Performance & Outcome Measurement in Clinical Capacity Building

Evaluation Strategy for Program to Integrate HIV into Primary Care

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10/17/13
Advances effective prevention, care, support, and health equity for people living with or at risk for HIV and hepatitis C—particularly within LGBT and other underserved communities—by providing education, capacity building, health services research, and advocacy to organizations, communities, and professionals.
Objectives

• Understand the background and purpose of the AIDS Education and Training Centers National Center for HIV Care in Minority Communities (AETC NCHCMC)

• Describe the targeting and evaluation strategy used to measure program outcomes for the AETC NCHCMC
• To increase access to comprehensive, high quality HIV primary care for racial and ethnic minority communities severely impacted by HIV/AIDS by building the capacity of non-Ryan White funded community health centers.
Program Strategy

- Develop a model for integrating HIV into primary care
- Capacity Building Assistance
  - Customized Clinical Training
  - Organizational Capacity Development
HealthHIV’s STEP Model

• Merges
  – Stages of HIV Clinical Care with
  – Models of HIV service delivery

• Provided a progressive staging framework for CBA delivery and a stepwise approach to HIV integration
External HIV Care
• Foundation
• Provide HIV testing (routine or targeted) but no medical management for patients with positive test results

Collaborative HIV Care
• Stage 1
• Onsite HIV care integrated with primary care through extensive consultation from clinical mentor for initiation of ARV regimen and for management of more complex patients

Supported HIV Care
• Stage 2
• Onsite HIV care integrated with primary care, supported by consultation with clinical mentor as needed for management of treatment failure and/or co-morbid conditions complicated by HIV disease and/or treatment

Comprehensive HIV Care Management
• Stage 3
• Onsite integrated HIV care with primary care, including management of complex co-morbid conditions, PMTCT, and complex OI's with access to consultation from clinical mentors as needed

Introductory HIV Care

HIV Primary Care
Primary Objectives of Program Evaluation

- Ensure the effective recruitment of CHCs
- Measure Improvements in CHCs capacity to integrate HIV services
- Evaluate the effectiveness of the model used for HIV care integration
- Review data to monitor program performance and inform modifications
- Disseminate findings to key audiences to inform the effort moving forward
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<tbody>
<tr>
<td>Tool(s): Application</td>
<td>Tool(s): HIV in Primary Care Learning Community Assessment, Self-Assessment &amp; Proficiency List</td>
<td>Tool(s): HIV Training Package, HIV Training Plan, Mentor/Coach Notes, Site Visit Reports</td>
<td>Tool(s): End of Cycle Evaluation</td>
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**Staging of Health Centers**

**Tool(s):**
- Qualitative Site Assessments for Stage Setting

**Outcome Evaluation**

**Tool(s):**
- End of Cycle Tiered Performance Indicators
- End of Cycle Self Re-Assessment
- Proposed Enhancement & Performance Modifications

**Process Monitoring**

**Anticipated Outcomes**
Methods

- Targeting for Need and Impact
- Organizational Assessments
- Performance Measurement
Targeting

• R&E team utilized publicly available data sources to identify CHCs in areas:
  – where impact of increased HIV services will be most impactful
  – of high need for HIV services
Targeting for Impact

• Relevant summary measures were identified and included HIV data as well as data on broader social determinants of health.
• Summary Measures were ranked to provide a list of states of greatest impact

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<tr>
<th>Summary Measures</th>
<th>Data Source</th>
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<tr>
<td>Percent Minority HIV-Positive Population</td>
<td>CDC – HIV Surveillance Data</td>
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<tr>
<td>Unmet Need</td>
<td>Statewide Coordinated Statements of Need</td>
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<tr>
<td>Age (20-49)</td>
<td>US Census Bureau</td>
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<tr>
<td>Sexual Orientation</td>
<td>2006 American Community Survey Estimates</td>
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<tr>
<td>Federal Poverty Level (under 100%)</td>
<td>US Census Bureau</td>
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<tr>
<td>Limited English Proficiency</td>
<td>US Census Bureau</td>
</tr>
<tr>
<td>Percent Minority Population</td>
<td>US Census Bureau</td>
</tr>
<tr>
<td>Education Level (high school or less)</td>
<td>US Census Bureau</td>
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</tbody>
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Results

- States/Territories were impact of increased HIV services would be greatest:
  1. California
  2. Illinois
  3. Washington, DC
  4. Texas
  5. New York
  6. New Jersey
  7. Georgia
  8. Arizona
  9. Alabama
  10. Maryland
Targeting for Need

