Monitoring What Matters Institute:

Using an outcomes perspective to develop quality indicators and measure performance in Care Coordination programs in the NY EMA

Ryan White Grantee Meeting 2012
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11/28/2012

AIDS INSTITUTE 25 years
1983-2008 New York State Department of Health

NYC Health

Presentation Agenda

- Learning Objectives
- Overview of HIV Epidemic in NYC
- Background of NY Ryan White Program
- Overview of Quality Management Program
- Use of Nominal Group Technique (NGT)
- NGT Exercise
- Data Review – Baseline and Current
- Discussion – What will work for you?

Learning Objectives

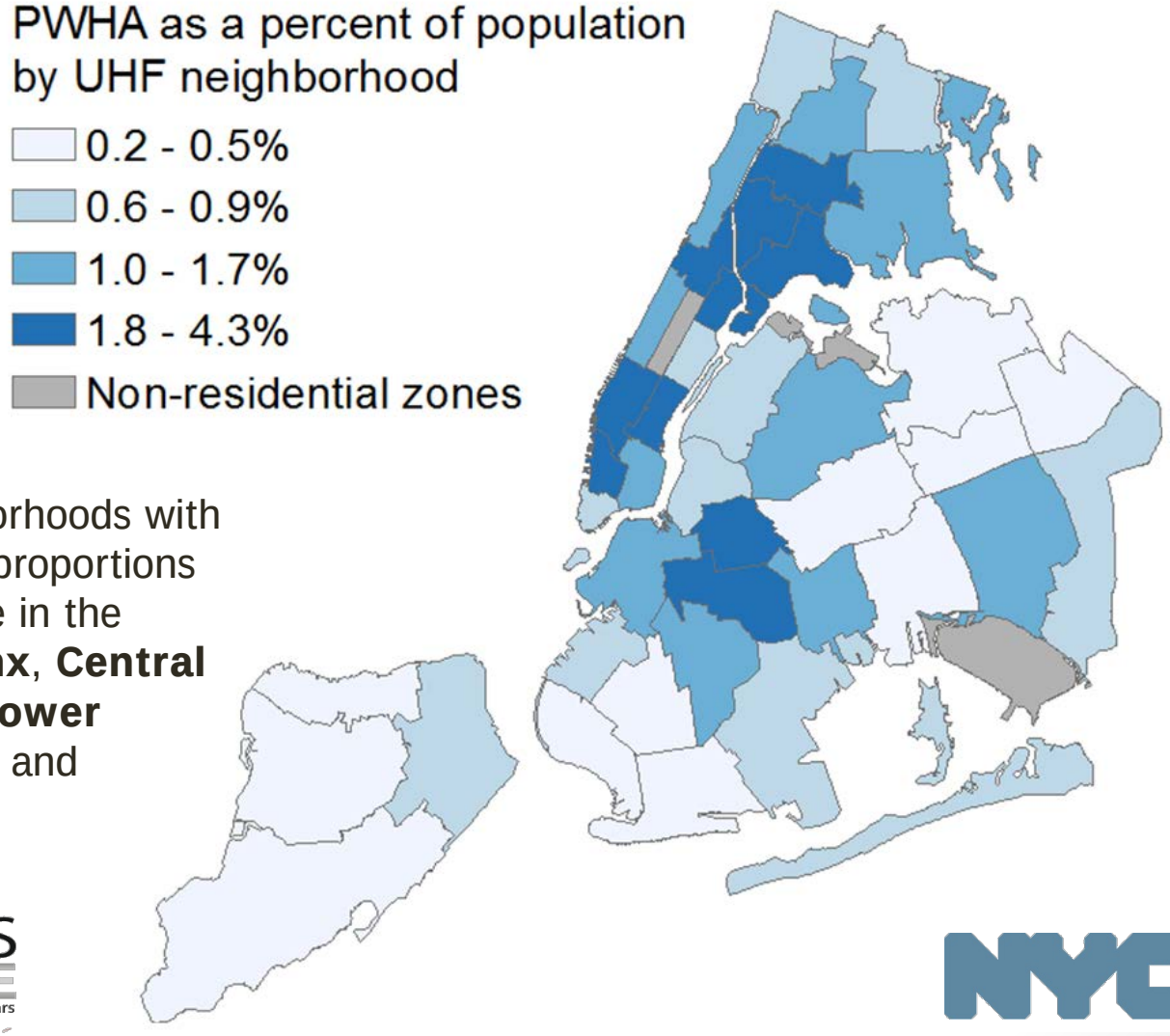
- To align program activities and outcomes
- To develop quality indicators following a process transferable to any setting
- To translate standards of care, as contained in a service model protocol, into specific, measurable performance indicators
- To identify ways to integrate the goals of quality management, program evaluation and improvement of health outcomes using a single data source
- To recognize challenges in the implementation of a medical case management program following a complex protocol
- To identify effective practices for engaging service providers in the integration of performance measurement results into their quality management efforts

HIV/AIDS in New York City, 2010

- **3,481** new HIV diagnoses (42.6 diagnoses per 100,000 persons)
  - 2,722 HIV without AIDS
  - 759 HIV concurrent with AIDS (21.8%)
- **2,520** new AIDS diagnoses
  - Includes 759 concurrent HIV/AIDS diagnoses
- **110,736** persons living with HIV/AIDS
  - 1.4% of the population of NYC
- **1,695** deaths among persons with HIV/AIDS
  - 15.1 deaths per 1,000 persons with HIV/AIDS

As reported to the New York City Department of Health and Mental Hygiene by September 30, 2011.

Persons with HIV/AIDS
by UHF Neighborhood in NYC, 2010



UHF neighborhoods with the highest proportions of PWHA are in the **South Bronx**, **Central Brooklyn**, **lower Manhattan** and **Harlem**.

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Background: New York EMA

- Grantee: NYC Department of Health and Mental Hygiene (DOHMH)
  - DOHMH Bureau of HIV/AIDS Prevention and Control
    - Care, Treatment and Housing Program
- 2012 Part A Award is $120,489,151 (Base and MAI)
  - 169 contracts among 94 agencies in NYC
  - 26 contracts among 18 agencies in Tri-County
- New York, NY EMA includes
  - Five boroughs of New York City, and
  - Tri-County area North and East of NYC
    - Westchester, Rockland and Putnam Counties
- Two master contracts to procure and administer subcontracts
  - Public Health Solutions – New York City Programs
  - Westchester County Department of Health – Tri-County

