2016 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Putting Care Before Competition:

SC Works Together for NHAS Success

Roshan McDaniel, ADAP Program Manager

Birddie Felkel, RW Quality Management Coordinator

Christal Davis, Program Solutions and Innovation, RW/ADAP/HOPWA

The SC HIV Program Overview

Factors of Need

Population	2012	2013	2014	2015
People Living with HIV or AIDS (PLWH)	15,305	15,695	16,222	***
Served by Ryan White Part B (Care)	53%	54%	54%	***
PLWHA Out of Care [1]	36%	37%	34%	***
Uninsured in ADAP	76%	75%	74%	65%
Unemployment (General Population)[2]	9.2%	7.6%	6.4%	6.0%

1. PLWHA Out of Care is based on absence of HIV tests at intervals within the calendar year.
2. Based on data published by the US Bureau of Labor Statistics.

SC AIDS Drug Assistance Program (SC ADAP)

Program Growth in Served by ADAP

SC ADAP Population (Served)	2012	2013	2014	2015
Direct Dispensing (DDP) – Uninsured	3,616	3,983	4,132	3,656
Insurance Assistance (IAP) – Private Insurance	1,185	1,304	1,848	2,251
Medicare Part D Assistance (MAP)	245	299	320	350
Total SC ADAP – Service Tiers	4,754	5,301	5,554	5,580
ADAP served with income less than 138% of the Federal Poverty Level (FPL)	61.4%	62.8%	61.8%	58.0%

1. The SC state Medicaid program is not participating in Medicaid expansion.
2. RW clients with income less than 138% of FPL continue to be served by the RW and ADAP programs.

Show Me the Money

The SC Ryan White Part B program serves as the financial anchor for the entire SC HIV/AIDS Care System.

Build It and They Will Come

This is the story of how SC combined its fiscal resources to address statewide NHAS continuum weaknesses in the service system.

ADAPting for Treatment Success

SC ADAPts to hear the Voice of the Consumer to provide life-long adherence strategies.

Proof is in the Previsit

SC adopts Pre-visit Planning, a core component of the Medical Home model.

The Continuum of *One*:

1. PLWHA have individualized:
   - Support systems
   - Life stories
   - Likes and dislikes
   - Reasons for seeking and engaging care
   - Care preferences and needs

2. Lifelong events can alter the individual walk along the continuum

3. The HIV Care System must develop and maintain systems to:
   - Hear, listen and rapidly respond-to the Individual
   - Provide statewide coordinated, culturally-relevant solutions.

NATIONAL
2016 RYAN WHITE
CONFERENCE ON HIV CARE & TREATMENT

Show Me the Money

Objective 1:
Show Me the Money

Learn replicable strategies from the SC RW Part B Program to:

1. "Vigorously pursue" Affordable Care Act (ACA) enrollment and leverage 340B cost-savings to fill unmet need gaps statewide – across Ryan White (RW) funding-parts.
2. Implement 340B spending compliance to ensure sustainable resources for National HIV/AIDS Strategy (NHAS) initiatives and service expansion identified through Statewide Coordinated Statement of Need (SCSN) and Integrated Planning.
3. Expand provider capacity through technology enhancements awarded from ADAP.

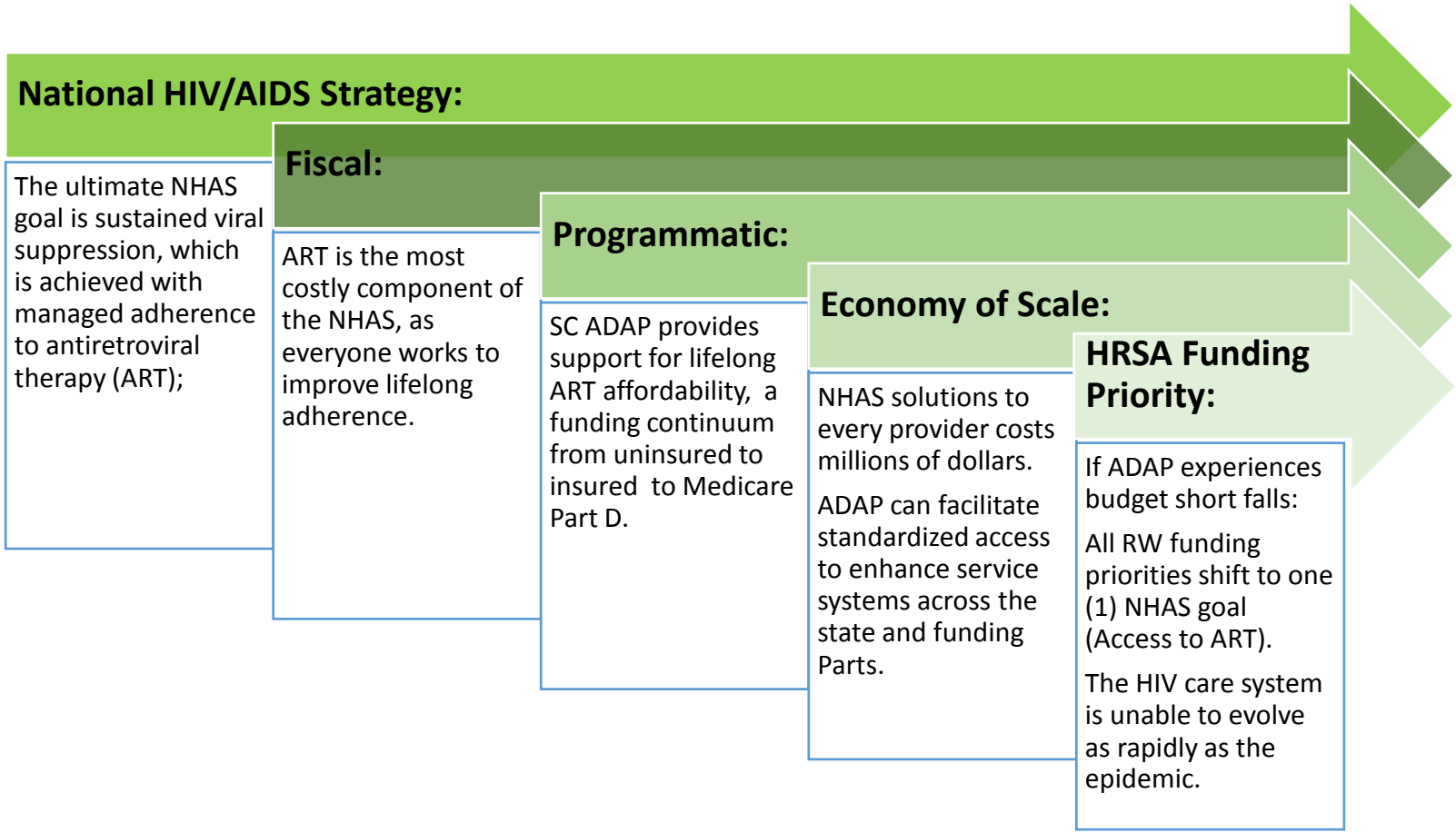
HRSA Expects Ryan White (RW) Part B Programs to:

