WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Electronic Health Records, Session #2

Community of Practice (CoP)

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Electronic Health Records, Session #2, Community of Practice Webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC.

The Partnerships for Care project is a three-year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department. And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, or HIV TAC.

Our presenter today is Heather Budd. Ms. Budd is passionate about clinical delivery transformation using data as a foundation for trust and measuring and driving improvement. Heather works at Azara Healthcare, which offers the business intelligence software DRVS, a scalable web-based data warehouse, reporting in analytics solution for community health centers.

Prior to that, she was the chief operating officer and director of quality at a community health center in Rhode Island. She led a care team transformation project which achieved NCQA PCMH level three, and partnered with a Medicaid payer to blend claims and clinical data. Ms. Budd was a health IT consultant and also started her career at Dana-Farber Cancer Institute, where she developed her love for quality improvement, and learn firsthand about care delivery and patient satisfaction. Please join me in welcoming Ms. Budd.

HEATHER BUDD: Thank you so much, Steve, for that kind introduction, and hello, everyone. Welcome to webinar two. Today we're going to be talking about specifically the data and the reports that are really needed to drive quality improvement in HIV care.

OK, so this is really just a little bit of background about the project. I think those of you are on the phone are probably familiar with it. Mostly we want to just make sure that we give credit to both HRSA and the CDC for making this funding available for the project. And really, the intention is to make sure that we get HIV prevention and care services within most-impacted

communities. In particular, surveying people living with HIV, especially those with racial and ethnic minority. And then also, supporting workforce development, infrastructure development, and service delivery across the [INAUDIBLE]. In particular, developing sustainable partnerships with state health department as well.

All, right so we're going to get into the meat of things. We're going to be talking about measure and reporting tools. And I always like to start with this slide, just to remind everyone that data really is not just an IT project. It can be so tempting whenever we're dealing with something technical-- and data of course falls within that realm-- to outsource these kinds of thing to the IT team. And of course we value the IT team extremely, but I think it's very dangerous to ask them to handle the whole thing.

And so it's important to have real sponsorship at the very top with your executives, and then working through population management leads, QI, QA. Course you need your network admin or DBA. Those from your team with EHR and HIT expertise. I mentioned QI already. Certainly having provider representatives. And I also really think having clinical support staff representation is very important as well. They're going to really be able to tell you where the rubber meets the road, and kind of how data is actually being entered in reality versus pure theory.

So I'd also like to just start by talking about what I see as the three layers of data quality. The very top layer which you see there is what I call external performance. You can also call it regulatory or compliance. And these are reports that we're all required to turn in to prove our performance. And a great example of this would be the [? P. Christie ?] data that you're all handing in because you're part of this grant.

That means that there are predefined measures and certain data elements that are tracked over time related to particular goals. And there's not a whole lot of control that you have over how these measures are defined. So you simply have to report them, and hopefully you're doing a great job collecting the data.

I think where the real work gets done is in this middle layer, which I call QI and population management. So it's a combination of delivering the care to the patient, making sure they're getting what they need, and incorporating the concepts of patients [INAUDIBLE], the wrap around services, care management, things like that.

But it's also really monitoring your data on an ongoing basis to make sure that it actually reflects the quality of care that your team is delivering so that you're getting credit for all the things that you're doing. And that means recording in such a way that your various recording tools are able to capture it. And this can also help you track and monitor QI, Plan-Do-Study-Act interventions, and watch the trends that you can understand which direction you're headed.

And then finally, point of care, which is what I like to think of as pre-visit and in-visit planning-- actually huddling to be sure that you're going to be delivering the care that the patient needs.

And then I like to incorporate the concept of care management here as well, because I think it's an opportunity for your care managers-- and particularly for those of you on this call, who probably have some HIV-specific care managers if you're fortunate.

You may have them involved in this process as well so that they can be aware of who's coming in on that particular day, who they want to have a face-to-face chat with, or perhaps who they want to make an effort to call and really follow up with later to see that they've understood any medication changes, the care plan that's been suggested for them, et cetera.

All right, before we even get into the external reporting, I just want to kind of talk about some general tips for success that I like to follow with regard to data management. So for me, it's really important-- and as a quality improvement director, this was essential for my role-- I think it's really important to create your own set of accountability. So for me that was partly having an agreement with the person that managed me around how often would reports be shared with the rest of the team, how often was I going to be looking at certain metrics, what was the plan.

