Impacting the Cascade: Approaches to Drilling Down Data and Evidence-Informed Interventions

NQC Regional Groups

Arizona, E. Pennsylvania and Mississippi and RWPs in Chicago and Masschusetts

(List of names and contact information on last slides.)

Welcome!Welcome!Welcome!

Outcomes

- Articulate two approaches to drilling down clinical data to identify sub populations by HAB disparity categories and by patient level.
- Describe some of the tools, terms, and resources to conduct a disparities analysis and a simple cross-sectional analysis.
- Define a) reasons for non-suppression, b) evidence informed interventions to increase VL suppression, and c) how to sustain gains.

Overview

Rationale

Drilling Down Data to Identify Disparities

Drilling Down Data to Target Patient Interventions

Interventions: Targeted interventions to improve Care Coordination

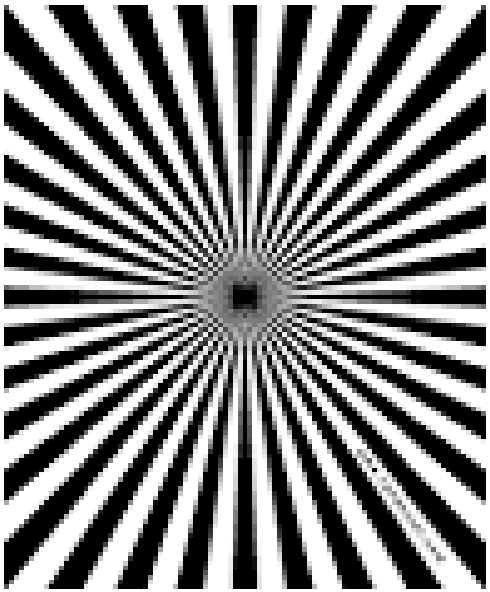
Results

Sustaining Gains

Key Learnings

Large Group Q&A

Our FOCUS



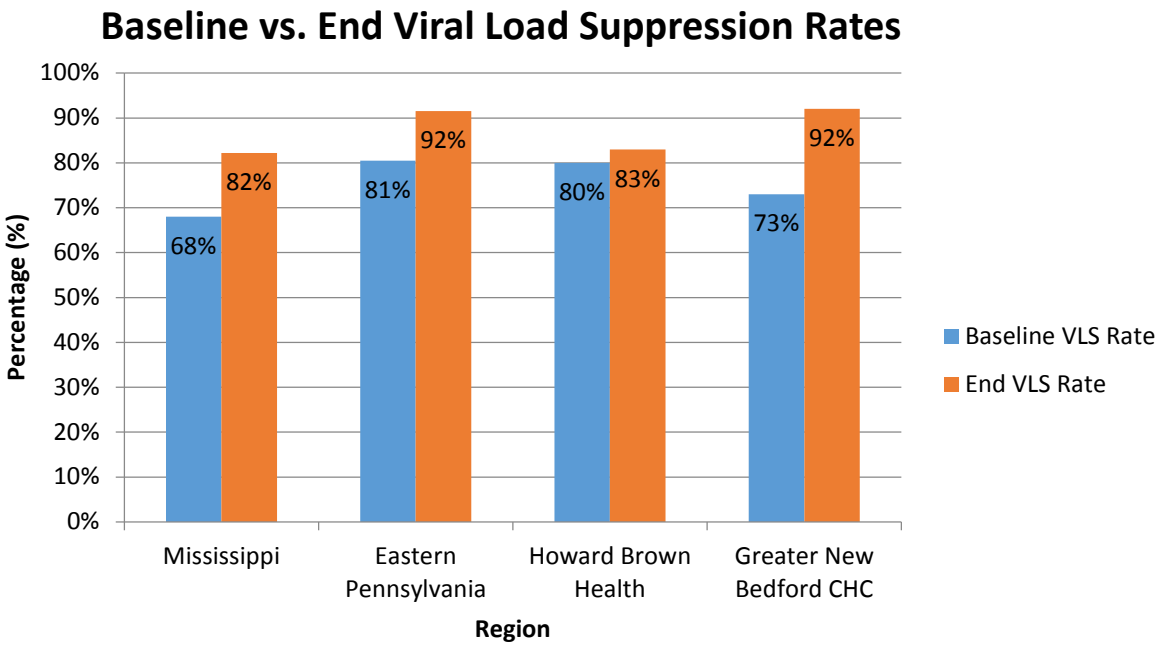
National HIV/AIDS Strategy

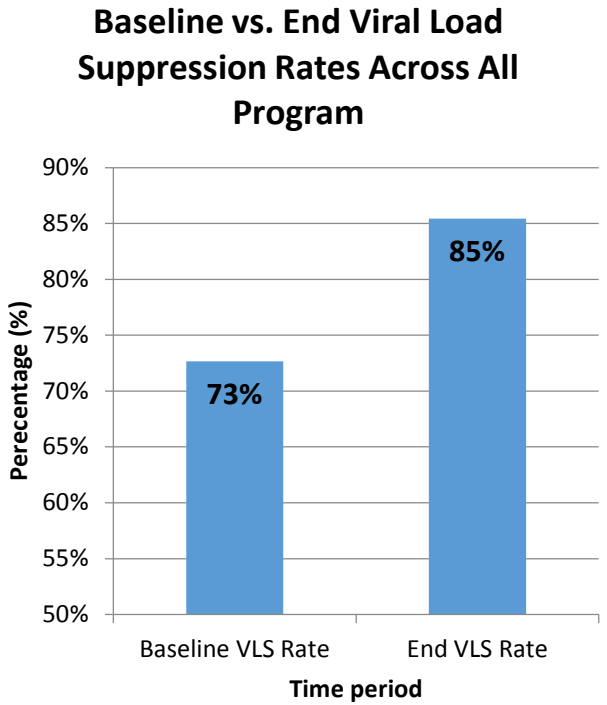
Goals:

- Reduce new infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities and health inequities
- Achieve a more coordinated response to the HIV epidemic

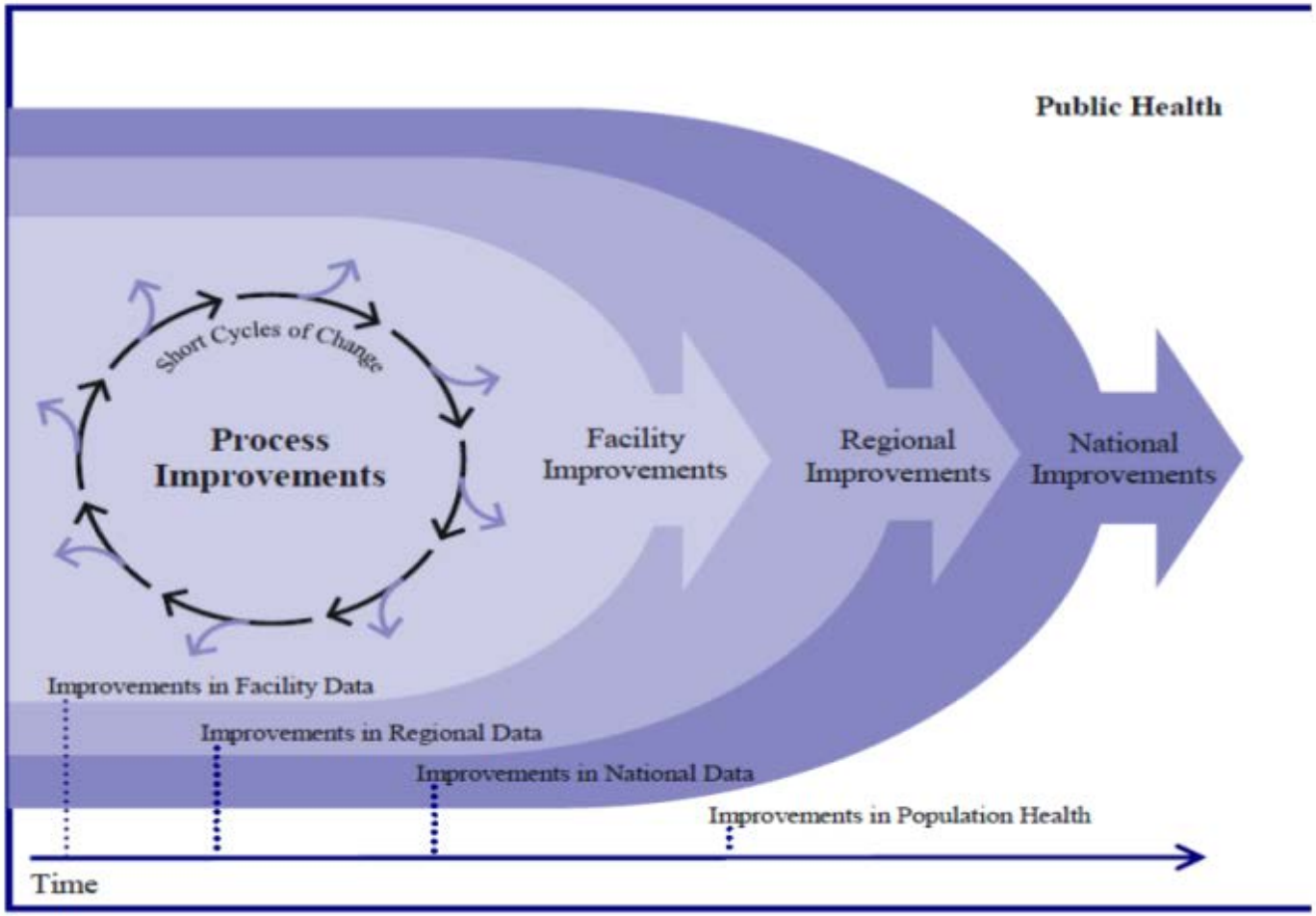
Results of 10 RWPs across Chicago, EPA, MA, and MS

Intervention: Care Coordination





Linking QI with Public Health Outcomes



Bruce Agins, MD, MPH, NYSDOH AIDS Institute, IAPAC Presentation,May 9, 2016.

Drilling Down Data

To have an in-depth understanding of patient barriers to care

Which comes first? Anaylsis of

Disparity Data or Patient Level – Root Causes

Arizona Regional Group

HIV Care Continuum, measures and results

What is a health disparity?

How do you calculate and determine significant disparities?

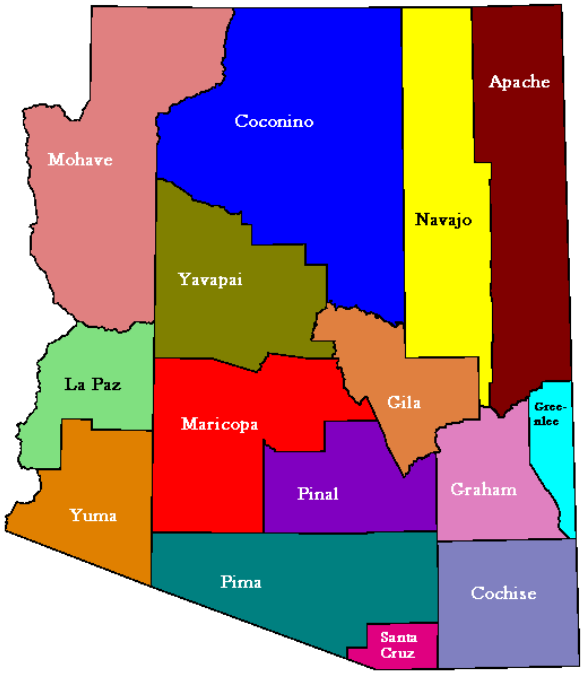
HIV Care Continuum

Tara Radke

Director of Grant Development and Management

El Rio Community Health Center

Tucson, Arizona



HIV Care Continuum

The Common Marigold & The Rajoman Flowers
Kubo Shunman (Japanese, 1757–1820)

Image courtesy of the Metropolitan Museum of Art, New York.