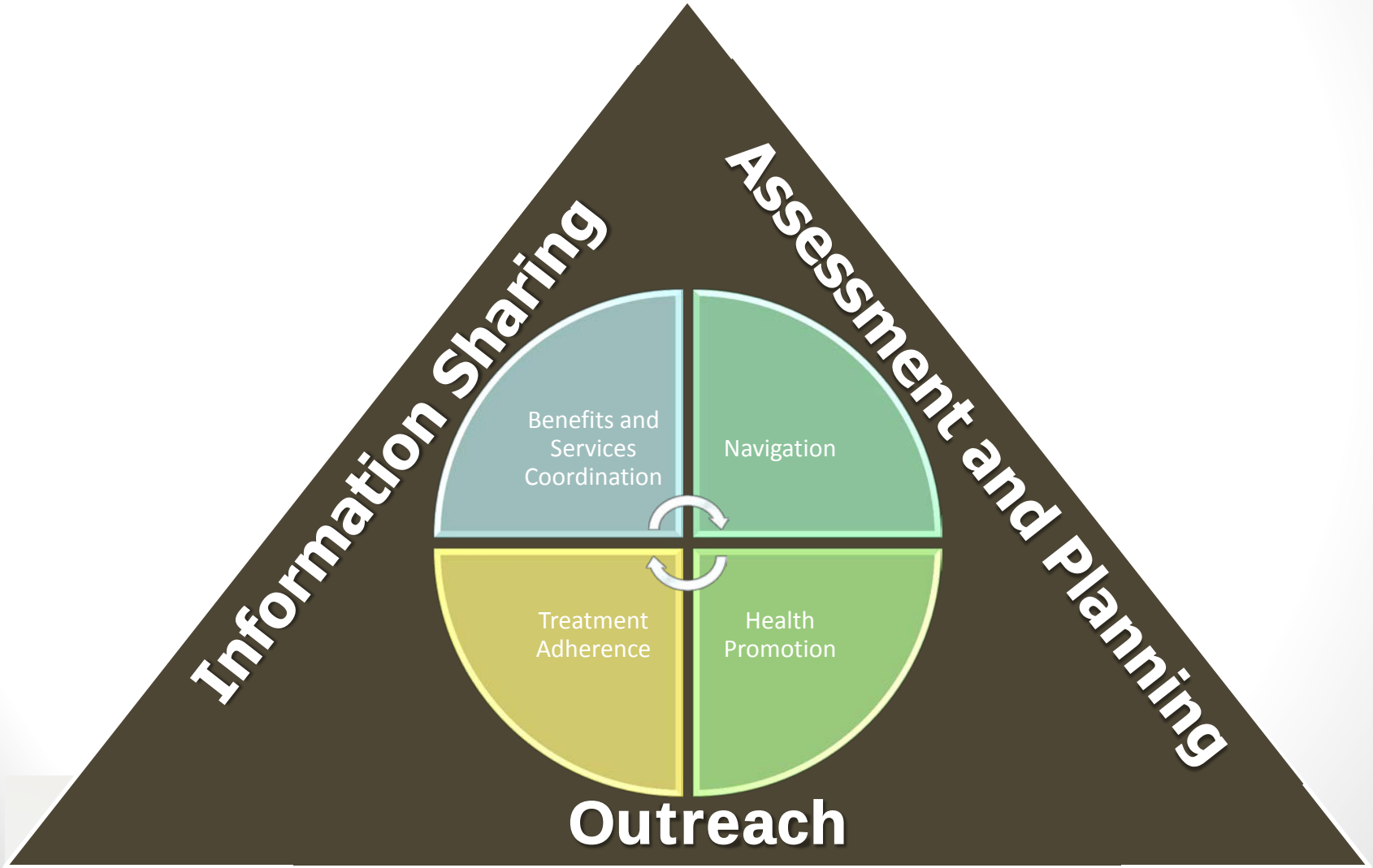
Background: Technical Assistance

- DOHMH Project Officer assigned to most service categories
  - Program monitoring and technical assistance (TA)
  - Liaison between funded agencies and DOHMH
- TA methods include
  - Site visits, conference calls and webinars
  - Provider meetings, workshops and trainings
  - Facilitate and encourage provider networking
  - Coordinate with Public Health Solutions (master contractor)
  - Research and share best practices

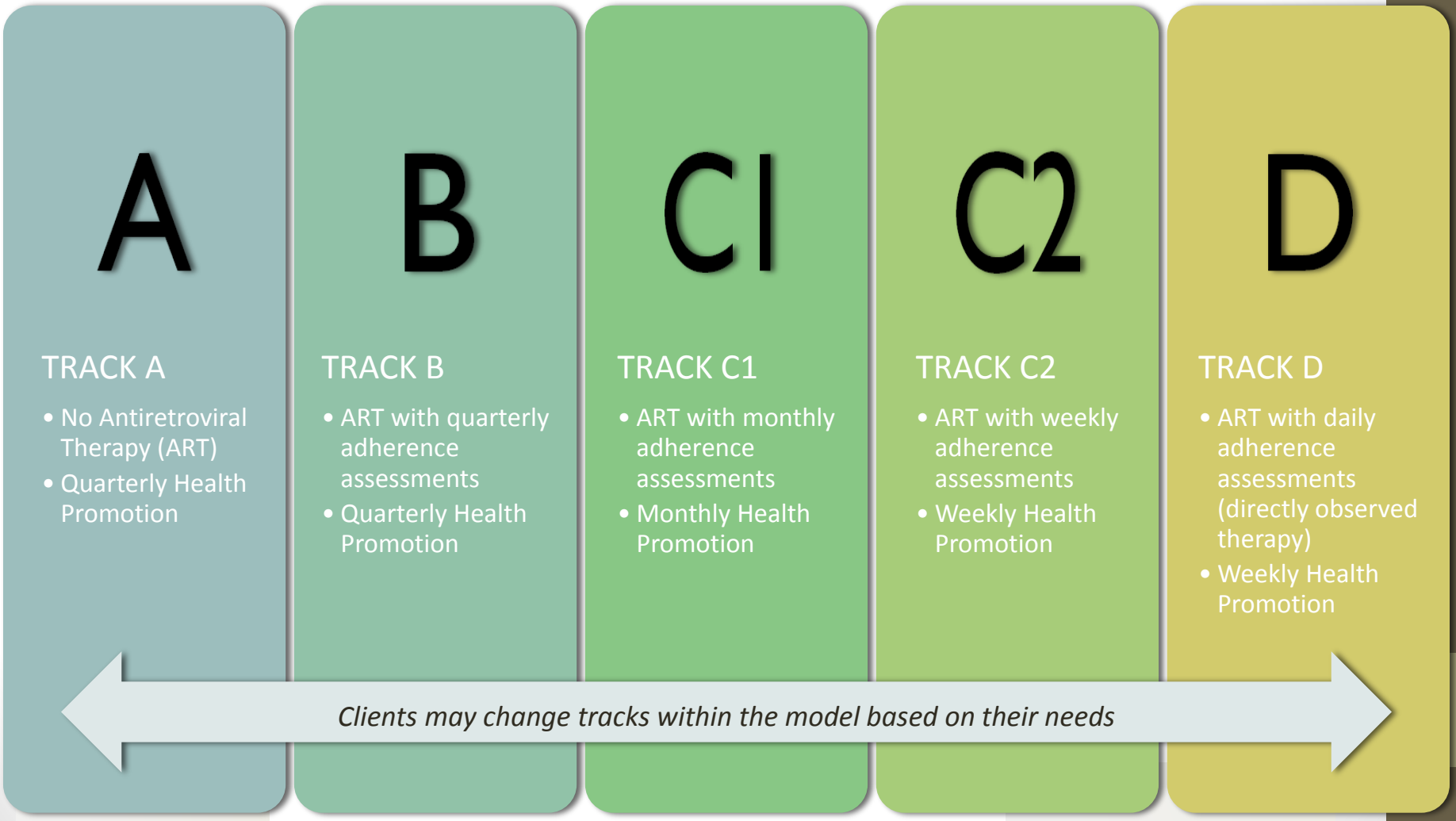
Background: Care Coordination

- Medical Case Management service category
  - Medical Home Model
- RFP Released January 2009
- Contracts began December 2009
- 28 Care Coordination Programs
  - 16 hospital-based programs
  - 12 community-based programs
- Maintain active portfolio caseload of approximately 3,300 PLWHA

Background: Ryan White NYC Care Coordination Program



CC Service Delivery Tracks



*Home visits are an integral component of all tracks in the model

Background: NY EMA Ryan White Data System

- Starting in March 2011, the New York EMA began using a new, **web-based data system** for provider reporting to the DOHMH.
- The new data system – the electronic System for HIV/AIDS Reporting and Evaluation (eSHARE) – was developed to capture **client-level data over time** and details of **local service models**.
- **Data elements** cover client demographics, service category enrollments and dates (as well as suspension periods, when no services can be delivered), clinical history, psychosocial and structural issues, service utilization, referrals, health behaviors, general health functioning, and key HIV health outcomes over time.
- eSHARE includes many **built-in quality controls**, including skip patterns, field requirements and validations, and enforcement of regular assessment and data entry of core outcome measures.