But also even just as basic as putting an Outlook reminder in your calendar just to make sure that you run reports on a regular interval. It's so easy, especially in community health-- as I'm sure all of you are very familiar, it's easy to get caught up in the fires of the day. So quickly, a month can pass by, and then another one, and you have all these wonderful intentions of running data and an understanding it, but it can pass you by quickly if you don't have those Outlook reminders in place. Or other ways to remind yourself. Obviously there are plenty of other methods you could use.

I'm also a really big fan of sharing results. I think sharing those results with your team, posting where everybody can see them. Sometimes that's the break room, sometimes that's on the internet, or intranet. You may have an internal sort of internet situation where people share information.

And then there are some practices that are also brave enough to share it on the web with their patients because they've made quality improvement such an essential element of their practice. And I think that doing this at regular times is important as well. Celebrate success at staff meetings consistently. Make it a recurring agenda item to really highlight something that's gone well. I think having a positive spin on things really helps.

And then just making sure that everybody's aware of what are the important measures that we are trying to work on at any given point, what's our strategy, ideally, what are our targets, and where are we? Kind of how are we doing? And then I also have this concept which I call kind of creating your own prescription for data usage in your practice.

And so to me, that means kind of setting up. For the given reports that you plan to have your staff use, that you've really set the what, who, when, why, where, and who's the responsible administrator, so that there's a very clear set of accountability, and also understanding why

you're actually doing something. And then who is it going to be shared with? What are you actually trying to accomplish? If you kind of make that clear to staff, and set up those regular intervals again, and establish a way for the team to know that things need to happen, you're going to be much more likely to be successful actually managing your data.

So what I want to start with here is just-- We're going to be walking through a number of examples of what reports might look like in terms of managing in your practice the HIV data. And so this is an example of what I like to call a measure of score card. And really what this is is a collection of measures related to a particular topic. Of course, I chose HIV for this particular presentation. And these are the P4C measures, as you guys will probably recognize.

And what I think is nice about this is just seeing the performance of the practice in aggregating, as you can see in our right hand side. I didn't include numerators and denominators here-- which do exist in this particular report-- because I wanted to be sure that no one would be able to identify which practice this actually is. But I think it's really great to be able to see the numerator and denominator as well, because it helps you understand the context of the performance results as well.

So I want to kind of just walk through each one of these measures. Because each of these measures has its own particular little idiosyncrasies. So just HIV testing in the lifetime of course, the main thing here I'm just going to talk about, what is the goal for each one of these? So the real goal here is getting an HIV screening to happen.

And then for the next one, HIV testing at medical visit reporting period. So this really relates to that medical reporting period. And again, it's just the same concept of getting the test done, but within a particular concept of the definition. The next is HIV testing at a non-medical visit reporting period. And as you guys know, this is the measure that's really trying to understand how many of our non-medical staff are actually helping us do these HIV screens. So it might be being done in a dental setting or something like that, where you're actually extending your outreach to patients and perhaps getting more patients tested.

Then new HIV diagnoses. I think this one's fairly self-explanatory, but essentially this comes down to confirming with a second test and entering the diagnosis correctly into a system. So the reason I like emphasize this here is that this is a challenge that we notice in working with a lot of practices that we have as clients around actually properly entering a diagnosis.

And what I mean by that is actually entering a date of onset. So oftentimes you might inherit a patient who actually had been going through ongoing treatment for HIV, and so it's really important to enter an onset date that's earlier than the date that you're entering that diagnosis into their record. And that will help differentiate between truly new HIV diagnoses to your practice, which need to be filed in a particular way. And of course there are EDF measures that are interested in that. As opposed to cluttering up that denominator of patients with those who are actually not truly new diagnoses for you.

OK, so then the next one is the new HIV diagnoses with the 90 day offset. Again, this is really getting the test done again to confirm with that separation of 90 days. And then the next one is new HIV diagnoses with follow up. This of course is looking to make sure that there is a visit for HIV care initiated shortly after this happened. And this connects to the EDF measure that you guys are likely familiar with as well. This is just making sure that those patients we diagnose are in fact getting care.

And then the next one is new HIV diagnoses with risk reduction. So this is another one that I think many of our clients have struggled with in terms of just documenting the data. And we talked about this in the last webinar. The risk reduction counseling that needs to happen. And so few EHRs have an existing template or field into which this can be recorded.

