NC Regional Quality Council: Making a Difference in Care & Services Statewide

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NC DHHS AIDS Care Program,

Quality Improvement Coordinator

N.C. Quality Council

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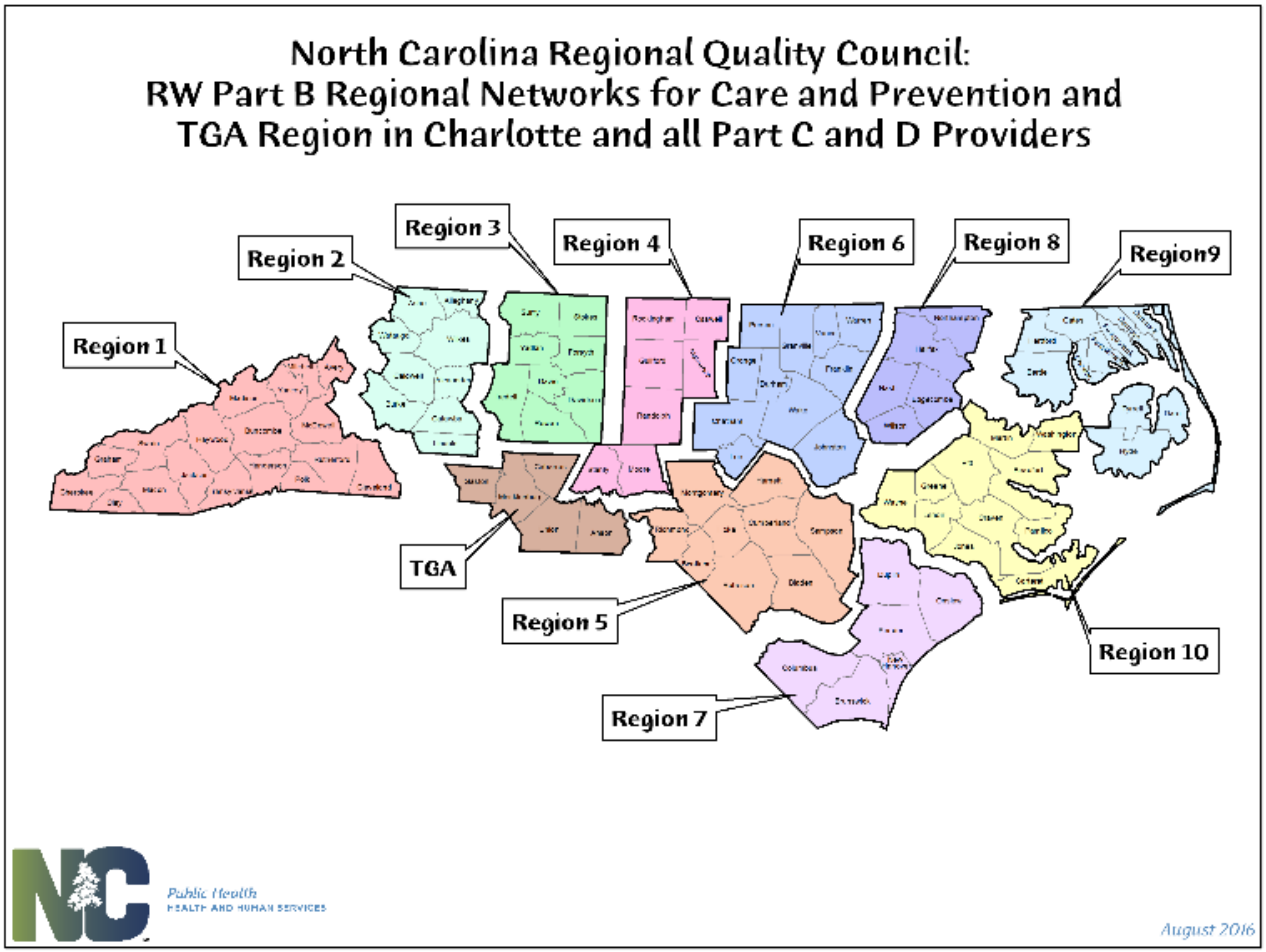


In 2009, first meeting of a statewide, all Parts Regional Quality Council

Primary goals of the RQC:

- **Provide guidance and technical assistance to NC Ryan White funded programs in quality infrastructure, performance measurement and quality activities.**
- **Assist participants in understanding HRSA's requirements regarding quality management.**
- **Promote successful methodologies and best practices.**
- **Create a forum for ongoing networking among grantees**

Structure of the NC RQC

- **Membership**

  21 Part B clinical providers,
  2 separate Part C clinical providers,
  1 separate Part D clinical provider,
  6 TGA clinical providers,
  NC ATEC,
  RW NC Part B consultants, and
  NC surveillance and Epidemiology programs,
  State bridge counselors
  Funded prevention agencies

  Supported by the National Quality Center

RQC Structure (cont'd)

