The Collaborative Connection

Summer/Fall 2013

Volume 1, Issue 2

DC Collaborative News

- Learning Session 8 will take place in the Charles Sumner School (1201 17th St, NW) on Nov 20th, from 9:30am-4:00pm. Please RSVP by emailing our Response Team Communicator Nima at nahmady@metrohealthdc.org.
- The DC Collaborative Response Team currently has the following vacancies: Quality Improvement Team (Lead and Support roles) and Provider Capacity Development Team (Lead and Support roles). Please see Page 6 of this newsletter for more information. Email justin.britanik@dc.gov with questions and to apply.
- Data submissions for Round 13 are due on December 27th, 2013. Please email our Data Lead Khalil at khassam@metrohealthdc.org with questions and submissions.

Inside this issue:

Welcome!

By Justin Britanik, Collaborative Co-Chair \ DC Grantee

I want to thank all of the agencies in the EMA for your efforts as part of DC Collaborative. We have been going strong since the Vanguard Meeting in January 2011. It is important to take a step back and reflect on how far we have come. Our efforts have not gone unnoticed either. The National Quality Center (NQC) is doing an internal evaluation, and included the DC Collaborative as a signature project. I wanted to let everyone know that blinded DC Collaborative data was shared with NQC's contracted evaluator, John Snow Inc. (JSI). This data was for NQC evaluation purposes only, and will not be otherwise shared or published publically. Our friends at NQC have been such a huge resource for us, and I am always happy to help them out.

Justin Britanik,
Quality Management Specialist at HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

Thank You all for your continued hard work, and your commitment to improving the quality of care for those in the EMA living with HIV through the DC Collaborative!

Response Team Co-Leads
Justin Britanik & Lena Lago

University of Maryland: Prevention Research Center

By Rachel Smith, Higher Education & Publication Liaison \ MD Community Partner

Funded in October of 2009 by the Centers for Disease Control and Prevention (CDC), the initial projects of the UMD-PRC focused on health improvement in Prince George's County between the National Capital Beltway, Montgomery County, and Washington, D.C. Relative to the rest of the National Capital Border region of Maryland, this area suffers disproportionately from a number of health problems.

UMD-PRC's funding from the CDC is currently being used to focus on HIV risk reduction in this area. The UMD-PRC is one of 37 developmental and comprehensive prevention research centers funded by the CDC. This interdependent network of community, academic, and public health partners works to conduct prevention research and promote the wide use of practices proven to promote good health. As a member of the DC Collaborative, the UMD-PRC seeks to support partnerships between community, government, and academic partners to answer research questions relevant to their common missions.

Rachel Smith, MSc
Deputy Director at the University of Maryland Prevention Research Center (UMD-PRC)

The unique environment of each jurisdiction in the EMA was carefully considered when crafting the updated QMP

QMP Highlights

- **The new QMP has a plan for activities through 2015**
- **The new plan better aligns with NHAS, HHS, and EMA goals—with a focus on retention and VL suppression**

Updated EMA Quality Management Plan

By Justin Britanik, Collaborative Co-Chair \ DC Grantee

The DC Collaborative EMA-wide QM Plan has been updated for 2013. It outlines the mission, vision, goals, and activities of the Collaborative for the next few years.

This QM Plan was originally prepared in 2011 by a Sub-committee of the DC Cross-Part Response Team under the leadership of Safere Diawara, QM Coordinator with the Virginia Department of Health (VDH). It was updated in 2013 by the HIV QM Plan sub-committee under the direction of Response Team Co-Lead Justin Britanik. The HIV QM Plan sub-committee is an interdisciplinary team that has been reviewing literature and samples of QM Plans and conferring for several months to develop drafts of the QM Plan. The drafts were reviewed and discussed at different levels of the Collaborative before final approval for publication. This final approved document will be shared with all stakeholders and healthcare providers who care for PLWHA in the DC EMA.