So it really does require some work on the part of the health center to create a structured field and a home for this, and then make the effort to consistently monitor and make sure that it is in fact being recorded. And you can see for this particular practice, they're actually at 0% in terms of reporting it. Which means there's a nice opportunity for growth there, in terms of improvement.

The next one is new HIV diagnoses with the STD screens. So again, this is including that concept of new diagnoses, but in addition screening with the other STDs that can often be associated with an HIV diagnosis. Just being sure that the treatment that the patient is getting is comprehensive for everything that they're facing.

The next one is HIV patients with antiretroviral therapy, medication. And it's really around making sure that medications are in fact recognized as the ARTs but they are. Some of you on the call will know that there are a lot of challenges in managing medication, even at the federal level still. There are a number of different designations, RxNorm codes, which are kind of the umbrella for different categories of medications. So there you would actually see categories of medications, like antiretroviral therapy.

But most EHRs operate with something called an NDCID, and those are individual codes for medications, all the way down to the dosage and the root, et cetera. So they're very, very specific. And the idea is how do we properly aggregate all of these different medications, especially with the pharmaceutical industry continuously creating new medication as well? How do we keep these lists up to date and make sure that we're in fact giving you proper credit for the work that you're doing? So just walking through the different issues with that.

Next is the HIV retention and care. Making sure that there's an HIV visit within the year, and also making sure that we actually retain those patients. They don't go out of our care. And then the next one, which I actually think we started-- yeah, there we go.

So the next one is the retention in care, where there has to be two HIV visits where they are greater than 60 days apart within that year. So again, that's just an attempt at measuring whether the patient is getting the care that they need across the continuum of time.

So the next one is HIV-positive patients. So again, this is just emphasizing the need for documenting that diagnosis properly in the EHR. Next one is viral load. And these two I'm going to talk about together, because less than 200 versus less than 75. Of course they mean different things, but the material that I'll mention here is that it's important to ensure that the data is being captured properly, that you are understanding the difference between results that are given in logs versus those that are given in absolute values.

And they really do look quite difference. There also are often results that come back with a less than sign in front of the numerical piece. And so this all can impact the way that reporting actually comes out at the lecture. All of you have grappled with this, but I just think it's important to understand and talk about all these different issues that can come up.

So we're going to talk about measure analysis here, and kind of the goal of data validation. So what I want to show you here is the value of trending. And so this is an example of a report that's showing you over time, we're looking at trailing year period. So that's what the TY stands for. Looking at a particular health center's performance over four different months. But of course each of these month periods that you're seeing actually encapsulate 12 months worth of data.

What we can see here is as they go over time how are they doing. And so there's a very slight downward trend here-- just 1%. Without kind of doing a statistical analysis, it's hard to know if this is significant or not. My guess is it's probably not, it's just something to be aware of. Looking at anything in kind of a trailing year sense also smooths out some of the jags of the trend lines so that you can get a little bit better sense overall of how things look.

And so I'm going to try to take viral load as an example here and how it actually can impact the data. So considering the time increment impact on data. So looking at data monthly rather than by the year or the trailing year to give the data more life, [INAUDIBLE]. As I mentioned, the trailing year period does smooth out the various different trends. But if you look month over month, which is my favorite time period to look at data-- particularly if an act of intervention is happening within a health center.

I want the data to be sensitive enough so that it's only looking at the patients who came in for an encounter during that particular month, so that I can see if that intervention is in fact effective. Couple different things I like to look at as well, particularly when I can see the data by month.

You can see if there's any kind of seasonality to this particular challenge-- which I don't think would make sense with viral load, but certainly can make sense with flu immunizations, for example. Has there been a steady decline, or any other sudden change? When did the decline begin? And thinking about how does that correlate with any other changes that you might be aware of?

Perhaps you changed lab vendors. So again, thinking about viral load, and knowing that results come in in different formats. If all of the sudden your reporting is not capturing a new viral load result because of that numeric sort of difficulty, it's worth looking into that and investigating to see if you can solve that by simply making a change to your reporting.

OK, so there's a couple different-- just to go into a little bit more detail. I've mentioned some of this already. But the viral load data challenges that I'm aware of, first of all, results can come back either as LOENC, which is the codified set of lab identifiers, essentially as laid out by the federal government. And so if your result comes back in that [? box ?] you will absolutely be able to know that the result is in fact a viral load.

However, there are many smaller reference labs that still don't incorporate the LOENC identifiers, and so you'll get a result by an order name instead. So again, just making sure that you're taking into account all the different possible viral load lab names that could be in play, and knowing that sometimes reference labs will change those name-- sometimes it feels like on a whim. I'm sure it's not. But it's something to be aware of, because they aren't static.