1. Identify cost-saving strategies, additional funding opportunities, and duplication of service;
2. Use existing data to identify HIV Continuum weaknesses and determine funding needs for improvement;

Show Me the Money

3. Apply innovation by combining proven strategies to rapidly implement statewide solutions;
4. Leverage funds derived from ACA-related cost-savings for statewide structure to support the goals of the NHAS.

Why Begin with ADAP



SC ADAP in 2014

Fiscal Reality Snapshot

Table 1.0: Aggregate Level of Need (All Service Tiers)

Calendar Year	Total PLWHA in SC	% Served by SC ADAP
2012	15,351	31% (4,278)
2013	15,695	34% (5,031)

Source: SC HIV/AIDS Epidemiology Profile 2014.

Table 2.0: Funding awarded to SC ADAP FY2013-14

Award Source (Rounded)	Award Amount
RW Part B (ADAP)	$12,000,000
RW Part B Supplemental	$1,000,000
State of SC	$5,400,000
Total	$18,400,000

RW Part B ADAP Base award is $12,700,000 for GY: 2016-17.

Table 3.0: Program Growth from 2008 to 2013:

Statistic Reported	Rate of Increase	% Increase
Enrolled June (Whole ADAP)	1.53	153%
Served June (Whole ADAP)	1.64	164%
Annual Expenditures	2.37	237%

Increase in expenditures reflects program growth, as drug costs/capita decreased.

Table 4.0: Current SC ADAP Expenditures (in $millions)

Monthly Expenditures	Expenditures/ Month	Expenditures/ Year
Drugs uninsured (not including dispensing costs)	$2.4	$28.8 million
All other SC ADAP Costs	$0.6	$7.2 million
Total	$3.0/month	$36 million/year

Balance of funds needed is generated from 340B rebates.

SC Must Collaborate for the Greater Good

Solution	Constraint	Philosophy
1. Expand Affordable Care Act implementation	340B Competition	Re-think 340B
2. Use 340B cost-savings to support the service for all PLWHA in SC	Funding needs for each regional RW program	Caring equals 340B Sharing
3. De-duplicate of service and effort	Variations in service models statewide	Establish consistency with activities of existing planning bodies
4. Health Information Exchange (HIE)	Variations in systems	Reduces missed opportunities

Re-think 340B Benefits:

<u>Opportunity</u>:

Thinking of 340B as Cost-savings

- Cost-savings are:
  - Typically derived from membership or partnership.
  - Usually based on:
    - Volume;
    - Negotiations;
    - Performance;
    - Timeliness;
    - Product/service bundle
  - Beneficial for all stakeholders.

<u>Constraint:</u>

Thinking of 340B as Revenue or Income

- Revenues are:
  - Typically derived from profits, taxes, or fines.
  - Business-driven targets rather than Public Health goals.
- Income is:
  - Typically derived from personal earnings and kept private.
  - Individual-driven thinking rather than community planning.

340B Caring is Sharing

SC ADAP Enrolls:	Providers Enroll:
ADAP client remains in ADAP as client becomes insured	Clients with Medicaid (unless wrap-around assistance is needed)
ADAP Formulary is a limited formulary (ADAP will claim rebate)	Clients with Medicare FLIS (Full Low-income Subsidy)
ADAP-direct pharmacy coordination to facilitate single pharmacy model for non-ADAP formulary medications	Clients who do not utilize ADAP services

SC ADAP Involves All Stakeholders in Solutions

Healthcare Systems/Funders

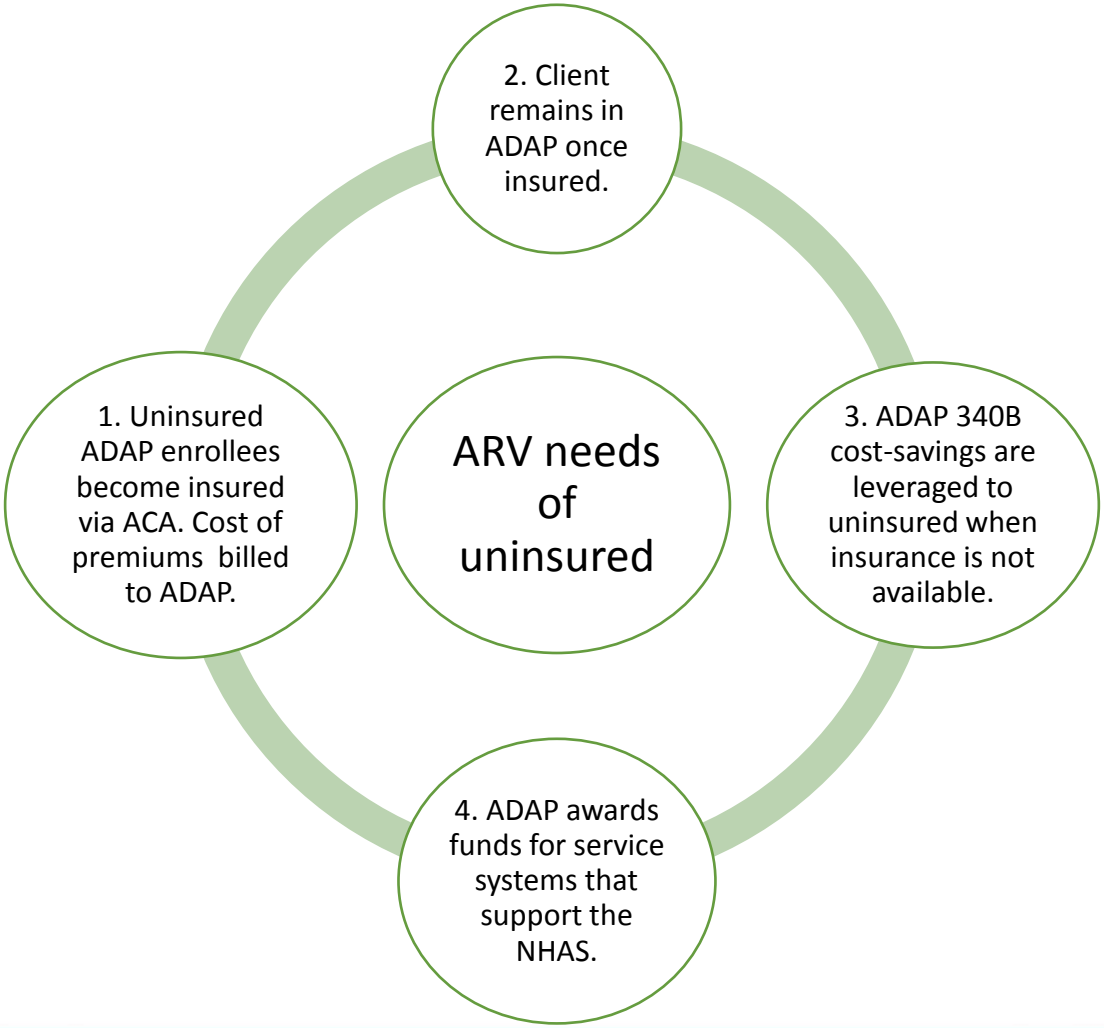
- CDC Prevention
- Surveillance
- RW Part B and HOPWA
- SC ADAP
- Private Insurers
- CMS – Medicare/Medicaid
- Pharmaceutical Rebates
- State Funds

