Choosing an Improvement Project

Learning Objectives

- Understand elements to consider when selecting an improvement project
- Apply specific tools to help you narrow, prioritize, and document your project

WHAT ARE THE STEPS?

Use the Data to Guide Your Work

- Before you begin, make sure you document the measurement process; examine:
  - What data are collected
  - Why is it collected
  - Who is collecting it
  - Where are data stored
  - What calculations or tools to use will be done
  - How are the data retrieved
- Think of this as the flowchart for your data

Kovach, J., *Data: Guilty Until Proven Innocent.* Quality Process, Sept. 2019, pp. 28-37.

Use the Data to Guide Your Work

Look at the data at least quarterly

- Doing well, or not?
- Performance stable, or a trend?
- Compared to other grantees?

Decide how to act on the data

- Which areas need improvement?
- What are our priorities for improvement?

Begin improvement work

- Identify project team
- Define improvement goal

Elements that Influence Project Selection

- Data
  - Review data quarterly; look for trends over time; can you benchmark?
  - Do a deeper dive into your data; demographics, location, etc.
  - Establish a baseline; grow from there
  - Data availability; can you even get the data you need?
  - Data validity; ensure its valid

Elements that Influence Project Selection

- Decide how to act on the data
  - Analyze it using quality improvement tools
  - What issues do you see?
  - Set your priorities; use a priority matrix
  - Develop a improvement project plan
  - Involve stakeholders
  - Use a structured methodology

Elements that Influence Project Selection

- Begin your project
  - Test your ideas – start small and build on what you learn
  - Look at your data results; do they confirm your improvement hypothesis
  - Use a data collection tool
  - Do you need to adjust your hypothesis

What other elements influence project selection?

Elements that Influence Project Selection

- External
  - Funders
  - National goals or collaborative
    - HIV care continuum
    - Ending the Epidemic
    - end+disparities ECHO collaborative
    - Patient-Centered Medical Home
  - Regional or statewide activities
  - Local or citywide activities

Elements that Influence Project Selection

- Internal
  - Mission/Vision of your agency
  - Leadership's priorities and commitment
  - Staff availability/QI competency
  - The voice of the consumer

Elements that Influence Project Selection

- Resources
  - Staff – Who needs to participate? How many?
  - Time – How much time each day? How much time overall?
  - Dollars – Will the project cost anything? Are funds available?
  - Training – Is training needed? Who will provide?

Elements that Influence Project Selection

- Impact - Will the project impact a few clients or many?
- Ease of implementation – Do you have the resources to accomplish the project?
  - AKA feasibility
    - Technical feasibility
    - Economic feasibility
    - Regulatory feasibility
    - Schedule feasibility
    - Operational feasibility