Background: NY EMA Part A Quality Management Program

- In collaboration with NYS AIDS Institute
- Structure in place to oversee & manage quality activities
- Activities to assess quality of services by Part A providers
- HIV Quality Learning Networks
- Organizational Assessments
- Performance reviews use specific indicators for each service category
  - Chart reviews
  - eSHARE (reporting system)

Background: Indicator Workgroup

- Introduced at a Quality Learning Network/Provider Meeting
- Asked for volunteers
- 12 agencies signed up and participated
- Began December 2011
- Monthly meetings
  - Face to face
  - Conference calls
- Tasked with developing quality indicators for the service category

Performance Indicators and Measurement

- An indicator may describe how services are delivered, demonstrate the quality of services or show the achievement of an outcome.
- An indicator focuses on one aspect of care and provides a way of assessing how often this specific aspect of care is properly provided.
- Indicators can measure many or a few kinds of elements of health care services.

Indicators Describe…

- Processes
  - The activities conducted to produce the output and/or outcome
  - The procedures for achieving the best outcomes
- Outputs
  - The immediate result of the input/process
- Outcomes
  - The end result (short-, mid-, long-term)
  - The effect on the individual or the population (public health)

Indicators Should Be…

- Specific
  - Who does this indicator affect and what will change?
- Measurable
  - Can the indicator realistically and efficiently be measured?
- Accurate
  - Is the indicator based on program protocols and definitions?
- Relevant
  - Does it have impact? Does the indicator affect many people or widely used activities?
- Time-Bound
  - When will this indicator be accomplished?
- Improvable
  - Can the performance rate associated with the indicator realistically be improved?

Indicator Measurement Needs to be Clear

- When building measures, we should consider:
  - What data elements go into measuring the indicator? (What are component variables in source data?)
  - What part of this client population should have received the care being measured *and* has the data required to measure the extent to which they did receive it? **(Who should be counted in the denominator?)**
  - What should count as success? **(Who should be counted in the numerator?)**

$$\frac{\text{NUMERATOR}}{\text{DENOMINATOR}} = \frac{\text{\# of patients who } \underline{\textit{actually received}} \text{ the care being measured}}{\text{\# of patients who } \underline{\textit{should have received}} \text{ the care being measured}}$$

Selecting a Data Source: Considerations

- How long will it take to collect measures with one source (e.g., reporting system) vs. another (e.g., chart review)?
- Which collection process entails less burden to agencies?
- How well does each potential data source capture the aspects of care to be measured?
  - Are there qualitative dimensions, for example?
  - Are there checklists or assessments that exist only in sources available at the sites, rather than in a central reporting system?
- Which source better ensures representativeness within agencies and comparability across agencies?
- Is there a different level of buy-in for each process?
- What is turnaround time for reporting back to agencies?

Nominal Group Technique (NGT)

- What is it?
  - Structured version of small-group discussion to reach consensus
- Four-Step Process to Conduct NGT
  - 1) Generate ideas
  - 2) Record ideas
  - 3) Discuss ideas
  - 4) Vote on ideas
- Works well in single-purpose, single-topic meetings

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Advantages of NGT

- Generates a greater number of ideas
- Balances the influences of individuals
- Diminishes competition and pressure to conform
- Encourages participants to confront issues through constructive problem solving
- Allows group to prioritize ideas democratically
- Provides a sense of closure

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Disadvantages of NGT

- Requires preparation
- Regimented and lends itself only to a single-purpose, single-topic meeting
- Minimizes discussion and does not allow for full development of ideas
- May be less stimulating than other techniques

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Group Exercise:

Using the Nominal Group Process

Medical Case Management

Approximately 30 minutes

Moderator Role

- Facilitate and guide the process
- Clarify member roles and group objectives
- Describe the importance of the task at hand
- Reinforce the importance of each group member's contribution
- Communicate how the results of the group will be used
- Maintain communication with group throughout the process

Step 1: Generate Ideas

- Moderator presents question or problem to the group
  - In written form AND
  - Read to the group
- Moderator directs everyone to write ideas in brief phrases or statements
- Participants work silently and independently to generate ideas and write them down

- What are the outcomes expected from the program?
- What program activities are most relevant and/or have the most impact on client-level outcomes?

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Step 2: Record Ideas

- Round-robin feedback session to concisely record each idea
  - Without debate at this point
- Moderator writes an idea from a group member on a flip chart that is visible to the entire group, and proceeds to next member, and so on.
- No need to repeat ideas unless there is a different emphasis or variation
- Proceed until all members' ideas are documented
  - Flip charts and markers are essential
  - Use "sticky" flip chart paper when possible, or have tape handy
  - Spread out ideas across the walls

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Step 3: Discuss Ideas

- Each recorded idea is then discussed
  - To determine clarity and importance
- For each idea, the moderator asks, “Are there any questions or comments group members would like to make about the item?”
- Provides an opportunity for members to express their understanding of the logic and the relative importance of the item.
- Any member of the group can clarify or explain an item, it does not have to be the creator of the idea

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

Step 4: Rank Activities

- Individuals privately rank/prioritize associated activities
- Votes are tallied to identify the ideas that are rated highest by the group as a whole
- To start, for each outcome identified, each group member selects the activities that contribute to them
- Next, each group member selects the ONE activity most closely associated with the outcome
- Moderator creates a tally sheet on the flip chart
  - 1) Total overall votes
  - 2) Won each outcome category

Slides developed using NGT resource at http://www.cdc.gov/healthyyouth/evaluation/index.htm.

The table below lists some key activities conducted by Care Coordination programs. It also lists some outcomes/expected changes that may be associated with these program activities.

Activities	Short-Term/Mid-Term Outcomes	Long-Term Outcomes
Conducting home-/field-based visits	Improved linkage to care	Decreased hospitalizations
Case conferencing	Improved retention in care	
Providing health education	Increased use of ARV treatment	Sustained viral load suppression
Accompaniment	Improved adherence to ARV treatment	
Adherence assessment/reassessment	Decreased viral load	

Below you'll see each of the outcomes listed. Under each outcome, write the CC activities that you think contribute to them (refer to the list of activities from above). Then place a check mark next to the activity that you think is **most closely associated** with the outcome (only one checked activity per outcome, please).

Improved linkage to care	Improved retention in care	Increased use of ARV treatment
o	o	o
o	o	o
o	o	o
o	o	o
o	o	o

Example of Outcome Tally

- OUTCOME
  - SUSTAINED VIRAL LOAD SUPPRESSION

- INDICATORS/ACTIVITIES:
  - Health Promotion/Education (5)
  - Case Conferencing
  - Adherence Assessment/Reassessment
  - Home/Field Visits (2)
  - DOT

Group Vote Tally

ACTIVITY	TOTAL VOTES	OUTCOME CATEGORIES WON
DOT	6	0
Health Promotion/Education	14	2
Case Conferencing	2	0
Home/field visits	4	0
Assistance with entitlements	4	1
Adherence Assessments/ Reassessments	5	0
Accompaniment	6	2

