INTEGRATED HIV/AIDS PLANNING IHAP TA CENTER

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Monitoring and Improvement Plan

Connecticut's Integrated HIV Prevention and Care Plan 2017-2021

REGION	Northeast
PLAN TYPE	Integrated state/city/county prevention and care plan
JURISDICTIONS	State of Connecticut, Hartford TGA, and New Haven EMA
HIV PREVALENCE	Medium

Connecticut's monitoring and improvement plan, which includes both the Hartford TGA and the New Haven area EMA, is an exemplary section as it is easy to read, concise, and provides illustrative visuals. While brief, it provides a nice description of the strategy to update planning bodies and stakeholders; how they will monitor and evaluate plan implementation; and how they will use surveillance and program data to assess health outcomes.

SELECTION CRITERIA: MONITORING AND IMPROVEMENT PLAN

Exemplary monitoring and improvement plan sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Description of the process of updating planning bodies/stakeholders on plan implementation and integrating feedback for plan improvement
- ☑ Description of the plan to monitoring and evaluate the implementation of the goals and SMART Objectives of the Integrated HIV Prevention and Care Plan
- ☑ Description/strategy of the use of data (surveillance and program/care data) to assess and improve health outcomes along the HIV Care Continuum which will be used to impact the quality of the HIV service delivery system, including strategic long-range planning

Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

SECTION III

MONITORING AND IMPROVEMENT

Who is involved in monitoring processes?

- *DPH, CHPC Committees, and CHPC co-chairs, among other parties*

What components are monitored annually?

- *Measurable objectives (CHPC performance indicators, Statewide Health Improvement Plan HIV indicators)*
- *Plan content (e.g., service descriptions, resources, initiatives)*
- *Epidemiological data*

How does DPH monitor planning and aspects of Plan implementation?

- *DPH is the lead agency for coordination of HIV prevention and care resources*
- *Six (6) programs within the TB, HIV, STD and Viral Hepatitis Section fall under the direct supervision of the TB, HIV, STD and Viral Hepatitis Section Chief.*

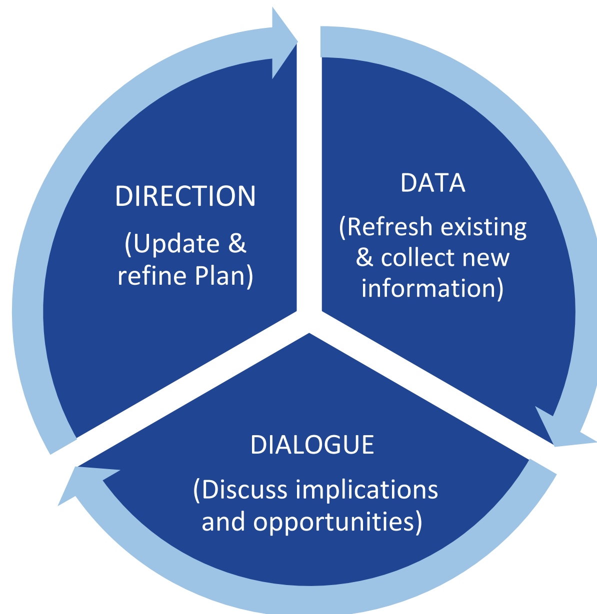
SECTION III. MONITORING AND IMPROVEMENT

A. Process to Update Planning Bodies and Stakeholders

The DPH and CHPC review and update the Plan on an annual basis. The SMART objectives, indicators and other program measures create a platform to assess progress (see section B on page 80).

Committees review data sets and coordinate any additional studies. For example, the Quality and Performance Measures Team will focus on quality improvement processes and the Needs Assessment Projects Team will continue to pursue more in-depth studies related to PLWH out-of-care or more specifically, those out-of-care who are not virally suppressed.

Figure 51. CHPC Annual Process to Review & Update Plan



The CHPC will review and refine its structure during 2017 to support Plan implementation with an emphasis on areas related to communication and supporting evidenced-based practices (including peer-driven strategies).

The HIV Funders Collaborative will assist in ongoing data collection to better understand HIV prevention and care workforce competencies.

The CHPC leadership team will develop and update a tracking tool specific to monitoring Plan implementation. The CHPC will review progress and refine the Plan annually.

In its commitment to transparency, parity, and communication, the CHPC emphasizes sharing data – both existing data in support of this document as well as those collected and refreshed in future years – with its diverse community stakeholders. Community-level sharing is a vital component to Connecticut's statewide planning process.

B. Plan to Monitor and Evaluate Plan Implementation

Each objective was selected by Connecticut's planning leaders from either the existing CHPC indicators or the existing DPH Statewide Health Improvement Plan (SHIP) 2020 HIV indicators to ensure statewide alignment on priority measures. All indicators representing Plan objectives are tracked consistently and refreshed annually.

The Epidemiological Profile data serves as a comprehensive resource with DPH epidemiologists refreshing the data annually and posting the data tables online.

The CHPC and DPH have identified 11 performance indicators (page 7) to measure progress towards Plan goals. The appendix contains a description of each indicator and the measurements. The CHPC Quality and Performance Measures Team developed these indicators over a three-year period and continues to revise and update them annually. The group will continue to develop indicators relevant to prevention work.

Several Plan objectives reference the State Health Innovation Plan (SHIP) HIV indicators, monitored by DPH. The CHPC and other relevant groups will receive updates on all Plan indicators throughout the monitoring process. These indicators can be viewed online via the "Healthy Connecticut 2020 Performance Dashboard."

