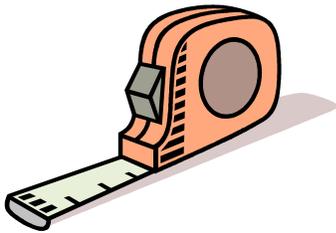


Guide to Measurement for the STOP HIV/AIDS Structured Learning Collaborative **(updated!)**

The Why? What? Where? When? and How? of Measurement for Collaborative Teams



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Why do we need to measure?

How will you know if a change you are making is leading to better retention in care or improved care for individuals with HIV? Simple: you measure.

Measurement gives your team the ability to see the results of your improvement efforts. Measurement allows for benchmarking across programs and for trending over time. It also gives your team the ability to adapt your improvement efforts according to the results of your measures. Therefore, measurement is critical to monitoring the progress and the success of your team's efforts, and to the progress and the success of the Collaborative as a whole.

What do we need to measure?

Five (5) core measures have been developed for all Collaborative teams (summarized in Appendix A). To facilitate learning and sharing in the Collaborative, it is a requirement that teams collect and report on the Core Collaborative measures on a monthly basis. A standardized reporting template (available in both electronic and paper versions) will be available to teams to facilitate this effort, and Collaborative staff will be available to assist.

Teams may also wish to report on additional measures that are relevant to their specific contexts and improvement efforts. As always, teams are encouraged to share any additional measures they are collecting.

Where do we need to measure?

Measurement will be at the practice, clinic or program level.

When do we need to measure?

Now! As your team prepares for Learning Session 1, your team should begin to consider measurement. Ideally, teams are able to collect a baseline so that they may begin to apply change ideas to begin improvement efforts after the first Learning Session (change package to be distributed at the Learning Session).

And, finally, How do we measure?

Each participating team will require routine and accurate data to collect the Core Collaborative measures. The following steps will be necessary:

- 1) Start by defining your Population of Focus (POF)
- 2) Identify the data sources your team will need to process to obtain the Core Collaborative measures
- 3) Create structures in your practice and accountabilities within your team for data collection
- 4) Start measuring!

1) Define your Population of Focus **UPDATED!**



Your Population of Focus (POF) will be the population of patients for which you will collect data relevant to the Core Collaborative measures. We encourage that you select your entire population of HIV patients; however, for larger and more complicated practices, it may be advised (at the onset of the Collaborative) that teams target initial improvement efforts to a subset of patients with HIV – the POF. Collaborative staff is available to assist your team and some ideas for selecting your POF are also outlined on page 21 of the Preparation Manual.

After selecting your POF, teams should review the status of each HIV patient in their POF to distinguish between ‘engaged’ patients and patients that have been ‘lost to care’. In doing this, your team can identify the HIV patients that require interventions to re-engage in care.