GENERATING IDEAS

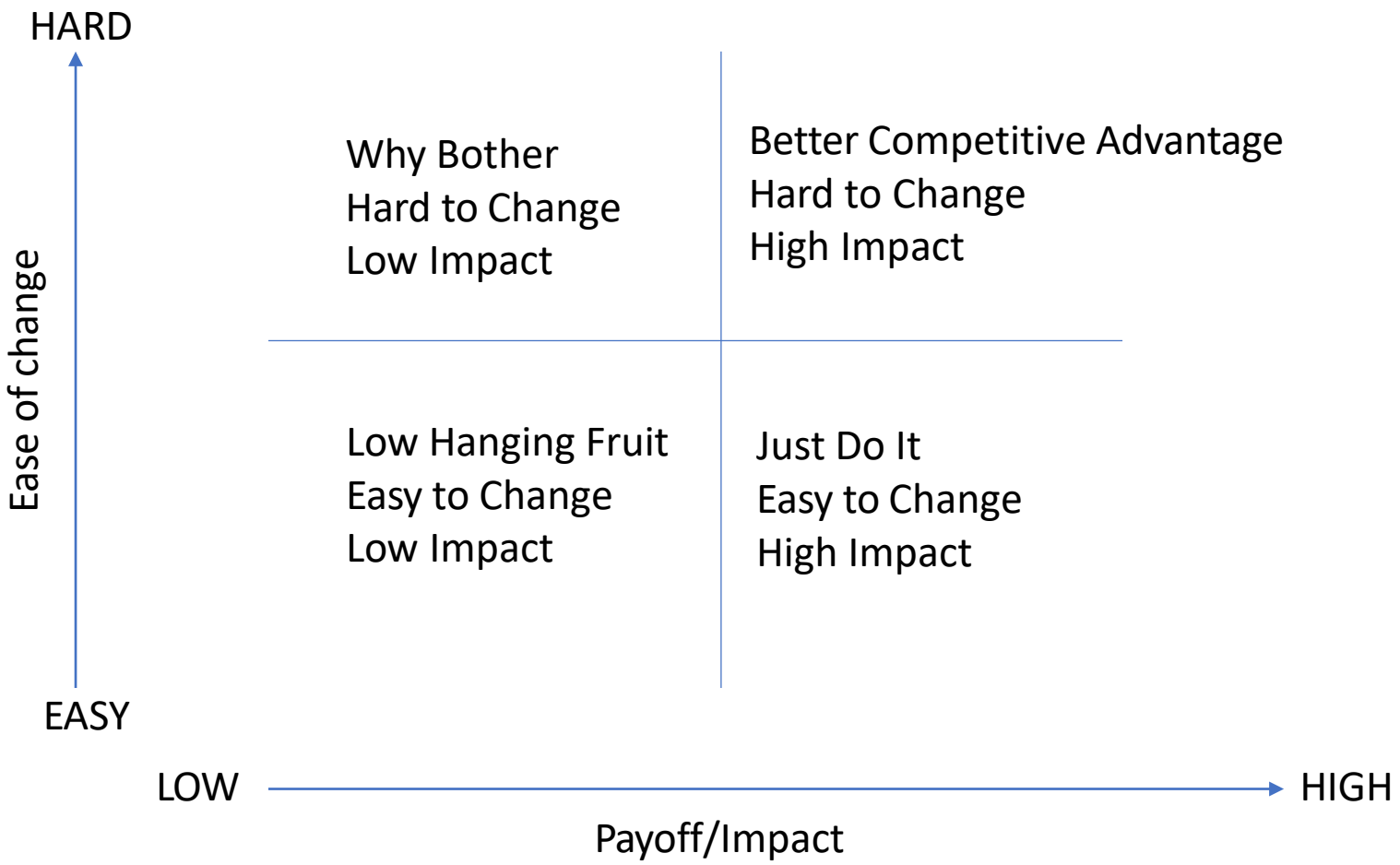
- START HERE

The Brainstorm

- An inclusive exercise meant to solicit ideas from all stakeholders
- Must be run by a skilled facilitator
- All ideas are welcome and no idea is judged
- Use your data
- Every idea is recorded; like ideas are grouped when the session runs out of new ideas
- Stay focused on the topic

PRIORITY MATRIX

Priority Matrix

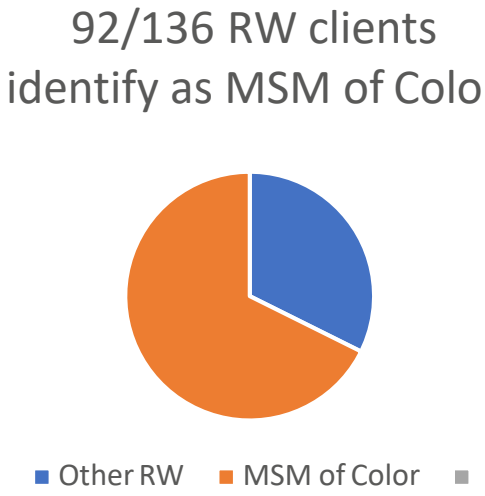


A REAL **LIFE** EXAMPLE

Erica Washington, MSW
AIDS Healthcare Foundation Upland/Riverside
Case Manager, San Bernardino/Riverside Counties CA
Upland HealthCare Center

Why MSM of Color?

What is your improvement opportunity?