Direct Service Providers

- RW Providers
- Clinical
- Medical Case Management
- Specialized non-medical
- Pharmacy service providers
- Federally Qualified Health Centers
- Housing
- Providers participating in planning bodies

Innovation: SC ADAP ACA Cost-efficient Strategy:

Introduced by SC ADAP in October 2014



REUSE
REDUCE
RECYCLE

Implementation:
SC ADAP Cost-efficiency Strategy Steps

1. Provider receives list of DDP enrollees (uninsured).

2. ADAP created a simplified service tier switch for continuous access to ADAP until insurance is confirmed.

3. ADAP modernized its rebate and service forecasting methodology to budget for all in need.

4. Funds awarded to providers create new or improved coordinated statewide services and interventions.

Setting ACA Switch Targets based on Uninsured Need

The SC ADAP targeted goal for "switch" from insured to uninsured: 1,111

- ($900 monthly per capita) x (1,111) = $1,000,000/month in savings ($12 million/year)
- Weighted goal for each agency is determined by the level of uninsured enrollment in SC ADAP

Agency	Target to Switch to Insured Tier with ACA plan	Monthly goal during Open Enrollment 2014-15
Agency A (Part B)	198	66
Agency B (Part B & D)	119	40
Agency C (Part B)	99	33
Agency D (Part B & C)	99	33
Agency E (Part C)	74	25
Total	589 (53% of Statewide Target)	

The chart above shows the impact of five (5) clinics achieving the targeted goal (real data). The SC ADAP serves enrollees from more than 20 RW service providers.

As we were working to meet our targets:

Let the Data

Suggest the Solutions

1. This is the story of how SC combined its fiscal resources to address statewide NHAS continuum weaknesses in the service system.

2. Use data to identify gaps and determine funding needed

3. ***Per RSR CY2014 – All RW Parts****
   - Viral Suppression
     - SC = 81.7%
     - *Nation = 81.5%*
   - Retention in Care
     - SC = 87.1%
     - *Nation = 80.1%*

*http://hab.hrsa.gov/data/servicesdelivered/2014RWHAPDataReport.pdf

National HIV/AIDS (NHAS) Strategy Indicators by 2020	South Carolina HIV Care Continuum Data CY 2014
Reduce the number of new HIV diagnoses by at least 25 percent.	773 New Infections in 2014[1]
Increase the percentage of people living with HIV who know their serostatus to at least 90 percent.	79.66%[2]
Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent.	75%[3]
Increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent.	54%[4]
Reduce the percentage of persons in HIV medical care who are homeless to no more than 5 percent.	Data not available outside of Ryan White/HOPWA reports[5]
Increase the percentage of persons with diagnosed HIV — infection who are virally suppressed to at least 80 percent.	53%[6]

1. Data Source: South Carolina Department of Health and Environmental Control.
2. Data Source: South Carolina – 2014 HIV Care Continuum. CDC estimates about 19,200 people in South Carolina are living with HIV, including about 3,200 people who are undiagnosed. (15,296/19,200 = 79.66%) Percentage calculations for PLWHA who are unaware of their HIV status may vary depending on the methodology used.
3. Data Source: South Carolina Department of Health and Environmental Control. CDC calculation of Newly Diagnosed for PLWHA in 2014 who were linked to care within 30 days of diagnosis. (577 /773 = 75%)
4. Data Source: South Carolina – 2014 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had ≥2 CD4 or viral load test results at least 3 months apart during 2014.
5. Data not available for all persons diagnosed with HIV SC.
6. Data Source: South Carolina – 2014 HIV Care Continuum. Percentage of persons with Diagnosed HIV, who had a Viral Load <=200 copies/mL at most recent test during 2014.

Common Ground:

All RW Programs Have Similar Issues

The Facts: What is Known

- SC has nearly 6,300 PLWH who know their status and are out of care.
- No RW providers in the state have a waiting list for services.
- Our service buffet has expanded and improved in recent years.
- No RW Provider has perfect appointment and ARV adherence.
- Big issues require big solutions.
- RW providers are limited to 75/25 service priorities.
- Health Information Exchange can eliminate duplication of service and effort.

The Facts: What is Unknown

- Client-centered reasons why or where PLWH fall out of care.
- If PLWH out of care with a provider are actually in care with another provider.
- How to fund Peer and Outreach at an adequate level and meet 75/25 service priority requirements.
- How to reverse competition for the greater good.
- How to seam numerous national and state quality initiatives across data systems.

HRSA Compliance Creates Fluidity

Spending compliance improves budgeting systems:

- Improved projection of ADAP costs for growth, coordination of benefits, cost fluctuations, and levels of utilization;
- Enhanced forecasting models for 340B rebates from eligible insurance services;
- Modified cash management to spend rebates in the year received before requesting federal funding;
- Opportunity for Unobligated Balance (UOB) to be returned without penalty for SCSN service expansion and innovation.

