Using the Continuum of Care as an Improvement Tool

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Learning Objectives

- Learn the relationship between data and quality improvement
- Understand the Continuum of Care
- Learn how to identify gaps in care
- Explore the concept of diving deeper into data
- Become familiar with the Continuum of Care as an improvement tool

Quality Improvement Is a Response to Performance Data

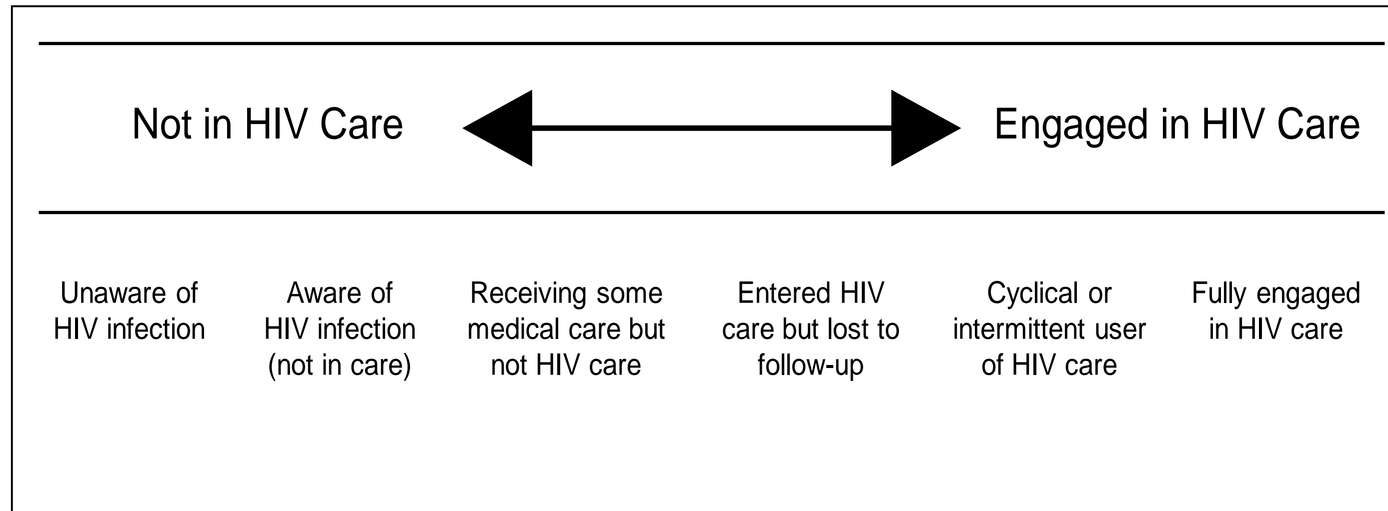
Recipients are required by HAB* to:

- Implement quality improvement (QI) activities aimed at improving patient care, health outcomes, and patient satisfaction
- Using a defined approach or methodology
- Implement QI activities in an organized, systematic approach
- Document all QI activities

*Clinical Quality Management Policy Clarification Notice, (PCN) #15-02 (updated Nov. 2018), HRSA

What is A Care Continuum?

HIV Care Continuum



Adapted from Eldred, et. al., AIDS Patient Care STDs 2007;21(Suppl1):S1-S2
Cheever LW Clin Infect Dis 2007;44:1500-2

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HIV Care Continua…

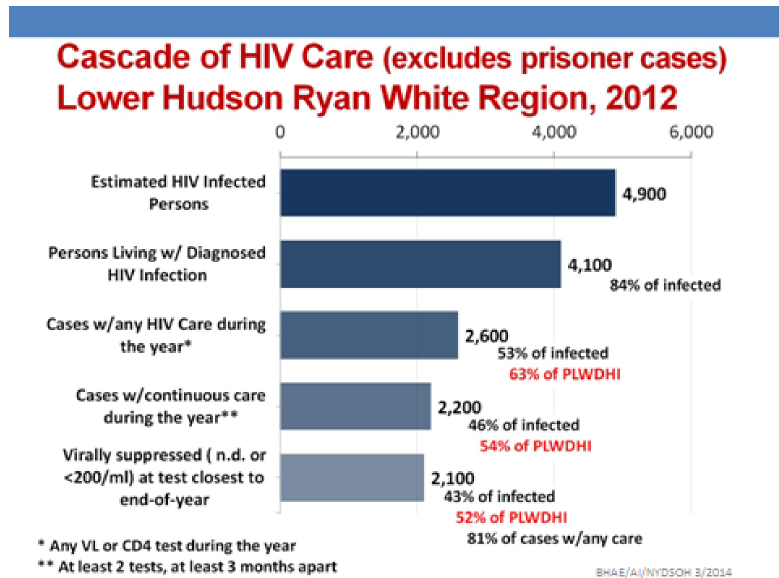
- Show the "number of individuals living with HIV infection who are impacted by each point along the Continuum"
- Are a visual tool of HIV care and outcome at a point in time
- Assess key parameters of care for persons living with HIV infection
- Identify gaps in care
- Prompt discussion on steps to improve HIV care outcomes