What we ended up with…

1. Health Promotion
2. Case Conferences
3. Home/Field Visits
4. Adherence Assessments/Reassessments

Moving Forward: First Draft of Indicator Data

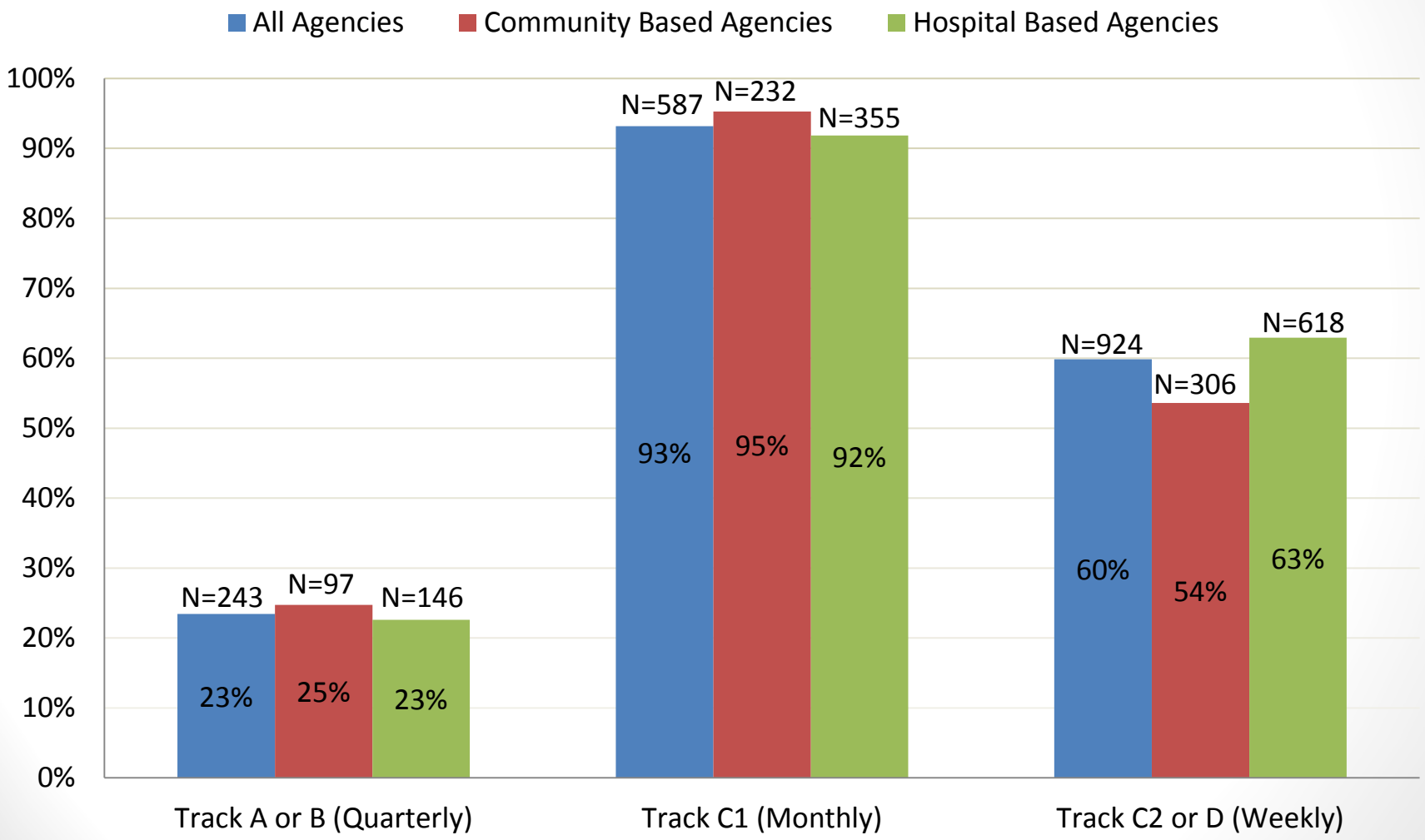
- Before finalizing indicators or setting targets, take a preliminary look at the local data to see:
  - where you are starting
  - where there is room for improvement, and
  - where the draft indicators might not yet fairly capture the process or outcome of interest

Health Promotion

- **Indicator:** % of CC patients receiving health promotion sessions according to track guidelines

- **Denominator:** patients continuously enrolled in the period, with no suspensions greater than or equal to 10 days
- **Numerator:** # of patients receiving health promotion sessions according to track guidelines
  - Track B: every 120 days
  - Track C1: every 44 days (success = one or no gaps)
  - Track C2 or D: every 10 days (success = 3 or fewer gaps)

First results: % of CC patients receiving health promotion according to track

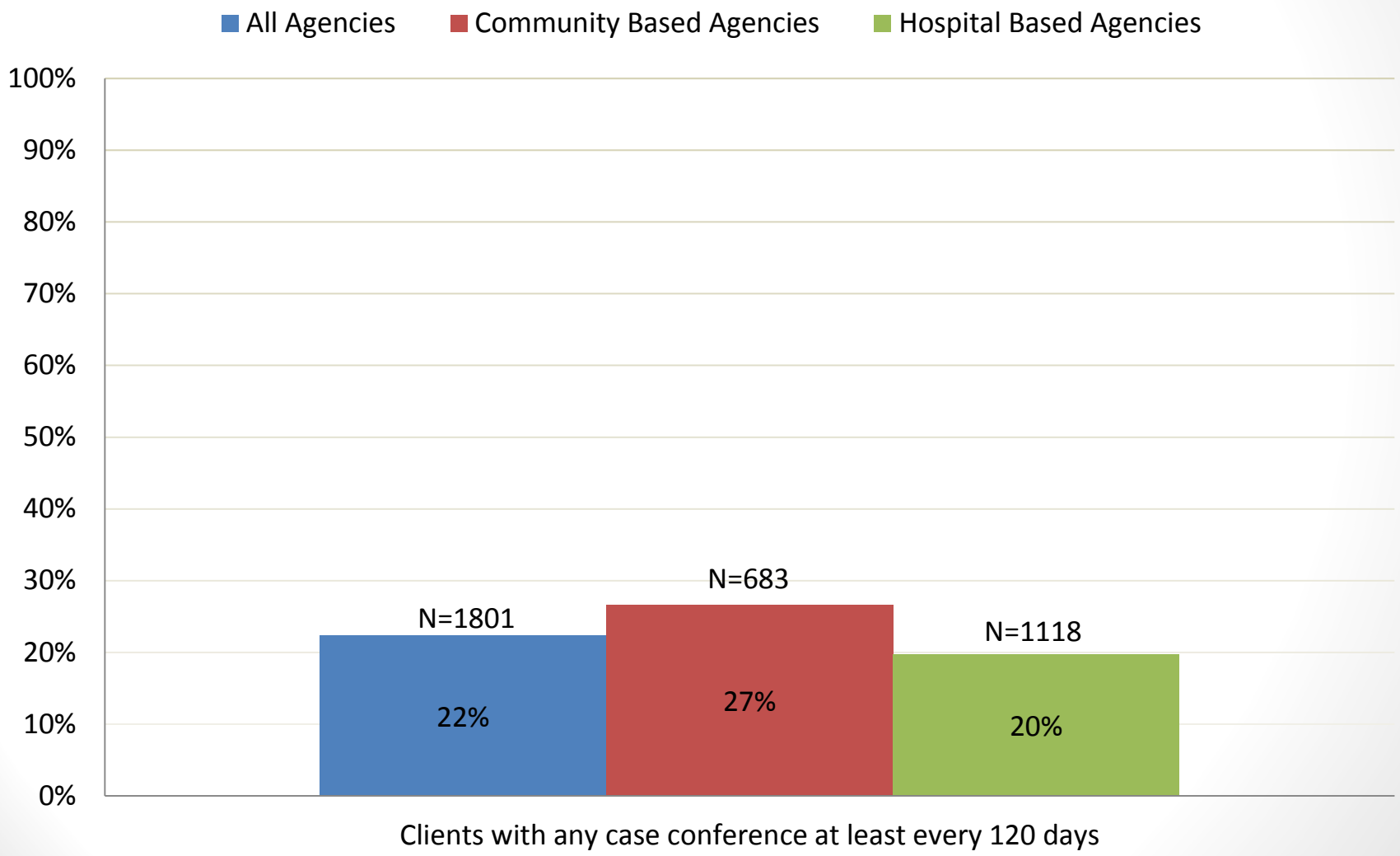


Case Conferencing

- **Indicator:** % of CC patients for whom there is a case conference quarterly or at least every 120 days

- **Denominator:** all patients continuously enrolled in the period
- **Numerator:** # of patients for whom there is at least one case conference during each 120-day period (includes initial case conference)