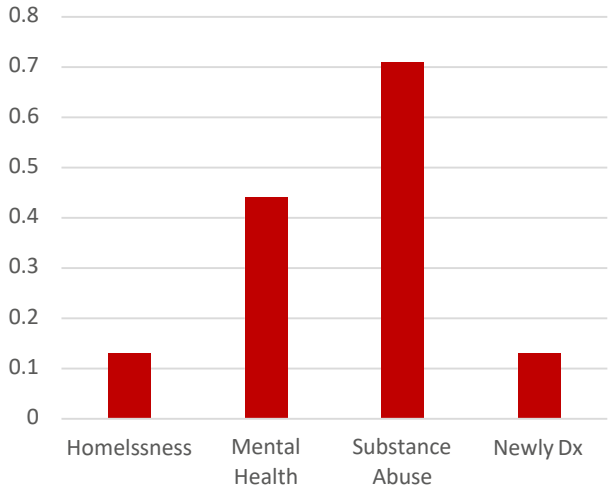


Why did you choose the selected subpopulation?

- We chose this subpopulation after completing the disparity calculator and finding the highest disparities amongst MSM of Color and AA and Latino Women. While both sub populations were at about 93%, there was just one woman out of 14 who was not virally suppressed and there were 6 men out of 92 who were not suppressed. We decided to focus our efforts with MSM of Color this round.
- Our improvement opportunities were to maintain high rates of VL suppression and to get as close as possible to 100% VL suppression.
  - 68% of all RW clients served at our locations were MSM of Color

Tools for Data Analysis

Data Drill Down



Data drill down of 16 unsuppressed clients throughout collaborative.