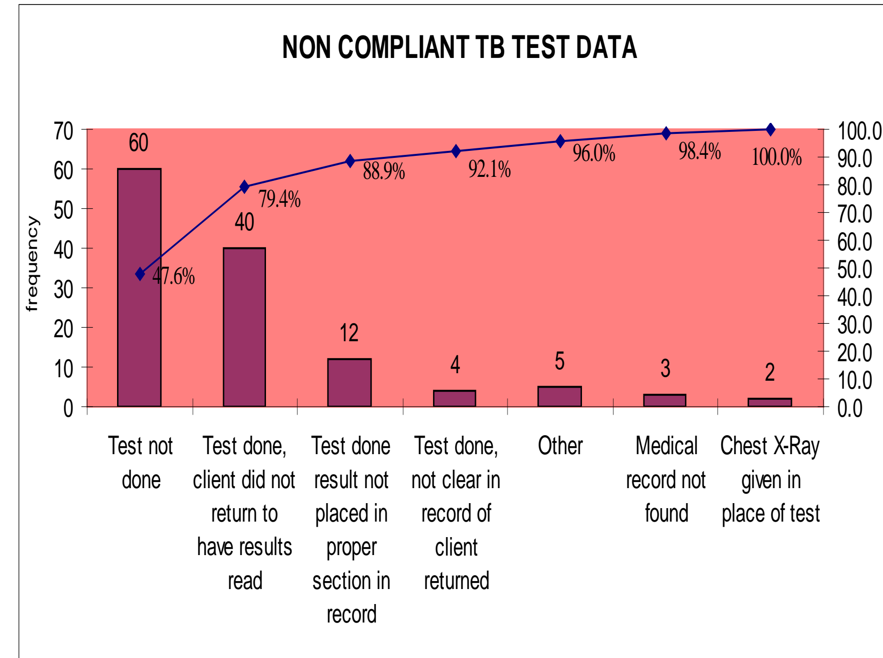
Why This Matters

- Without data, you do not know what to improve
- The data should be shared with stakeholders in as easy a way to understand as possible
- People can process a graphic more quickly than a table or a paragraph

Data Visualization

A way to present data in dynamic but simple visual formats such as interactive maps, infographics, Cascades, etc





A way to convey time specific, complex population information to a wider public audience

Care Continuum Elements

Considerations When Building an HIV Care "Care Continuum"

- What is the purpose?
- Who is your target audience?
- Can you manage the analytic requirements?
- What is already being done?

Considerations When Building an HIV Care "Care Continuum"

- Is your measure clearly defined?
  - Denominator
  - Numerator
  - Population of interest
  - Exclusions
- What part of the continuum needs the most attention
  - How will you proceed
  - What improvement projects do you foresee

Considerations When Building an HIV Care "Care Continuum"

Data

- What data are available to you?
- Feasibility of data extraction from your system
- Limitations of available data
- How are your measures defined?
- Will your results be comparable to those used by others?

Care Continuums of New York

New York State Cascade of HIV Care, 2017

Persons Residing in NYS† at End of 2017

	Count	
Estimated Persons Living with HIV (PLWH)‡	122,600	
Persons Living w/Diagnosed HIV (PLWDH)	111,500	91% of PLWH
Cases w/any HIV care during the year*	92,100	75% of PLWH 83% of PLWDH
Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year	80,400	66% of PLWH 72% of PLWDH 87% of cases w/any care

Axis: 0, 50,000, 100,000, 150,000

†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.

‡ PLWDH and persons living with undiagnosed HIV (7.4% for NYC and 14.5% Rest of State)

*Any VL, CD4, genotype test during the year.

Cascade of HIV Care: History of Male to Male Sexual Contact§

Persons Residing in NYS† at End of 2017

	Count	
Estimated Persons Living with HIV (PLWH)‡	60,500	
Persons Living w/Diagnosed HIV (PLWDH)	50,900	
Cases w/any HIV care during the year*	41,800	69% of PLWH 82% of PLWDH
Virally suppressed (n.d. or <200 copies/ml) at test closest to end-of-year	37,500	62% of PLWH 74% of PLWDH 90% of cases w/any care