First results: % of CC Patients with case conferences every 120 days

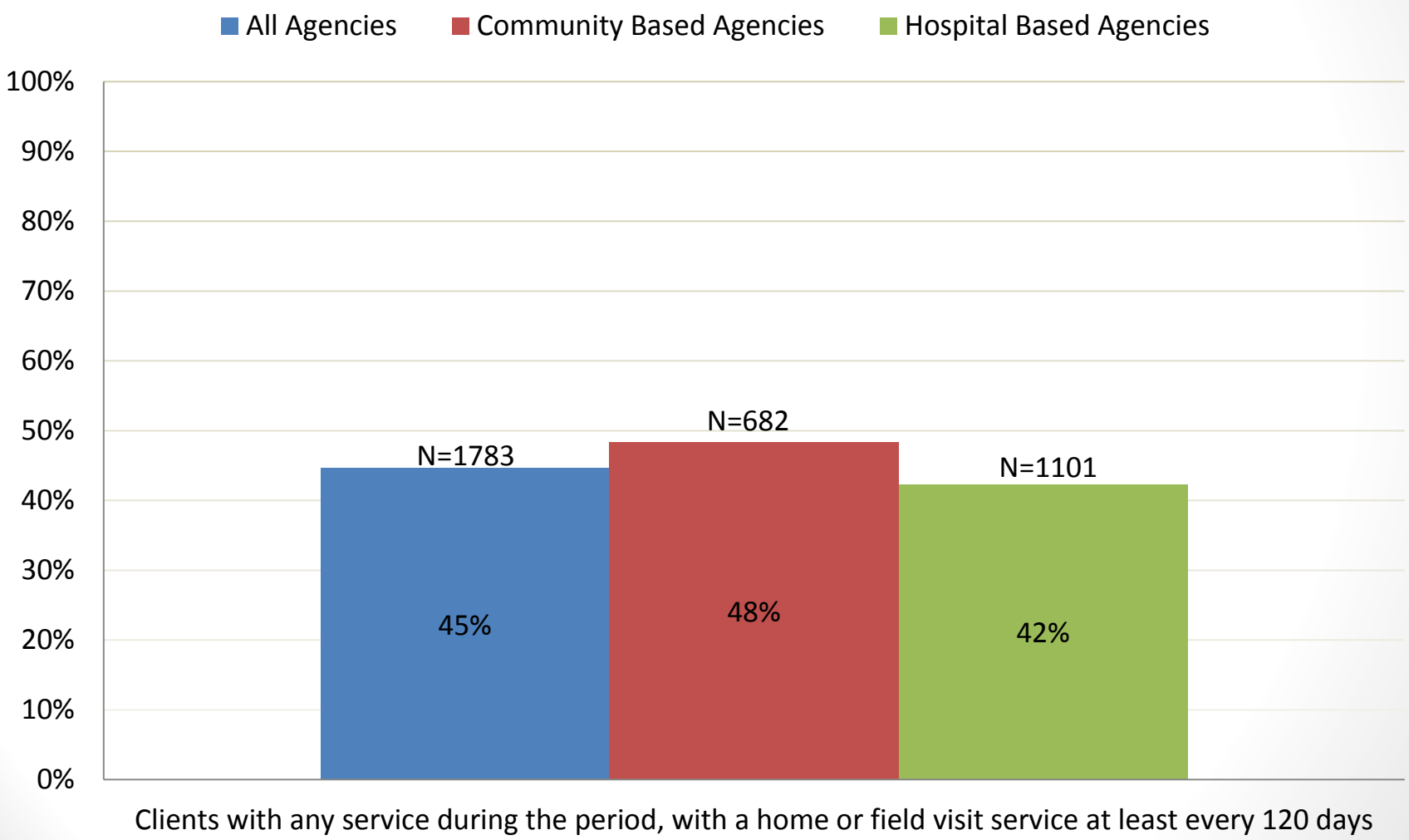


Home/Field Visits

- **Indicator:** % of CC patients for whom there is a home- or field-based service quarterly or at least every 120 days

- **Denominator:** all patients continuously enrolled in the period, who had at least one service during the period
- **Numerator:** # of patients for whom there is at least one home- or field-based service during each 120-day period

First results: % of CC patients with field visits every 120 days



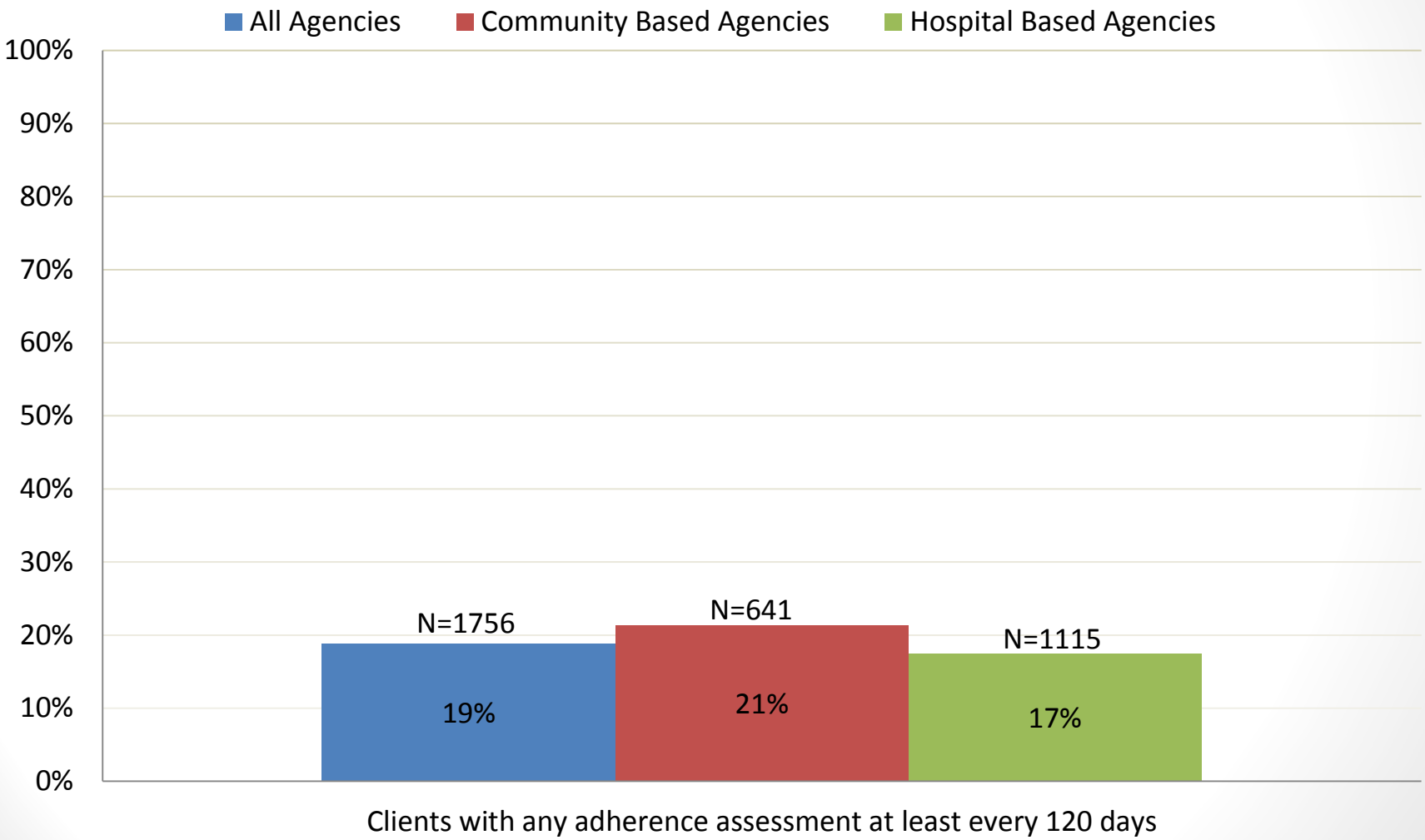
Clients with any service during the period, with a home or field visit service at least every 120 days

Adherence Assessments/Reassessments

- **Indicator:** % of CC patients for whom there is an adherence assessment/reassessment quarterly or at least every 120 days