- Categories were known:
  - Infected
  - Diagnosed
  - Linked to Care
  - Retained in Care
  - Prescribed ARV
  - Viral Suppression
- Common definitions were difficult to find.

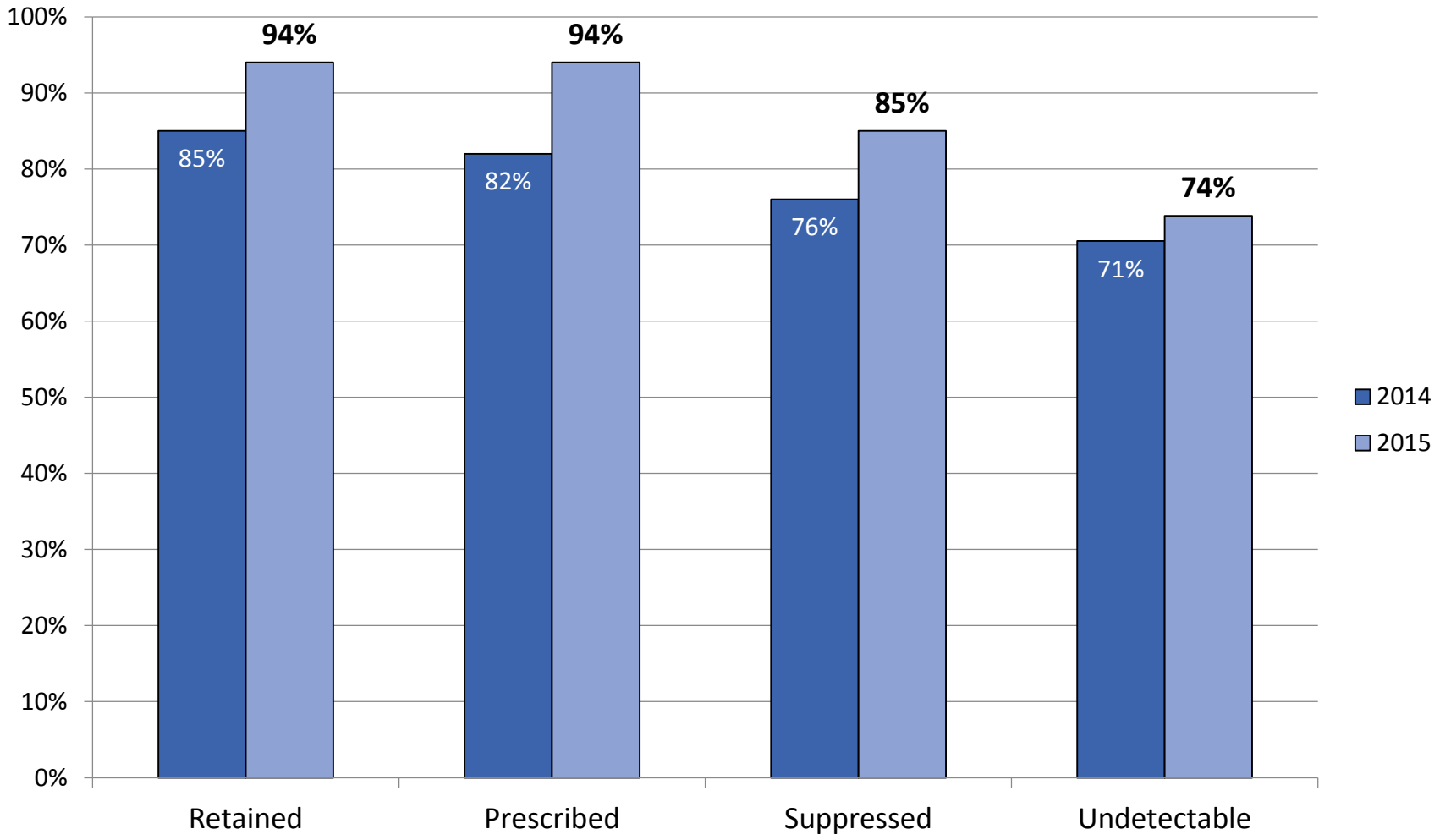
Arizona's HIV Care Continuum Definitions

- HIV-Infected
  - Prevalent cases & estimated unaware cases of HIV infection (end of year).
- HIV-Diagnosed
  - Prevalent cases.
- Linked to HIV Care-Prevalent
  - Prevalent cases with a documented lab test, provider visit, or ARV use in the calendar year.
- Retained in HIV Care
  - Prevalent cases with a documented lab test, provider visit, or ARV use in the first 6 months & the second 6 months of the calendar year or one documented lab test, provider visit, or ARV use in the calendar year with a lab result indicating viral suppression status.
- On ARV Therapy
  - Prevalent cases with documented ARV use or whose last viral load of the calendar year was suppressed. All "Adherent/Suppressed" are in this category.
- Adherent/Suppressed
  - Prevalent cases whose last viral load of the calendar year was suppressed (<200 C/mL).

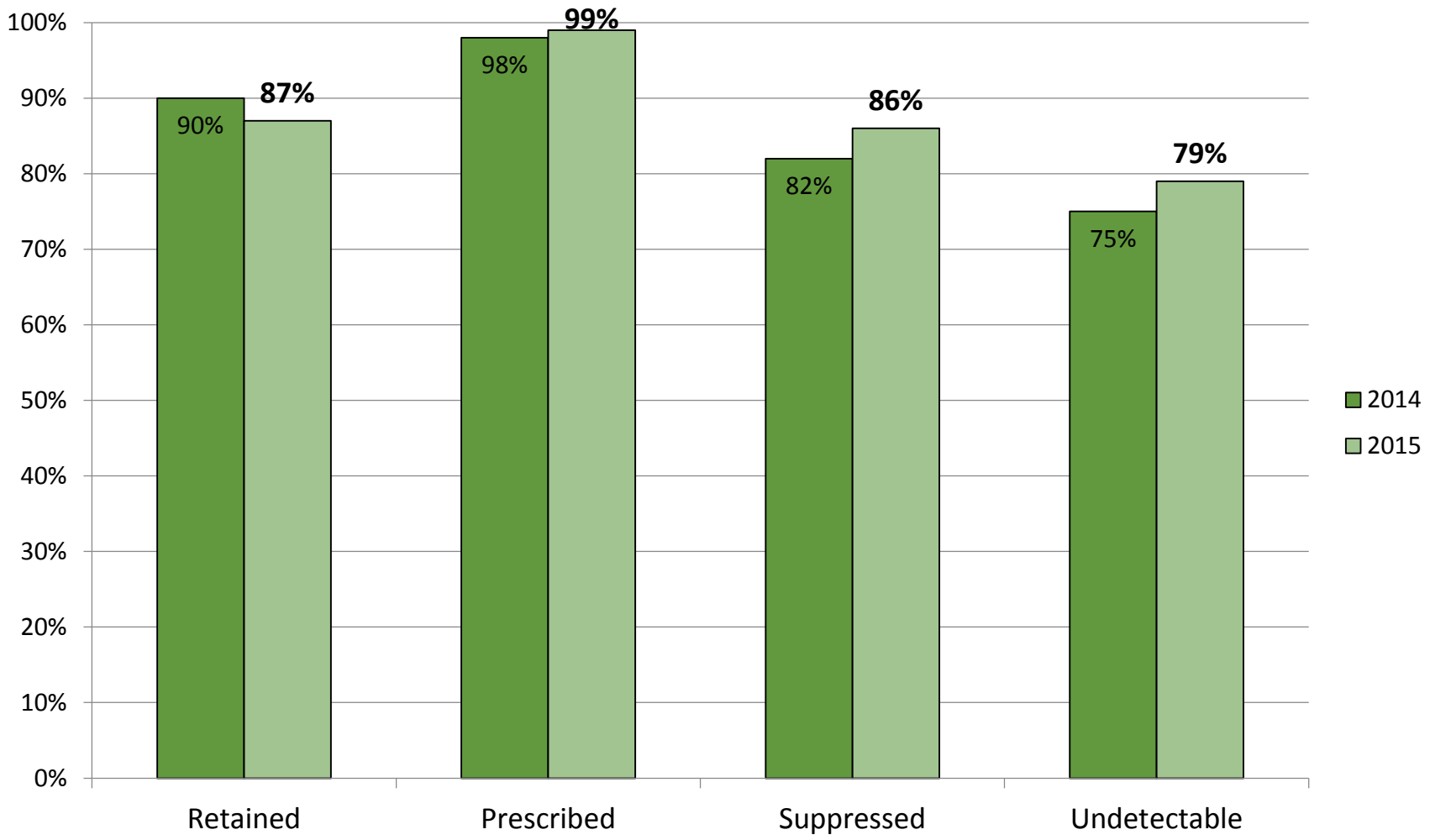
Notes:

- All percentages are calculated using the diagnosed value as the denominator.
- Prevalent refers to the population of analysis; so for health care facilities all of their patients.

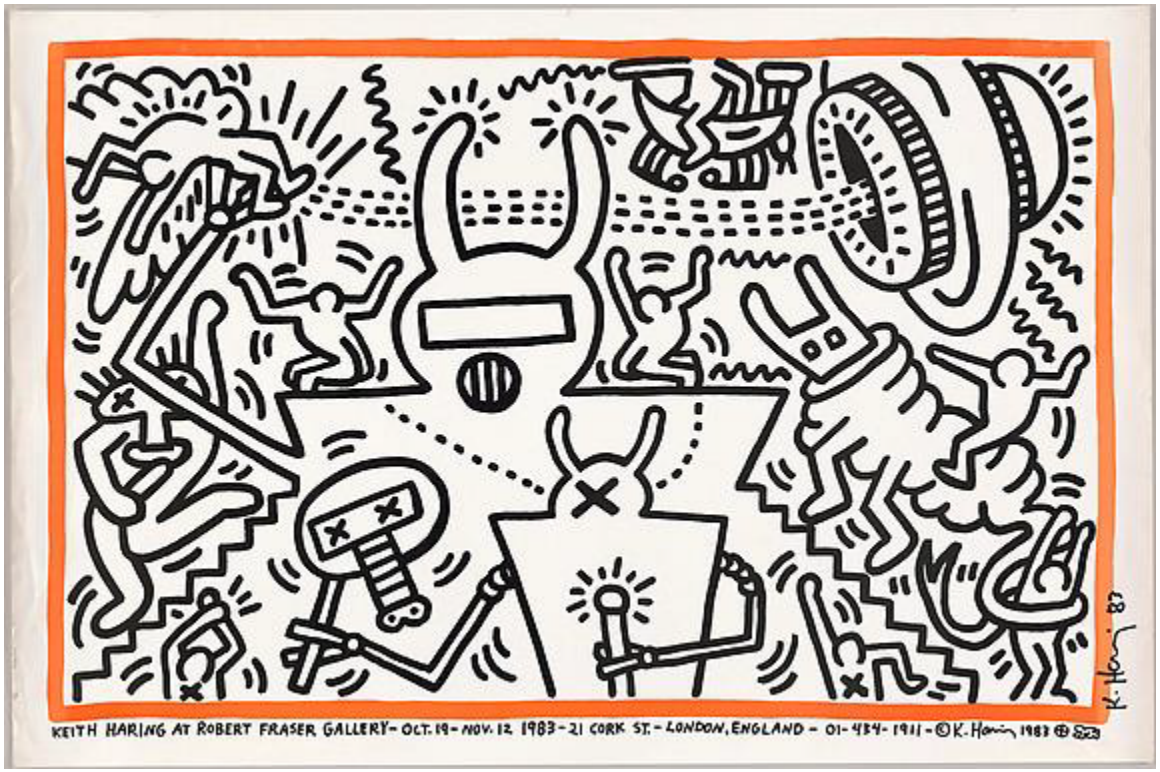
El Rio SIA HIV Care Continuum



McDowell HCC HIV Care Continuum



Disparities and Equities



Untitled

Keith Haring (American, 1983)

Image courtesy of the Metropolitan Museum of Art, New York

What is a Health Disparity?