All right, and then just really making sure that you're standardizing those lab results to calculate the results based on measures. Now looking at the results themselves, I mentioned before considering the log copies versus the standard numeric or absolute results. So ensuring that a reporting system can differentiate between these two so that you actually get a meaningful value when we're talking about that less than 75 and less than 200 measures. And this here's just a little example of how the logarithms work. And you'll probably remember this back from probably middle school or school.

All right, so I also think it can be really valuable to look at data in terms of comparison with your peers. So these would be health centers. And of course they're de-identified here. But the idea is to be able to see where do I stand in comparison to my peers? And in this case, we're just following that viral load measure all the way through so that we can understand it in a lot of depth.

So in this particular case, the center is toward the bottom of the pack. But it just sort of says that there's a lot of opportunity for possible growth. And what I would do in this case is reach out to whoever the health centers are that are over on the far left hand side to try to understand how are they doing this, and what do we think we're missing. And I'd probably do an investigation first, so we're going to keep drilling down through the layers of the data to see what would we want to do differently to impact our measure. So we're looking inward and also looking outward for some best practices to help us.

OK, so here you can actually compare your locations as well. Sometimes there are differences between locations, whether they be the physical layout, the services offered, the staffing model, the resources, and anything the patient population that actually tends to come in to this particular location. So that can impact the results. So you may find this to be a meaningful way

to look data, or it may not be as helpful. But it's important to know is this a lens through which you want to actually investigate your data?

And then this is what I think might be the most interesting level to really look at, and that is to compare your providers. So again, there are going to be certain providers that don't see a lot of HIV patients. And so they very well may not need particular investigation. If you look over on the very far left hand side here, you'll see that there's-- I don't even know, something like 15 providers that are at 100%. If we hover over those bars, my guess is that the denominator for those providers are probably fairly low, so it's easy for them to be in compliance with this measure.

But the ones that kind of start around 90% are probably your truly high performance, and the ones that you would want to look for with harvesting those best practices. And then you can look all the way to the far right hand side and understand who's actually needing some additional support. Are these results for some reason coming in differently? Is a provider ordering an unusual or more rare viral load test that's coming in with one of those results that we talked about that you're not aware of, and so they're not getting proper credit in the reporting tool? There's a whole bunch of different possibilities for what could be going on there.

And then I think it's really interesting to drill into each of those individual providers that you're investigating and trying to understand their trends. So in the first example, we see a provider who probably got some really good support and training, and really made some major improvements and hit 100%. And that's probably pretty unusual anyways to be at 100% compliance. But then fell back off a little bit, but still is in a really good range.

Whereas then we have example number two, where a provider it started out with 100%. And my guess again is that that's probably a low denominator-- a number of patients that he or she was seeing with HIV. And then really dropped off again, and then came back up. This is just really jagged data. And then kind of fell off a little bit again, but seems to be sort of smoothing out. The second one in particular is one that I really want to investigate.

What's the numerator and denominator for each of these? Really understanding what is happening. Again, I think it is a population shift that would be likely to be responsible here. Or is their support staff changing over time? Maybe there's not consistency there. Who knows? Again, there's a number of different things that could be happening.

So what I like to do from these investigations is to hypothesize different interventions that might help your improvement, so that you're planning a PDSA cycle that's really based on the findings of your analysis. And then take action on that intervention, possibly with a small set of provider teams really piloting the change. SO you can test to see if it's effective before you spread it across the whole organization.

Of course, study your results via the data that you collect. And also, really check out what does the data mean with more than just yourself. Take it to the quality improvement team, or meeting and really collect feedback on what others think is actually going. It can be very surprising some of the ideas and insights that can come out of that kind of conversation.

And then finally, take your next set of actions. Determine that the intervention should stay in place, be altered, be spread across the organization. Or maybe you want to test a new intervention, if you encountered some version of failure. Or maybe you're feeling successful and you've already spread it across and you want to test something else out that could be effective.

I think at the very bottom of the stack what's really important is to actually get into the actual detail that's behind the numbers that you're seeing for each provider. And so this detail list essentially represents each of the patients that make up the provider's denominator. And then in the numerator column, you can sort of see there it tells you whether, via an N or a Y if they've met the numerator.