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Build It and They Will Come

Objective 2:
Build It and They Will Come

Learn replicable techniques used in SC to develop statewide initiatives that support NHAS improvement including the following statewide:

1. Outreach Program expansion to locate PLWH who are out of care;
2. Specialized Medical Case Management Program to re-engage as PLWH return to care;
3. Peer Adherence Program for life-long viral suppression outcomes.

Learn supportive options for NHAS success including:

1. Funding to providers (all RW-Parts) from SC ADAP;
2. Dedicated Program Coordinators for each initiative;
3. Built-in Public Health Outreach Workforce;
4. Customized data collection and reporting for each intervention, aligned with HAB Performance Measures, the In+Care Campaign and Data to Care.

HRSA Expects
Ryan White Part B Programs to:

1. Use existing all-PLWHA data to determine HIV continuum weaknesses;
2. Identify continuum weaknesses at the provider level;

Build It and They Will Come

3. Work with stakeholder to determine solutions and funding needs;
4. Offer all-Parts funding to support NHAS Success.

SC Care Continuum Reveals:
Workforce Expansion and Synergy Are Needed

Continuum Weakness	Solution for Expansion and Coordination
PLWH who know their status are out of Care	Outreach Services
Sustainable re-linkage programs that customize services as PLWH re-engage care and treatment	Specialized Medical Case Management
Consumer involvement in linkage and lifelong adherence	Peer Adherence Services
Funding for providers to serve more while improving service experience	Special Projects – Capacity-building and Technology

SC RW Interactive Outreach Program:
Outreach Intervention

Together We Will!

Data Shows Clients Out of Care:
Outreach Program Expansion and Support

Providers ask for:

- Expanded workforce to go out and locate clients
- Workload management system to reach all clients needing Outreach
- Program Coordination to expand provider-to-provider support
- Data management technical assistance to assemble information and identify and confirm PLWH who need outreach
- Integrated outreach efforts to Jail and Prison
- Improved integrity of retention and gaps in care reporting
- De-duplication of service and effort via Data to Care

1. ***Data***: All RW providers have clients who are at risk of falling out of care.
2. ***Committee***: Expansion and improvement of Outreach efforts are needed for every RW program in SC.
3. ***Compliance***: Outreach programs are difficult to expand and stay within the 75/**25%** constraint at the RW program level.

ADAP Offers $70,000 to All-parts Providers: Outreach Program

Funding and Support

- $ 70,000 for Outreach Specialist to each provider for Outreach workforce
- RW Program Coordinator with Disease Intervention Specialist (DIS) and Expanded Testing Program Coordination experience
- Regional Service Coordinator Workforce to ensure outreach to all PLWH
- Cost = $1.5 million per year for 19-21 RW Outreach Specialists; funds are allocated for 3-year funding cycle

ADAP Offers Synergy

Synergy and Coordination

- Cohort report for Presumed Out of Care and Outreach documentation module
- Match Presumed Out of Care to statewide lab data to ensure Outreach is not looking for someone in care elsewhere
- Outreach expansion integrated with state and national performance measurement framework i.e. Visit Frequency and Gaps in Care
- Focus existing Minority AIDS Initiative (MAI) outreach to jail and prison
- Promotes seamlessness using no recertification, pregnancy, and high viral load as urgency-level markers for coordinated outreach

Other Coordination:
Data to Care (D2C) to Confirm Who Needs Outreach

Data to Care in SC

The CDC offers systems to use surveillance data to assist with identifying who is out of care:

- SC providers will submit Presumed Out of Care based on information available to the provider
- Surveillance program will confirm if out of care based on all-labs scope of reporting per state law
- RW Part B program will provide data management support to simplify the exchange process

Ease is Key

SC Data to Care model features ease of participation by:

- Integrating In+Care Campaign reporting mechanisms that existing in all RW systems
- Allowing all Core Medical Service providers to participate
- Keeping providers involved throughout the D2C process
- Allowing clients in care elsewhere to reflect in In+Care Campaign results to improve reporting integrity

Other Coordination:
Returning to Care (RTC) Assessment

RTC Assessment: HPC Integration

The SC HIV Planning Council (HPC) – Needs Assessment Committee developed a RTC Assessment to achieve the following:

- Determine why/where PLWHA fall out of care
- Customize the client's service model to off-set these reason
- Review statewide data on reasons out of care to create system-level solutions

RTC Assessment: Practical Use

As Outreach locates clients, use the RTC Assessment to:

- Discuss the impact of stigma; prior service use, life events, and service experience
- Guide the re-engagement process based on individualized client priorities
- Provide an individualized service roadmap and identify service enhancements to support retention

Components of SC RW Interactive Outreach Program

Outreach Workforce Committee participants include:

- HIV Outreach Specialists – regardless of funding source
- MAI Prison Discharge Planning
- CDC Perinatal Case Managers
- RW Part B and ADAP Staff
- HIV Planning Council members including consumers
- Directors of Client Services

Re-engagement success is long-term - not short lived:

- Client Returns to Medical Care
- Client and Outreach complete the RTC Assessment
- Client enrolls in SMCM to ensure customized service solutions

Specialized Medical Case Management (SMCM) Intervention:
Enhanced Support for Returning to Care

Together We Will!

Experience Says:
Clients Returning to Care Need Enhanced Support

Providers ask for:

- MCM Workforce expansion and customization
- Strengths-based intervention
- Understanding why/where client fell or is falling out of care
- Enhanced Care Plan and specialized training
- Help with Outreach volume and other SMCM needs
- Monitoring of on-ongoing retention
- Dedicated Program Coordinator

ADAP Offers $70,000 to All-parts Providers: Specialized MCM Program

Funding and Support

- $ 70,000 for SMCM to each all-parts provider for SMCM workforce
- Dedicated Program Coordinator with Housing, RW Part B and Social Work experience
- Partner to Outreach
- Cost = $1.5 million per year for 19-21 RW SMCM; funds allocated for 3-year funding cycle

ADAP Offers Synergy

Synergy and Coordination

- Designed for seamless transition to traditional MCM
- Integrated MCM training content
  - Motivational Interviewing, Health Literacy, Trauma Informed Care, etc.
- Understands client life experience to create a customized re-engagement care plan
- Allows client to set Care Plan priorities, extending beyond Medical Care
- Uses documentation systems and existing reporting platforms that are available for adoption