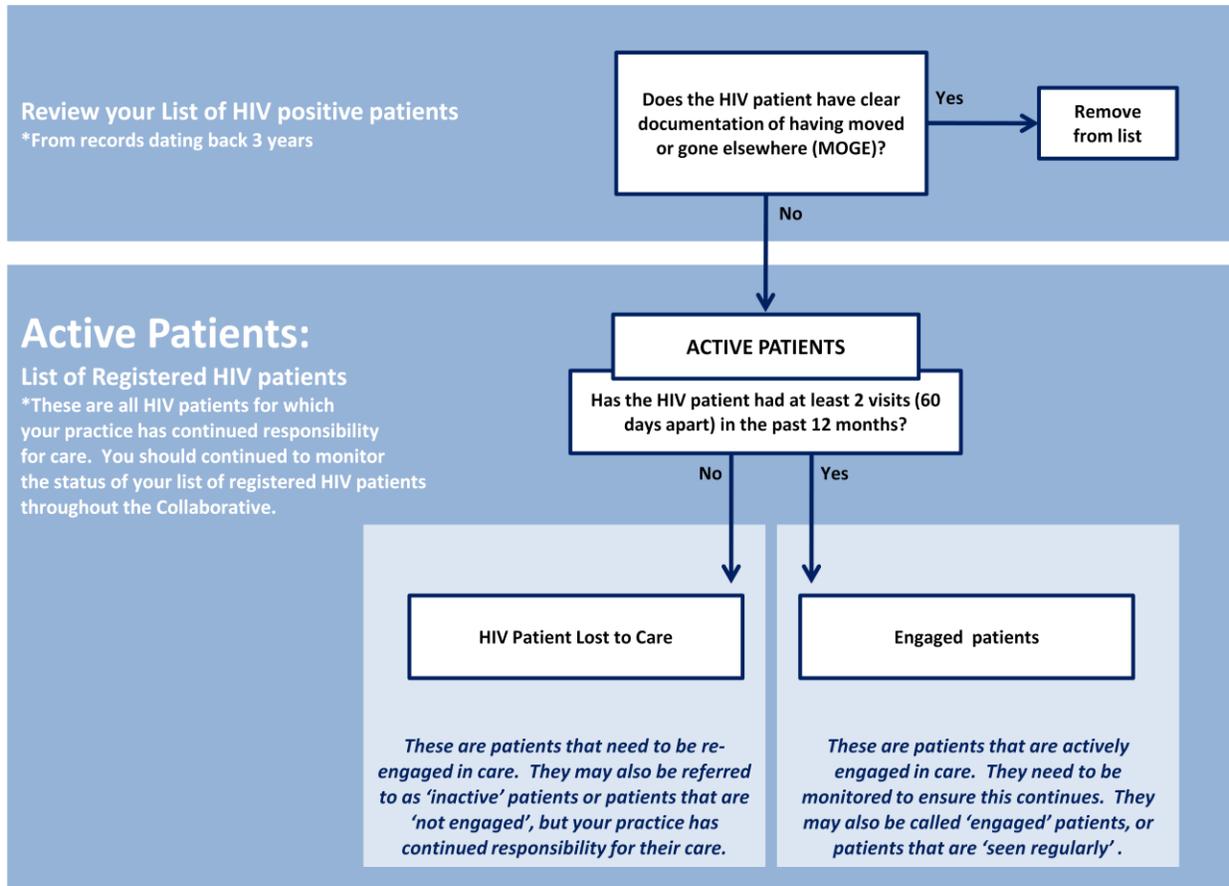
Active Patients = Engaged patients + Patients Lost to Care

‘Engaged’ patients and patients that have been ‘lost to care’ are all HIV positive patients who have been registered for HIV primary care at your practice, in the past three years, and who do not have clear documentation of having “moved or gone elsewhere” (MOGE). These are your active patients: all the HIV patients within your POF for which your practice has continued responsibility for HIV primary care (see figure below).

To determine the patients for which your practice has continued responsibility for HIV primary care (active patients), review your list of HIV positive patients from records dating back three years. If a patient has clear documentation of having ‘moved or gone elsewhere’ (MOGE), they can be removed from your list of active patients. Sample criteria to identify MOGE patients:

- Documentation of transfer of care (e.g., request for records from another primary care provider)
- Documentation of death
- Documentation of moved without local forwarding address. Most teams will utilize all avenues including case management partners to try to find patients before classifying them as inactive (i.e., MOGE).

Patients that do not have clear documentation of MOGE are all the remaining patients for which your practice has continued responsibility for care – these patients may be either *engaged* or *lost to care*. Within this pool of patients, *engaged* patients are patients that have been seen for at least two (2) visits (60 days apart) in the past 12 months. Patients that have been *lost to care* are all patients that have *not* had at least two (2) visits (60 days apart) in the past 12 months – these patients will likely need outreach to re-engage in care.



Please note that your practice may provide HIV primary care to a number of patients whom may also be receiving care from a number of different clinics and/or practices. If this is the case, your team should not exclude these patients from your 'active' HIV patient list unless there is clear documentation of MOGE. While this raises a number of issues (e.g., who is the most responsible HIV care provider, duplicate reporting on single patients), these issues will be excellent targets for improvement efforts that attempt to improve retention in HIV care, strengthen HIV care partnerships, and improve HIV care throughout the Structured Learning Collaborative.

Example to illustrate POF and active patient selection:

From records dating back three years, Wellbeing Clinic has 2,500 patients registered in its roster. Out of these, 300 are HIV positive. From the HIV positive patients, 20 died and 30 moved outside of the province or transferred to other practices. In the previous 12 months, 210 patients have two visits (60 days apart). You concluded that:

- 300 HIV positive patients are registered, within the past three years, in your practice

- 50 HIV positive patients died or moved
- Thus, there are 250 **active** patients
- Out of the 250, 210 ($210/250 * 100\% = 84\%$) were **engaged** patients and 40 ($40/250 = 16\%$) were **lost to care**

2) Identify your Data Sources



Take a closer look at the Core Collaborative measures

Teams should look closely at each of the Core Collaborative measures outlined in Appendix A. Each of these measures provides details relevant to what data your team will be required to collect, and how to process the data to produce the Core Collaborative measures. More specifically, the denominator, as well as the numerator¹, indicates the populations of patients that receive the desired care - screening, medical visit, etc.