And so in the cases of the Ys, you're going to see the viral load absolute, a log copies, the actual results, and the types indicated. If they are in the No, they're not compliant, and so there's some interesting results there. And it's also possible that those results are out of date. So all these different things that you want to investigate. They may need to be brought in more recently.

This gives you the opportunity to really compare what's happening in your reporting system versus what do you see in the actual EHR itself, and making sure that there's credibility around the data itself or the providers. That's number one. And then two, what can I learn from this detailed data so that we can make changes in the way we operate.

I also think that doing validation from that level of detail is really important. I just mentioned comparing the EHR and your reporting system. So what I like to do it basically mimic the fields or the columns that you're seeing on the reporting system, and then making a spreadsheet that replicates all of that, and then going into the EHR and working through a series of patients.

And just taking a sample to figure out to, do these patients and their results-- in this case, the viral load results-- actually mimic what we're seeing in a reporting system? And if they don't, what do we need to do to take action to be sure that we fixed whatever the problem is? And then of course communicate your findings, either to your vendor, or if you're doing internal reports, to that report writing team, and/or potentially to your reference lab, who may be doing these tests for you.

OK, we're going to talk about registries now for population management. Again, this is really in that middle layer of the three different layers of reporting that I talked about. So I'm going to walk through a number of different registries. And the slide-- essentially what I'm trying to do

here is each of these layers and the different data points going across are really to illustrate what I think are helpful pieces of data in order to manage a population of HIV patients.

So this is not just limited to P4C data elements. This goes beyond that. We have a number of clients who have [INAUDIBLE] reports for the AIDS Institute in New York, and many of you are involved in Ryan White reporting, et cetera. And so a lot of these different data points are useful for you in terms of managing your population of HIV patients. So of course the diagnosis codes, the depression screen, the result of those depression screens, knowing that there's a real emphasis on mental health management of these populations.

The screen type itself, violence screening, which can be very significant for certain members of the population. Of course, wanting to understand whether they're using any form of tobacco, so there's the data of that as well as their status. Have they received cessation intervention if they're a tobacco user? Anxiety screening, again back to the mental health kind of emphasis of this area. PTSD screening, cognitive function assessment, sleeping habits assessment, appetite assessment, psychosocial assessment.

And those last five there are again things that aren't necessarily always well capturing in the EHR. There is a [INAUDIBLE] that's often in some of the EHR. So the PTSD screening, the cognitive function assessment, the appetite assessment, and psychosocial assessment are often not available out of the box in most of the electronic health records. So those are things that you probably have to create homes for, as we talked about.

And then having a registry to help you track whether or not this data is being recorded is incredibly helpful. So by the time you're ready to go ahead and report a number of these different things when you get to that compliance level, you don't have to go back and fill all the data in.

OK, so again continuing on some of the general data needs for HIV. The BP dates, the systolic and diastolic measurements for the blood pressure, ophthalmology referrals, medication reconciliation, last physical, rectal exam, colonoscopy, mammogram, hypertension. So just whether or not they are in fact hypertensive. It would include their diagnosis code there. When was their last flu immunization? And again, also new [INAUDIBLE] vaccine. And also prophylaxis medication.

And then we've got [INAUDIBLE]. Some of these we've already talked about, but I'll just keep going through here. So of course this most recent CD4, minimum CD4, tuberculosis dates, the result of that, most recent Pap. And of course, there's a need to differentiate between anal Pap and also the other kind of Pap. Viral load dates, we've already talked in detail about these. Anogenital HPV, and then of course baseline resistance testing as well, which of course helps you figure out which medication makes the most sense for the patient.

So in population management, we use registries for outreach to patients who need to come back for visits, screening, tests, medications, et cetera. I'm sure you guys are all very familiar

with that. I also like to recommend the use of registries for care managers to help zero in on patients who need additional help or services. This is to sort ascending or descending results like labs to assess the patient's health and any kind of need for immediate intervention.

You could also sort by results in mental health screenings, things like that. That's another way to a better integrate your behavioral health team as well in terms of the care of HIV patients. But again, the whole reason for looking at these registries, along with patient care as we were just talking about is to be sure that the data is actually making its way into your electronic health record in such a way that it can be incorporated into a reporting system.

So this is really getting at data at the point of care. I'm a huge believer in using a visit planning report and incorporating HIV-specific data in that visit planning report. So we're not going to spend a ton of time on this, but the whole idea is that rather than doing a manual chart audit for what to actually do for a particular patient that's coming in that day, really letting the reporting system leverage and harness the power of all the data that you've already captured and making it meaningful and actionable on a given day.