- Healthy People 2020
  - A particular type of health difference linked with social, economic, and/or environmental disadvantage.
  - Adversely affect groups of people who have systematically experienced greater obstacles to health.

- Racial or ethnic group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation or gender identity
- Geographic location
- Other characteristics historically linked to discrimination or exclusion

http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

What is Health Equity?

- Healthy People 2020
  - The attainment of the highest level of health for all people.

- Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Selecting Measures

Eric Moore
Senior HIV Program Manager
Maricopa Integrated Health System
Phoenix, Arizona

Selecting Measures to Address Health Disparities

1. Define which aspects of health to measure.
2. Identify the relevant population groups.
3. Choose a reference group for comparison.
4. Decide to use absolute or relative difference.
5. Select among alternate social weights.

Carter-Pokras, O. and Baquet, C. (2002) "What is a 'Health Disparity'?" *Public Health Reports*, v. 117, pp 426-34.

1. Define Indicators

Retention in Care

Viral Load Suppression

2. Identify Groups

Gender

Age Group

Race and Ethnicity

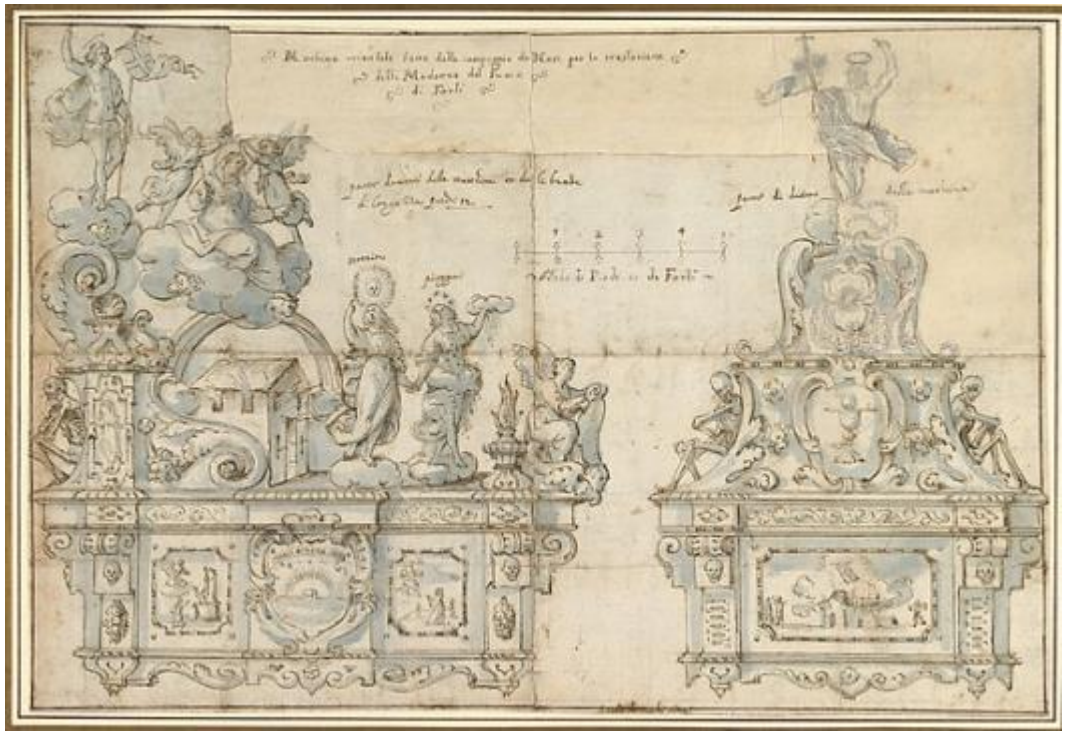
Payer Category

Income Level

HIV Exposure Risk

3. Reference Group

Entire clinic population



Design for a Processional Float
Anonymous (Italian, 17th century)

Image courtesy of the
Metropolitan Museum of Art,
New York

4. Absolute or Relative Difference?

- Relative Difference
  - A measure of the strength of the association between a factor and a disease or outcome.
    - Odds Ratio
    - Women who did not use statins have "x" times the risk of breast cancer compared to women who used statins over the study period.
- Absolute Difference
  - A measure of the impact of the risk factor with a focus on the number of cases that may be prevented by eliminating that risk.
    - Risk Difference
    - The excess risk of breast cancer among statin users is "x" over the study period, compared to non-statin users.

5. Alternate Social Weights

- When considering two or more indicators, is one of them more important than the other?
  - Is viral suppression more, less, or equally as important as retention in care?

"It is the Roots of Who I am that Remains - Suppression Notwithstanding"

Juan Sanchez
(American, 1987-88)

Image courtesy of the Metropolitan Museum of Art, New York

Analysis

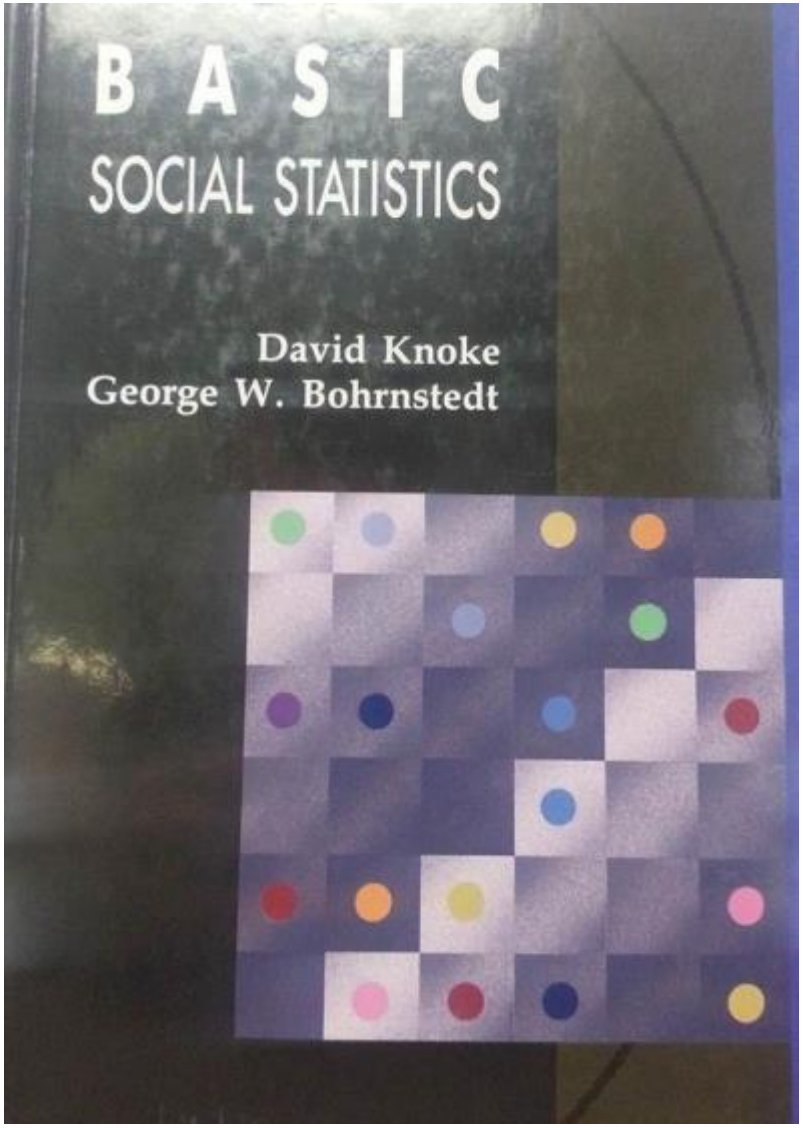
The Card Players

Paul Cézanne
(French, 1890-92)

Image courtesy of the Metropolitan Museum of Art, New York

"In God we trust. All others require data."

Bernard Fisher, MD



Definitions

- Cross-Sectional Analysis
  - An observational analysis involving data collected from or about a population at one specific point in time.
- Odds Ratio
  - A measure of association between an exposure and an outcome.
  - If ratio ≥ 1, then the odds are more likely.
  - If ratio < 1, then the odds are less likely.
- p-value
  - A measure that quantifies the idea of statistical significance.
  - To be considered statistically significant, the p-value must be ≤0.05.
  - The smaller the p-value, the greater the significance.

Remember

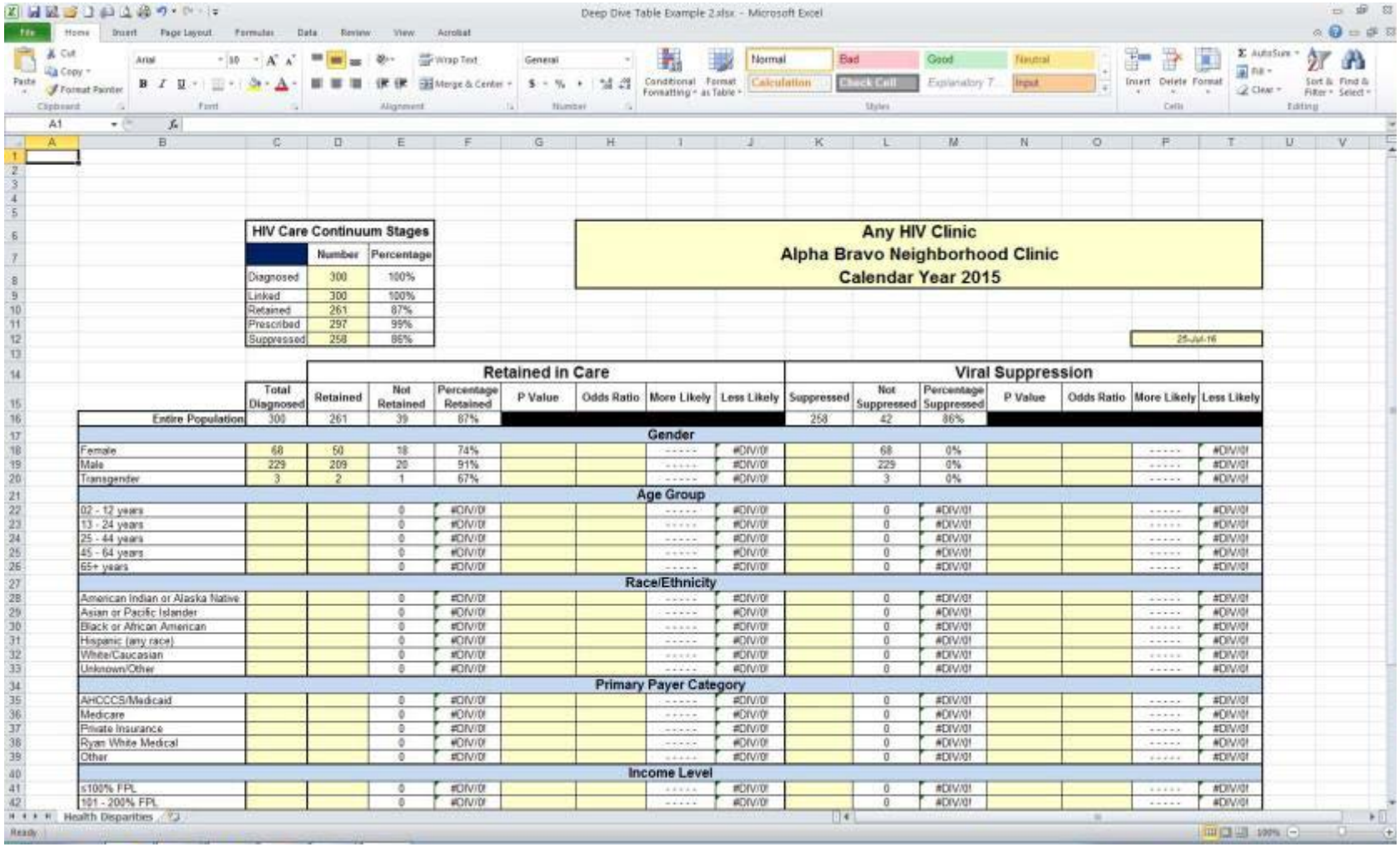
- This cross-sectional analysis is not research.
- It's useful for quality purposes and focusing limited resources on the populations of greatest need.
- The result is more than just chance.
  - The result is not cause and effect.
  - There is a statistical significance to which we should pay attention.