Investigate potential sources of data at your practice

Once your team has gleaned what data is required by reviewing the Core Collaborative measures, your team should investigate potential sources of data and consider the ease with which these sources may be queried from within your practice or clinic. For example, the medical record is the most complete source of information on diagnosis, management, treatment, and clinical outcomes of care.

Consider the following sources of data:

- Paper charts
 - Manually audit a sample of charts each month to extract necessary data. A template to expedite the data collection is often used. Alternatively, keep data elements essential to calculate the measures in a separate registry or database.
- Registries
 - Key data elements are entered separately into the registry. This may involve data entry in more than one place but reports from the registry can be automated. Often, teams will load key data elements up front for their POF and then update as patients receive care. If you require advice in setting up a registry, please contact the Collaborative staff.

¹ The numerator is a subset of the denominator for each Collaborative Core measure.

- EHRs
 - Match the templated fields in the EHR to the numerator and denominator detail. Ensure that the reporting capability of your EHR will allow you to report each measure.
- Practice management systems, scheduling systems (e.g., billing systems, appointment books)
 - May be able to track by diagnosis and provider to facilitate identification of certain POFs. Also may be able to track by service provided (medical visit, CD4 count) and date. This strategy is not useful when a value is needed such as viral load.
- Lab and pharmacy systems
 - Ideally, lab dates and values can be transmitted electronically to an EHR or registry. If this can be done fairly quickly, this automated transfer facilitates improvement efforts for lab testing and screening performance. For example, the Drug Treatment Program at the BC-CfE has a repository of HIV-specific laboratory and antiretroviral information.

Evaluate all data sources for the ease with which they may be queried

Because the Core Collaborative measures will be reported monthly, it is important to evaluate potential data sources for ease and efficiency of data extraction. For each data source that is identified, consider the efficiency and ease with which you can generate the necessary data for reporting. For example, consider:

- Sampling (suggested only in cases where manually auditing records would be very laborious, or where data extraction from an EHR is very difficult)
- Automated data sources
- Same data that is already regularly reported
- Despite the availability of some electronic formats, you may still need to collect some data on your own through chart reviews and by distributing patient access surveys (Appendix B)

When your team has identified your data requirements and your data sources, you may consider data reporting structures and accountabilities to ensure that you are able to collect and report the Core Collaborative measures regularly.

3) Create Structures and Accountability for Data Collection



3.1) Structures for Data Collection

It is prudent to document in writing how you will collect data for each measure. This ensures that you collect data in the same way over time and also facilitates transitions in case of staff turnover. An example is provided below to demonstrate how some teams document their data collection including the source for each component, while leaving space to fill in when it is to be reviewed.

Example of a Team’s Structure for Data Collection:

Focus Indicators	Description	Collaborative Goal	Numerator/Source	Denominator/Source	Calculation	Internal Review	QIC Review	Comments
Viral Load	Active, HIV-infected patients who had a viral load within last 4 months	>95%	Number of active, HIV-infected patients who had a viral load within 4 months of the audit date/procedure code and date report (Report Title: Monthly viral load Report) from practice management system	Number of active, HIV-infected patients/POS patients from EHR that meet active criteria	Num / den x 100	Dates the team will review data	Date the larger QI group or leadership will review data	
Viral suppression	Achieving maximal HIV virologic control if prescribed ART	>95%	Total number of those in the denominator who have a pVL less than 200 copies/mL at last pVL measure/ Lab export report that includes patient name, date of test and value	Total number of active patients who have been on continuous ARV for six months or more/ EHR report filtered for presence of current Rx for ARV drugs in medication list	Num / den x 100	Dates the team will review data	Date the larger QI group or leadership will review data	

3.2) Accountability for Data Collection

Collectively, the team should assign responsibility for performing and overseeing consistent and accurate data collection, data processing, and data reporting. The assigned individual(s) should also be responsible for validating data (i.e., making sure it’s right) and liaising with the Collaborative staff to ensure it is reported on a monthly basis.

Depending on your practice, clinic or program, teams may choose to assign this role to a single staff person or to a team member to ensure consistency. Alternatively, teams may choose to select a sub-group of individuals to share joint responsibility for performing and overseeing

these activities. The identified individual(s) should receive brief training to review the measurement process and to fully understand each measure in which data is collected.

4) Start Measuring!



Start measuring! And, if you have questions or difficulties, contact the Collaborative staff and the Virtual Community of Practice (on the website) for assistance.