- Geo-mapping
  - HIV Prevalence and Incidence
  - Minority Populations Living with HIV
  - Unmet Need
  - County level HIV prevalence

- CHC data on minority patient populations
State shading based on percent of people living with HIV that are racial or ethnic minorities calculated using 2010 CDC surveillance data.
Estimated Percentage of HIV Positive Clients Not in Care

Percentage of PLWHA Not in Care
- 10% - 21%
- 22% - 34%
- 35% - 43%
- 44% - 55%
- 56% - 69%
- No Data

Estimates of people living with HIV/AIDS who are not in care calculated using the Statewide Coordinated Statements of Need.

July 24, 2013

HealthHIV
Putting Health First
An Example of Geo-Mapping in the South

Counties with higher HIV rates and existing Community Health Centers are targeted for assistance to improve or expand HIV care. Circled geographic areas provide a target list of centers and primary care providers for mentoring.
• Once CHCs were identified, R&E team verified minority patient population using Uniform Data System (UDS) data
Organizational Assessments

• The HIV in Primary Care Learning Community Assessment Tool
  – Determined the stage of HIV care integration that the CHCs fell into
  – The capacity of the organization to engage in CBA

• Self-Assessments
  – Individual participant competency in the learning proficiencies of the HIV Training Package
Performance Measurement

DASHBOARD
HIV in Primary Care Learning Community

Practice Transformation
- % of pts assigned to a PCP
- 3rd next available appointment
- Rejected claims as a % of total claims
- Exchange of information with hospitals (tbd)
- Team development or leadership engagement (tbd)

HIV Clinical
- % of HIV+ pts who had two or more medical visits (at least 60 days apart) that incorporate HIV care in the measurement year.
- % of HIV+ pts who received HIV risk counseling within the measurement year.
- % of pts who had two or more CD4 counts in the measurement year.
Performance Measurement

• Limitations
  – Indicators were not inline with the CHCs capacity to provide HIV care and treatment services
  – Non-Ryan White funded CHCs often did not have the capacity to collect and report data

• Solutions
  – Revised performance indicators that were tiered to better align with CHCs capacity to provide services and incorporated latest research (IOM, Treatment Cascade)
    • Tier 1 – Testing, Diagnosis and Linkage to Care
    • Tier 2 – Retention, Monitoring and Adherence, Viral Suppression
  – Implemented Evaluation Capacity Building to assist CHCs in collecting, reporting and using HIV performance indicators
Stages of Engagement in HIV Care

- HIV-infected*: 1,178,350
- HIV-diagnosed*: 941,950
- Linked to HIV care*: 725,302
- Retained in HIV care*: 480,395
- On ART+: 426,590
- Suppressed viral load (≤200 copies/mL)**: 328,475

Engagement in HIV care

MMWR December 2, 2011 / 60(47);1618-1623
Revised Performance Measures

• Tier 1:
  1. Number of total patients seen
  2. Number of patients offered an HIV test
  3. Number of patients who refused an HIV test
  4. Number of HIV tests conducted
  5. Number of positive HIV tests
  6. Number of newly diagnosed who received their test results
  7. Number of newly diagnosed linked to a medical visit within three months

• Tier 2:
  8. Number of unique HIV positive patients
  9. Number of HIV positive patients with 2 or more HIV medical visits at least three months apart
  10. Number of HIV positive patients with 2 or more CD4 T-cell counts
  11. Number of HIV positive patients on ART
  12. Number of HIV positive patients that receive 2 or more viral load tests
  13. Number of HIV positive patients that have undetectable viral load
Performance Measurement

• Challenging to see measurable changes in patient outcomes due to:
  – One-year project period
  – Competing priorities
  – Realistic amount of time to engage in CBA activities
  – Existing HIV service infrastructure in CHC communities
Outcomes Measurement

• Core Measures
  – Added/Expanded HIV clinical services
  – Enhanced service delivery/QI structure to support HIV integration

• Additional Measures
  – Changes in rate of competency in HIV training package learning proficiencies
  – Overall project satisfaction
Evaluation Lessons Learned

• Patient level indicators were not an accurate gauge of program successes.
• The scope of the project was too broad to measure in the beginning stages.
• It is difficult to isolate outcomes with program interventions due to the multiple initiatives, quality improvement goals, and funding priorities available to CHCs.
• It can’t be assumed that CHCs have strong capacity to collect and report HIV data.
Questions??

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