- **Denominator:** all patients continuously enrolled in the period (excluding Track A)
- **Numerator:** # of patients for whom there is at least one adherence assessment/reassessment during each 120-day period

First results: % of CC patients with adherence assessment every 120 days



After first look at data…

- Refine/revise indicators as needed
- Repeat analysis with finalized indicators
  - Baseline results

FINALIZED PERFORMANCE MEASURES FOR CARE COORDINATION PROGRAMS IN NY EMA:

BASELINE RESULTS

Indicator 1: Health Promotion

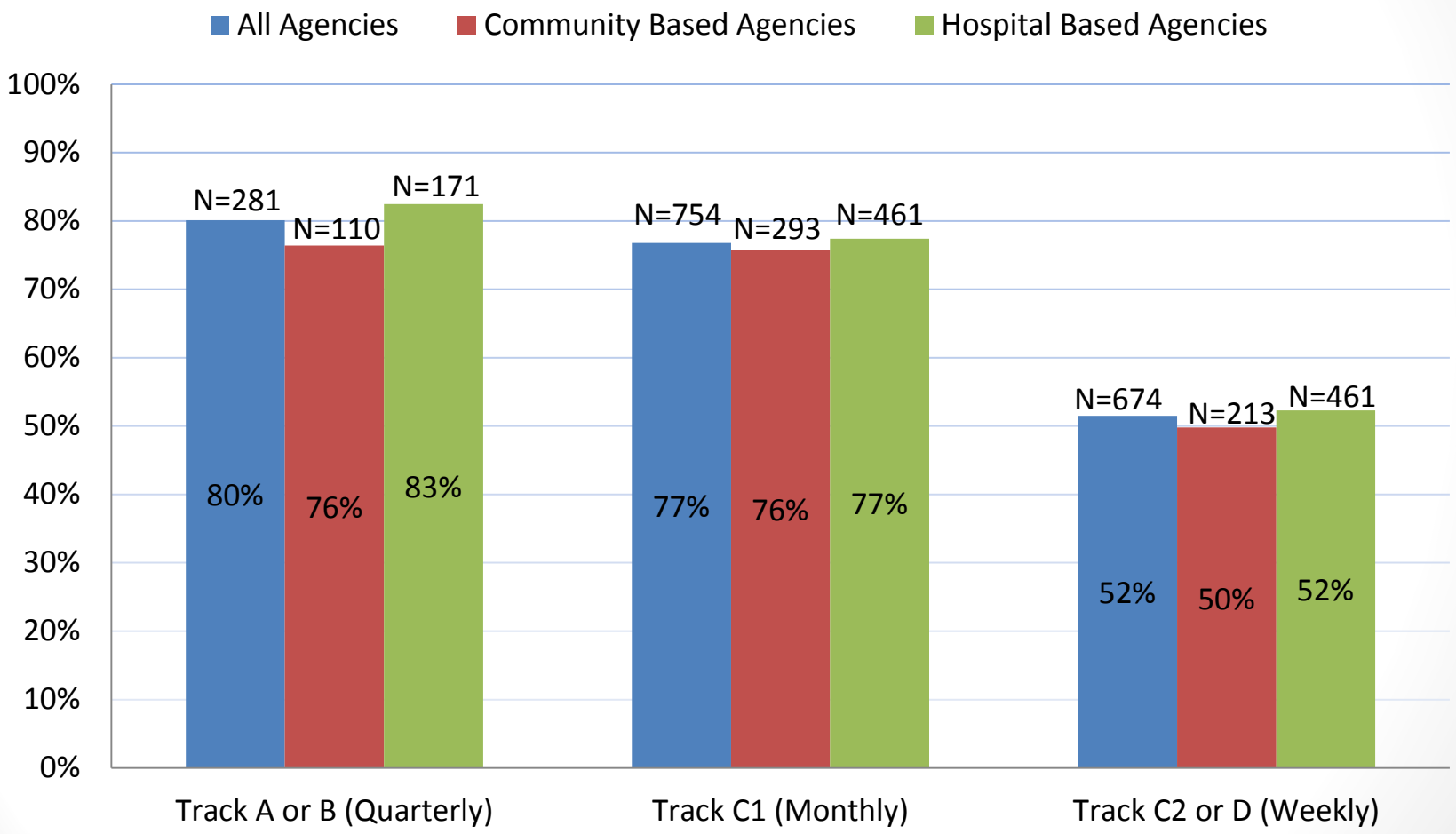
- Indicator: Percent of CC patients who received a health promotion service as indicated by their enrollment track
  - Track A or B: health education every 120 days
  - Track C1: health education every 44 days
    - Failure is more than one gap in service greater than 44 days
  - Track C2 or D: health education every 10 days
    - Failure is more than five[1] gaps in service greater than 10 days

[1] Changed from the preliminary data run, and based on average failures, or gaps in health education, for Tracks C2 or D

Indicator 1: Health Promotion

- Eligibility
  - Continuously enrolled during the period
  - Completed an Intake Assessment by beginning of period
  - No track change in the period OR track change of similar intensity in period
  - Suspensions are track-specific
    - Track A or B: No suspension ≥ 120 days within the period
    - Track C1: No suspension ≥ 44 days within the period
    - Track C2: No suspension ≥ 10 days within the period
- Period of review: June 1, 2011 – February 29, 2012