- **Meeting Frequency**

  4 meetings/year, 3 face-to-face, 1 virtual

- **Expectations of Participation**

  Presentation of site-specific interventions to include data, change ideas, what worked and didn't, presented through lightning round format. Mandated through RWB contractual funding

- **Quality Management Plan**
- **Evaluation**

State level RQC development discussion ideas

- Data uniformity
- QM plan sharing
- Provision of data in advance
- Support from HIVQUAL advisors
- IN+CARE campaign launch
- Ways to present data
- Planning Group
- Development of an RQC QM Plan

Strategies to Improve Cervical Cancer Screening

- QI projects to improve rates of cervical cancer screening
  - **Pap Smear days with gifts and refreshments**
  - **Incentives, Pap and pamper bag, Schedule on birthday**
  - **Check charts to determine if a patient coming in that day (or week) needs a pap smear**
  - **Make sure the pap tray is in the room so there are no delays getting supplies**
  - **Coordinate with women's clinic in the health center (especially CHCs and Health Departments) to get their data when a woman has a pap smear in their clinic.**
  - **Train NPs**

Barriers to improving Cervical Cancer Screening Rates

- **Women prefer to go to their own OB/GYN**
- **Women don't want a pap smear done by their ID doc, especially a male doc**
- **Patient does not come in for appointment**
- **Doctors do not want to do pap smears**
- **Some male foreign doctors do not want to do pap smears because in their culture males do not examine women.**
- **Doctor is available but staff to assist are not**
- **Rushed to do visit**
- **Need tickler system**
- **Print pap rates by provider (unidentified or identified)**
- **Women do not understand the seriousness of Cervical Cancer in HIV+ women.**

Strategies to Increase Retention

- **Identify patients not seen:**
  No-shows, lost to care
- **Time frame:**
  day of no-show, weekly, monthly, 4 months, 6 months, 9 months
- **Contacting patients:**
  Before visit, after no-show, when “lost to care”
- **Ways to contact:**
  cell phones (calls & texts), home visits, Facebook, email, letters, 1-800 numbers for call back, automated calls
- **All staff:**
  Bridge Counselors MCM, front desk staff, interns, support staff, nurses, doctors;

Strategies to Increase Retention

- **Outreach**

  Outreach blitzes, “tough love”

- **Pre-Visit:**

  new patient calls, nurse guide, automated calls

- **Scheduling:**

  1 Stop Shop, walk-in clinic, coordinate other visits same day, Support Groups Weekly

- **Staff team meetings**:

  flow charts for no-shows , stop med refills

Areas of Exploration

- What do the data tell us?
- What questions do we have about the data?
- What are the cross-cutting themes?
- How can we use the data?
  - Who do we share it with?
  - How do we present the info?
  - Should we share everything or does it need to be packaged differently?
- Discuss new National HIV/AIDS Strategy
- Drilling down data. For example- r/e

Learning and Sharing Tools

- **Storyboards**
- **Fishbones,**
- **PDSA, Lean and Six Sigma, Model for Improvement,**
- **Dashboards,**
- **Benefit/Effort Matrix**

Improving Viral Load Suppression Rates

Scott Parker

Ryan White Network Administrator

Western NC Community Health Services (Region 1 provider)