There are several noteworthy changes in this edition of the plan. The response team re-evaluated our vision statement to the following: ***The Collaborative's well-defined Ryan White network of community partners and resources will build capacity to provide quality HIV-related care and services for all persons living with HIV/AIDS in the DC EMA.***

Most of the substantive changes can be found in the work plan. We have made an effort to align with state and national projects to improve the continuum of care in the EMA through increased linkage and retention leading to durable viral-load suppression. Key activities include; a Regional QM Summit, a quarterly newsletter, and updates via GlassCubes (which has replaced ProjectSpace). New training opportunities for consumers in conjunction with A4Q have also been added.

Focus on the continued development and implementation of measurable outcomes and performance measures was a high priority. The new performance measure—***Viral Load Suppression Retention Measure***, which is defined as the percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/m at last viral load test during the measurement year—was included as it is relevant to our project.

A lot of hard work went into making this a living document. Please review the plan at: https://nationalqualitycenter.glasscubes.com/cube/document/517651.

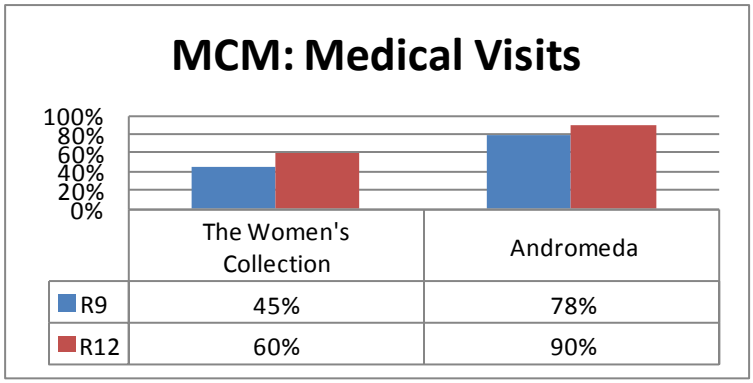
As you finalize your plan for your agency, be sure to review the EMA-wide plan to incorporate your activities and align your work. If you have any questions, or would like any technical assistance with your QM Plan, please feel free to contact me at Justin.Britanik@dc.gov.

Group projects involving providers and consumers from the most recent QI Summit (07/18/2013)

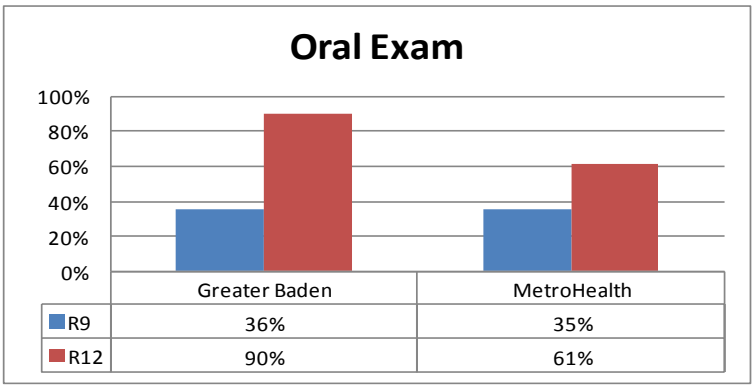
Focus on Data

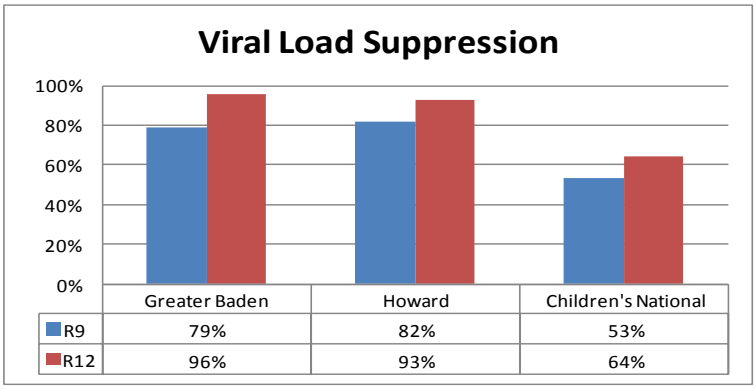
Compiled by Khalil Hassam, Collaborative Data Lead \ DC Provider

Most Improved Clinics in Medical Visits (MCM), Oral Exam, and Viral Load Suppression Measures