Root Cause Analysis

Environment

- Decrease length of wait time in clinic
- Teamwork, multidisciplinary approach

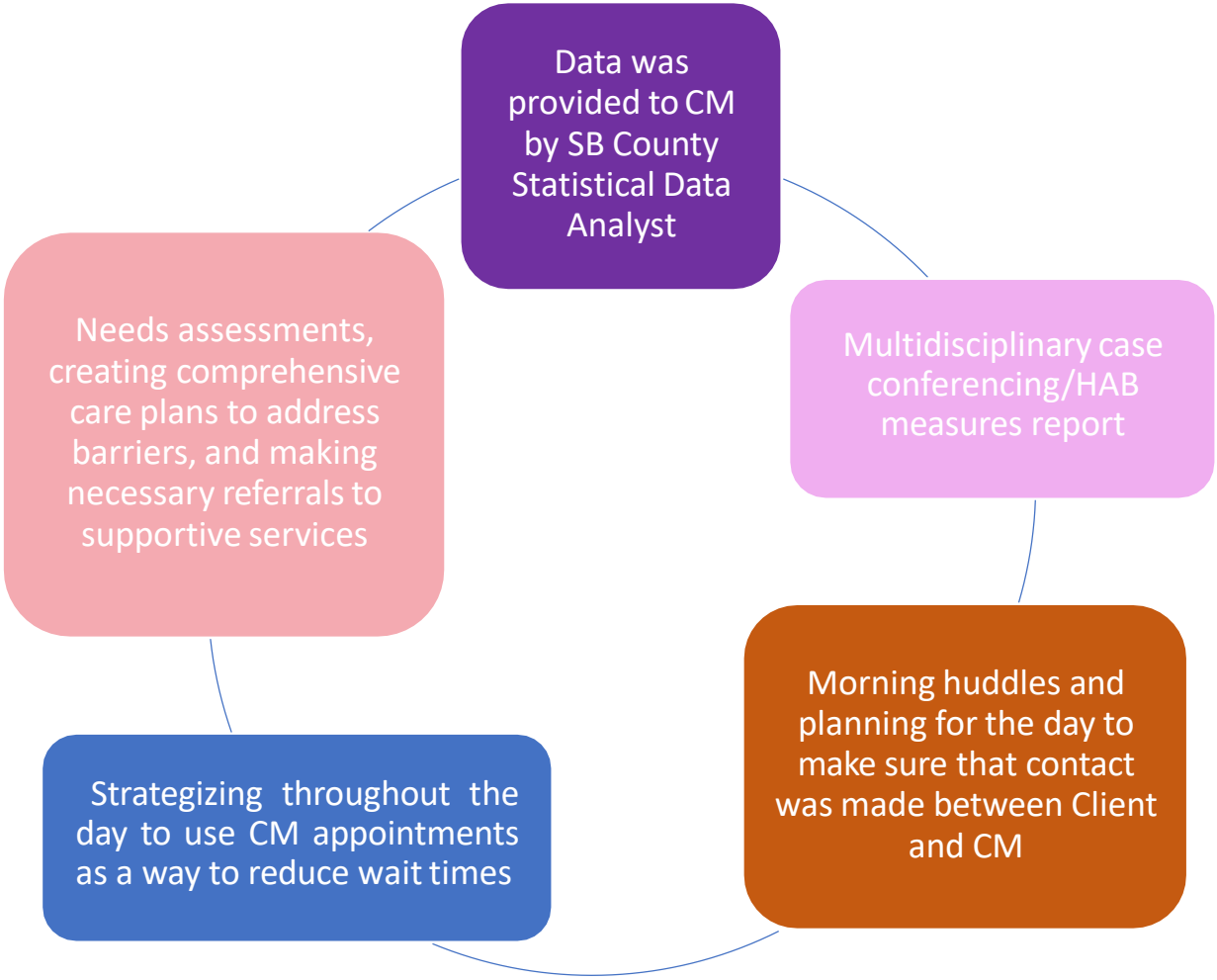
People

- **<u>CM to link with all clients who have detectable viral load</u>**.
- Staff/provider/consumer training to on disparities and needs of affinity population.

Processes

- Enhance multidisciplinary team approach to client care
- Case conference patients who are not virally suppressed
- Access to transportation

Implementation



Results – Drilling Down Data to Patient Level

- 9 MSM of Color patients **case managed**
  - 8 Became virally suppressed through care planning and case management interventions
  - 1 patient unsure – assume not suppressed; LTC
- 7 MSM of Color patients **not case managed**
  - 4 became virally suppressed by using a range of services to make it easy to access services without a case manager
  - 2 transferred care
  - 1 LTC
- Results: 14/16 patients became suppressed

Integrating Changes into Staff Roles - Plan

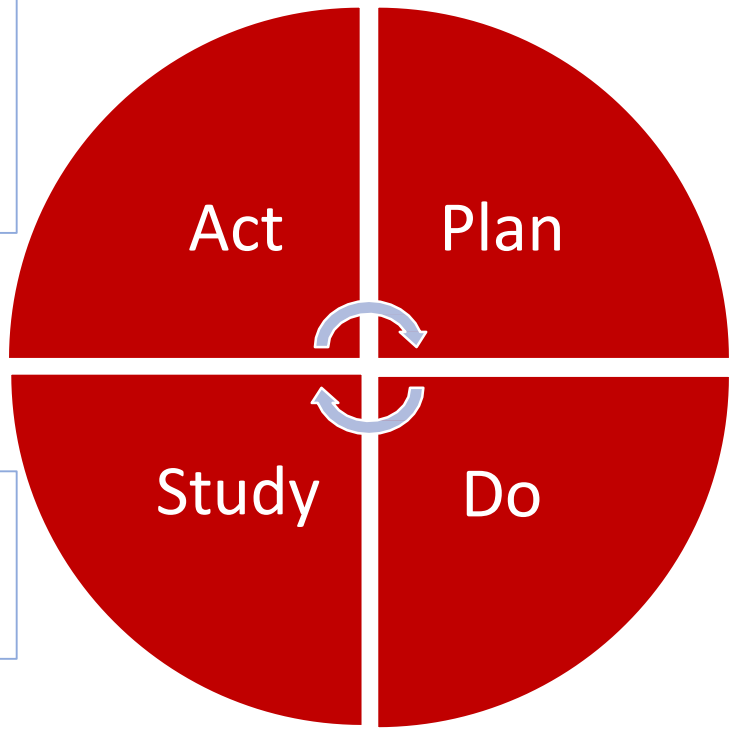
Task	Who	When
CM Outreach to remaining unsuppresed MSM of Color	Case Manager	12/31/19
Re run Disparity Calculator	Case manager	12/31/19
Complete second Data Drill Down, Print list of clients not suppressed	Case Manager	12/31/19
Follow up on getting our lobby TV to play educational material	Receptionist	8/31/19
Implement Nurse Manager Position to serve a Liaison for referrals into Case Management	Provider	8/31/19
Incorporate more substance abuse and mental health education in support group	Case Manager	8/8/19
Post message on back of clinic door encouraging all clients to complete feedback survey on their way out of the HCC.	Receptionist	8/31/19
Provide ongoing adherence education, address barriers, etc. Use of pamphlets, teach back tools, pill planners, transportation assistance, switch to mail order	Case Manager/Provider/Pharmacy Reps	8/31/19

