception, breastfeeding counseling)

Action Period #2 Data & Progress

SMART Goal for Action Period #2

- Conduct culturally competent preconception counseling training session for providers and relevant staff over the next year; record attendance.

PDSA Cycle

- P: Breastfeeding and HIV education session at provider meeting completed October 4, 2023; general pre-conception counseling for providers is planned for April 3, 2024 (Action Period #3)
  - Addressing physician and patient queries about breastfeeding
- D: Attendance is tracked
- S: Feedback is encouraged for all sessions
- A: Re-training will be planned as needed/requested

Key Takeaways & Next Steps

Key Takeaways from Action Period #2

- Providers welcome new information regarding guidelines and practice management
- There is expertise within our hospital community which is readily accessed and willing to educate (Pediatric Infectious Disease Specialist)

Next Steps toward Achieving Goals in Action Period #3

- Culturally sensitive preconception counselling educational session for HIV providers is scheduled for April 3, 2024
- Revise Epic template pending chart review and physician feedback

HRSA
Health Resources & Services Administration

Callie Clinic, Sherman, Texas

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

Vision: Healthy Communities, Healthy People

Callie Clinic, Sherman, TX

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

Program Description

- Organization serves far north Texas and is mostly rural.
- The clinic is a one-stop shop (15 RW funded services).

Core Team

- Dr. Minaxi Rathod, Medical Director
- Glenn Moreland, HIV Program Director
- Stacey Wheatley, APRN (Clinical Provider)
- Bethany Deaton, PA (Clinical Provider)
- Whitney Vaughn, RN (Clinical Support/MCM)
- Kelly Fretwell, Office Manager (Data/EMR)
- Gwynne Palmore, CEO
- Norma Piel-Brown, CQM Manager

CoP #1 PCC Initiatives

SMART Goals for CoP Involvement (original)

By February 2024, increase preconception counseling for our client population by:

- Goal #1: Develop/adopt PCC guidelines and integrate into the clinical intake process (EMR/paper format).
- Goal #2: Conduct PCC guideline kick-off event (start of new guidelines), market internally with posters/flyers, and develop and distribute a brief survey to clients.
- Goal #3: Provide staff training annually. Provide external stakeholders (regional) training biannually. Distribute a brief satisfaction survey at each training and include a culturally competent training component for all trainings.

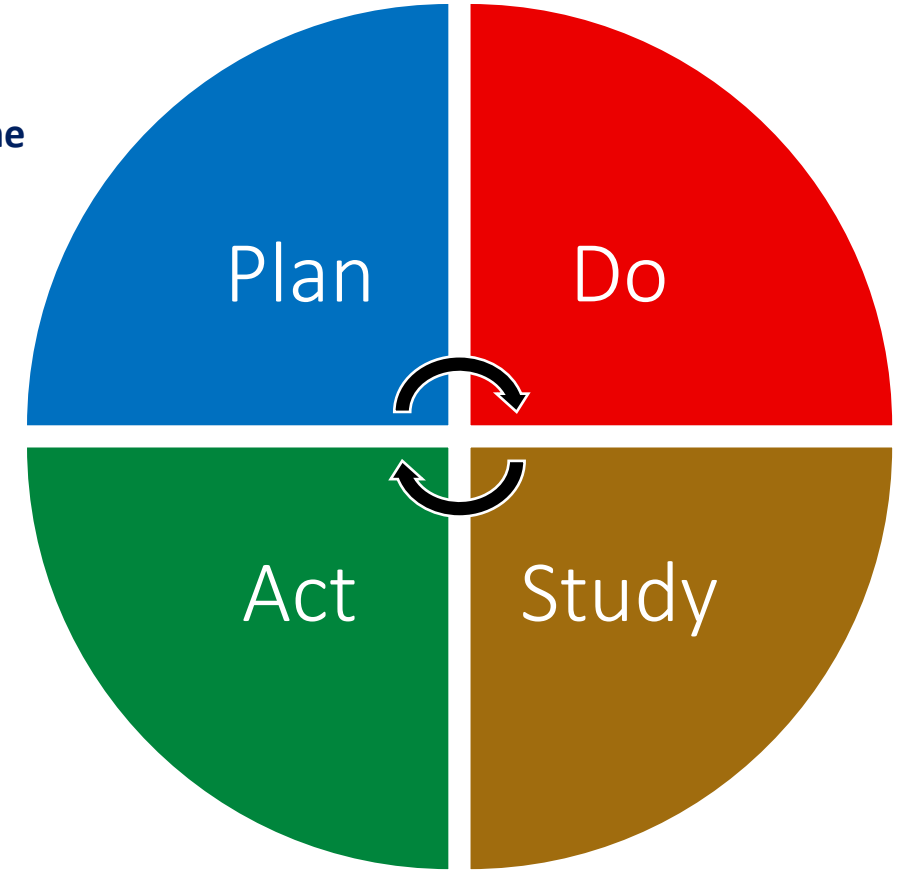
The previous SMART goals were revised and are listed below. These are the goals worked on for this CoP:

- Goal #1: Develop a method within the EMR to integrate and track the provision of preconception counseling.
- Goal #2: Provide staff training annually that includes a culturally competent component.
- Goal #3: Develop posters/flyers to engage consumers at clinic on preconception counseling.
- Goal #4: Develop a brief survey to distribute to clients after medical care visits and once EMR integration is complete.

Action Periods #1, #2 & #3 Data & Progress

SMART Goal #1: Develop a method within the EMR to integrate and track the provision of preconception counseling.

Develop a template w/in the EMR to document PCC screening to identify childbearing intentions.



Identified staff to implement EMR changes, 3 revisions made:
#1 Chart Tab – PCC subtab to indicate date and comments.
#2 Flow Chart Tab - PCC subtab that indicates the same as #1 and
#3 Encounters Tab - detailed PCC info in Care Plan. Completed August 2023. Began collecting data.

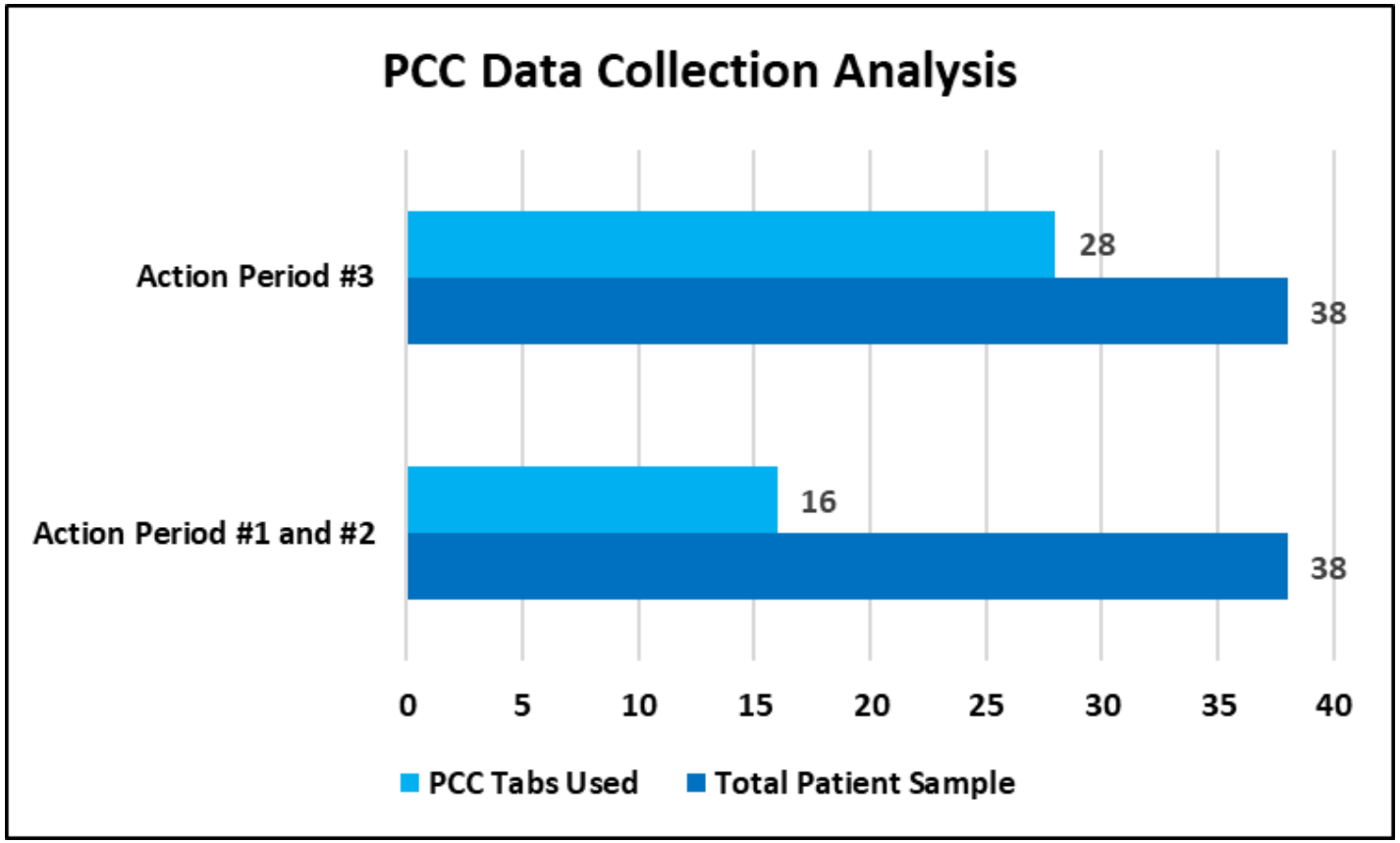
Regrouped w/team on Nov. 14th. Shared results and developed a unified approach to improve PCC responses. Then sample again.