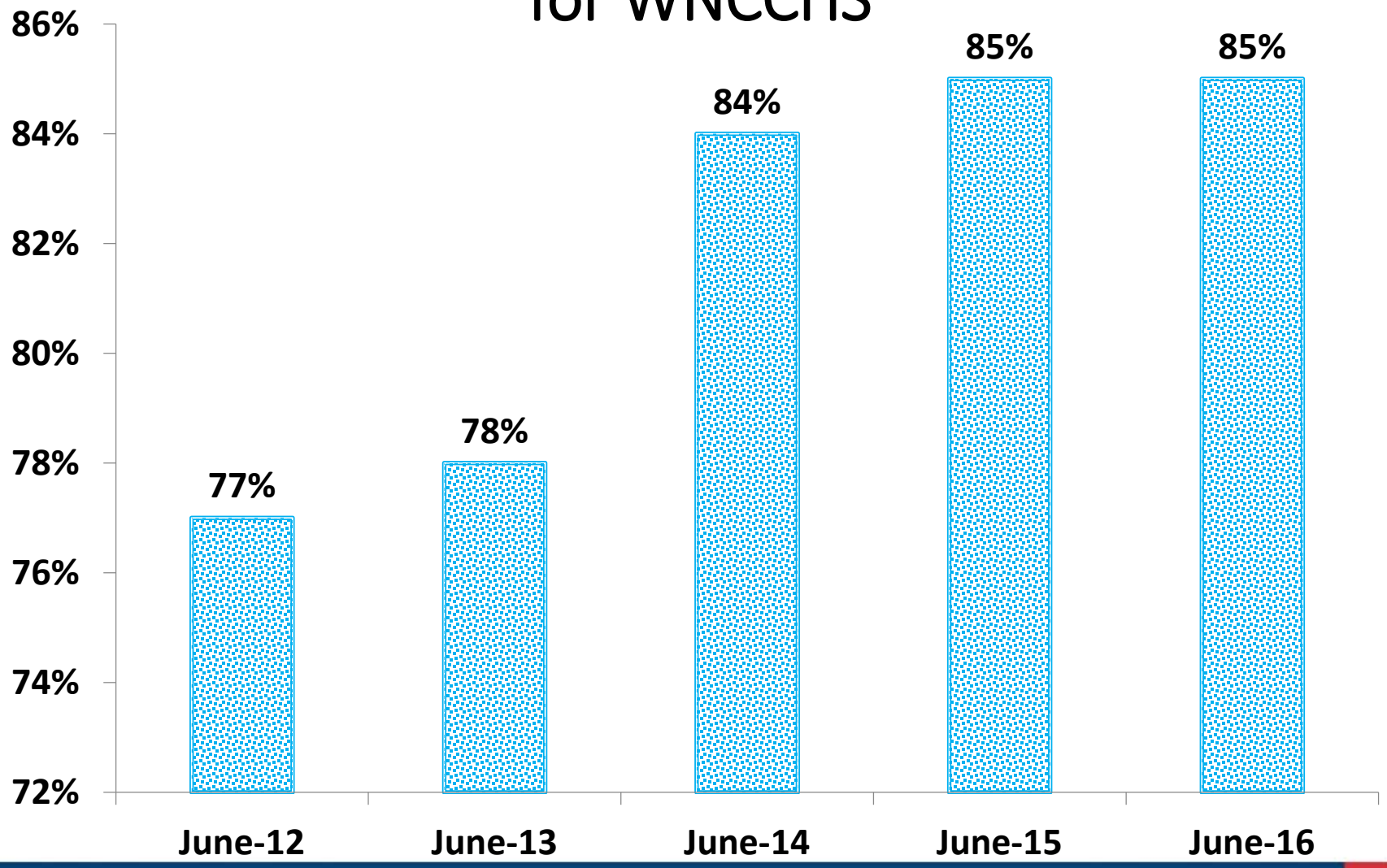
FQHC-based Ryan White

- **Highly integrated care at one location**
- **Parts B, C, D, HOPWA**
- **Primary HIV medical care**
- **Integrated Behavioral Health, including psychiatry**
- **Dental**
- **Prenatal**
- **On-site lab**
- **On-site 340B pharmacy**
- **On-site paralegal who assists with Medicare disability apps**
- **Out posted county DSS Medicaid screener on-site**
- **15,000 total HC patients with 750 HIV+ RW**

FQHC-based Ryan White

- **Transgender Health Program with over 200 patients**
- **Aligned Transgender service area to overlap with RW service area – 18 counties in western NC, mostly rural**
- **PrEP**
- **PEP**
- **Participated with National Quality Center past 6 years and with North Carolina Regional Quality Council for past 6 years**
- **Worked with NCRQC on improving outcomes by sharing best practices around HIV performance measures, including viral load suppression**

Core 1 July 2011 – June 2016 for WNCCHS



WNCCHS QI projects for VL suppression

- PDSA VL Suppression
- Learned about best practices around PDSA's by participating in NC RQC meetings and NQC trainings. Also sharing clinical best practices through meetings and sharing and comparing data across the state via NC RQC.
- Included nursing staff, physician and FNP, medical social workers, scheduling staff, front desk staff
- Used CAREWare to identify those not suppressed, then cross-checked in EMR to "dig deeper"
- Three groups: "in care" and not suppressed; "in and out" of care and not suppressed; "out of care" and not suppressed
- Goal: Why in care and not suppressed, link sporadic care with MCM and alert provider; FIND and reengage out of care.