So this is just an example of what a visit planning report could look like. You'd have your patient-- actually, this doesn't happen to show an HIV screen on it. But that's a great examples of one of the alerts that can come up to help you increase the number of patients that are getting HIV screens in your population just in general.

So that's really going to help you with outreach. But also, you could incorporate things like the viral load and CD4 counts et cetera. I know this planning report is specific to HIV patients, so that you're insuring that all the different data points that need to be collected are both-- that the care is being delivered, but also that it's being documented in such a way again that it can be captured so that by the time you do reporting you don't have to go back in and enter data in order to make those reports work.

So this is just kind of a list of some alerts that might be incorporated in a visit planning report. And you can just go to the next one as well. These are just examples. It's not all the way everything that's possible. But certainly it helps incorporate HIV into all of the other comprehensive care that we're trying to offer in primary care setting.

So we're going to take a little bit of time to talk about referral management and care coordination, because we're moving toward thinking about sharing data with other entities as well. And obviously there's a number of different referrals that need to be managed for HIV care.

So I like to break the referral process down into a couple of different steps. The first one is the order date. The order date of course is the moment that the referral was actually placed in the record. Then I like to track when was the referral actually scheduled. So this means maybe your referral management team called-- let's say it's a dental referral for an HIV patient. So this means that your referral coordinator calls up the dental office-- if it's not your own internal

dental service-- and basically gets an appointment for the patient. So now that's the date that the referral was actually scheduled.

The next bucket is what's the date that the actual referral was obtained? So this is the date that that referral actually occurred. So it means the date that the dental visit actually happened. And then hopefully you get a result back from whatever practice you referred to and we can close out the loop-- or start to close out the loop-- with the actual resulted date. So this is the day that you actually received a consult note or an update or that kind of thing.

And then finally, some practices-- and I think this is actually a really, really important idea, particularly for STCA liability reasons-- encouraging providers to sign off on a particular result, and then marking that as the completed date. So that that is the final loop closing. Of course, those of you who are familiar with your patient center medical home standards, the closing of this loop is actually a pretty important component of that whole process.

So this is just an example of a referral registry, where each of those five buckets that we just talked about is captured, along with a couple of other different data points to help you manage. And this is really just to track the different referrals that are out there, where they are in their status so you can kind of tell from some of the gaps in the date, which referral hasn't been fully carried through yet.

And it starts to give you a sense of what tends to be the bottleneck for us. Is it because we don't have enough referral coordination staff? Is it because a lot of the practices that we're referring to aren't as interested in seeing Medicaid patients as perhaps they had promised they were? All kinds of different things that can be going on, and I'm sure all of you have faced some of these challenges as referral. But in particular with HIV patients-- although I think this is true across the board-- it's really important to be able to monitor this and be sure that the patients are in fact getting the care that they need.

And so this is actually where Steve mentioned that we were interested in having a little bit of a conversation with those if you are on the line with us. And we're interested because such an important part of this project is really interfacing with other external agencies. And health departments are one example of this, but they're really not the only. It could be that you're needing to refer outside to get additional behavioral health, if you don't have as robust a behavioral program internally, or other medical facilities.

And so I'm really interested in hearing how you're doing this. How you're sharing your data. And also, what kind of experiences you've had with trying to get particularly your HIV patients care externally. So I'm just going to give you guys a couple of minutes to start raising your hands and letting us know what your experience has been.

I know that there a number of you who worked with homeless patients for example, and the way that you managed their care is quite different than a practice who has just had more static locations, as opposed to doing more local outreach to patients. So I just want to kind of reach

out and say we're interested in hearing any of these models. Because what you have to say may help some of your other fellow attendees.

STEVE LUCKABAUGH: OK, if you have a comment here, you can raise your hand and we'll get to you. We did have a couple questions that came in. One's a clarification question on the measure for retention. I think the measured document reads with at least 60 days between visits in each half of the year. Clarification on the measure for retention, I think the measure document reads, quote, "with at least 60 days between visits in each half of the year."

HEATHER BUDD: Yes, that's true. That's what I meant to indicate, if that wasn't clear. Whoever wrote that is absolutely correct. Yes.

STEVE LUCKABAUGH: OK, and another comment. Some sites don't consider it a trend until there are nine data points. Also some organizations use control charts for variation analysis, common versus special cause. What are the thoughts on these approaches?