Appendix A **UPDATED!**

Detailed descriptions for the Core Collaborative Measures are presented in the following table:

#	Core Measure	Objective	Suggested Target	Numerator	Denominator
1	HIV Primary care visits	To determine the proportion of patients engaged in standard care	> 95%	Total number of those in the denominator who had at least one visit to a HIV primary care provider in the past 4 months	Total number of active HIV patients included in the Population of Focus
2	HIV Viral load	To determine the proportion of patients receiving standard of care laboratory monitoring, can also be used as a proxy for engagement in care	> 95%	Total number of those in the denominator who had at least one HIV plasma Viral Load (pVL) test in the past 4 months	Total number of active HIV patients included in the Population of Focus.
3	Antiretroviral Therapy (ART) uptake among those unequivocally in need of ART	To determine the proportion of patients who urgently require ART and are receiving HIV-related care that are actually NOT being prescribed ART	> 95%	Total number of those in the denominator who are currently taking ARV (updated!)	Total number of active HIV patients included in the Population of Focus known to have had a CD4 cell count <200 cells/mm ³ (updated!)
4	Achieving maximal HIV virologic control if prescribed ART	To determine the proportion of patients on ART who are being successfully treated	> 95%	Total number of those in the denominator who have a pVL less than 200 copies/mL at last pVL measure	Total number of active HIV patients included in the Population of Focus who have been on ARV for six months or more (updated!)
5	Patient Experience	below	>90%	Sum of all responses that were Excellent and Very Good for respective question 1 through 4.	Sum of all responses from the respective question, 1 through 4 from the patient access survey.

<p>5</p>	<p>Patients have valuable insight into the quality and process of care that is provided for them. You can choose to measure patient feedback specific to access to care by using the Patient Access Survey attached to this document (Appendix B). This survey can be completed at the time of the visit to give a real time measurement of satisfaction.</p> <p>See Appendix B for Patient Access Survey (updated!)</p> <p>Question # 1. How would you rate your satisfaction with getting through to the office (either by phone or in person)? Objective: To determine the level of satisfaction with the office (either by phone or in person)? Numerator: Sum of all responses that were Very Good or Excellent on question 1. Denominator: Sum of all responses from question 1 on the patient access survey.</p> <p>Question # 2. How would you rate your satisfaction with the length of time you waited to get your appointment? Objective: To determine the level of satisfaction with the waiting time to see a clinical provider. Numerator: Sum of all responses that were Very Good or Excellent on question 2. Denominator: Sum of all responses from question 2 on the patient access survey.</p> <p>Question # 3. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)? Objective: To determine the level of satisfaction with the care provided. Numerator: Sum of all responses that were Very Good or Excellent on question 3. Denominator: Sum of all responses from question 3 on the patient access survey.</p> <p>Question # 4. How would you rate your satisfaction with the time spent with the person you saw today? Objective: To determine the level of satisfaction with the time spend by the provider with the patient Numerator: Sum of all responses that were Very Good or Excellent on question 4. Denominator: Sum of all responses from question 4 on the patient access survey.</p> <p>Question # 5. Did you see the clinician, or staff member, that you wanted to see today? Objective: To determine the level of satisfaction with continuity of care provided by the team. Numerator: Sum of all responses that were Yes. Denominator: Sum of all responses (yes + no) for question 5.</p>
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Appendix B

Patient Satisfaction with Access Survey

Patients have valuable insight into the quality and processes of care that we provide. You can choose to measure patient feedback specific to "access" to care - how patients experience getting an appointment by using the Patient Access Survey below. This point of service survey can be completed at the time of the visit to give "real time" measurement of satisfaction.

You can also choose to measure the total visit experience using the *Patient's Office Practice Viewpoint Survey*.

Patient Access Survey

1. How would you rate your satisfaction with getting through to the office (either by phone or in person)?

- Excellent Very Good Good Fair Poor

2. How would you rate your satisfaction with the length of time you waited to get your appointment today?

- Excellent Very Good Good Fair Poor

3. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?

- Excellent Very Good Good Fair Poor

4. How would you rate your satisfaction with the time spent with the person you saw today?

- Excellent Very Good Good Fair Poor

5. Did you see the clinician, or staff member, that you wanted to see today?

- Yes No Did not matter who I saw today

Comments:

Adaptation of 2003, Trustees of Dartmouth College, Godfrey, Nelson, Batalden, Institute for Healthcare Improvement Rev. 10/08/04. Adapted for the STOP HIV/AIDS Collaborative.