Indicator 1: % of CC patients receiving health promotion according to track

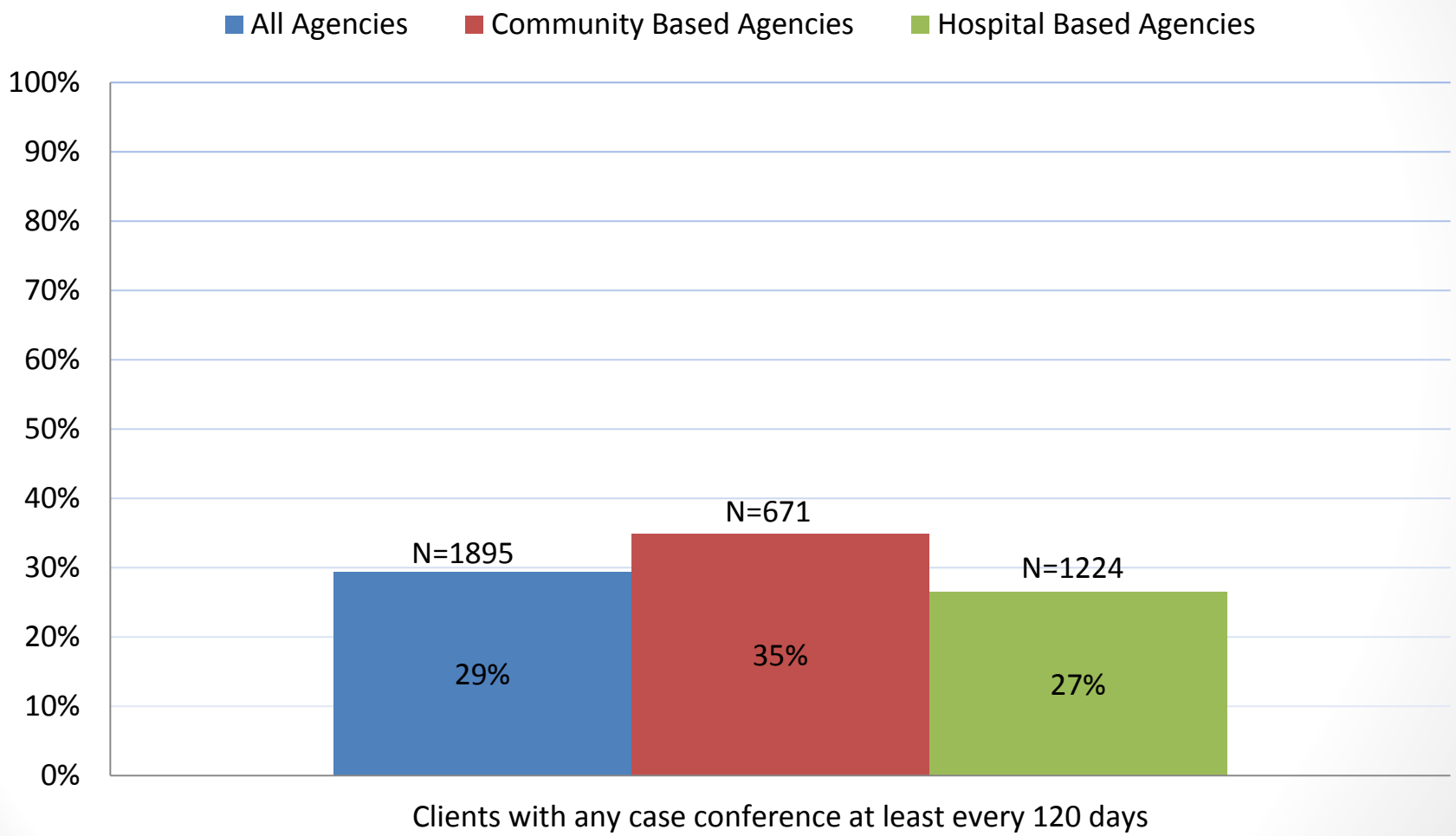


Indicator 2: Case Conferences

- Percent of patients with a case conference[1] at least every 120 days during the period
- Eligibility
  - Continuously enrolled during the period
  - No suspension ≥ 120 days within the period
  - Have ever completed an Intake Assessment
  - Have any service within the period
- Period of review: June 1, 2011 – February 29, 2012

[1]Current analysis utilizes case conference service data only. Case conference form data were not available at this time, but can be reviewed in future analyses.

Indicator 2: % of CC Patients with case conferences every 120 days



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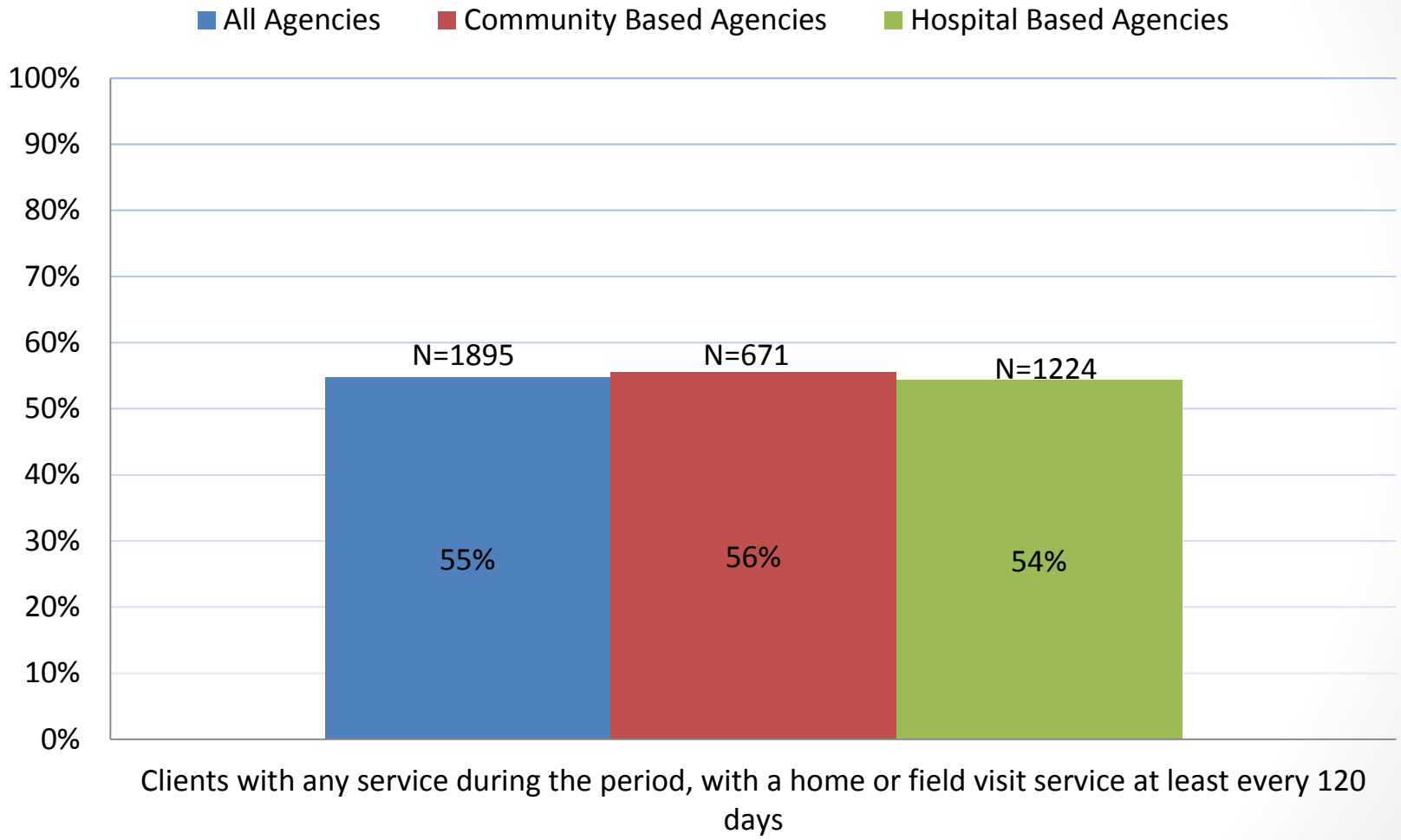
Indicator 3: Home or field visits

- Percent of patients with a home or field visit service at least every 120 days during the period
- Eligibility
  - Continuously enrolled during the period
  - No suspension ≥ 120 days within the period
  - Have ever completed an Intake Assessment
  - Have any service within the period
- Period of review: June 1, 2011 – February 29, 2012