§ Includes cases with MSM and MSM/IDU HIV transmission risks

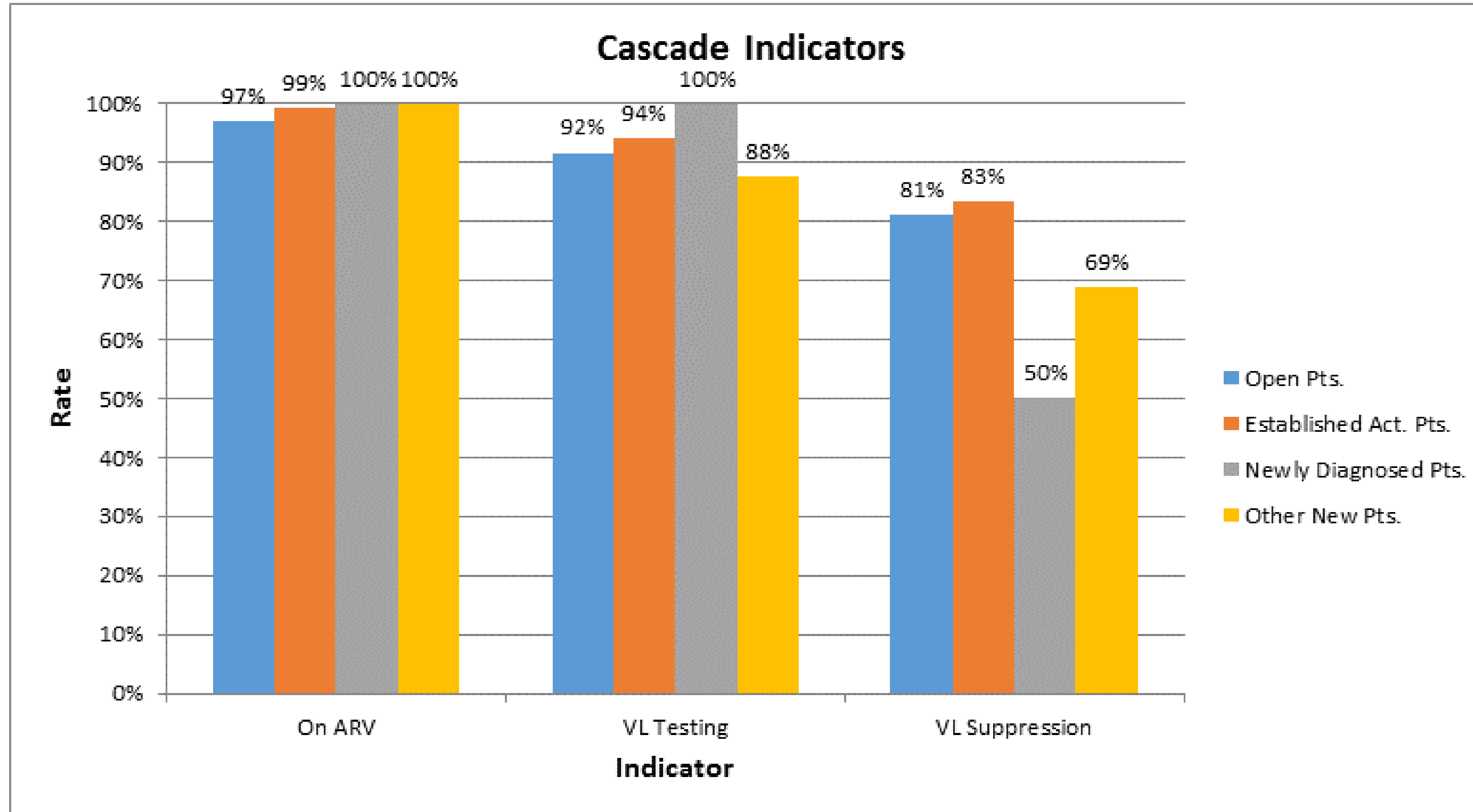
†Based on most recent address, regardless of where diagnosed. Excludes persons with AIDS with no evidence of care for 5 years and persons with diagnosed HIV (non-AIDS) with no evidence of care for 8 years.

‡ PLWDH and persons living with undiagnosed HIV (15.95% CDC estimate)