WNCCHS QI projects for VL suppression

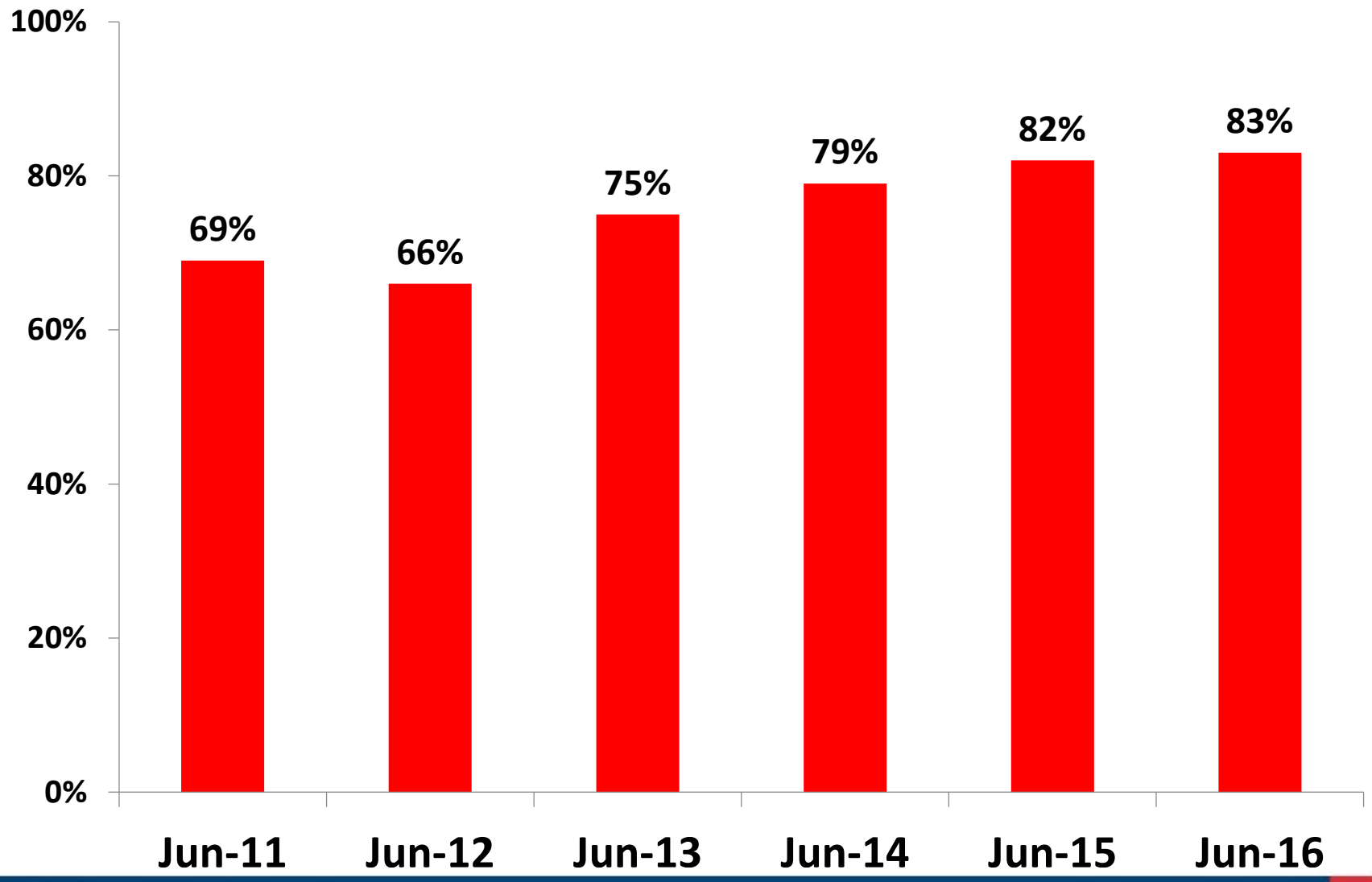
- High percentage of substance abuse/behavioral health issues among non-suppressed patients

- Now using PHQ9 depression screening on all patients at each appointment to try and engage in integrated BH services on site and same day when needed

- Connecting patients who are in sporadic care with MCM and out of care with SBC

- Every month generating lists of those with no medical appointment in 180 days and scheduling appointment or referring to MCM or SBC.