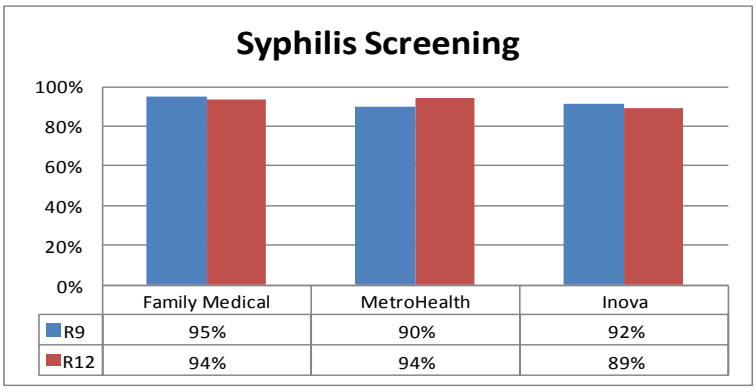


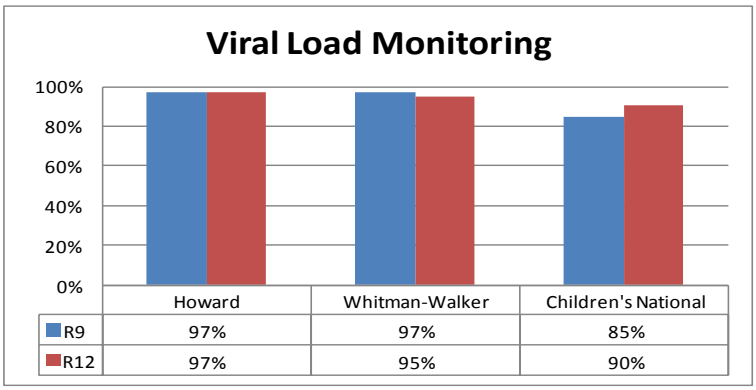
We have discussed EMA-wide trends in the last Performance Reports and will be discussing the most recent data at Learning Session 8 (November 20th, 2013). In the interim, we are taking a moment to celebrate our strengths. Looking at two years of data (Rounds 9 & 12) there are two groups of clinics we will focus on: those who have had significant improvements in measures (either through data integrity or clinical improvement) and those clinics who consistently perform at a high level. Below are just a few highlights.

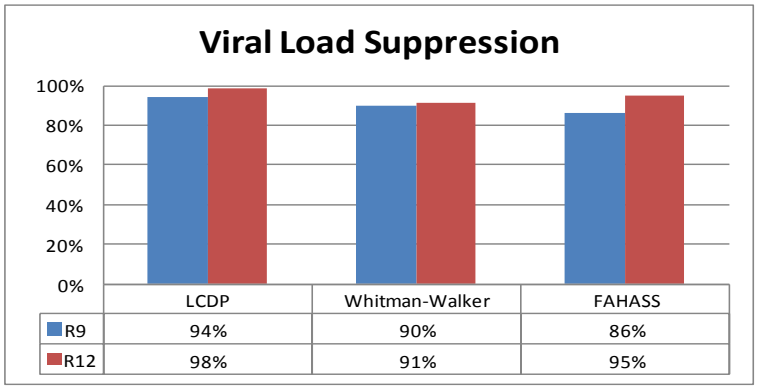




Consistently High-Performing Clinics in Syphilis Screening, Viral Load Monitoring, and Viral Load Suppression Measures







And They Grow Up: HIV and Youth

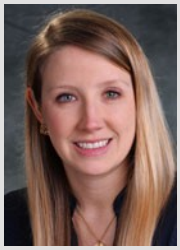
By Donna E Marschall, PhD \DC Provider

By Megan M King, PhD \ DC Provider

Children's National Medical Center, Washington, DC

Donna E Marschall, PhD

Director of HIV Services Mental Health Program at Children's National Medical Center



Megan M King, PhD

Department of Psychology at Children's National Medical Center

Children, adolescents and young adults diagnosed with HIV experience developmental changes during the course of their care. As such, the care needs of pediatric patients evolve as they age. To ascertain programmatic efficiency and efficacy within Children's National's HIV Support Services, we investigate the outcomes of our clinical efforts using research practices. This is done in order to determine the effectiveness and efficiency of our work with young patients, allowing us to revise our efforts, if needed, to better support patients' medical and mental health needs. Specifically, we have taken an empirical look at two specific programs designed to address the pressing needs of HIV-positive youth, 1) the Transition Program, and 2) the Treatment Adherence Program.