Wisconsin Landscape

John Steuart Curry
(American, 1938-39)

Image courtesy of the Metropolitan Museum of Art, New York

Deep Dive Template



Deep Dive Table Example 2.xlsx - Microsoft Excel

HIV Care Continuum Stages	Number	Percentage
Diagnosed	300	100%
Linked	300	100%
Retained	261	87%
Prescribed	297	99%
Suppressed	258	86%

Any HIV Clinic
Alpha Bravo Neighborhood Clinic
Calendar Year 2015

25-Jul-16

		Retained in Care							Viral Suppression						
	Total Diagnosed	Retained	Not Retained	Percentage Retained	P Value	Odds Ratio	More Likely	Less Likely	Suppressed	Not Suppressed	Percentage Suppressed	P Value	Odds Ratio	More Likely	Less Likely
Entire Population	300	261	39	87%					258	42	86%				
Gender															
Female	68	60	18	74%			------	#DIV/0!		68	0%			------	#DIV/0!
Male	229	209	20	91%			------	#DIV/0!		229	0%			------	#DIV/0!
Transgender	3	2	1	67%			------	#DIV/0!		3	0%			------	#DIV/0!
Age Group															
02 - 12 years			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
13 - 24 years			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
25 - 44 years			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
45 - 64 years			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
65+ years			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Race/Ethnicity															
American Indian or Alaska Native			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Asian or Pacific Islander			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Black or African American			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Hispanic (any race)			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
White/Caucasian			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Unknown/Other			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Primary Payer Category															
AHCCCS/Medicaid			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Medicare			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Private Insurance			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Ryan White Medical			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Other			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
Income Level															
≤100% FPL			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!
101 - 200% FPL			0	#DIV/0!			------	#DIV/0!		0	#DIV/0!			------	#DIV/0!

Do the Math Here!

- Open Epi
  - OpenEpi is free and **open source** software for epidemiologic statistics.
  - Created by Emory University and supported by CDC.

http://www.openepi.com/Menu/OE_Menu.htm

Results – Gender

El Rio SIA Disparities (n=1,193)								
Group	**Total Diagnosed**	**Retained**	**Not Retained**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
Female	180	166	14	92%	0.2007	0.773	- - - - -	1.294
Male	1,009	947	62	94%	0.2273	1.258	1.258	- - - - -
Transgender	4	4	0	100%	0.7856	2.731	2.731	- - - - -

McDowell Healthcare Center Disparities (n=3,045)								
Group	**Total Diagnosed**	**Retained**	**Not Retained**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
Female	597	508	89	85%	0.06511	0.8215	- - - - -	1.217
Male	2,419	2,117	302	88%	**0.03735**	1.254	1.254	- - - - -
Transgender	29	23	6	79%	0.1096	0.571	- - - - -	1.751

Age Group – Retention

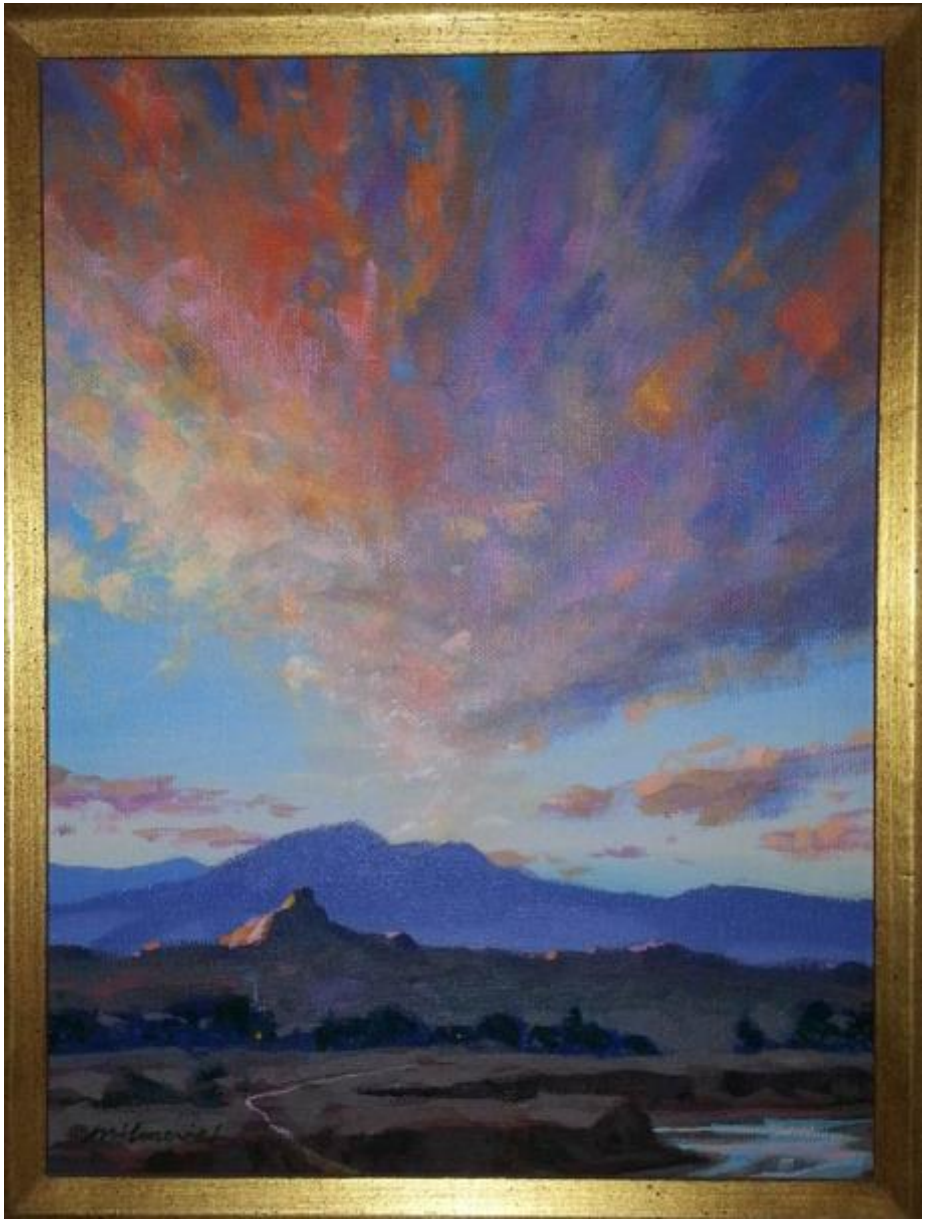
El Rio SIA Disparities (n=1,193)								
Group	**Total Diagnosed**	**Retained**	**Not Retained**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
13 – 24 years	17	14	3	82%	0.1086	0.3396	- - - - -	2.94
25 – 44 years	318	293	25	92%	0.102	0.7254	- - - - -	1.38
45 – 64 years	753	713	40	95%	0.02511	1.588	1.59	- - - - -
65+ years	105	97	8	92%	0.2917	0.8083	- - - - -	1.24

McDowell Healthcare Center Disparities (n=3,045)								
Group	**Total Diagnosed**	**Retained**	**Not Retained**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
13 – 24 years	206	158	48	77%	0.00000294	0.4614	- - - - -	2.17
25 – 44 years	1,424	1,217	207	85%	0.01067	0.7806	- - - - -	1.28
45 – 64 years	1,344	1,206	138	90%	0.00002731	1.57	1.57	- - - - -
65+ years	71	67	4	94%	0.03041	2.55	2.55	- - - - -

Age Group – Suppression

El Rio SIA Disparities (n=1,193)								
Group	**Total Diagnosed**	**Suppressed**	**Not Suppressed**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
13 – 24 years	17	10	7	59%	0.008604	0.2502	- - - - -	4.00
25 – 44 years	318	253	65	80%	0.001339	0.6008	- - - - -	1.66
45 – 64 years	753	652	101	87%	0.07298	1.277	1.28	- - - - -
65+ years	105	96	9	91%	0.02304	2.017	2.01	- - - - -

McDowell Healthcare Center Disparities (n=3,045)								
Group	**Total Diagnosed**	**Suppressed**	**Not Suppressed**	**Percentage**	**p-value**	**Odds Ratio**	**More Likely**	**Less Likely**
13 – 24 years	206	155	51	75%	0.000000484	0.4414	- - - - -	2.27
25 – 44 years	1,424	1,211	213	85%	0.01354	0.7911	- - - - -	1.26
45 – 64 years	1,344	1,201	143	89%	0.00002047	1.571	1.57	- - - - -
65+ years	71	67	4	94%	0.02487	2.656	2.66	- - - - -



Patsy's Sunset

Paul Milosovich
(American, c. 2010)