NC RW Viral Load Suppression Rates



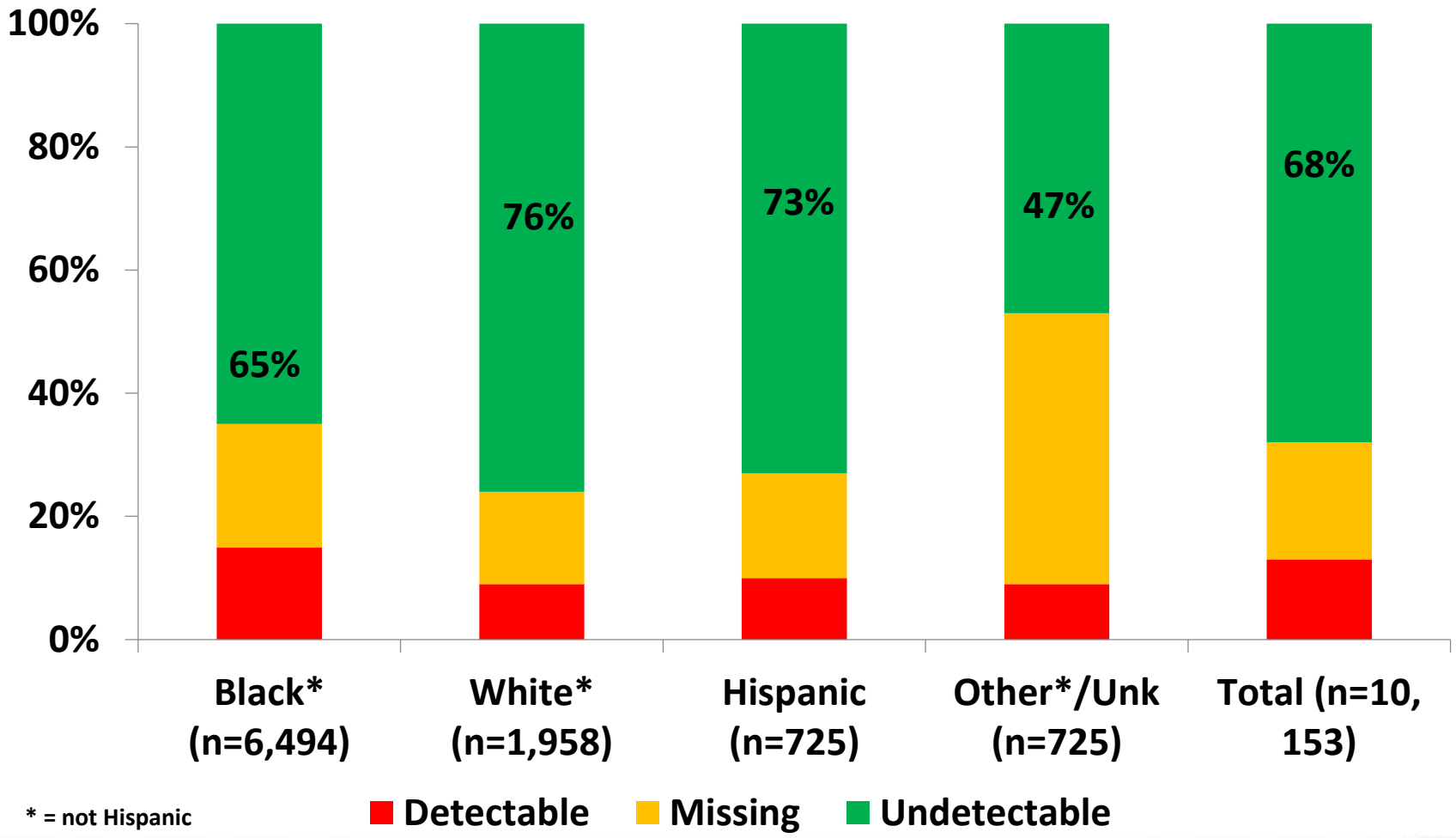
Strategies and best practices to improve viral load suppression rates

- **Identify patients not on HAART,**
- **Identify patients who are not virally suppressed?**
- **Look at length of time on HAART,**
- **Compare new clients to clients enrolled for several years,**
- **Are patients on first regimen or new regimen after failing on previous one**
- **Role of Medical Case Managers and PharmDs in improving viral load suppression**
- **Pillbox or other mechanism to help client keep track and show to MCM or PharmD**
- **Reinforce medication adherence pharmacist, providers, case managers, nurses, peer counselor, behavioral health**

Strategies and best practices to improve viral load suppression rates

- **Providers prescribing meds much quicker**
- **Onsite Substance abuse counseling and behavioral health**
- **Use of Readiness Assessment tool**
- **Show providers the viral load suppression rates of their patients**
- **Make sure data is recorded correctly**
- **Look at subsets: youth, women,**

Viral Load by Race/Ethnicity, RW Part B Clients, 4/15 – 3/16 (n=10,153)



* = not Hispanic

Improving STD screening rates

Amy Heine, MSN, RN, FNP-BC

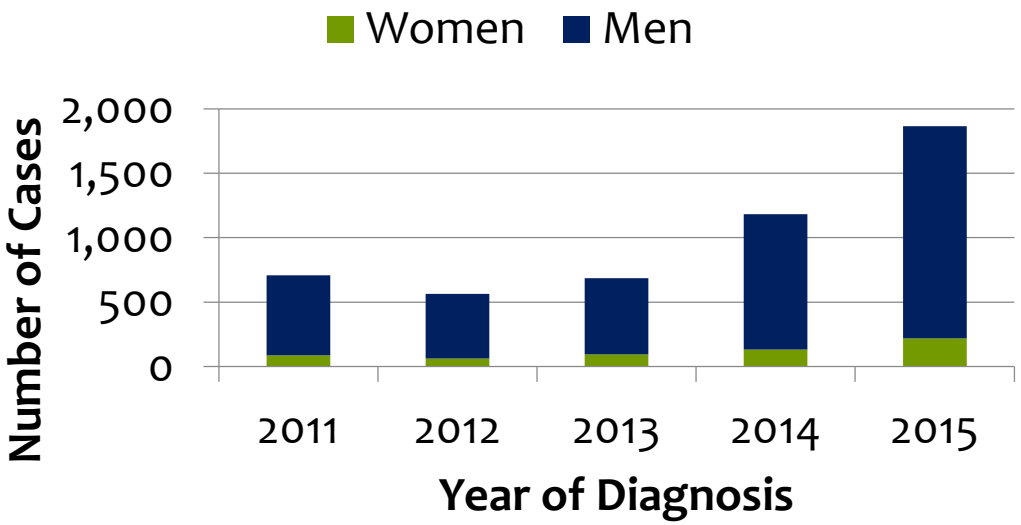
University of NC- Chapel Hill, ID Clinic, (Region 6)

Problem Identification

- State Epidemiology Department issued alert:

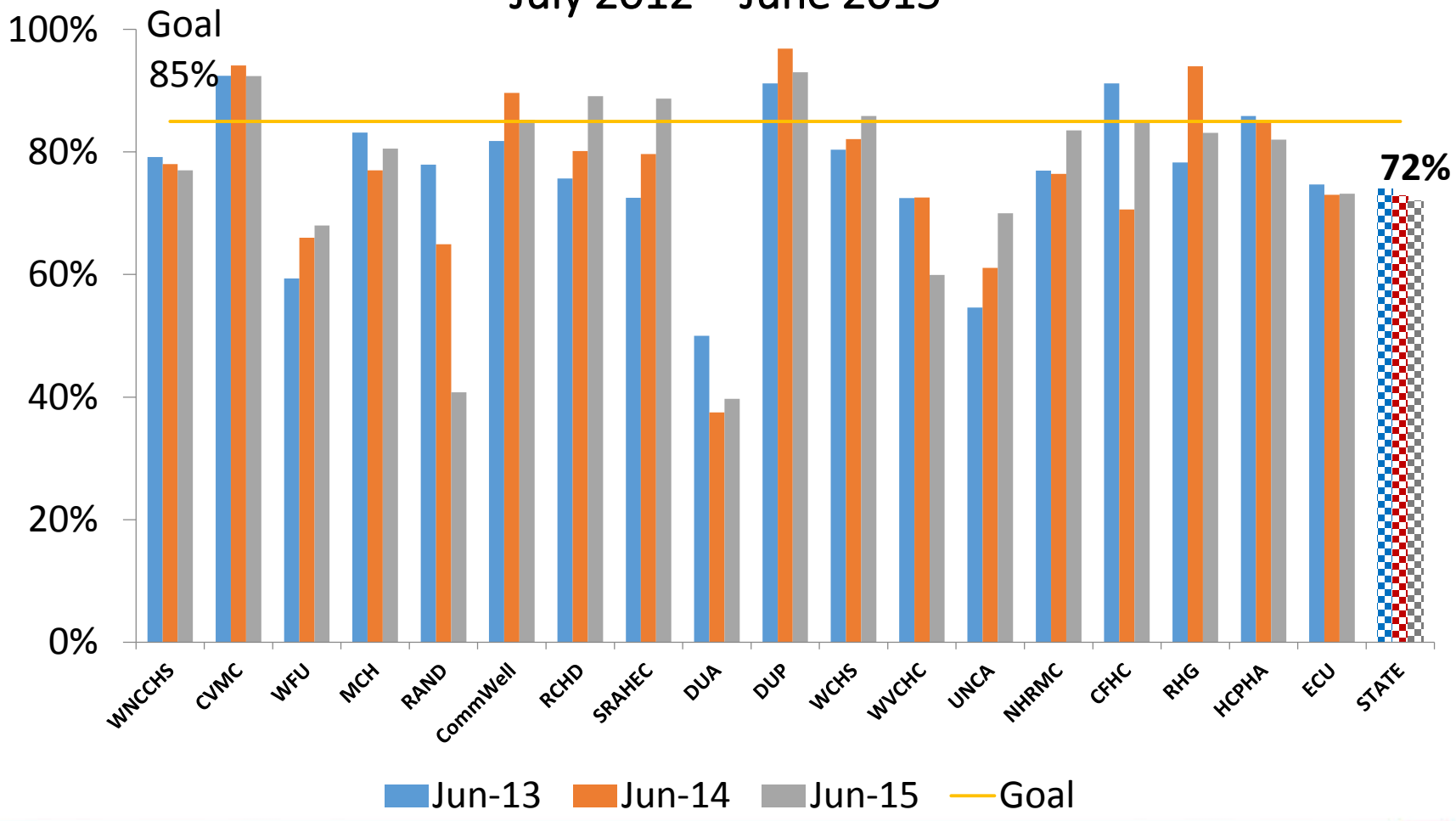
Between January 2014 and December 2015, there was a **64% increase** in the number of early syphilis cases reported across North Carolina.

- African American MSM disproportionately affected.



Data Source: North Carolina Electronic Disease Surveillance System (NC EDSS) (data as of June 1, 2016).

NC RQC Cross Site
HAB 13 – Annual Syphilis Screening
Comparison of 3 Annual Cycles
July 2012 – June 2015



Examining the Syphilis Data

- **Why are screening rates low?**
- Knowledge deficit r/t scope of the problem
- Comfort of providers in screening
- Not part of routine orders

What should be the state goal be for RW clinics?