AHF Work-plan for MSM of Color

TASK/WHAT	WHO responsible	WHEN completed by	RESOURCES/ COMMENTS
Continue Cm outreach to engage remaining detectable MSM of Color in CM services.	Erica Washington	12/31/19	
Update new MSM of color spreadsheet with new data	Erica Washington	12/31/19	
Create work flow to help funnel detectable RW clients into CM through Provider and Nurse Manger assessments.	Erica Washington and Patricia Salas	ongoing	Pending a nurse being hired soon.
Incorporate findings into our Provider and Consumer Trainings	Erica Washington	10/11/19	
Provide medical case management to unsuppressed MSM of color	Erica Washington	Ongoing	Provide actions according to the individual patient barriers.
Complete Story Board for AHF Upland	Erica Washington and Staff	8/7/19	
Multidisciplinary Team Meeting to see what interventions are having impact on suppression.	All Staff	8/7/19	Work planning lunch session
Schedule a presentation for ECHO Collaborative MSM of Color	Erica Washington	October/November 2019	Planning to present at Provider training and on CQII webinar.
Review data to see what actions produced results and incorporate these actions into the clinic for unsuppressed patients.	ECHO Team	01/31/20	Incorporate interventions that assisted in VL suppression for all unsupressed patients.
Provide a new spreadsheet on all unsuppressed patients in the clinic. Update format as needed.	Erica Washington	01/31/20	Phase II

Overview of PDSA Cycle

Continuous assessment of Clinic workflow and effectiveness of strengths based CM interventions.



Planned to increase rate of VL suppression from 91.91% to 95% through strengths based Case Management and multidisciplinary team planning.

Aim was not met, but important lessons were learned. Workflow strategies to engage clients in CM needs work.

Little by little, we engaged unsuppressed clients in CM. worked hard to identify pt. barriers and conference with new Provider, and connect Client to necessary resources.

Dental-HIV Integration QA PI Project

Zufall Health Center
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Director of HIV Programs
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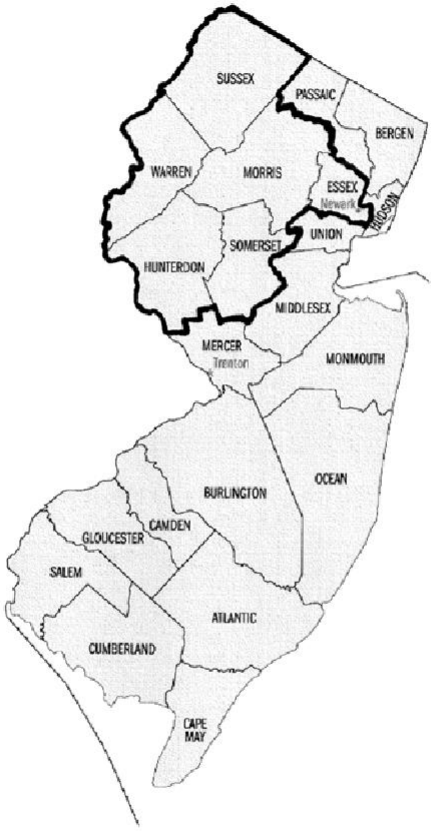
Chief Medical Officer

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

ZUFALL HEALTH COMMUNITY HEALTH CENTERS



Zufall Health Center

- FQHC in Northwest NJ serving 6 counties (suburban/urban) at 8 sites, 2 vans
- Medical and Dental services at all sites
- HIV/primary care services at four sites; Newark EMA Part A, Middlesex TGA Part A, and Part C Funding
- 208 active patients; viral load suppression rate 93%
- Integrated behavioral health, medical and dental services model