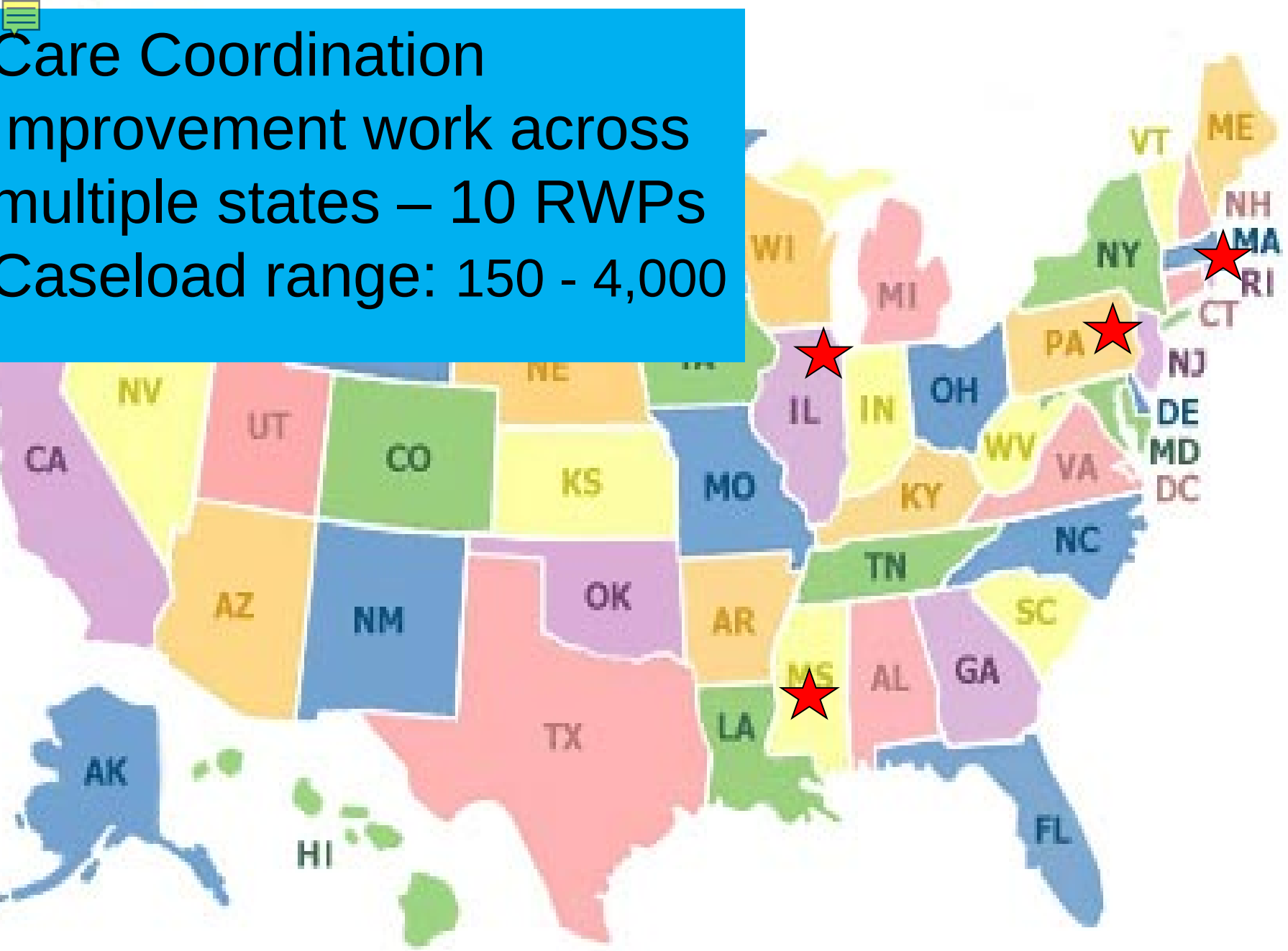
Image courtesy of the artist.

Targeting Interventions to Improve Care Coordination

QI Process

- Continuous use of drilled down data by multidisciplinary team
- Target patient or sub population level interventions
- Continuous measurement of results to effect outcomes
- Continuous tweaking of managing care coordination

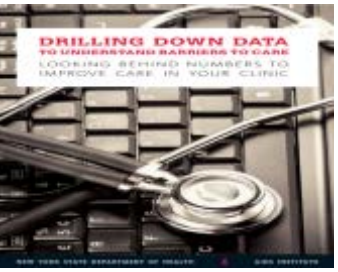
Care Coordination
mprovement work across
multiple states – 10 RWPs
Caseload range: 150 - 4,000



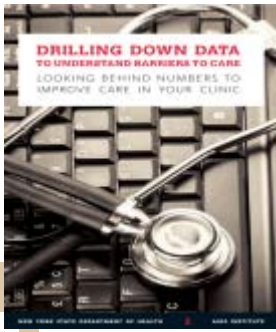
Drilling Down Data at Clinic Level

Why?

- Helps identify barriers to care
- Helps look beyond the numbers
- Helps identify areas for improvement
- Encourages involvement from all clinic team members
- Helps to improve care in the clinic



NYSDOH AIDS Institute, “Drilling Down Data To Understand Barriers to Care”



4 MAIN STEPS TO DRILLING DOWN DATA:

1. Develop a list of patients who do not meet the defined criteria of your measure.

2. Identify reasons each patient does not meet the criteria.

3. Tally the reasons.

4. Develop targeted plans to address the most common or relevant issues.

Mississippi Statewide QI Initiative

GOAL:

To increase VL suppression rates across RW Programs from an average of 65% to 80% by the end of December, 2015.

Mississippi Statewide Barriers-Root Causes for Non Suppression

5 RW Programs

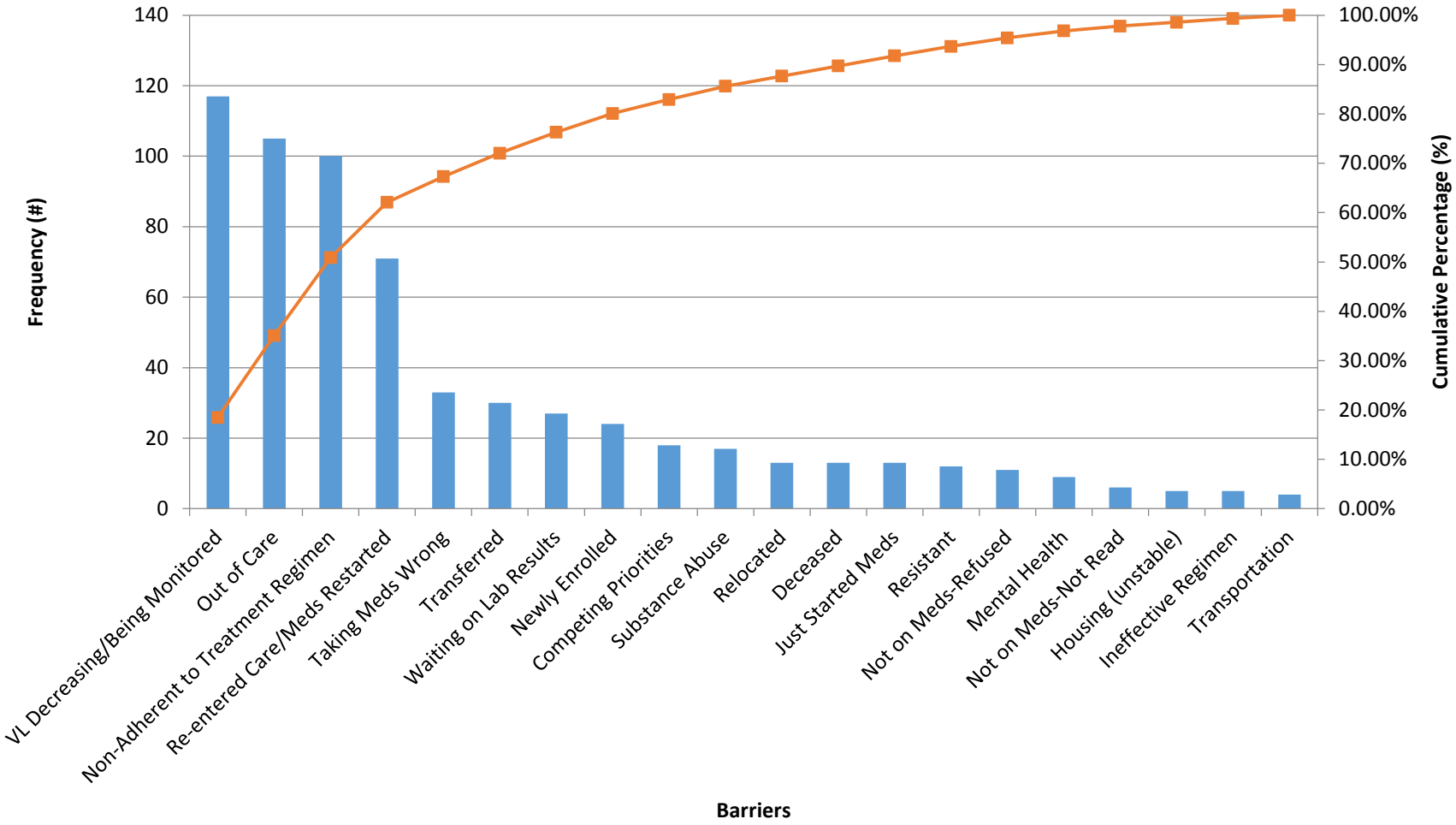
Total HIV caseload:

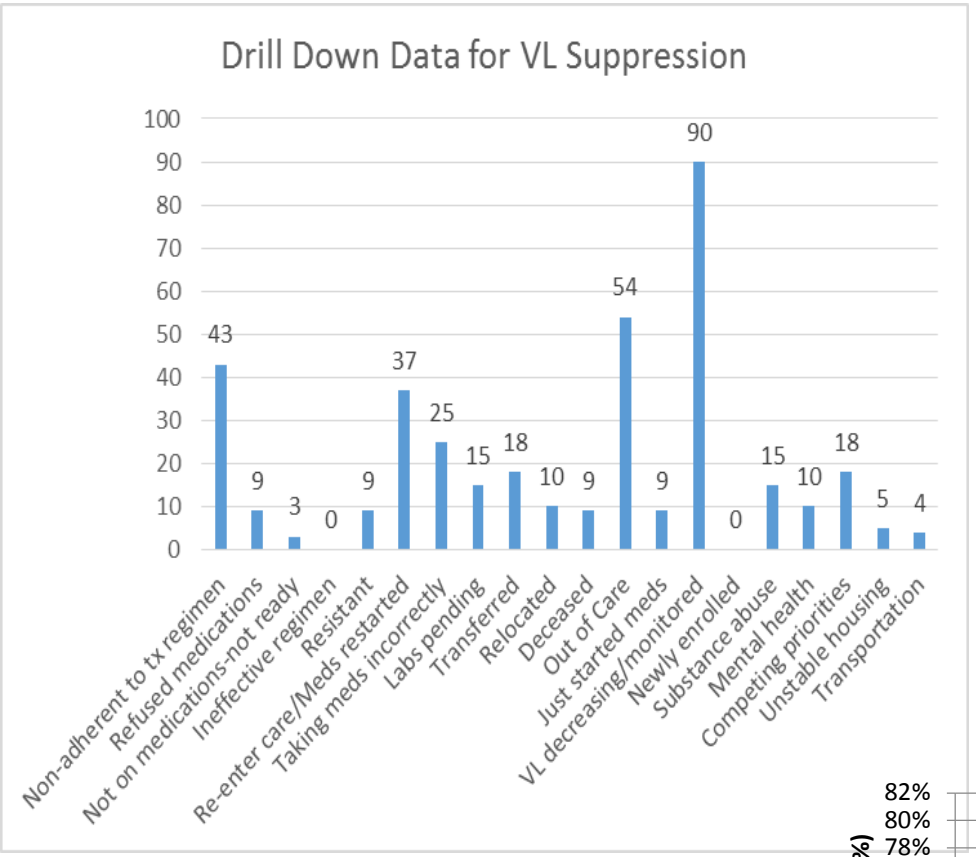
Total non suppressed <200:

633 patients – 56*= 577

Reasons	Total
Non-Adherent to Treatment Regimen	**100**
Not on Meds- Refused	11
Not on Meds- Not Ready	6
Ineffective Regimen	**5**
Resistant	12
Re-entered Care/Meds Restarted	**71**
Taking Meds Wrong	**33**
Waiting on Lab Results	**27**
Transferred*	30
Relocated*	13
Deceased*	13
Out of Care	**105**
Just Started Meds	13
VL Decreasing/Being Monitored	**117**
Newly Enrolled	24
Substance Abuse	17
Mental Health	9
Competing Priorities	18
Housing (Unstable):	5
Transportation	4

Missisippi Statewide Barriers to Suppression



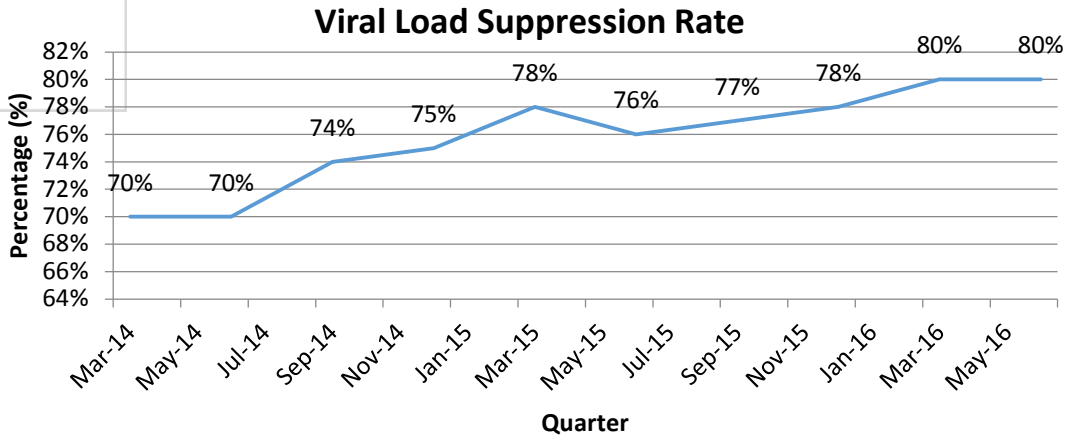


Increasing VL Suppression

March 2016 – Data analysis excluding transferred, relocated, deceased.

# of pts	383	330
% suppressed	79%	81.6%

Interventions
March 2014 – Adherence Tool
March 2016: =refer out of care patients to MSDH for re-engagement



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MS Statewide Care Coordination - Targeted Interventions

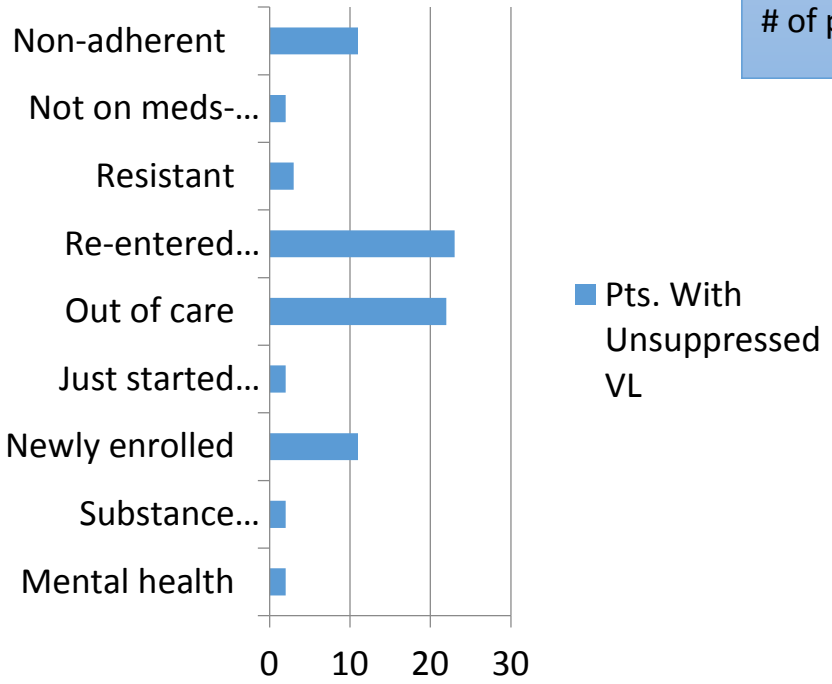
Using Drilled Down Data to Target Interventions	Total: 5 MS RWPs
Transportation	5
Assist with co-pays	4
Mail order meds	3
Reminder calls	4
Pill planners	3
Mental Health Services (psychiatrist)	4
Housing assistance	2
Extra adherence education, Health Literacy Teach Back Adherence Tool	4
Targeted Provider communication	3
Pharmacy verification of meds	3
Refer patient out of care to District SWs	3
Home visits	2
Clinical team response to medication problems	1
Alarms set on patient phones	2

Viral Load Suppression

Viral Load Suppression: Strive for 80% of patients to achieve VL suppression.

	Baseline	Post intervention
% suppressed	77%	85%
# of patients	121	77

Reasons for Unsuppressed VL- Drilled Down Data



Interventions – Care Coordination

- Medical Case management interventions (HIV & adherence education, addressing barriers to care, etc.)
- Engaging those who are out of care or are soon to be via outreach efforts

Next Steps

- Discuss non-adherent pts. cases in depth during morning huddles to address possible barriers
- Ensure frequent VL monitoring
- Follow-up with pts. either non-compliant or out of care.

Increasing Viral Load Suppression Rates

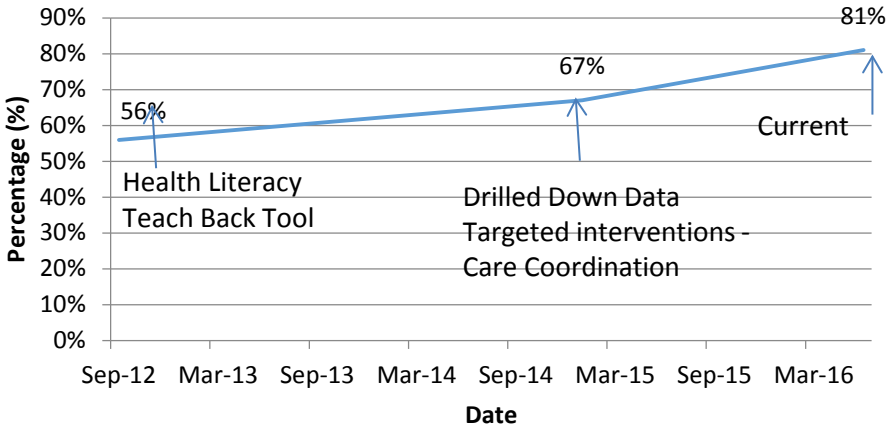
MAGNOLIA MEDICAL CLINIC
A member of the Greenwood Leflore Hospital Clinic Network
The Convenience of a Clinic, the Resources of a Hospital

Reasons	Total
Non-Compliant	15
Resistant	1
Re-Entered Care/Meds Restarted	3
Waiting on Lab Results	3
Transferred	6
Deceased	1
Mental Health	6
Newly Enrolled	9
Other	1 (incarcerated)

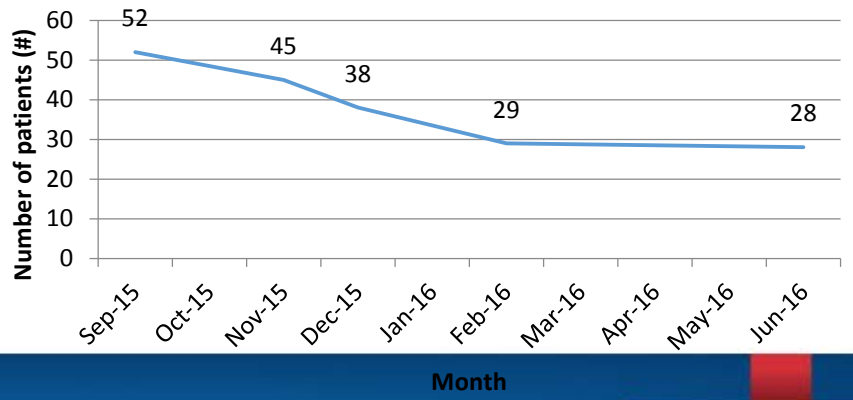
Process and Interventions- Care Coordination

*Pro. Coordinator-Print list of clients not suppressed
*NP and Pro. Coordinator- review list &compare to lab results; start HART
*SW/Case Manager- reminder calls for apt, arrange transportation to apt, pharmacy verification of pick up
*Data Clerk –Check data for errors
*Multidisciplinary Team: ongoing adherence education and address barriers

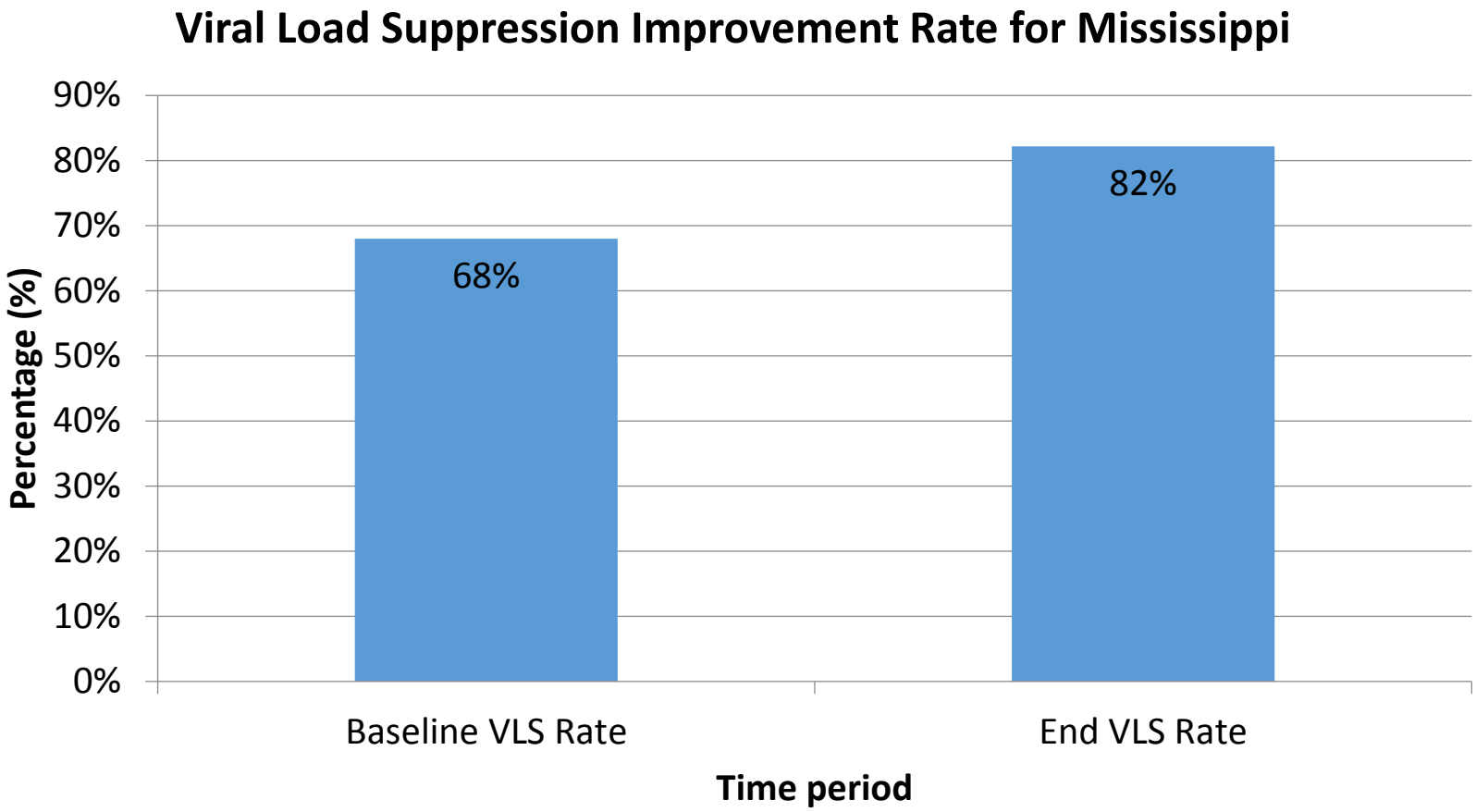
Viral Load Suppression Rates Across Interventions