*Any VL, CD4, or genotype test during the year

Organization Care Continuums and How They Are Used

Community Health Center; Jan 1 through June 30, 2019



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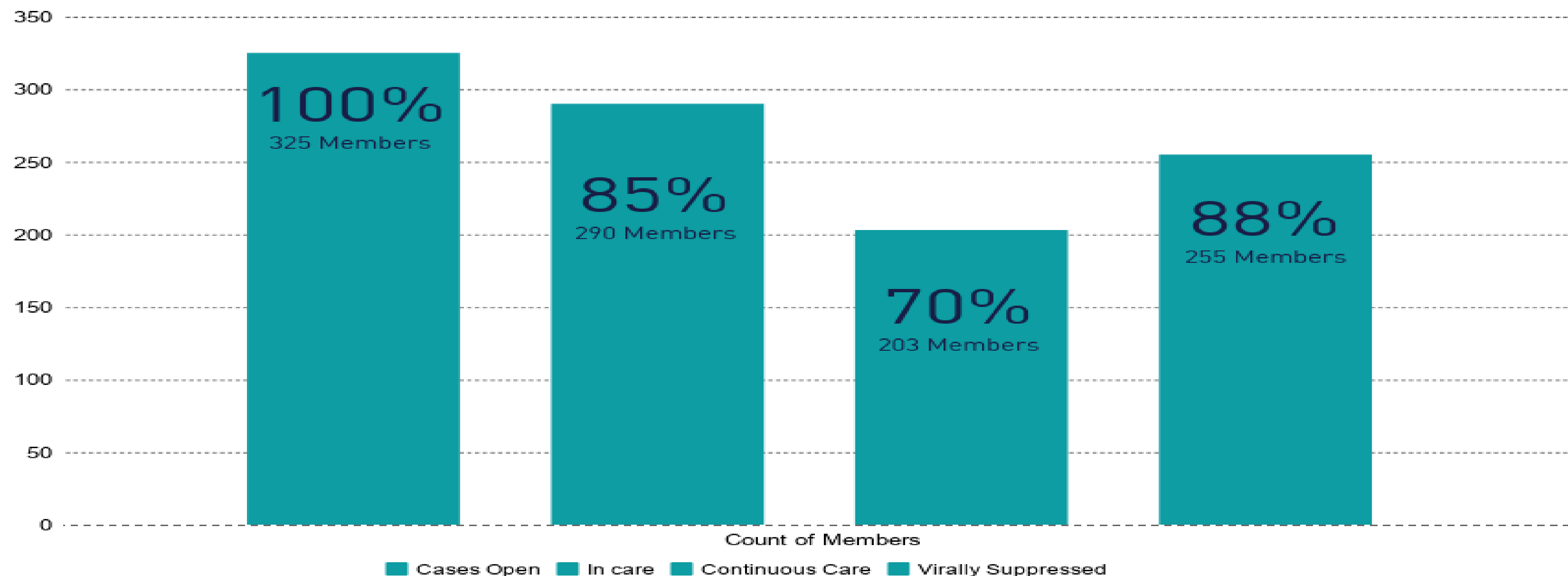
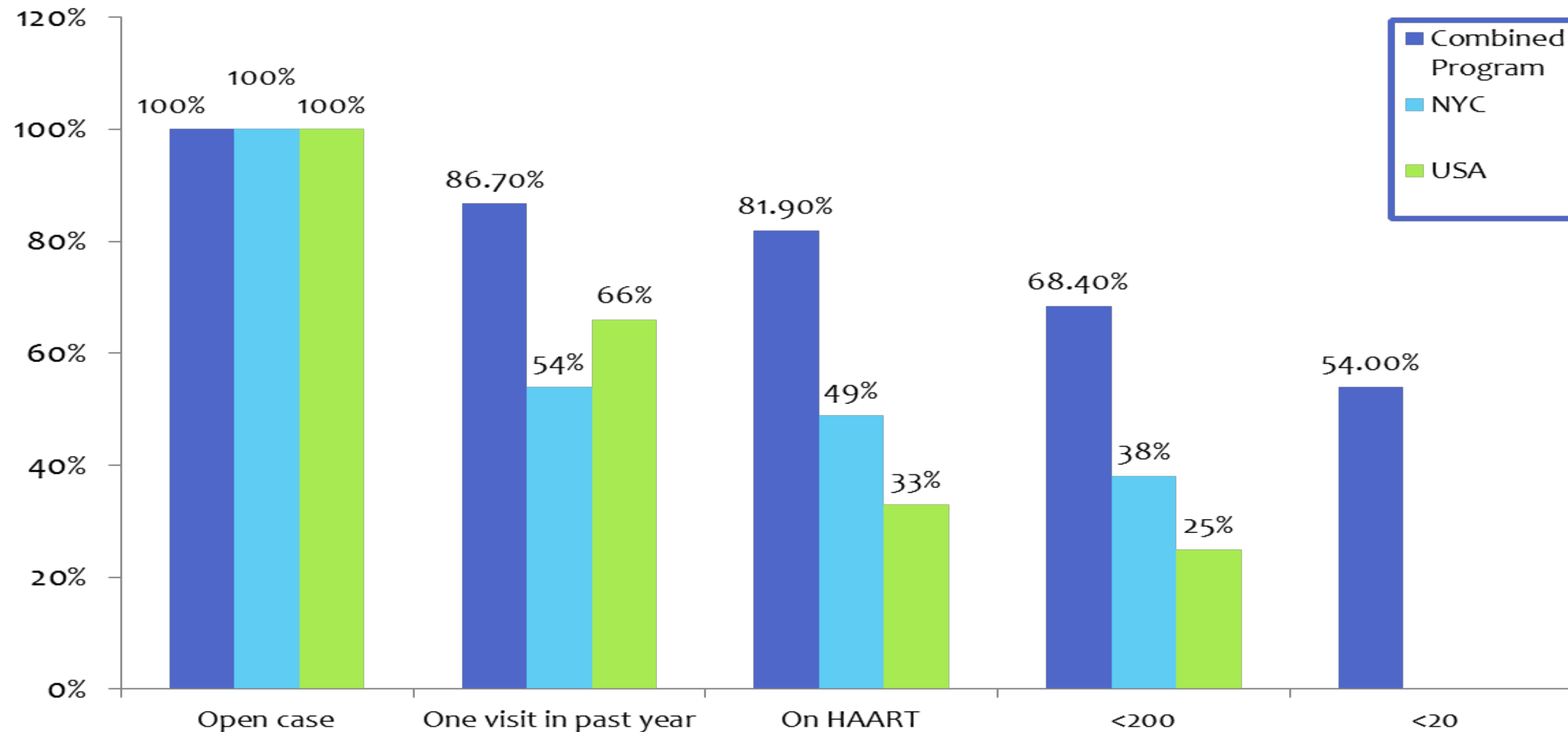
Agency Cascade
Albany Damien Center (2018)

325 Members 100%	290 Members 85%	203 Members 70%	255 Members 88%
Open Cases of Members living with HIV and actively served at the Center	Of those members served at the Center, with an evidence of care, had at least a VL or CD4 lab during the calendar year	Members