SC RW Peer Adherence Program

ADAPted for Treatment Success

Evidence Shows:
Peers support adherence for life-long success

Consumers ask for:

- Expanded Peer Workforce
- Structured Peer Adherence intervention
- Built-in Peer support for New clients
- Improved adherence support from ADAP
- On-going Peer employment training and support
- More diversity in Peer representation
- Integrated, meaningful consumer inclusion on service systems
- Available adherence tools
- Individualized inter-disciplinary solutions
- Balanced Peer Workload
- Tangible inventory of service accessibility
- Published service resource guide

ADAP Offers $70,000 to All-parts Providers:
Peer Adherence Program

Funding and Support

- $ 70,000 for each all-parts provider for Peer Adherence Coach (PAC) Workforce
- Dedicated Program Coordinator with MCM, ADAP and Counseling experience
- PAC works with new clients and those with adherence – including ADAP
- Cost = $1.5 million per year for 19-21 RW Peer Coaches; funds allocated for 3-year funding cycle

ADAP Offers Synergy

Synergy and Coordination

- Integrated Newly Diagnosed assessment collection and reporting to HPC
- Designed for lifelong support that focuses on the Voice of the Consumer
- Integrated with In+Care Campaign and HAB Performance Measures for providers and ADAP
- Allows Peers to leverage experience being HIV positive
- Provides an inter-disciplinary ADAP adherence intervention
- Uses documentation systems and existing reporting platforms that are available for adoption

SC RW Peer Continuum

Graduation

As consumers graduate from Medical Case Management, they have achieved:

1. Sustained viral suppressed
2. Readiness to self-manage care with minimal support and assistance
3. Eagerness to offer their experience to help others.

Peer Institute

As consumers and providers seek to partner for solutions they need:

1. On-going Peer employment training
2. Consumer-centered information-sharing
3. Peer service resources and consumer engagement

Peer Adherence Coaches

As consumers need lifelong adherence, Peers support the entire continuum:

1. Linkage – Do It Right the First Time
2. Retention – Enhance health literacy
3. ART – Explain importance
4. Viral Suppression – Use technicques for success

Capacity Enhancements

ADAP Special Projects

ADAP Offers $2.4 Million to All-parts Providers: Capacity Enhancements

Technology/Information Systems:

- Funding for Health Information Exchange (HIE) interface
- Funding for Electronic Lab Interface
- Funding for Data Security enhancements
- Funding for client Needs Assessment survey systems

Capacity-building Funding:

- MCM Technical Assistance (TA) for ACA and other training needs
- Provider to Provider technical assistance
- Laboratory testing funds for new and returning to care
- Funding for Benefits Enrollment supportive personnel

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

ADAPting for Treatment Success

Objective 3:
ADAPting for Treatment Success

Participants will learn replicable strategies from the SC ADAP:

1. To expand accessibility of ADAP services
2. To customize service options for PLWH with enhanced care needs
3. To coordinate client-centered solutions among ADAP, pharmacies, clinics, and medical case managers using Health Information Exchange.

ADAPs – Most of All Must:

1. Engage meaningful consumer engagement

2. Seek barriers and solutions via ADAP policy

ADAPting for Treatment Success

3. Develop systems to “hear” individualized needs for lifelong adherence

4. Integrate and market its service enhancements via existing planning bodies

ADAP Relies on Consumer Engagement: Every day for life

Voice of the Consumer is critical for ADAP in particular since:

- Adherence is a daily task
- There is potential for drug and drug class resistance
- Missed refills are a conversation – not a conclusion
- Multi-drug therapies offer convenience with a high need for adherence
- Lifelong adherence management is humanistic
- Adherence requires self-acceptance of the disease
- Overcoming adherence barriers often require social support
- Consumers must understand insurance coverage options
- Consumers must understand ADAP polices to activate program flexibility

SC ADAP Expands Service Flexibility:

By Location

Enrollees who are:

- Informed of HIV status while in jail
- Transferred to Jail out of state
- Receiving Substance Abuse Treatment Out of State
- Working in seasonal or traveling industries
- Attending college in-state but are residents of another state
- Discharged from prison or hospital

By Enhanced Care Need

Enrollees who are or have:

- Pregnant
- Youth transitioning to adult programs
- Limited English proficiency
- Hearing or visually impaired
- Limited literacy
- Fear of HIV disclosure from participating in care and treatment

SC ADAP Improves Ability to "Hear"

The Voice of the Consumer is heard through:

- All RW Part B providers must provide clients with telephone number to report issues/concerns to RW Part B program management staff
- All SC ADAP Enrollees have access to ADAP Patient Advocate for enhanced assistance
- All Eligibility-verification staff are cross-trained to optimal support at application, recertification and point-of-service
- Annual training for ADAP staff to understand urgency of response due to viral resistance and re-infection
- ADAP staff co-train with Part B for MCM to understand the challenges enrollee and case manager in ADAP coordination

ADAP Must Be Cutting Edge

- Viral Load requirement at recertification
- Inappropriate Regimen monitoring
- Pregnancy clinical review
- New providers are introduced to AIDS Education Training Center (AETC)
- HepDAP will launch in GY2016-17 for clinical monitoring and expansion of ADAP formulary for Hepatitis
- RW Part B and Hepatitis Integration Program
- RW Part and health department Smoking Cessation Integration program

ADAP Patient Advocate:
Scale-up Meaningful Consumer Engagement

- Improve access to ADAP for enrollees with specialized needs and circumstances
- Troubleshoot enrollee, provider and grievance issues/concerns/complaints
- Work closely with the consumers and provide a more expansive consumer voice to improve ADAP services
- Review ADAP policies for cultural awareness and inclusiveness
- Review ADAP correspondence to enrollees to enhance program participation
- Identify, maintain and publish county level resource guide of services identified as important to consumers (RW and non-RW)
- Ensure meaningful consumer inclusion in the planning and evaluation
- Ensure successful Peer Adherence program outcomes

Proof is in the Pre-visit

Objective 4:
Proof is in the Pre-visit

Learn replicable processes to:

1. Synergize performance measurement across the Ryan White Services Report (RSR), HAB Performance Measures , In+Care Campaign, and ADAP.