Patients Not Suppressed



MS Statewide Results – Improved Care Coordination



VL Suppression: Interventions and Results

Baseline	District SW/DIS	Care Coordination
65%	69%	80% (164/205)

Reasons	Total 41
Non-Adherent to Treatment Regimen	**17**
Re-entered Care/Meds Restarted	0
Waiting on Lab Results	0
Transferred	1
Relocated	0
Deceased	2
Out of Care	**8**
Just Started Meds	2
VL Decreasing/Being Monitored	**8**
Newly Enrolled	2
Mental Health	1

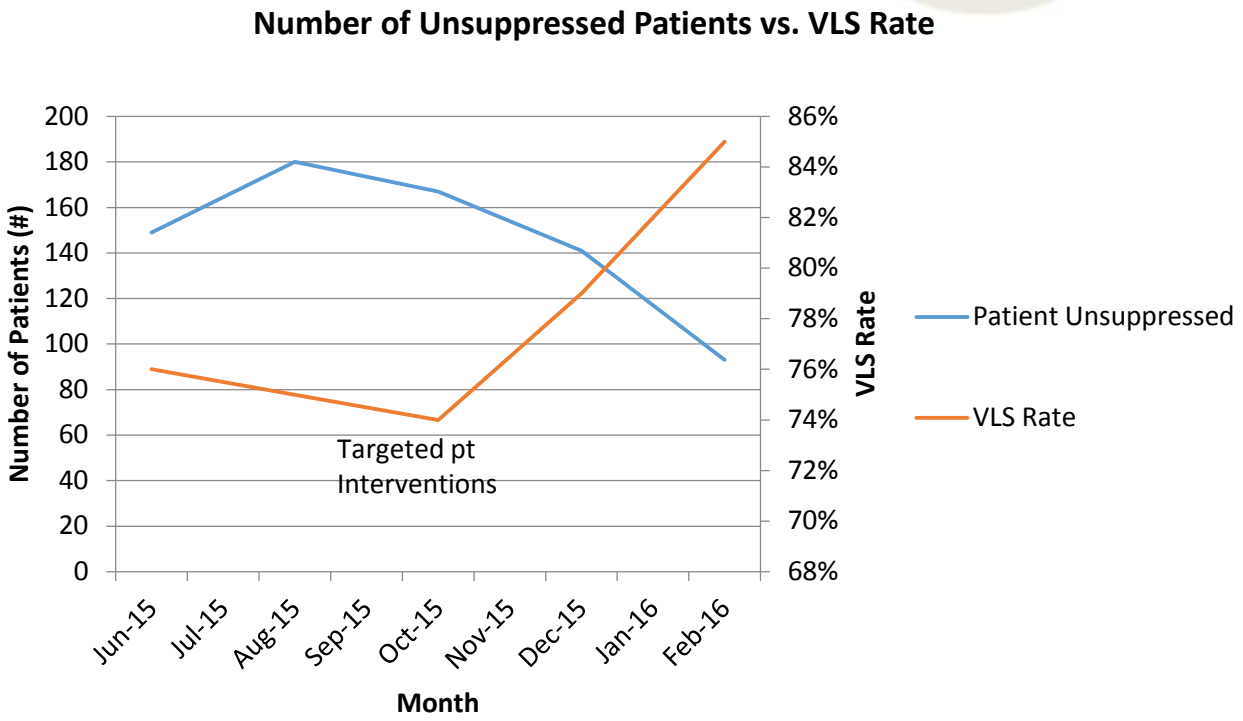
Targeted Interventions – Improving Care Coordination

Out of Care – continue partnership w DSWs and DIS
Non-Adherent to Treatment Regimen – team approach to discuss concerns w patients
VL Decreasing – monitor patients; check in
Mental Health – partner with client's caregiver to support importance of medication adherence, distribute pill bottle alarm as a medication reminder

Improving Viral Load Suppression June 2016 – Care Coordination

Targeted Interventions

- teach-back tool,
- daily patient huddle (multi-disciplinary approach),
- re-engage out of care patients,
- new LCSW in February 2016 to address behavioral health issues impacting adherence and retention.
- July 2016 to provide intense medical case management (MCM) to address barriers of non suppressed pts..

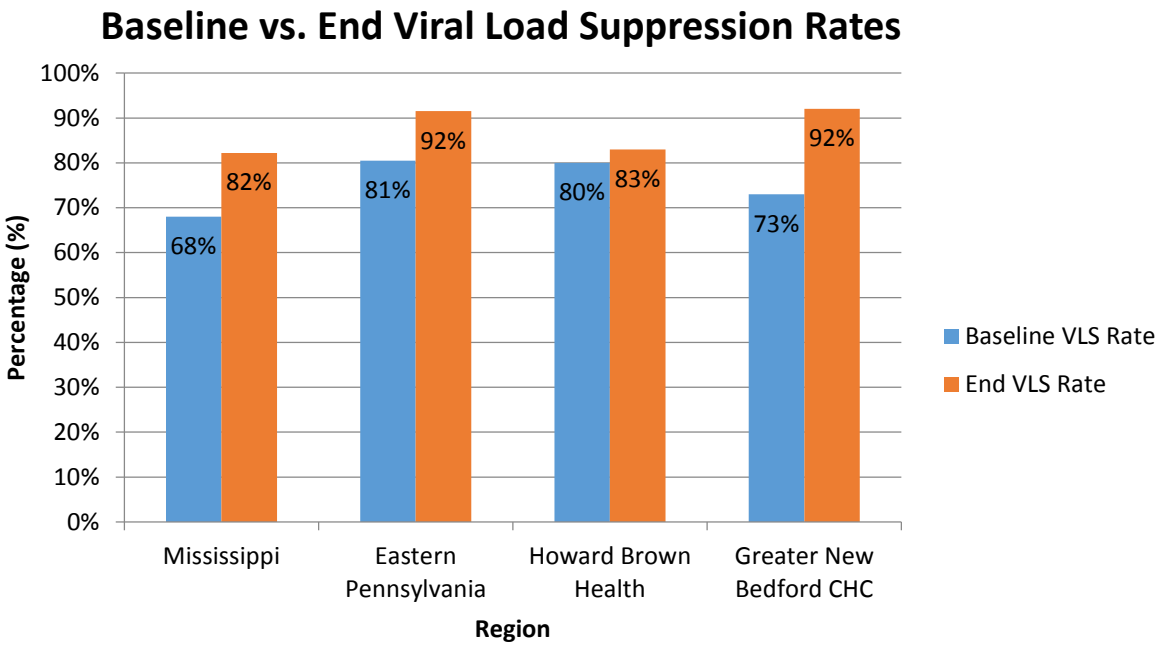


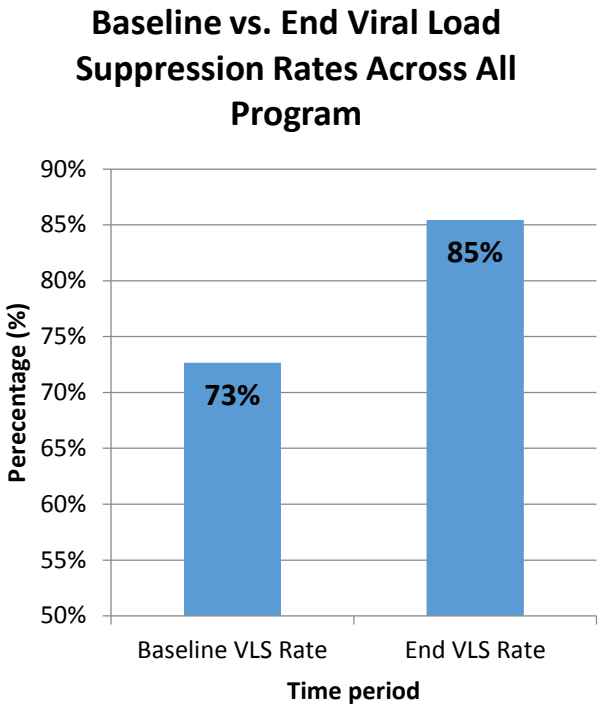
What does it take to sustain improved patient outcomes?

Use of drilled down patient level data to improve management of:

- care coordination
- medical case management

Results of Improving Care Coordination:10 RWPs across Chicago, EPA, MA, and MS





Family First Health Retention QI Project

Measure	Initial (As of 7/1/14)	Goal	Actual (As of 6/30/16)
Medical visit frequency	70.60%	75%	**81.22%**
Viral load suppression	85.44%	maintain	**90.04%**

Drilled down retention by:

- Race
- Ethnicity
- Site (FFH vs sub-contractor)
- By provider
- Age
- Risk factor
- Gender
- Poverty level

Results

- No disparity except **75% out of care were under 100% poverty** - Sub population of Focus

Improving Care Coordination:

Sub population Intervention: ARTAS – tweaked for sub-population

Policy changes: 5-month limit on medication refills; no refills if lab work incomplete

Process changes: quarterly review of Out of Care client list at provider meetings; weekly huddles to discuss all clients scheduled for a visit; use of DOH field staff to locate clients

Expected consequence: increase in VL suppression rates!

Sustaining and Continuous Improvement of VL Suppression

Greater New Bedford Community Health Center, Inc.