with at least 2 lab tests, at least 13 months apart, during the year	Of the members served during the calendar year were virally suppressed



Treatment Care Continuum comparison of Mt Sinai, NYC, & USA



Quality Indicator #1 is Viral Load Suppression

- To increase the total percentage of HIV+ patients on ART
- To increase the total percentage of HIV+ patients with a controlled and/or undetectable HIV Viral Load

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Utilizing Care Continuums to Inform Improvement

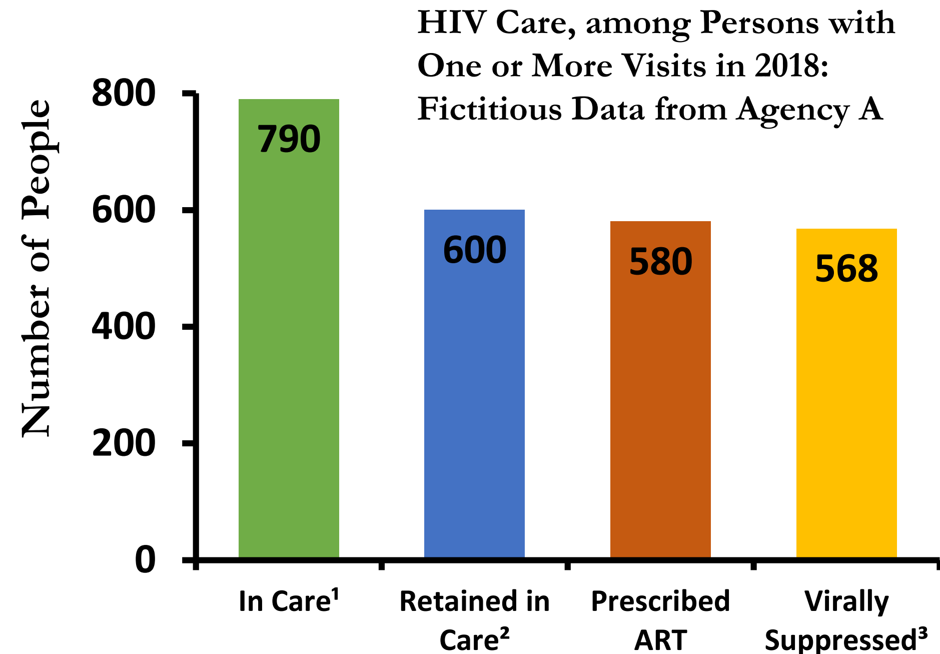
Setting Goals Based on HIV Care Outcomes