2. Establish a single set of statewide measures and targets that can be evaluated and reported to HRSA

3. Facilitate an all-parts standardized system of Health Information Exchange (HIE) to avoid missed opportunities

HRSA Expects
Ryan White Part B Programs to:

1. Identify and use replicable assets and datasets;

2. Think collectively across disciplines, RW-parts, and quality initiatives;

Proof is in the Pre-visit

3. Adopt a single, statewide Continuous Quality Improvement (CQI) initiative;

4. Bring it to life with Health Information Exchange (HIE).

Replicable Assets – Across RW Providers

Identify and use replicable assets and data sets

Asset	Required of	Built-Datasets or Features
RSR Client Level data	All RW Providers	Visits, MCM, Specialized Needs
ADAP Client Level data	All ADAPs	Information from applications, enrollment status, recertification frequency, refill history
RSR-ready systems	All RW Providers	In+Care Campaign Measures; HAB Performance Measures
Certified Electronic Health Record (EHR)	All Medical Providers/Clinics	Import/export batch files; e-Scribing;

SC Participation by Data System

Provider Type	System Used	Number of Participants
RW Part B	*Provide Enterprise* and EHR	13 of 13
RW Part C	*Careware* and EHR	6 of 11
RW Part C	*Provide Enterprise* and EHR	5 of 11
RW Part D	*Provide Enterprise* and EHR	2 of 3
RW Part D	*Careware* and EHR	1 of 3
RW Part A	*Provide Enterprise* and EHR	1 of 1
HOPWA Providers including 5 city/county-direct	*Provide Enterprise*	11 of 11
SC ADAP	*Provide Enterprise*	8 of 11 Part C 13 of 13 Part B 1 of 1 Part A 2 of 3 Part D

The RW Part B Program operates a highly customized Provide Enterprise (PE) system since 1996. The providers listed for SC ADAP submit applications and recertifications to ADAP using PE.

SC Quality Management (SC QM) Steering Committee

Membership includes representatives from:

- RW Part A-F, including ADAP.
- Representation also includes: STD/HIV Prevention and Surveillance program staff, Office of Pharmacy and consumer.

The SC QM Steering Committee utilizes a collaborative and multidisciplinary approach to:

- Select priority quality performance measures for SC RW providers.
- Establish goals and targets for selected performance measures.
- Share best practices among RW providers, in order to replicate optimal outcomes.
- Adopt universal quality campaigns and facilitate synergy across parts, initiatives and system platforms.

Collective Thinking Process:
At-a-Glance

SC QM Steering Committee
Technical Assistance Session: Part I, Part II, Part III

- Synchronized measures with In +Care Campaign, HAB and other quality initiatives to establish new 2015 South Carolina Quality Management (SC QM) Performance Measures and set targets for 2015 performance measures
- Discussed and identified quality tools needed to drive improvement
- Expanded the Viral Hepatitis Integration Plan
- Released SC QM Data Collection Tool Template
- Discussed Medical Home Model emphasizing:
  - Pre-visit planning and
  - Interdisciplinary coordination
- Established implementation plan for utilization of Pre-visit Planning

About the 2015 SC QM Performance Measures

- Selected key measures from HAB Performance Measures
- Grouped as Core, Optional and ADAP
- Identified additional exceptions based on treatment guidelines and provider recommendations
- Included in the RW Part B QM Plan
- Reviewed twice per year for treatment and practice updates

Collective Thinking Results:

SC QM Performance Measures – Core Group 1

#	HIV Care Continuum	Measure Brief Description (* Indicates new performance measure)	Target %	Source	Status
1.0	Linkage	Late HIV diagnosis*	30%	HAB measure only; RSR	No change
2.0	Antiretroviral Therapy (ART)	Prescribed ART	95%	HAB measure only; RSR	No change
3.0	Retention	PCP Prophylaxis	95%	HAB measure; RSR	Modified
4.0	Retention	TB Screening	65%	HAB measure; RSR	Modified
5.0	Retention	Syphilis Screening	90% ongoing 95% new	HAB measure; RSR	Modified
6.0	Retention	STI Screening	80% ongoing 95% new	HAB measure	Modified
7.0	Retention	Hep C Screening	95%	HAB measure only; RSR	No change
8.0	Retention	Hep C Screening-High Risk*	50%	SC QM developed measure	Modified
9.0	Retention	Hep B Vaccination	50%	HAB measure; RSR	Modified

Link: http://www.scdhec.gov/Health/docs/stdhiv/2015%20SC%20QM%20Performance%20Measures.%20Core.%20ADAP.%20Optional..pdf

Collective Thinking Results:

SC QM Performance Measures – Core Group 2

#	HIV Care Continuum	Measure Brief Description (* Indicates new performance measure)	Target %	Source	Status
10.0	Retention	Oral exam	75%	HAB measure; RSR	Modified
11.0	Retention	MCM-Care Plan*	85%	HAB measure only	No Change
12.0A	Retention	Medical Visit Frequency	75%	In Care Campaign Measure; RSR	Modified
12.0B	Retention	MCM-Medical Visit Frequency*	80%	HAB measure; RSR	Modified
13.0A	Retention	Gap-No Medical Visit*	25%	In Care Campaign measure; RSR	Modified
13.0B	Retention	Gap-MCM No Medical Visit*	20%	HAB measure; RSR	Modified
14.0A	Viral Suppression	Viral Suppression	85%	In Care Campaign measure; RSR	Modified
14.0B	Viral Suppression	Sustained Viral Suppression*	60%	SC QM developed Sustained Viral Suppression	Modified
15.0	(ART)	Pregnancy-ART	100%	HAB measure; RSR	No Change

Link: http://www.scdhec.gov/Health/docs/stdhiv/2015%20SC%20QM%20Performance%20Measures.%20Core.%20ADAP.%20Optional..pdf