The CHPC will rely on these data sets, as well as information from the HIV Funders Collaborative and other stakeholders, to assess the Plan's implementation status.

Figure 52. Number of HIV Testing Events in Connecticut: Funded Expanding Testing Initiative (ETI) Programs.
Source: Healthy Connecticut 2020 Performance Dashboard

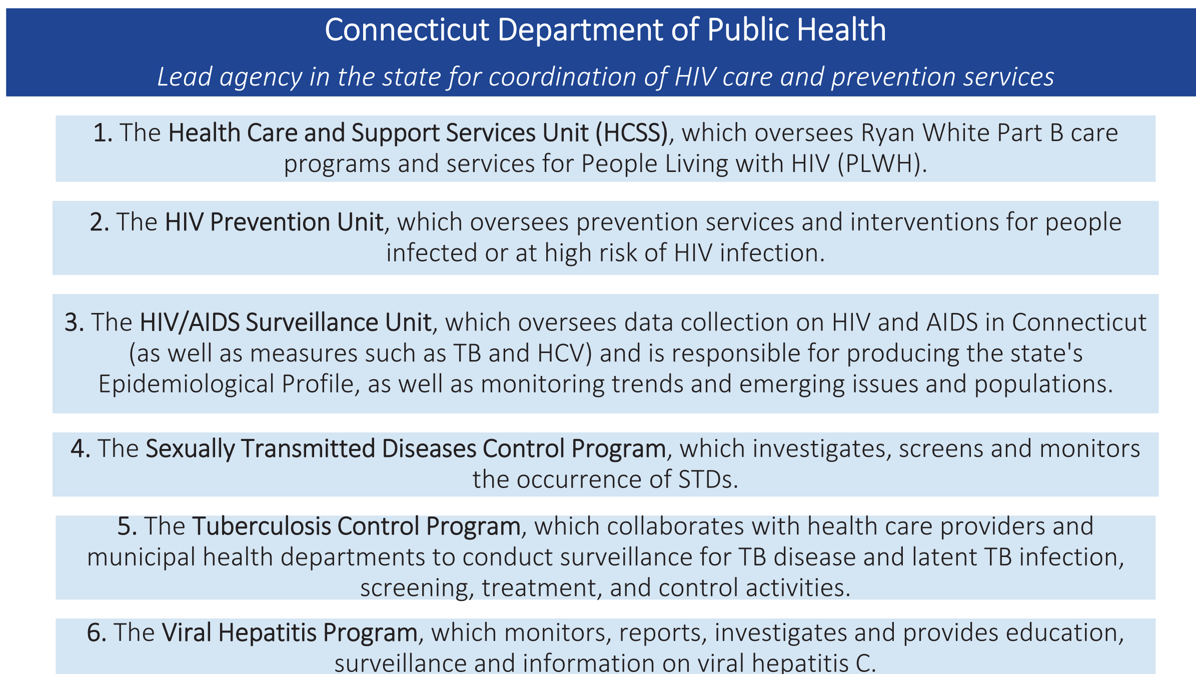
Story Behind the Curve

Between 2008 and 2015, a total of 169,683 HIV tests have been conducted by CT DPH HIV Prevention Program's funded agencies conducting routine HIV testing in healthcare settings. From 2012 to 2014, a quantum leap occurred in the number of HIV tests conducted due to ETI interventions' coordinators successfully increasing the number of HIV testing sites within their organizations.

C. Strategy to Utilize Surveillance / Program Data to Assess Health Outcomes

The Connecticut Department of Public Health serves as the lead agency in the state for coordination of HIV care and prevention services addressing the HIV/AIDS epidemic, as well as the control, monitoring and prevention of sexually transmitted diseases (STD), tuberculosis (TB), and viral Hepatitis (B and C). Six programs within the TB, HIV, STD and Viral Hepatitis Section fall under the direct supervision of the TB, HIV, STD and Viral Hepatitis Section Chief.

Figure 53. Relationship to the Connecticut Department of Public Health



This new coordination and linkage of programs positions the Department of Public Health to advance Program Collaboration Service Integration (PCSI), specifically TB, HIV, STD and Hepatitis Programs. The PSCI model addresses interrelated health issues through the development and implementation of integrated planning, service delivery, results-based accountability, quality improvement, and communications, among other factors that facilitate comprehensive delivery of services, promote healthy lifestyles, and improve quality of life and health outcomes. DPH places a priority on training and analytic services that build capacity of statewide, regional and local partners to perform more effectively and achieve their goals and objectives to reduce the transmission and negative impact of HIV/AIDS.

HIV surveillance/ program data will be utilized to identify HIV-positive clients who have been in care (defined as one documented viral load) for 12 months, and then determined to be out of care for longer than the following 12 months. The information is then provided to an EIS or HIV-Disease Intervention Specialist (H-DIS) to identify and work with clients who have fallen out of care. The databases include, but may not be limited to, eHARS, HARMS< STD*MIS/MAVEN and Lexis Nexis.

HIV surveillance data will also be utilized to identify HIV-positive clients who have not received care 12 months after initial diagnosis. The information is shared with either an EIS or H-DIS. Program data will also be utilized to determine community viral load suppression of HIV clients who are recipients of Ryan White core medical and support services including coordination of services to ensure retention in care. MCMs will review caseloads at least every 3 months to identify potential clients who may be at risk of falling out of care, and will pass this information to the EIS or H-DIS for appropriate follow up.