Collected data. Analyzed it. Results were not what we anticipated with this strategy.

Action Periods #1, #2 & #3 - Data Analysis

Key Takeaways for Goal #1:

- Needed to regroup and ask why we weren't seeing what we thought we should and how to get there.
- We learned so much more the 2nd time around (Action Period #3):
  - Creation of alerts in EMR to assist with PCC.
  - 50% (19/38) had tubal ligations/hysterectomies or menopausal. We have an aging population.
  - Of the 15 who did not have PCC screening 5 (33.3%) would not have needed it.
  - There was a 31.5% improvement rate from Action Period #1 & #2 to Action Period #3.



Action Period #2 & #3 Data & Progress

SMART Goals # 2, #3 and #4 for Action Periods #2 & #3 – Oct. - Nov. 2023 and Jan. 2024.

- Goal #2: Provide staff training annually that includes a culturally competent component.
- Goal #3: Develop posters/flyers to engage consumers at clinic on preconception counseling.
- Goal #4: Develop a brief survey to distribute to clients after medical care visits and once EMR integration is complete.

PDSA Cycle – By Feb. 29, 2024

- Plan: Goal #2: Select staff training from Title X – Litmos On-line Learning Modules.
  Goal #3: Develop PCC poster to engage consumers at clinic.
  Goal #4: Develop survey questions to be incorporated into overall clinic satisfaction survey.

- Do: Goal #2: Training has been selected and will be assigned. It includes No Wrong Door to Sexual and Reproductive Health, Engaging Clients in Reproductive Life Goals – Conversations in the Social Service Setting, Engaging Clients in Contraceptive Counseling and PATH Skills Practice and Contraception Quick Start. Goal #3 and Goal #4: In progress.

- Study: Goal #2, Goal #3 and Goal #4: To be determined.

- Act: Goal #2, Goal #3 and Goal #4: To be determined.

Key Takeaways & Next Steps

Key Takeaways from Action Periods 1, 2 & 3

- Never assume everybody is doing the same type of documentation. Validate understanding.
- It's not a test; there are many correct responses but make it easy for your team.
- We didn't have lots of patients who needed PCC but we got lots of practice using the new EMRs tabs.
- More time…

Next Steps toward Achieving Goals

- Continue working on Goals #2, #3 and #4.

Questions?

Closeout Remarks

- RWHAP Part D CoP Team
- Bizzell CoP Team