#	HIV Care Continuum	SC QM Performance Measures – ADAP Group Measure Brief Description (* Indicates new performance measure)	Target %	Status
A-1.0	Antiretroviral Therapy (ART)	ADAP-Application Determination: SC ADAP applications approved/denied for new SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete application in the measurement year.	95%	Modified
A-1.0a	Antiretroviral Therapy (ART)	ADAP-Application Determination: SC ADAP applications that were incomplete and returned to provider.*	5%	Modified from A-1.0
A-2.0	Retention	ADAP-Eligibility Recertification: SC ADAP enrollees reviewed for continued SC ADAP eligibility two or more times in the measurement year.	85%	Modified
A-2.0a	Retention	ADAP-Eligibility Recertification: SC ADAP recertification incomplete and returned to provider. *	5%	Modified from A-2.0
A-2.0b	Retention	ADAP-Eligibility Recertification: SC ADAP recertification approved/denied for continued SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete recertification in measurement year.	95%	Modified from A-2.0
A-2.0c	Retention	ADAP-Eligibility Recertification: SC ADAP enrollees who were closed for "no recertification" in measurement year.	15%	Modified from A-2.0
A-3.0	Antiretroviral Therapy (ART)	ADAP-Formulary: New anti-retroviral classes included in SC ADAP formulary within 90 days of the date of inclusion of new anti-retroviral classes in the PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents during measurement year.	100%	No Change
A-4.0	Retention	ADAP Inappropriate Antiretroviral Regimen Components Resolved: Identified inappropriate antiretroviral (ARV) regimen components prescriptions resolved by SC ADAP program during measurement year.	100%	No Change/ Update as new ART approved by FDA

Link: http://www.scdhec.gov/Health/docs/stdhiv/2015%20SC%20QM%20Performance%20Measures.%20Core.%20ADAP.%20Optional..pdf

Campaign for Quality:
Adopt a Single CQI Initiative

In the SC RW Part B program, of time spent on quality:

- 70% is reviewing client information *prior to the visit*
- 30% is reviewing aggregate data *on a monthly basis*

Pre-visit Planning

- Solves nearly every issue related to service quality
- Is an essential feature of the Medical home model
- Is supported by HRSA and AHRQ

Keys to Success

- Facilitate ease of use and participation
- Take inventory of systems, data, and built-in reports that are available to all stakeholders – regardless of system brand
- Think collectively to determine relevant information to drive improvement

Campaign for Quality:
Every client, Every visit, Every time

Pre-visit Planning: Purposes and Benefits
▪ To avoid re-work for clinical and MCM staff
▪ To alert staff when information is missing from HIE or data entry as it occurs rather than at the end of the year
▪ To educate providers on changes to treatment protocols as they occur
▪ To identify client-specific clinical events that are due or past due
▪ To alert-quality program on issues before it is too late
▪ To utilize information assembled in a single convenience area
▪ To trigger interdisciplinary communication among providers
References: • https://pcmh.ahrq.gov/page/medical-home-what-do-we-know-what-do-we-need-know-review-earliest-evidence-effectiveness-of-the-patient-centered-medical-home-model (page 3-4) • https://aidsinfo.nih.gov/contentfiles/lvguidelines/aa_tables.pdf (pages 26-28)

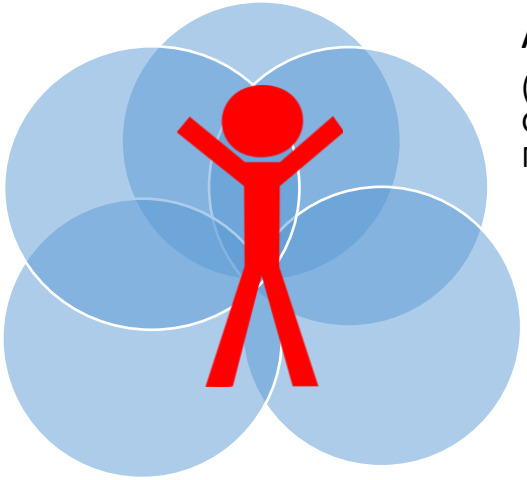
The SC RW CQI Brand:
Pre-visit Planning and Interdisciplinary Model

Provide quality, coordinated, patient-centered care

(Quality Drivers: NIH recommended-approach, AHRQ Medical Home)

Provide culturally competent, services for each client's individualized needs

(Quality Driver: Statewide Coordinated Statement, RSR report, Client Satisfaction Feedback, AHRQ)



Adhere to treatment standards

(Quality Drivers: NIH Treatment Guidelines; HAB Performance Measures)

Continuously integrate, monitor and adapt systems of care

(Quality Driver: SC QM Site Visits; SC QM Steering Committee TA; PDSA Cycles)

Link and retain in care and treatment

(Quality Drivers: HIV Care Continuum, Epidemiology Profile, EIIHA , In+Care Campaign, SC QM/HAB Performance Measures, Data to Care)

Bring it to Life:
Health Information Exchange (HIE)

- Establish a standard set of measures and batch files needed to build a HIE model:
  - Include all care providers - regardless of system used;
  - Include EHR(s), RSR-ready, ADAP, and files from 340B in-house/contract pharmacy systems.

- Include only information derived from standard batch files or entered manually for RSR reporting:
  - Remind providers of replicable features of each system (importing/exporting and ADAP web-based modules).

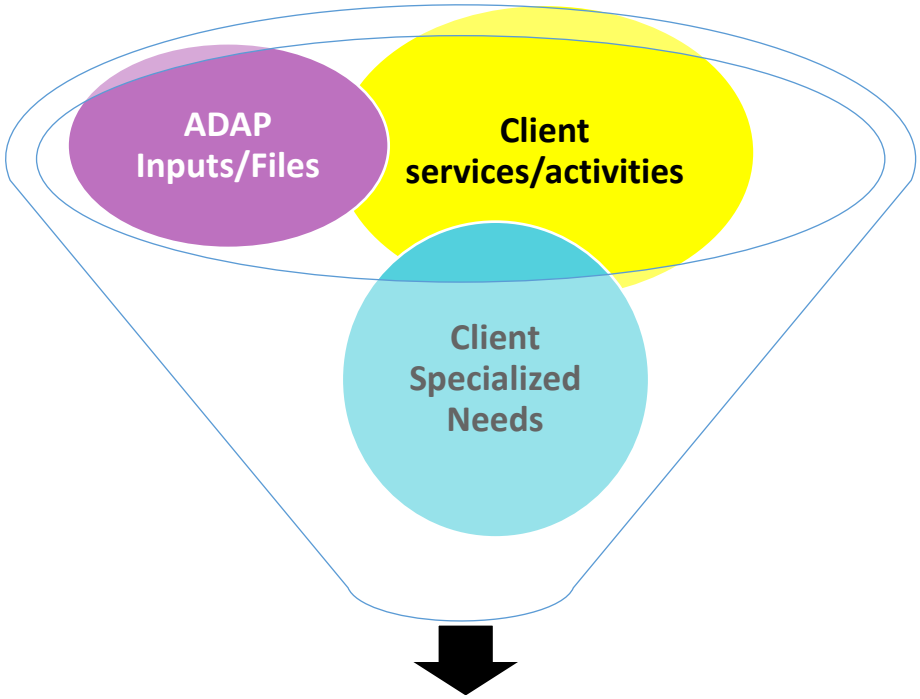
- Work with providers to establish an agency-level data warehouse and basic batch file formats.