Internal Goals

- Address the greatest gaps
- Target specific outcome
  e.g., viral suppression
  - "Prescribe ART to all persons who are in care"

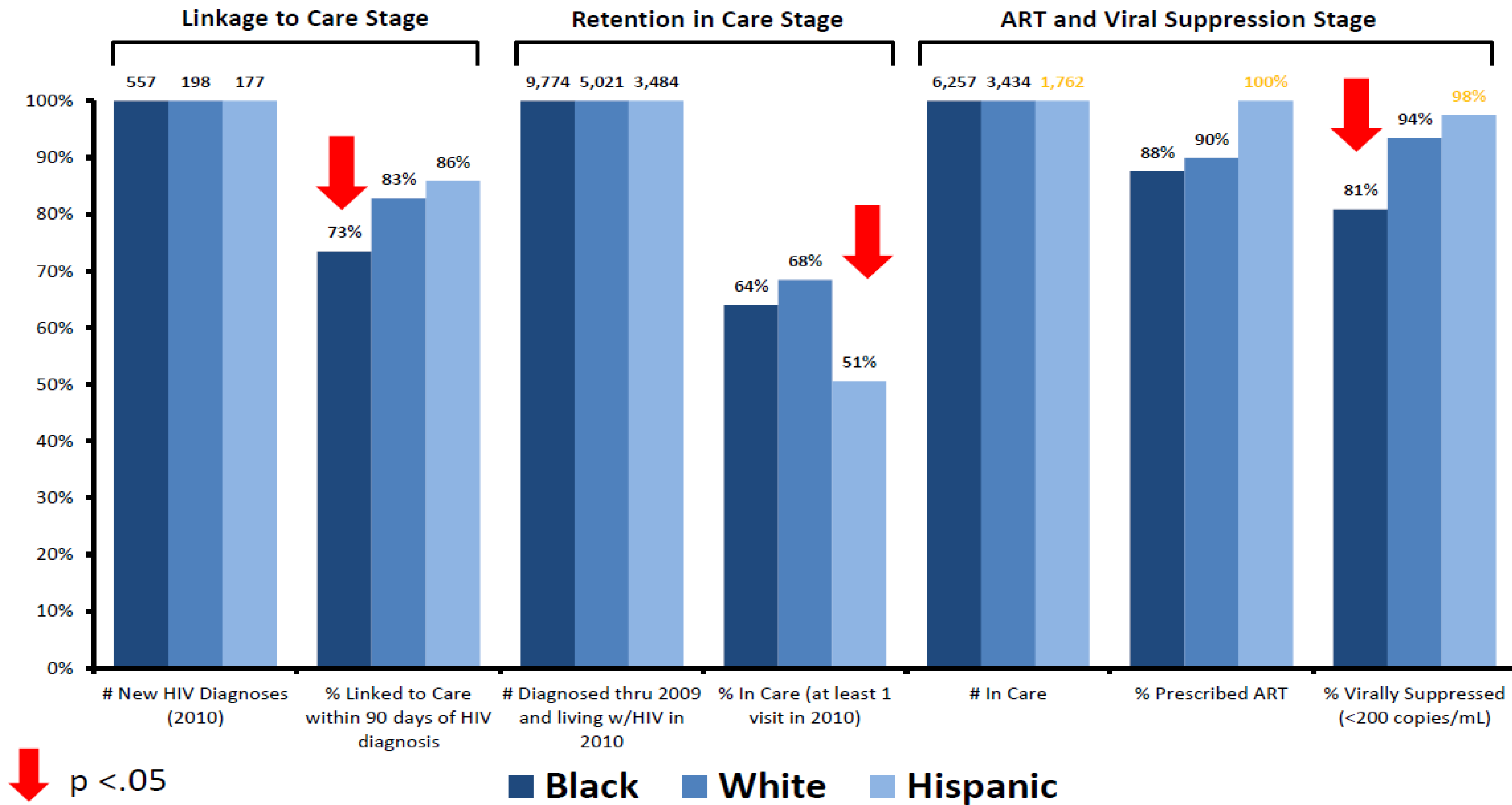
External Targets

- Achieve specific targets such as the NHAS goals



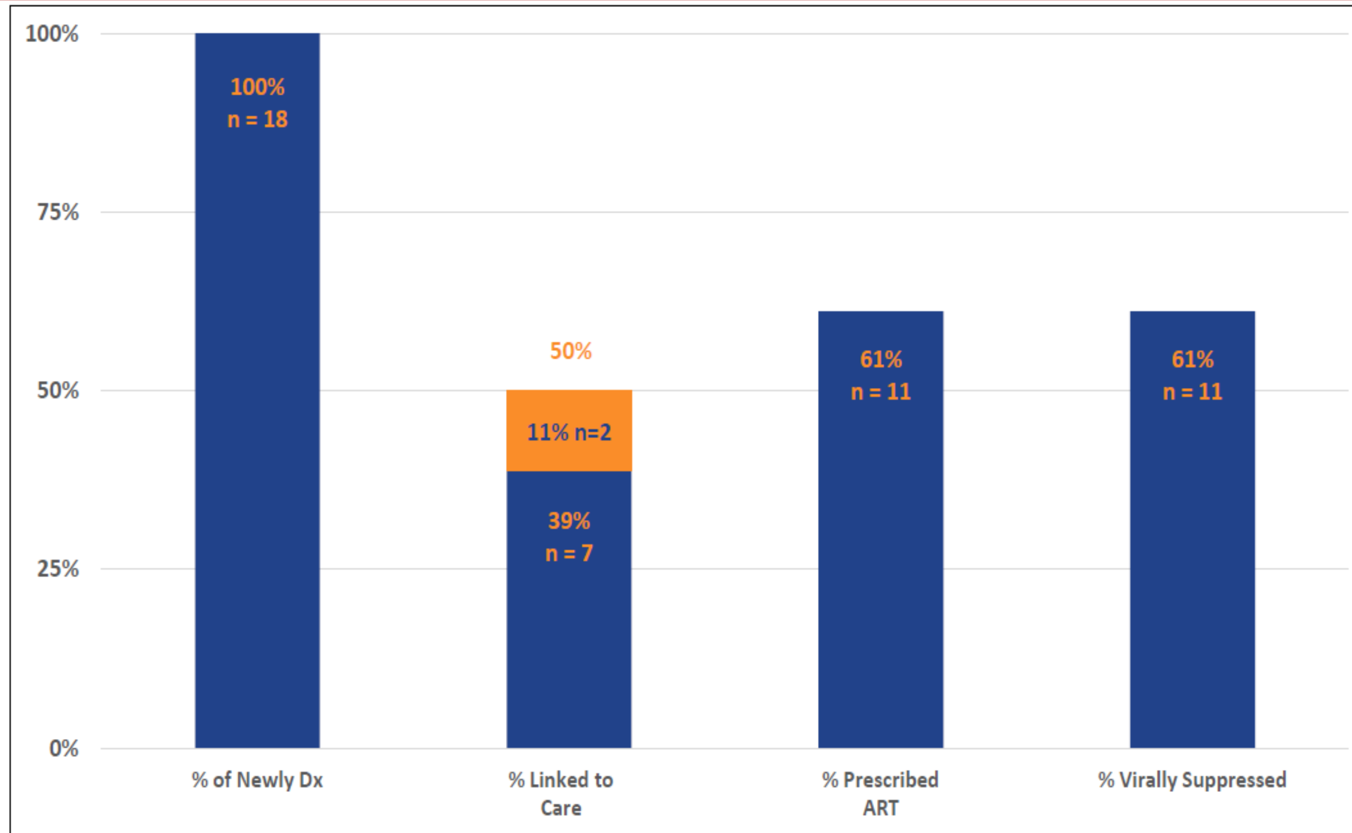
[1]HIV positive clients with at least one clinic visit in 2018
[2]HIV positive clients with at least 2 visits, at least 3 months apart
[3]HIV viral load of <200/mL (detectable or non-detectable) at last test during the measurement year

HIV Continuum of Care by Race/ Ethnicity
Chicago, Il



Exercises using Continuums

Example 1



Legend:
Newly Dx. Pt = # of unique pts. diagnosed for HIV within the facility during 2016 that self-reported their 2016 diagnosis was their first HIV diagnosis.
Linkage to Care = # of newly dx. pts. that attended an HIV primary care visit within 3 days (orange) + between 4 and 30 days (blue) at the diagnosing facility.
Prescribed ART = # of newly dx. pts. with a record of an HIV ART prescription during 2016.
Virally Suppressed = # of newly dx. pts. with an HIV viral load level less than 200 copies/mL.