85% of all clients screened annually

Interventions to Improve Screening for Syphilis, Chlamydia and Gonorrhea

- **Flag Charts; Chart reviews**
- **Don’t wait 12 months for annual syphilis screen, do it past 9 months**
- **Increased patient education – especially around oral sex risks**
- **Target MSM and high risk patients for GC/CT every 3 months or at regular appointments (USPSTF)**
- **Make condoms and dental dams easily available.**

UNC Clinic level - RPR Screening

- **Reviewed baseline data as a group**
- **Identified quality leader(s) – Nurse established a "STI multi-disciplinary workgroup"**
- **PDSA cycles**
- **Action Ideas and Implementation:**
  - **Developed booklet on oral sex information**
  - **Discussed project with CAB – "people don't use condoms"**
  - **Nursing orders in advance? Rejected by some providers**
  - **Reviewed and updated protocols**
  - **Established monthly tracking reports and posting**
  - **Flagged chart on check in for those needing screening**
- **Sharing progress visually– posting in conspicuous places**

Lightning Round Example

UNC-Chapel Hill

Area of Focus:
-Improve syphilis screening for MSM
-Improve syphilis screening for all patients
-Clinic QI project

Baseline Data:
Screening rates as of 1/1/15:
63.9% all pts
69.41% MSM

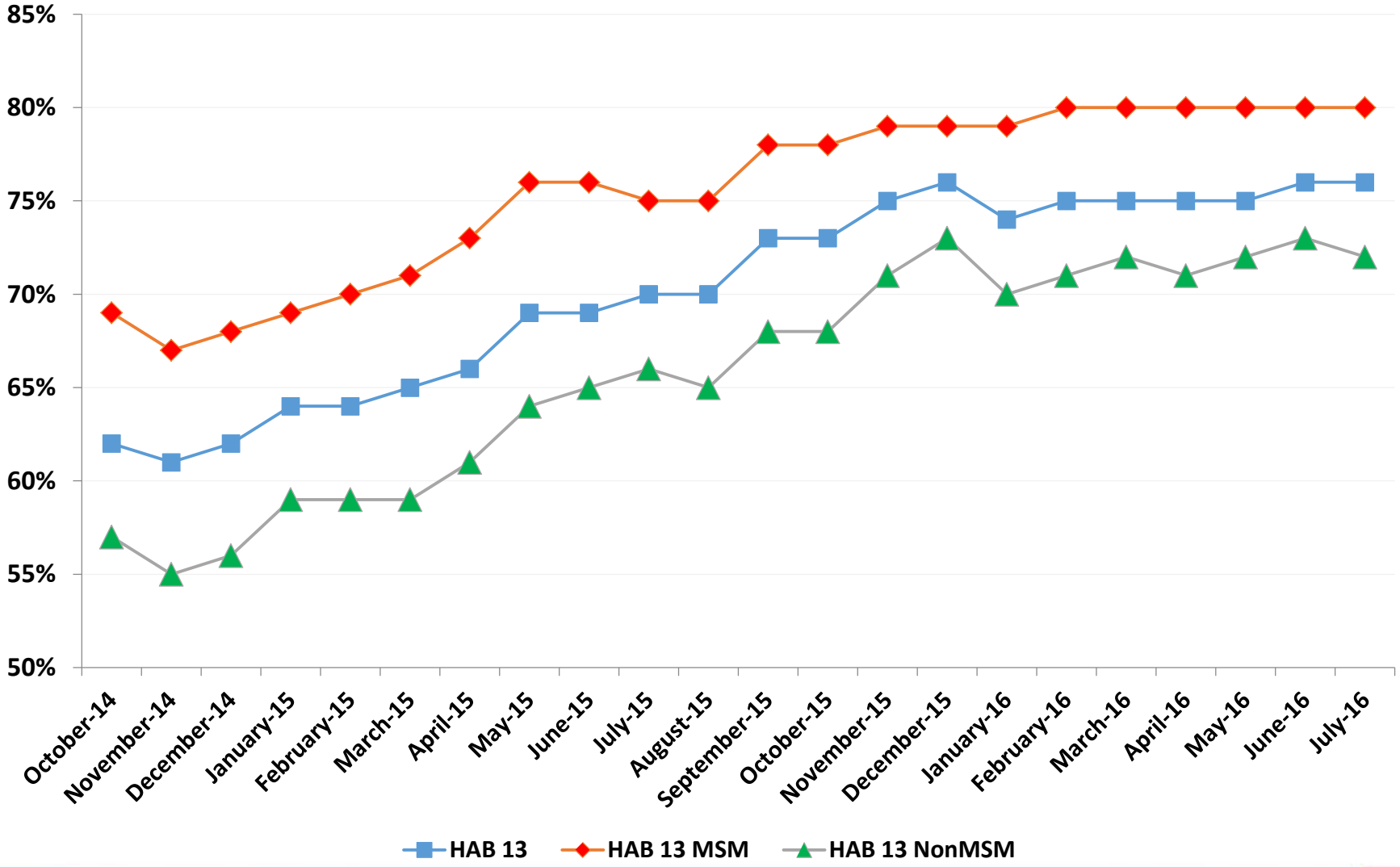
Client-Related Barriers:
Lack of knowledge about STIs-
In particular risks with unprotected oral sex and ability to be re-infected

Provider-Related Barriers:
-Providers not offering or recommending STD screening especially in perceived low risk patients
-Lack of knowledge about screening rates and goals
-Unaware that clients are due for screening