- Determine information needed for Pre-visit Planning contained within the standard batch files.
  - Review of information at pre-visit helps events *occur,* drives improvement and reduces re-work;
  - Review information needed by provider type.

- Provide sample Pre-visit Planning templates with information that all providers will need:
  - Encourage providers to have the template built in each EHR and RSR-ready system;
  - Encourage providers to add more information beyond the standardized fields;
  - Facilitate implementation in each system brand and platform.

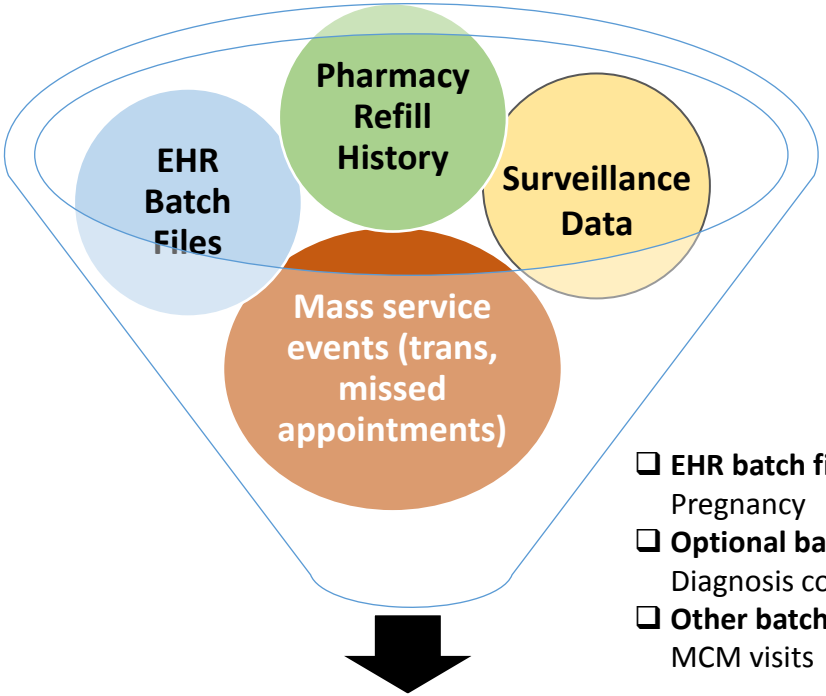
HIE Data Warehouse:
Use Your RSR-ready System

Information that is entered:



HIE Data Warehouse:
Use Your RSR-ready System

Information that is imported:



- ❑ **EHR batch files**: Labs; Medical Visits; Vaccines; Pregnancy
- ❑ **Optional batch files:** Medication(s) prescribed; Diagnosis codes for chronic conditions
- ❑ **Other batch files:** Refill history from pharmacy, MCM visits

RSR Ready Data Warehouse

Pre-visit Planning:
Information by Provider Type

For Clinicians focus Pre-visit Planning on:

- EHR template or report-on-the-fly
- Clinical performance-related events that have/have not occurred in the year
- Alerts of clinical performance events that should occur and have not been done this year

For Medical Case Managers focus Pre-visit Planning on:

- RSR-ready system reports
- Availability of information from clinics
- Client participation in care
- Updated information regarding change in care providers (i.e. physician, pharmacy, ADAP)

For All Providers add "Pre-visit Planning - Clinical Outcomes" summary for all provider types that contains:

- Computations of information that is already gathered in the HIE model
- Information beyond capturing of events to actually summarize outcomes
- Missed appointments, viral suppression as of end of prior year, missed refills, dates of last service/care plan update and names of assigned providers

Pre-visit Clinical Outcomes

	Same data used in RSR/HAB Performance/In+Care Campaign?	*Same data used in SC QM Performance Measure*
Decrease in CD4 in the last 12 months?	*Yes*	*Yes*
Increase in viral load in the last 12 months?	*Yes*	*Yes*
Achieved viral suppression (less than 200)?	*Yes*	*Yes*
Maintained viral suppression for two or more years?		*Yes*
Number of missed ARV refills in last 6 months?		*Yes*
Is client pregnant?	*Yes*	*Yes*
Other chronic conditions?		*Yes*
Medical visit in last six months?	*Yes*	*Yes*
Need to contact any of the following care providers?	*N/A*	*N/A*

Pre-visit Clinical Outcomes Review

Client Id: 1234 Gender: Female Age: 36			
Test Results:	CD4: 600 Date: 2/15/16	VL: 100,000 Date: 2/15/16	
Decrease in CD4 in the last 12 months?	____Yes	From_____ to_____	__X__No
Increase in viral load in the last 12 months?	__X___Yes	From: 75,000 to 100,000	____No
Achieved viral suppression (less than 200)?	_____Yes __X__ No		
Maintained viral suppression for two or more years?	_____Yes __X__ No		
Number of missed ARV refills in last 6 months?	__X_ 1 ____2 ____3 ____4 or more		
Is client pregnant?	__X__ Yes ____No		
Other chronic conditions?	__X__ Yes ____No (Systems: Cardiovascular, Endocrine, Respiratory, Renal, Digestive, Neurological, Reproductive, Muscular, Immune, Skeletal, Integumentary) Diabetes, Pregnancy		
Medical visit in last six months?	___X__ Yes ____No ____Rescheduled Date: 2/15/16		
Need to contact any of the following care providers?	__X___Clinic __X___Pharmacy ___SC ADAP ___ Other MCM ___Caregiver ___ Transportation ___Peer ___Outreach __X___Other (OB)		

Auto-fill simulated above.

Support from RW Part B Program

General Financial Support to All Providers:

- Provided funding to agencies for EHR enhancements and HIE exchange from EHR to RSR-ready system(s)
- Developed template that converts summarized Performance Measures to Client level pre-visit templates in EHR and RSR-ready systems

Support in the RW Part B RSR-ready system, Provide Enterprise:

- Revised client level, self-populating report to match new and customized measures for pre-visit review
- Revised and enhanced aggregate performance reporting (Clinical Report Card)
- Established customized documentation and reporting module for each new intervention (i.e. Peer, Outreach and SMCM)
- Expanded use of existing data for MCM Graduation monitoring and reports