May 2013	Nov 2012	Feb 2013	July 2013	Jan 2014	May 2014	Jan 2015	July 2015 44pts	July 2016 24pts
73%	74%	76%	81%	84%	86%	86%	86%	92%

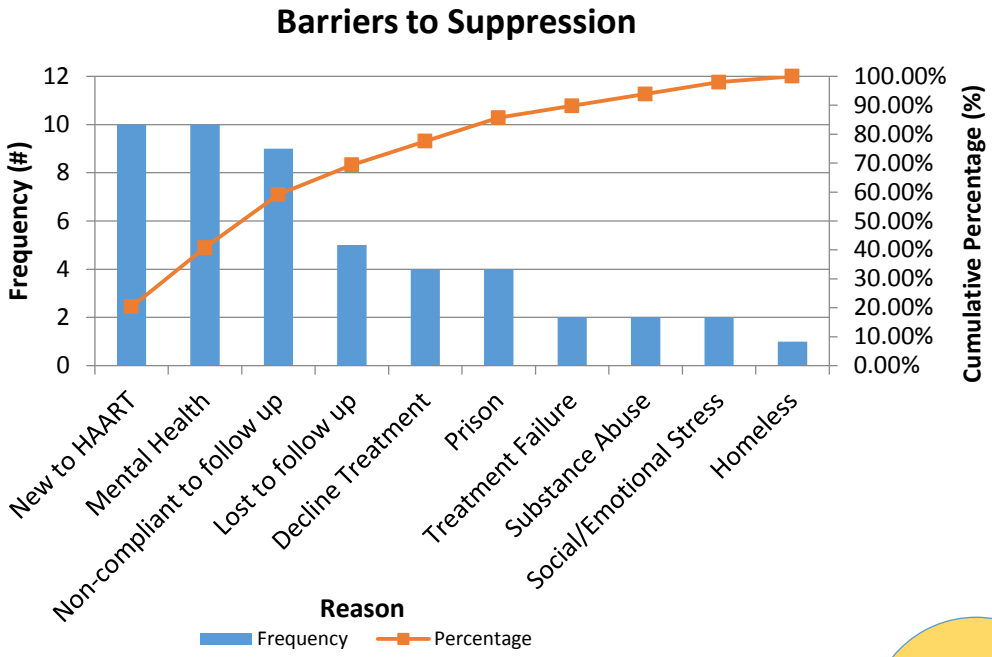
- **Intervention: Care Coordination by Multi Disc Team**

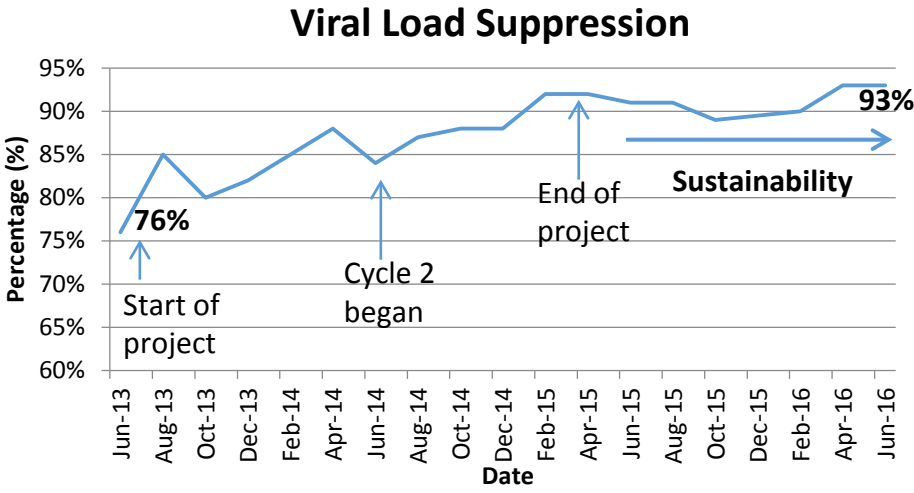
Caseload: 350

- Drilled down data to identify patients <200
- Development of tailored Care Plans
- Assigned specific staff
- Approx 20 pts at a given time for team

- RN: Side Effect Mgt-Pill boxes weekly/monthly
- Peers: face to face or telephone coaching
- Peer Support/Youth Support Groups – emotional support
- SWs: Partner Notification support; MH assessment and referral; SA assessment and referral

AIDS Services Center: Viral Load Suppression QI





Project Review:

1. Created Fishbone & Driver diagrams to identify barriers to viral load suppression
2. **Utilized CAREWare to identify non-suppressed patients (not in numerator)**
3. **Categorized patients by barriers to identify which barriers impact VLS the most**
   - **Pareto diagram to analyze data –*above***
4. Interventions tested with a PDSA for 5 of the largest barriers to VLS

Drilled Down Data

SUSTAINING Improved Care Coordination:

- **Continually drilling down data**
  - Review "not in numerator" list monthly
    - Identify ("drill down") barriers to suppression and utilize project interventions, as needed
  - Involve entire multidisciplinary team in drill-down efforts as part of *program protocol*

Mental Health Barriers and Impact on Delivery of Care

Establish guiding frameworks for patient-centered care & quality improvement

Population health	Cultural competency

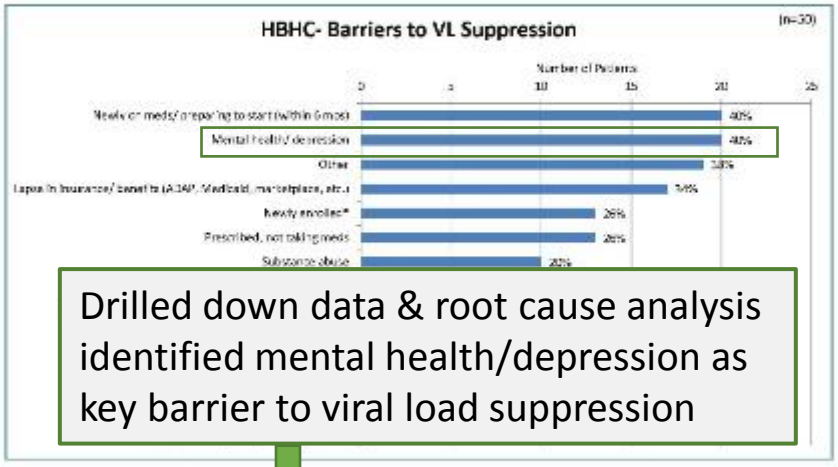
Identify mental health as important barrier to viral load suppression & respond with CQI tools

Root cause analysis	PDSA & direct work w/ staff

Integrate mental health support & options into primary care

Accessible, responsive care	Harm reduction

Site 4: Howard Brown Health Center



Drilled down data & root cause analysis identified mental health/depression as key barrier to viral load suppression

PCMH reporting & care plan workflows

Improved VL suppression & care integration

Howard Brown Health RW CQM

- Root cause analysis – Drilled down data
- PDSA/QI cycles – Process improvement
- User-friendly reporting infrastructure
- PCMH integration – Care planning

Measurement Period	Viral Load Suppression
10/1/2014 – 9/30/2015	80.45%
4/1/2015 – 3/31/2016	83.30%

CHRONIC DISEASE MANAGEMENT

Patients Scheduled On: *05/03/2016*

Doctor	*Patient ID*	*Patient Name*	*Problem*	*Visit Date/Time*

PCMH DAILY CARE MANAGEMENT PLANS

Patients Scheduled On: *01/14/2016*

Site	*Doctor*	*PatientId*	*Legal Name*	*Needs Care Plan*						*Visit Date/Time*
				Last Viral Load	*Depression Dx*	*Sliding Scale*	*Diabetes Dx*	*HbA1c %-Obsvalue*	*Nbr Total NoShow*	

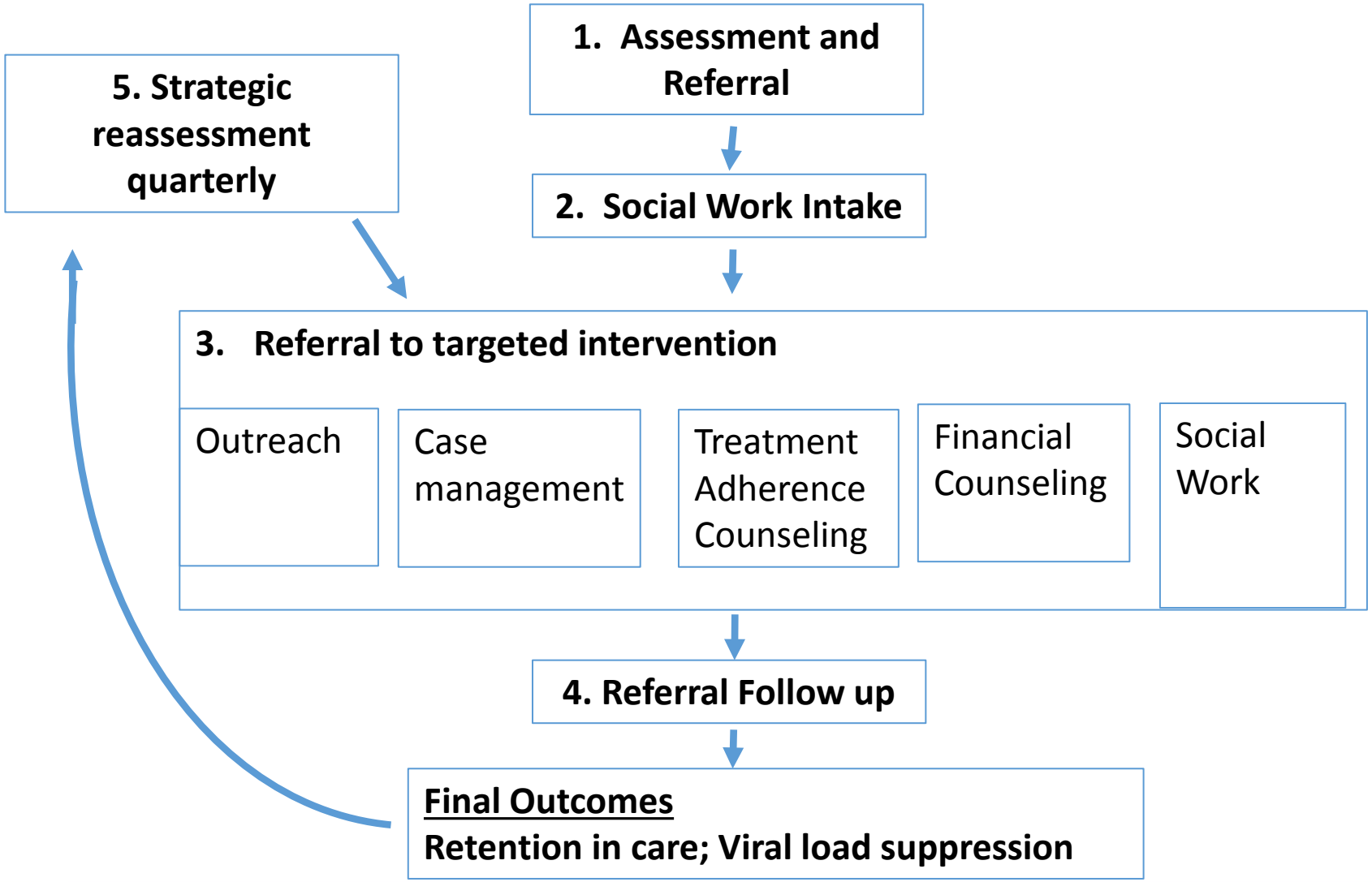
Howard Brown Health

REACCH: Improved MCM Sustaining Interventions and Outcomes

above 90% VL suppression

Outreach	Case Management	Treatment Adherence Counseling	Financial Counseling	Social Work
• Lost to Care • No phone • No phone response • Missed appointments • Not virally suppressed	• Intensive support for accessing services • Paperwork help • Needs EFA • Needs housing assistance	• Comes regularly • Needs mental health services • Not virally suppressed	• ADAP/ • Insurance lapses • Not compliant due to financial issues • Needs ongoing financial support	• Has immediate need • Needs mental health referral • No need for case management

REACCH Referral Process Map



Concluding Remarks

- Important not to lose bigger picture of ending the epidemic
- More in-depth understanding of our patients
- Expand experience in QI and therefore buy-in
  - Data and interventions are integrated into morning huddles
  - Data and results are shared at consumer meetings
- A lot of work, but rewarding to team and patients
- Increasingly allows more time for patients not suppressed
- Continuous process and analysis of data
  - Ex. results in hiring bi-lingual peer
- Tweaked ARTAS (evidence-based) to meet needs of sub population

Large Group Discussion – Q&A

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QI Project Example: Mental Health & Viral Load Suppression

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A member of the Greenwood Leflore Hospital Clinic Network

The Convenience of a Clinic, the Resources of a Hospital

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National Quality Center

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