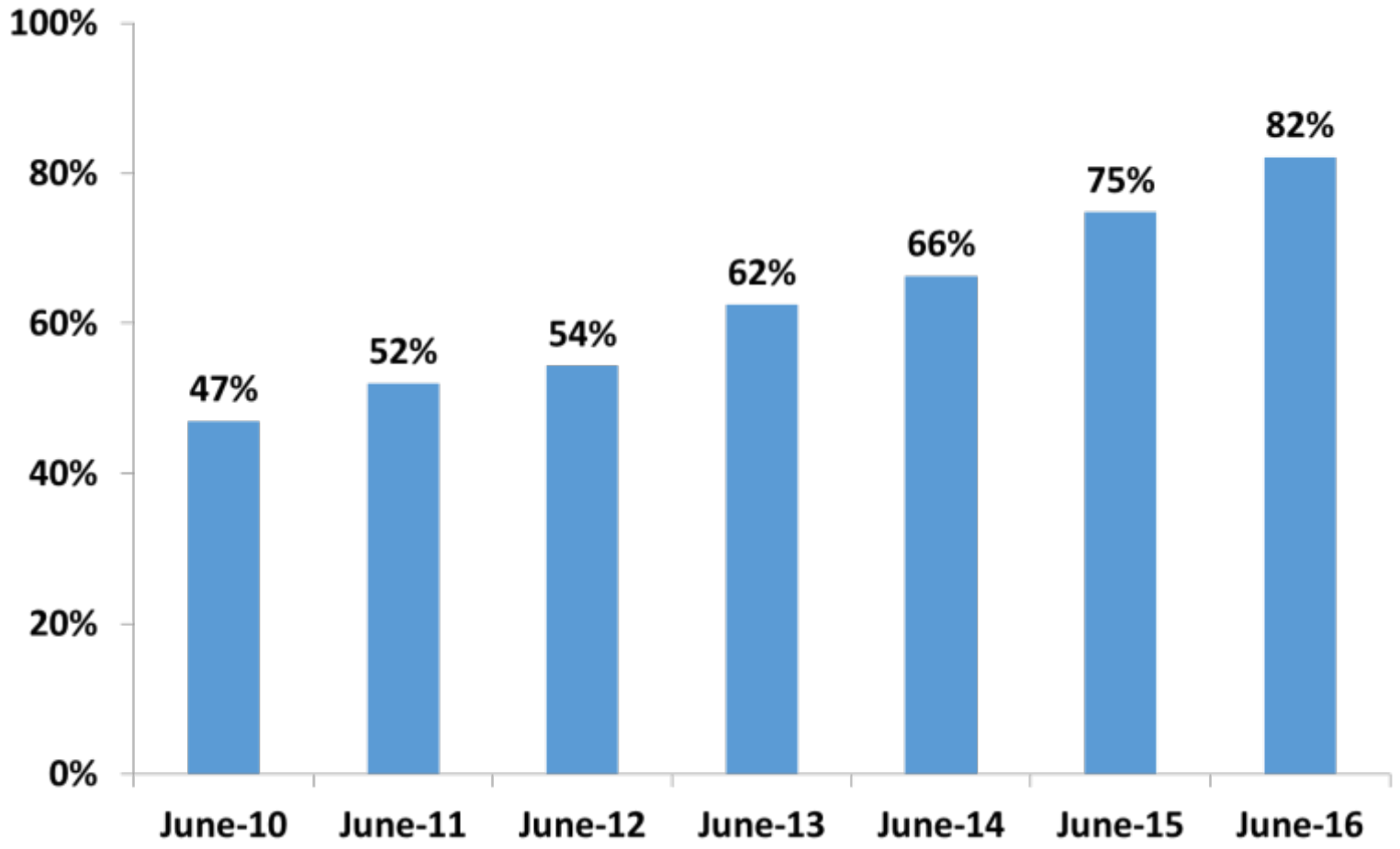
Goal: Increase Syphilis Screening rates to 75% among all patients and 80% among MSM by 12/31/2015

Strategy:
-Inform providers of baseline data, current syphilis rates in state and project goals in standing meetings
-Engage nursing staff for improved patient education and identification of RPR screening needs to flag for providers or enter EPIC orders for co-sign
-Provide periodic feedback to providers and staff on progress

UNC Syphilis Screening Rates (9/13 – 7/16)



NC Annual Syphilis Screening Rates



Gonorrhea and Chlamydia Screening
Don’t overlook the small things

Clinic Participation in State RQC Challenges & Benefits

- Challenge: Anonymity of data until built trust, fear of deficiency exposure
- Challenge: Competition vs. collaboration
- Challenge: Time and logistics
- Challenge: Administrative tasks
- Challenge: Leadership & Planning (internal/external)
- Benefit: Collaboration, best practice sharing & power of benchmarking
- Benefit: Data standardization and statewide level data/trends
- Benefit: Data analysis options and drilling down data
- Benefit: Sharing CAREWare custom reports
- Benefit: Learning different ways to present data

Questions?

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