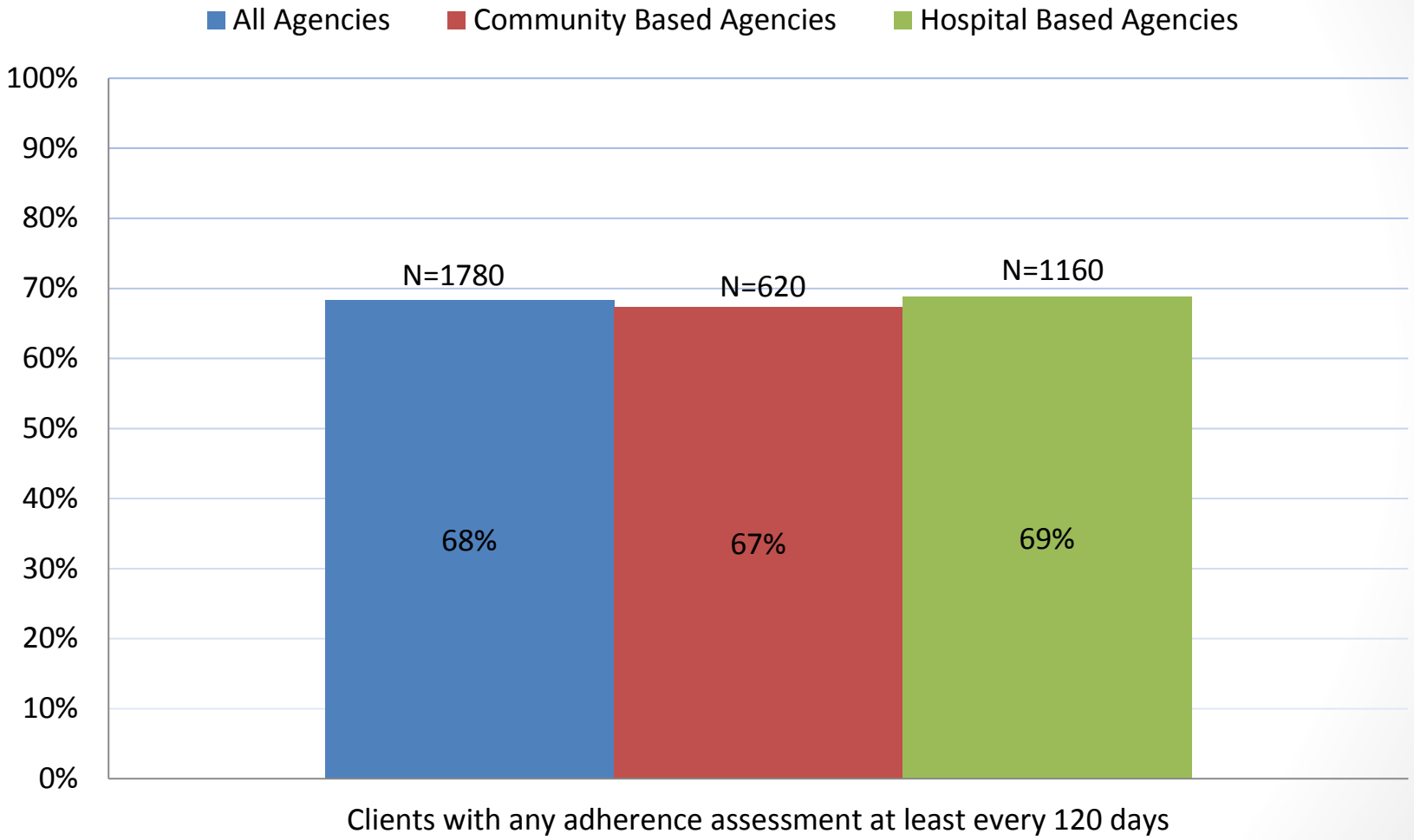
Indicator 3: % of CC patients with home/field visits every 120 days



Indicator 4: Adherence assessments

- Percent of patients with any adherence assessment at least every 120 days
- Eligibility
  - Continuously enrolled during the period
  - No suspension ≥ 120 days within the period
  - Have completed an Intake Assessment by the beginning of the period
  - No time in Track A during the period
- Period of review: June 1, 2011 – February 29, 2012

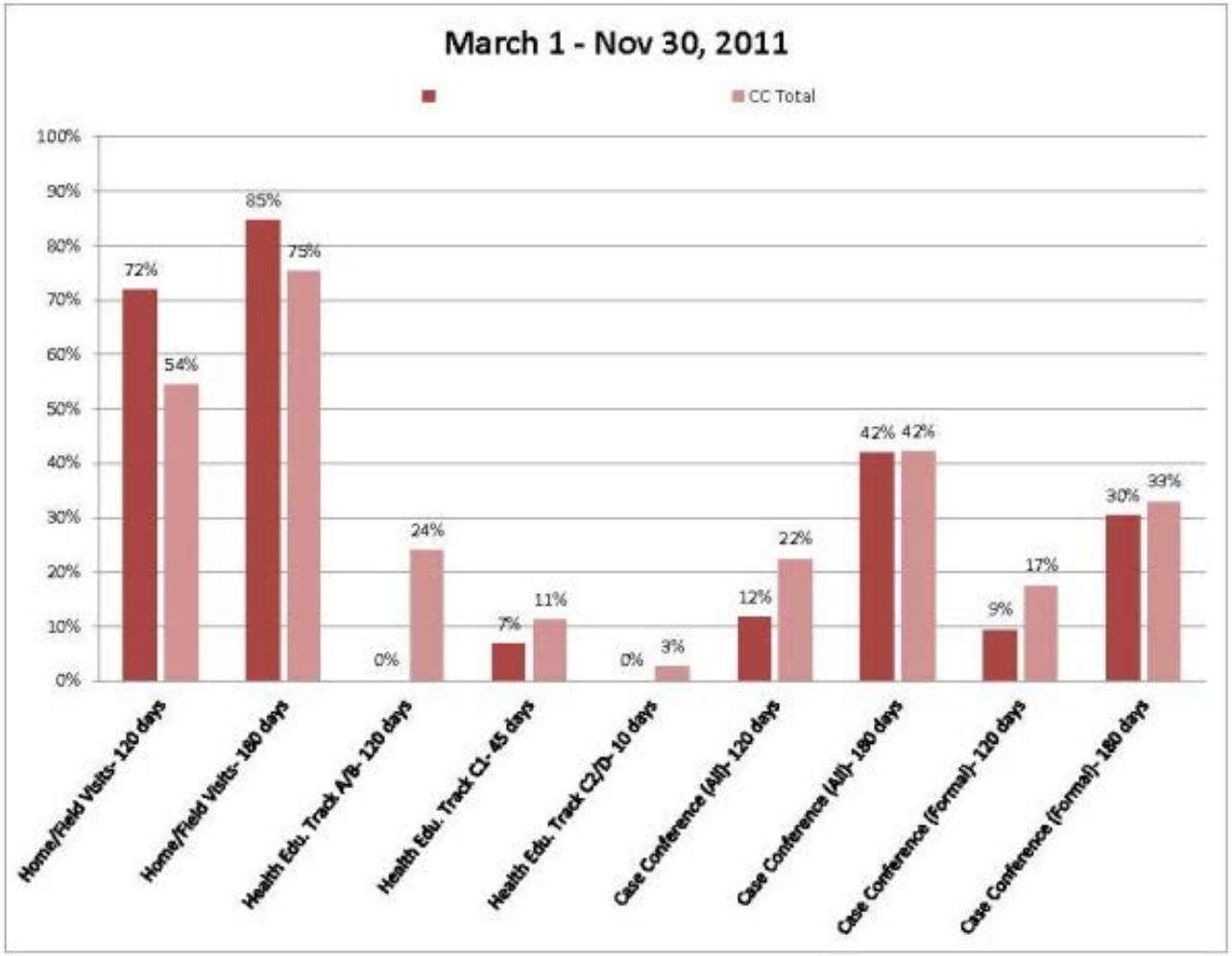
Indicator 4: % of CC patients with adherence assessment every 120 days



Summary of Baseline Results

- Percentage with health education as indicated decreased with track intensity, even after adjusting C2/D success definition
  - 80% of eligible Track A or B (quarterly) clients (vs. 23% in initial run)
  - 77% of eligible Track C1 (monthly) clients (vs. 93% in initial run)
  - 52% of eligible Track C2 or D (weekly) clients (vs. 60% in initial run)
- 29% of eligible clients had timely case conferences
  - vs. 22% in initial run
- 55% of eligible clients had timely home or field visits
  - vs. 45% in initial run
- 68% of eligible clients had timely adherence assessments
  - vs. 19% in initial run
- Minor differences between hospital and community-based

Sharing Results with Agencies



Next Steps for Agencies

- Post-data provider QI projects (formal and informal):
  - Scheduled standing interdisciplinary staff meetings to increase case conferences
  - Provided training to staff on expected frequency of health promotion services, case conferences, and adherence assessments
  - Instituted activity tracking and supervision tools to monitor home/field visits, health promotion services, case conferences, adherence assessments
  - Developed QA process to improve documentation and reporting of indicator activities

What will work for you?

- Discussion around adapting these processes and tools for use in your own jurisdictions
  - Using the Nominal Group Technique
  - Provider Involvement and Buy-In
  - Data Availability
  - Time and Effort of Staff Involved

Questions/Comments

Thank You
CC Indicator Workgroup Participants

- Thank you to all Care Coordination providers for continued work on the program and to colleagues who assisted in the CC indicator development.
- NYC DOHMH BHIV CTHP
  - Mary Irvine, Beau Mitts, Ellenie Tuazon, Julie Rwan
- NY AIDS Institute
  - Tracy Hatton, Johanna Buck, Nova West
- Care Coordination Workgroup Participants
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