Care Model and Model for Improvement (PDSA)

May 2017 HIV Clinical Indicators: Additional Measures

Achieving Goal

Mental Health Screening 93%
- ZHC Goal: 90%
- HAB Goal: 36%

Nutrition Counseling 99%
- ZHC Goal: 95%
- HAB Goal: 65%

Yearly Cervical Screen 63%
- ZHC Goal: 75 %
- HAB Goal: 63%

Needs attention

Dental 40%
- ZHC Goal: 60%
- HAB Goal: 35%

Tobacco Cessation 66%
- ZHC Goal: 70%
- HAB Goal: 61%

What are we trying to improve?

Description	Percent of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year
Numerator:	Number of patients with a diagnosis of HIV who had an oral exam by a dentist during the measurement year, based on patient self-report or other documentation
Denominator:	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges[1] at least once in the measurement year
Patient Exclusions:	None
Data Elements:	1. Does the patient have a diagnosis of HIV? (Y/N) a. If yes, did the patient receive an oral exam by a dentist during the measurement year? (Y/N)

Steps in Process Improvement

- Focus on Dover due to residency program/largest HIV care site with a dedicated team
- Engage residents in HIV care through training, curriculum development, staff support
- Schedule screening visits during medical visits and make dental appointment
- Identify patients due for dental via data reports and at huddles
- Develop reporting tool using EMR and Bridge-IT to analyze and track data; share data at meetings

Successful PDSAs

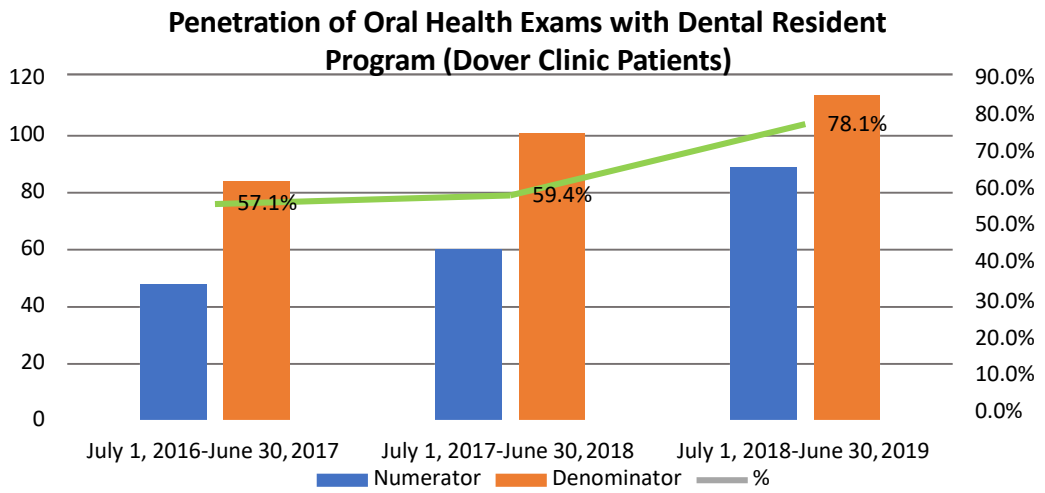
- Residents received specific training on stigma, HIV and oral lesions, and motivational interviewing
- Medical case managers and Linkage to Care navigators trained on importance of oral health and reviewing dental risk assessment tool
- Blocked dental schedules to improve access to patients when seen at medical visit
- PCPs received training on head and neck exam
- Patients screened during clinic visit receive a goody bag (toothbrush, toothpaste & dental floss)

Dover Clinic Patients

Numerator: Had appt with medical provider + dental exam during resident program year

Denominator: Had appt with medical provider during resident program during resident program year

	Numerator	Denominator	%
July 1, 2016-June 30, 2017	48	84	57.1%
July 1, 2017-June 30, 2018	60	101	59.4%
July 1, 2018-June 30, 2019	89	114	78.1%



Next Steps

Spread successful PDSAs to other sites

Review and develop dental follow up process for MCMs

Continue to provide trainings on HIV to medical and dental staff

Questions?

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