The Transition Program at Children's National was developed out of the increased need to securely transition young adults to adult care. As HIV treatment options expanded and outcomes improved, the likelihood of our young patients aging out of pediatric care increased notably. While this was a welcome development, our providers were nonetheless faced with the new challenge of keeping up with and maintaining services for HIV-positive youth who were aging out of pediatric care. Through our experience and use of empirical evaluation methods, we have learned much from implementing a structured and supportive transition program that follows the young adult to the adult care world and for one year after transition. By conducting interviews with patients and their providers, we were able to determine what types of issues pose the biggest barriers to transition. For example, two superordinate (Psychological/ Educational, Economic/ Logistical) and six subordinate (e.g., Losing Relationships, Lack of Preparedness, Resource Challenges, Insurance Access) categories of barriers emerged. These were used as a framework for program development. The resulting program addresses these barriers through four phases of the transition process including a full 12-month monitoring phase after the individual has entered into adult care. In the end, the results of this research helped shape our development and ongoing implementation of a Transition Program to ensure that patients successfully make it to adult care and their needs are met within that context.

The Treatment Adherence Program (TAP) at Children's National was also an outgrowth of acute patient need. While some of our young patients are able to maintain consistent medication adherence with standard-of-care intervention and support, others continue to struggle significantly. For those requiring intensive adherence assistance, TAP provides one-to-one support and intervention multiple times a week. Looking at the program with an empirical eye, we found that for HIV-positive youth, family stability is a key factor associated with viral suppression and disease control. We also found that individuals with high viral load display a distinct profile of difficulty and disadvantage over a number of areas, ranging from basic life needs to psychiatric illness, as compared to patients with lower viral load. Such factors can be formidable obstacles to effective adherence and should be assessed and addressed as part of a comprehensive medical care plan. Furthermore, in addition to more proximal, concrete barriers, environmental and psychosocial factors should also be considered when working with complex and traditionally underserved patient populations.

As we continue to learn from our youthful patients we, like them, continue to develop. We grow in our ability to become more effective care providers, guided by research and the daily patient inspired lessons.

"In the end, the results of this research helped shape our development and ongoing implementation of a Transition Program to ensure that patients successfully make it to adult care and their needs are met within that context."

Reflections on the United States Conference on AIDS in New Orleans, LA

By Justin Britanik, Collaborative Co-Chair \ DC Grantee

This past September, I had the pleasure of attending the 2013 United States Conference on AIDS in New Orleans, LA, hosted by the National Minority AIDS Council. (NMAC) It was an excellent opportunity to come together with nearly 2,000 of my colleagues from around the nation for four days of conversation and sharing information, tools, and stories related to improving the care for those living with HIV. Major themes of the conference included ending the epidemic in the hard hit region of the Southern states, and also a focus on impending changes coming in the form of the Affordable Care Act (ACA). The opening plenaries really examined these issues. Emphasis was placed on leveraging the National HIV/AIDS Strategy (NHAS), the increased capacity of ACA, and the science of care continuum in combination to end the epidemic.

Given the timeliness of this event, it was invigorating to see so many high-level staff from Federal Agencies offering a national perspective. Dr. Laura Cheever, who oversees HRSA's HIV/AIDS Bureau (HAB), lauded the ACA for no longer requiring that PLWH be ruled disabled to qualify for Medicaid—for states expanding the program. Secondly, she spoke about the expanded access for PLWH because the law forbids discrimination of those with pre-existing conditions including HIV. Dr. Grant Colfax, Director of the White House Office of National AIDS Policy (ONAP) echoed Dr. Cheever's sentiments. He underscored the importance the Affordable Care Act has in national efforts.