HEATHER BUDD: Yeah, I am a huge fan of-- well, first of all, everyone has their own opinion on how many different data points are needed to indicate a trend. And certainly, if you feel that nine is what you need, then that's great. I think I'm a big fan of control charts. And so for anybody who doesn't know what that is, it's really indicating an upper and a lower bound that's typical, almost like a standard deviation.

So you can tell when you're out of that realm, and that gives you a sense of direction, potential need for a tremendous, that sort of things. So yes, I am a big fan of control charts. Again, we're just giving examples of what things could look like. I'm certainly not giving an exhaustive, comprehensive run through of what all the different kinds of tools that are out there. Just an example of how you might analyze data to understand what's happening and to inform your intervention.

STEVE LUCKABAUGH: OK, thanks. Not seeing any hands right now.

HEATHER BUDD: I want to just sort of say too, for those of you who are out there. We're not just looking for successful stories around this. It may be that you're really having a challenge with this. And so I'm interested to hear if that's the case as well. I think many of you are potentially referring some of your patients for the risk reduction counseling to your health department. And I would love to hear how that's going if that's something that people are finding successful.

I think the intention there, as I understand it, is to try to provide an additional resource to really get that education around HIV prevention. And so I want to know if that's-- and I think probably the funders would be interested in knowing too if that's something that is working for you, are you finding it difficult, is there any kind of transportation barrier around that, is their availability, scheduling conflicts? I can imagine there would be a number of different barriers, as well as a lot of positives to this particular model.

STEVE LUCKABAUGH: OK, Cindy Cabalas has raised her hand. I will unmute you now. Go ahead.

CINDY CABALAS: So you're asking for some of the challenges that we're experiencing? In terms of coordination, first, we don't have specialty teams here. We have I think nine integrated primary care teams with live representation, from medical, including medical providers, MPs, MDs, RNs, CMAs, unit clerks. But then we also have some site case management, behavioral health, outreach, and housing support staff here.

And what I'm finding to be a challenge for us is really being able to share the information with staff so that they can react to it. And also in terms of just coordinating different ways. Some of the issues are, it seems to be hard, if you can even share the data, to get people's attention to what our performance currently is.

I think one of the challenges we've also had too is the assumption has been, because we've had Ryan White funding, we're already doing this. And I think we're finding that a lot of the data is showing-- we're doing it, but we're not doing as well as we though, necessarily.

HEATHER BUDD: Yeah, yeah. That sounds like what I've seen kind of across the board too, Cindy. Can I just ask you some clarifying questions around this difficulty of sharing data? Can you just share a little bit more about specific challenges that you've experienced? You mean that you're having a hard time sharing representations of the data? Or is it more specific to each patient? Hey, this is what's going on with Heather. How can we as a team address it? I just want to understand what you're--

CINDY CABALAS: So on the latter end, when it comes to-- we are using the what we call huddle reports. The trade of reports on a daily basis to see what kinds of things might be on slate for a patient that's been seen in the clinic on that day. Unfortunately, the HIV module isn't turned on yet. But we're getting those kinds of ticklers and reminders for like A1C, which are flu shots.

But when it comes to sharing provider-level data, we really don't have a forum for that. We really have had some discussions about how it would be great to share information across the organization, and it would be great to share information with our patients and clients, but there really isn't a mechanism for it. Even at this point right now at our PI committee meetings, the focus tends to be primarily on just UDS data and [INAUDIBLE].

We've talked about possibly presenting HIV team of care data there, but there seems to be some resistance to showing just grant-specific data there. When I've been able to sneak in a measure or two in terms of like a project team meeting, there seems to be a lot of interest. But there just doesn't seem to be traction in terms of where and how to share that. So I'm kind of interested in how other organizations might be overcoming that. Or if they're not making it an issue to share with staff at all.

HEATHER BUDD: Right, yeah. I think that's a great question. So can I just ask one more clarifying question? Then I'm really interested in if any of your peers have anything to add to what you

said or feedback for you. But I'm curious, is some of the data sharing really case-specific? Like we're having a challenge with this particular patient, and kind of wanting to problem solve together? Or is it really more how do we get this patient the care that they need?

CINDY CABALAS: It's more the macro than the micro. We're not really doing case-level, like individual patient-level discussions using data. It's more looking at us as an organization, what is our aggregate performance. How are we as a whole performing on this measure? We're just now beginning to implement peer review or peer comparisons.