Data Sources:
Financial, clinical, and lab records

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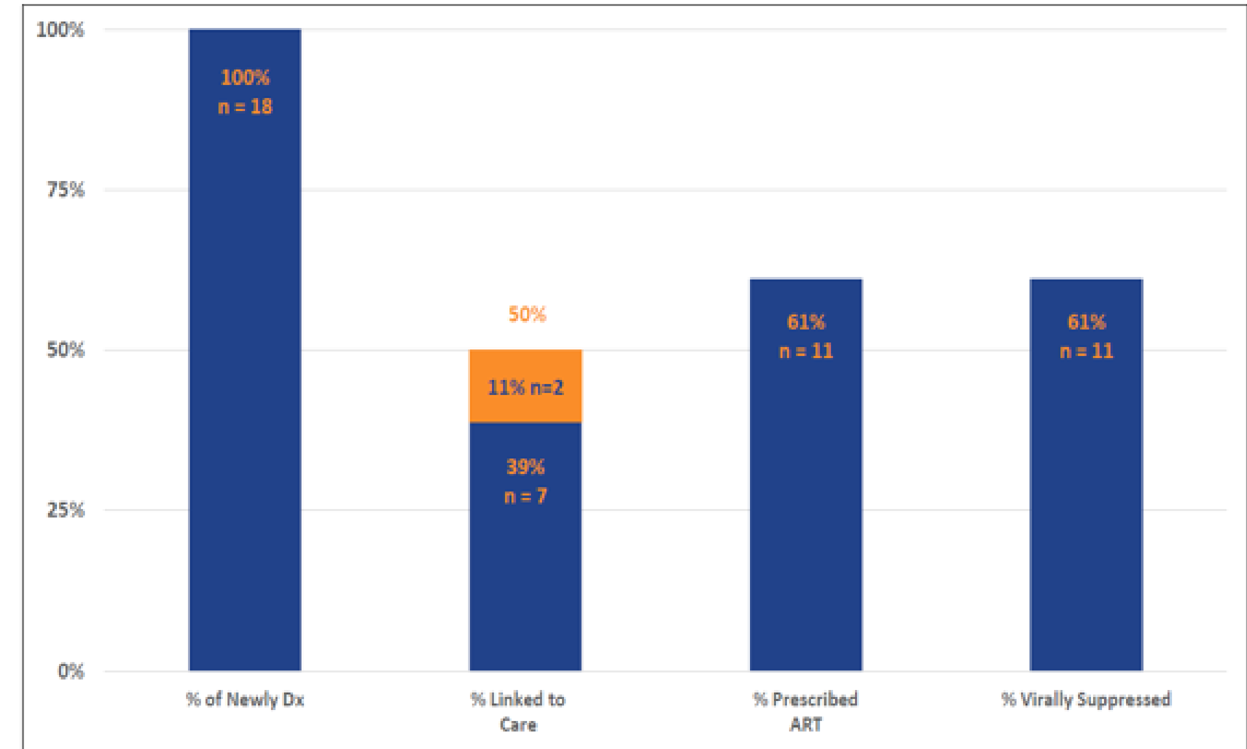
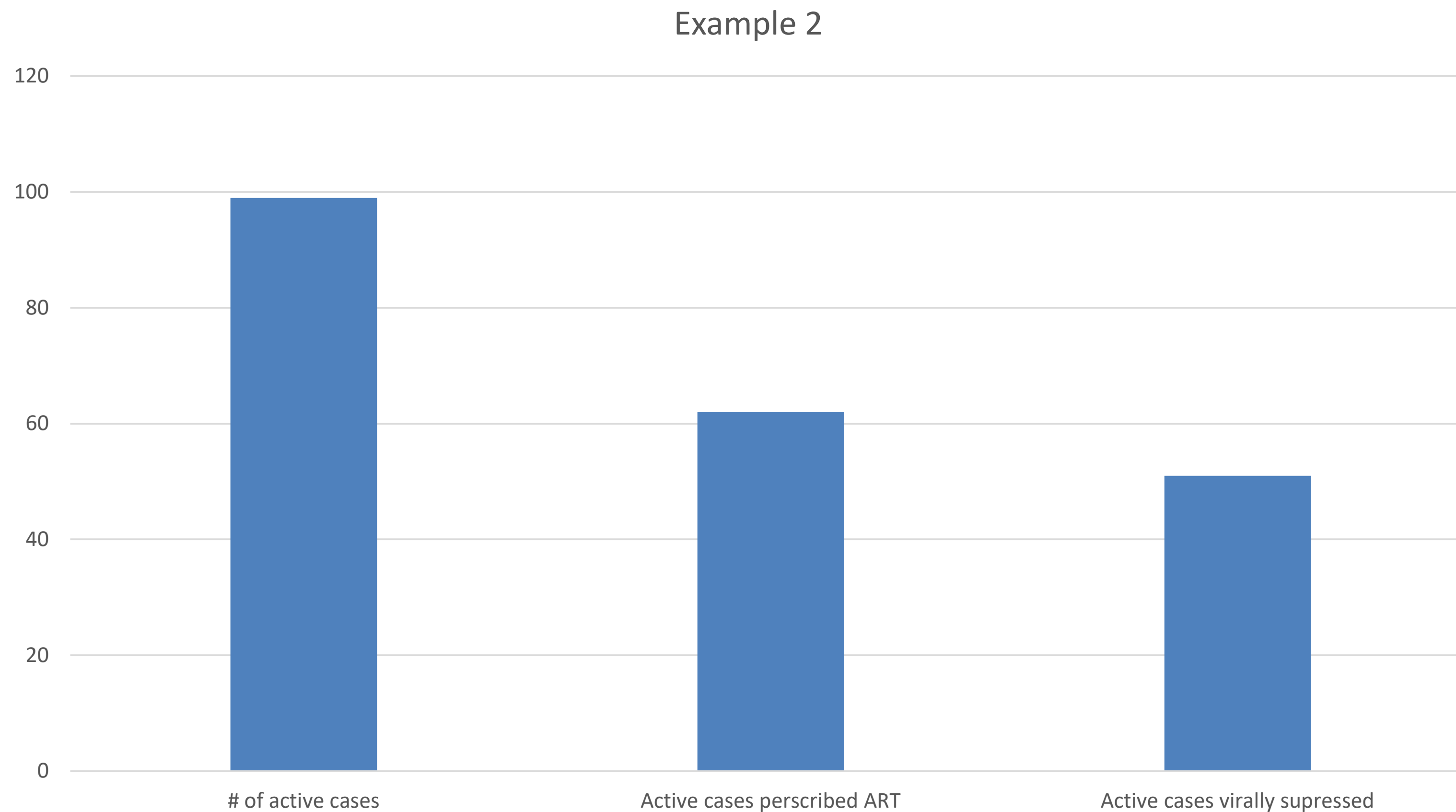
Example 1

Using Example 1 Newly Diagnosed Continuum, answer the following questions:

- Where is improvement needed?
- Is additional data needed? What type? In what areas?
- What types of improvement plan could be developed?