Most of the sessions I sat in were related to quality improvement, improving the care continuum, and there was a heavy emphasis on the ACA in some of the sessions as well. I wanted to share a few of the most innovative with you here. One was Oregon Reminders, which is a free mobile service for HIV testing and medication reminders. This service harnessed the power of smart phones and text messaging for prevention and treatment adherence. While it just launched, it really is a pretty novel model. Learn more at: http://www.oregonreminders.org/.

The next one which was particularly relevant to the activities of our Collaborative was a statewide Collaborative in Pennsylvania using motivational interviewing and quality management. They engaged in a project to reduce community viral load and link patients to care by using assistant case managers to navigate patients who had fallen out of care back into the system. This presentation demonstrated how training these individuals with social work and motivational interviewing techniques played a significant role in the Ryan White -funded AIDS service community throughout Pennsylvania to streamline operations, create new processes, and provide peer outreach workers with the skills to empower others to re-engage them into medical care.

Along with all the new friends I was able to network with, it was great to see some familiar faces. DC Collaborative contributors Advocates for Quality (A4Q) were there to share the great work they have done spreading QM concepts with consumers in an Affinity Session. This Affinity Session was a great impromptu meeting of conference attendees who wanted to discuss how to activate a core group of consumers to improve skills related to QI. Martha Cameron, Debra Frazier, and Corey Franks shared their journey from DC Collaborative consumer capacity group, to QPAC, to A4Q with participants from all over the US and some from as far away as the Caribbean.

The DC Collaborative was also represented with a poster in the exhibition hall. I had the chance to interact with my counterparts from other areas. I felt really lucky to be in an EMA with an abundance of great infrastructure such as the DC Collaborative, FQHC's becoming medical homes, state governments embracing Medicaid expansion, and perhaps most of all consumers who are active in their care and knowledgeable about the care delivery system. While it is easy to get frustrated with what we lack here in DC, the challenges being faced by our counterparts in the rural south are magnanimous. It was a nice chance to reflect that while we are always striving to improve, others look at us a model.

DC Collaborative Poster Presentation at the United States Conference on AIDS (September 2013)

Overall, the conference was a lot of fun. I certainly had some "a-ha" moments and I was proud to represent the DC DOH, the EMA, and the Collaborative. Not to mention the Southern hospitality and delicious New Orleans Creole cuisine including beignets, muffaletta, and a variety of po'boys. Definitely keep an eye out for the 2014 Conference in San Diego, it would be a great opportunity to share how your agency made improvements through the DC Collaborative, learn best practices from across the nation, and probably get some great fish tacos.

Cross Part Quality Collaborative

Consumer Contact
dccollaborative@novaregion.org

NQC Glasscubes
https://nationalqualitycenter.glasscubes.com/

The D.C. Quality Management Collaborative engages Grantees, healthcare providers, and people living with HIV/AIDS in the Washington, D.C. metro area, including grantees and sub-recipients from Washington, D.C. Maryland, Virginia and West Virginia, to jointly improve HIV care across regional boundaries.

The initiative was launched in early 2011. Through intense work over the past two year the DC Collaborative has moved closer to its vision of a well-defined network of community partners and resources providing seamless accessibility to quality HIV-related care and services for all consumers in the region.

We're on the web!

http://doh.dc.gov/service/dc-quality-collaborative

Join the DC Collaborative Response Team!

Positions Currently Available

The DC Collaborative Response Team is looking for engaged and dedicated providers to join our team. Currently vacant positions include:

- Quality Improvement (Lead and Support roles):
  - Facilitate and support project improvement
  - Set goals for each improvement project
  - Communicating best practices derived from improvement projects to Collaborative members
- Provider Capacity Development (Lead and Support roles):
  - Support development of DC Collaborative QI activities
  - Develop and implement QM trainings as needed
  - Educating providers and consumers to enhance their knowledge about and ability to conduct QM and QI activities

Please contact the DC Collaborative Co-Chair Justin Britanik at justin.britanik@dc.gov with questions, to obtain more details about the positions' responsibilities, and to apply.

Join the Response Team and make a difference by working within the Collaborative network!

DC Collaborative Response Team at the most recent QI Summit (07/18/2013)