So we're very early in that stage. But again, the emphasis is that this plan is just looking at EDS measures. So it's just very challenging. We've got some great comparison data, like for the [? Gardner's ?] cascade continuum of care. We've got some really good data to show how we're comparing against the state and against national data. But there's no form to share that.

HEATHER BUDD: Interesting. So it sounds like a lot of realizations have been coming up for you around this particular grant, or even just the assumption that you had Ryan White funding and the [? Pap ?], and so everybody's doing this. But in fact it's not really being done as consistently as you thought. And do you think that's more about documentation, or is it a combination of documentation and execution or delivery?

CINDY CABALAS: I think it's both. Because for example, it's an issue of documentation, as you highlighted, with risk reduction, behavioral, screening, and counseling. There's no structured placed to document that, really. And even when we have done chart reviews to look at the different provider notes, it's not always consistently documented. I think it's also a matter of process, because I think we're still in the process of updating and raising attention to what an ideal screening practice should be for the organization.

I mean, I just had a meaning last week with the disciplinary team that's really interesting. So I raised the question, if these are the screening criteria based on CDC guidelines and US preventative task force guidelines, how many of you actually are having conversations with your patients or clients about this? And half the room out of eight people said they really aren't having that discussion. And that included a medical provider.

HEATHER BUDD: Yeah

CINDY CABALAS: So I think it's great information to share, if you have the forum to share it. And I just think one of the challenges I'm facing here is just not really having a forum to share it. I'd just like to hear if any other organizations have a way that they're sharing it with their staff, or are they not sharing it with their staff? Are they only sharing it with management? Are they not sharing it all?

HEATHER BUDD: Yeah, so that's the call to you guys. If there's anybody on the phone that would like to share what they're doing with Cindy. Whether it's successful or not, because I

think even just what you've tried is really helpful to know about. Steve, let us know if there's anyone that's raising their hands.

STEVE LUCKABAUGH: OK, I'm not seeing any hands raised right now. So this is your chance to chime in, folks, if you have a comment. You could also type your comment in the question pane, if you do not have audio enabled and I can read those out. But I'm not seeing anything right now.

HEATHER BUDD: Seems like this is something that would be really useful to follow up on. See if we can kind of work some more of this into one of the next webinars. Because I think that's going to be really helpful. And maybe if we give people a little bit more time in advance to think about this, then we'll have a little bit more feedback for you. I just really want to appreciate all your comments and willingness to share what you guys are experiencing, because I think that's helpful for all of us to be aware of.

STEVE LUCKABAUGH: Yeah.

HEATHER BUDD: At this point, general questions, Steve?

STEVE LUCKABAUGH: Yeah, anyone, if you have any general questions, you can type them in now, or raise your hand if you want to ask it. Victor, did you want to come in here?

VICTOR: Sure. Thanks, Steve. And thank you very much Heather, and also thank you to the Massachusetts League of Community Health Centers, for not only today's webinar, but the series in general for being the lead faculty. And just a reminder for everyone, you can register for the third session of the Community of Practice. The slides are not available for download at the moment, but we can send them out.

And of course, in the next couple weeks, we will be sending out via the listserv the registration notice for the third session. Just want to let you know that if you have the time or if you can scribble down the URL, the registration is open. And this will be on Thursday, May the 24 from 1:00 to 2:00 PM Eastern time.

And again, just an invitation for all the health centers to [INAUDIBLE]. Hopefully we can get you to participate both during our webinars. Participate when a presenter or a moderator asks for health center input. But also to serve co-presenters in some of our other communities of practice that we have ongoing and that will be forthcoming in the future. You should be sent out notices requesting health center participation. And again, just a thank you to those health centers who have participated, both during the webinar, responding to a question, and also for those of you who have participated at the Cooper Center.

STEVE LUCKABAUGH: OK, well I'd like to thank you for participating in today's webinar, and we hope that you're able to find the information provided useful as you continue your P4C project.

We ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email.

Today's webinar was recorded, and audio and video versions of the entire webinar, as well as the slides from today's webinar will be made available on the P4C website within the next few weeks. Copies of all our prior P4C webinars are currently available on the website on the P4C Resource Materials page at P4CHIVTAC.com. You'll need to log in to access the materials.

If you need login credentials, send an email to p4chivtac@mayatech.com. Thank you again for participating in today's webinar, and thank you Ms. Budd for that excellent presentation. If you have any additional questions for the P4C project or for Ms. Budd, please email us at p4chivtac@mayatech.com. Take care everybody, and we'll see you next time.