Example 2



Legend

Active Cases - #/% of pts receiving any HIV care in the facility

Active cases prescribed ART - # of pts with documented prescription in the current year

Active cases virally suppressed - # of pts with a viral load of <200 copies/ml.

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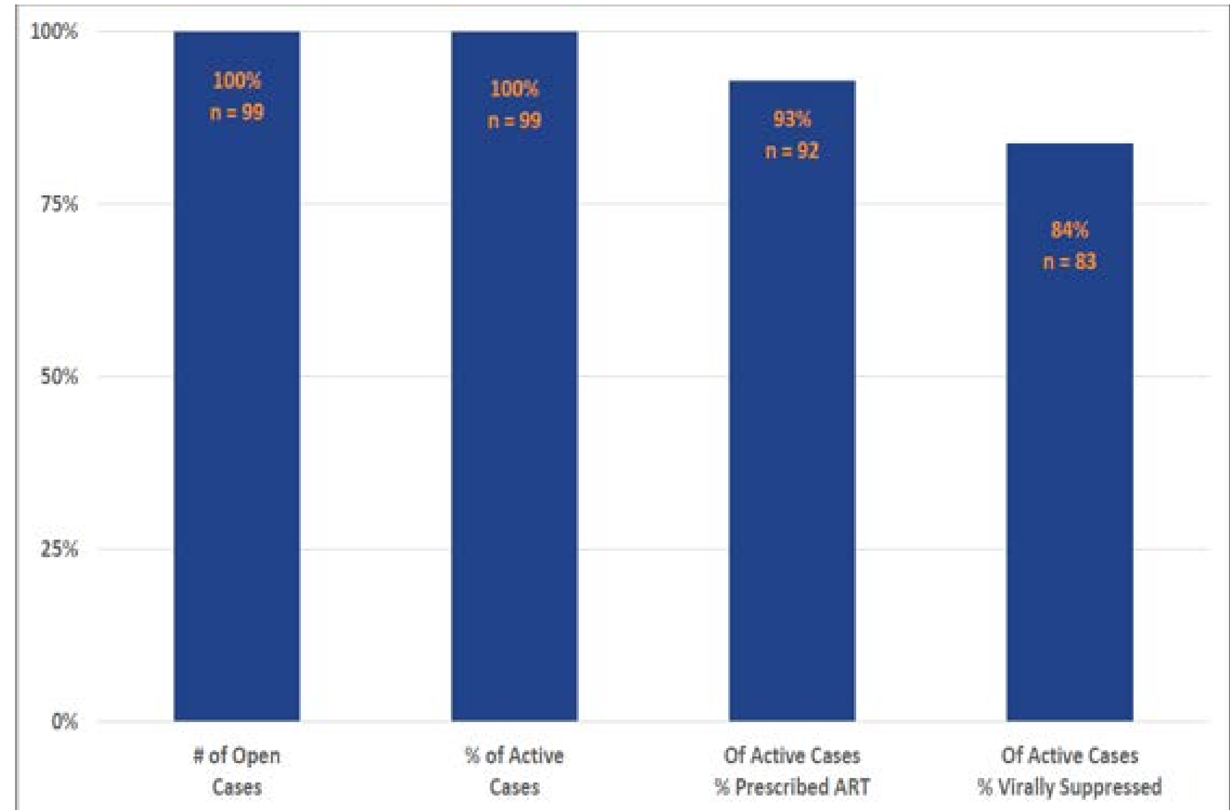
Example 2

Using Example 2, answer the following questions:

- Where is improvement needed?
- Is additional data needed? What type? In what areas?
- What types of improvement plan could be developed?



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When you build your intervention, remember

- Data informs improvement
- PDSA
- Keep it simple
- Rapid tests of change
- Improvement grows exponentially the earlier you intervene

NY Links

home about ny links events measures and data webinars interventions resources

Welcome to NY Links

NY Links focuses on improving linkage to care and retention in care and supports the delivery of routine, timely, and effective care for Persons living with HIV/AIDS (PLWHA) in New York State. We also bridge systemic gaps between HIV related services in order to achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS. We use a regional approach, utilizing the learning collaborative model, to fortify the links holding together communities of practice, and the links grounding them in the communities of consumers they serve.

New York Links was created through a HRSA HIV/AIDS Bureau (HAB)-sponsored Special Projects of National Significance (SPNS). Since September of 2015 it is under the Governor's Ending the Epidemic Initiative through the NYSDOH AIDS Institute.

+ New York Links Ryan White Conference Presentations

+ New York Links Poster Presentations at the National Ryan White HIV/AIDS Conference

New York State Ending the Epidemic Initiative

On June 29, 2014, Governor Andrew M. Cuomo detailed a three-point plan to move us closer to the end of the AIDS epidemic in New York State. The goal is to reduce the number of new HIV infections to just 750 (from an estimated 3,000) by 2020 and achieve the first ever decrease in HIV prevalence in New York State.

The three-point plan:

1. Identifies persons with HIV who remain undiagnosed and link them to health care.
2. Links and retains persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
3. Facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

Ending the Epidemic (ETE) in New York State will maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. It will move New

Sign-in to database

Regional Group Listings

- Bronx
- Brooklyn
- Central New York & Southern Tier
- Long Island
- Lower Manhattan
- Mid and Lower Hudson Valley
- Northeastern New York
- Queens
- Upper Manhattan
- Western New York

Have Questions?

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To listen to the recording of the webinar:

https://meetny.webex.com/meetny/ldr.php?RCID=33ae6f4b5f6d409bb359a865fd821bd4