The VNHS Team!

Vancouver Native Health Society:

- Non-Profit Aboriginal Service Organization
  - Clinic:
    - Primary & specialist medical care
    - 7 days/wk; 20,000 patient visits/yr
  - Positive Outlook Program:
    - HIV/AIDS Nursing & Social Supports
    - Low barrier drop-in
    - Food security & hot meals
    - Drug & Alcohol Counselling
    - Intensive Case Management team
  - Other:
    - Dental Care / Food Baskets / Child & Family Support

VNHS Aim Statement:

- "To improve the quality of HIV care at VNHS though innovation and improved coordination of services in line with the principles of the Chronic Care Model" [as measured by the following 11 indicators of success]:

Specific Objectives:

1. **>95% of patients have a primary care visit in the past 4 months**
2. **>95% of patients have CD4/VL in the past 4 months**
3. **>95% with CD4 <200 are on ART**
4. **>95% of patients on ART (>6mths) will have a VL<200**
5. <1% of patients remain "lost to follow up" by the end of 2011
6. >95% of patients are up to date for their immunizations (Hep A/B/pneumovax/flu)

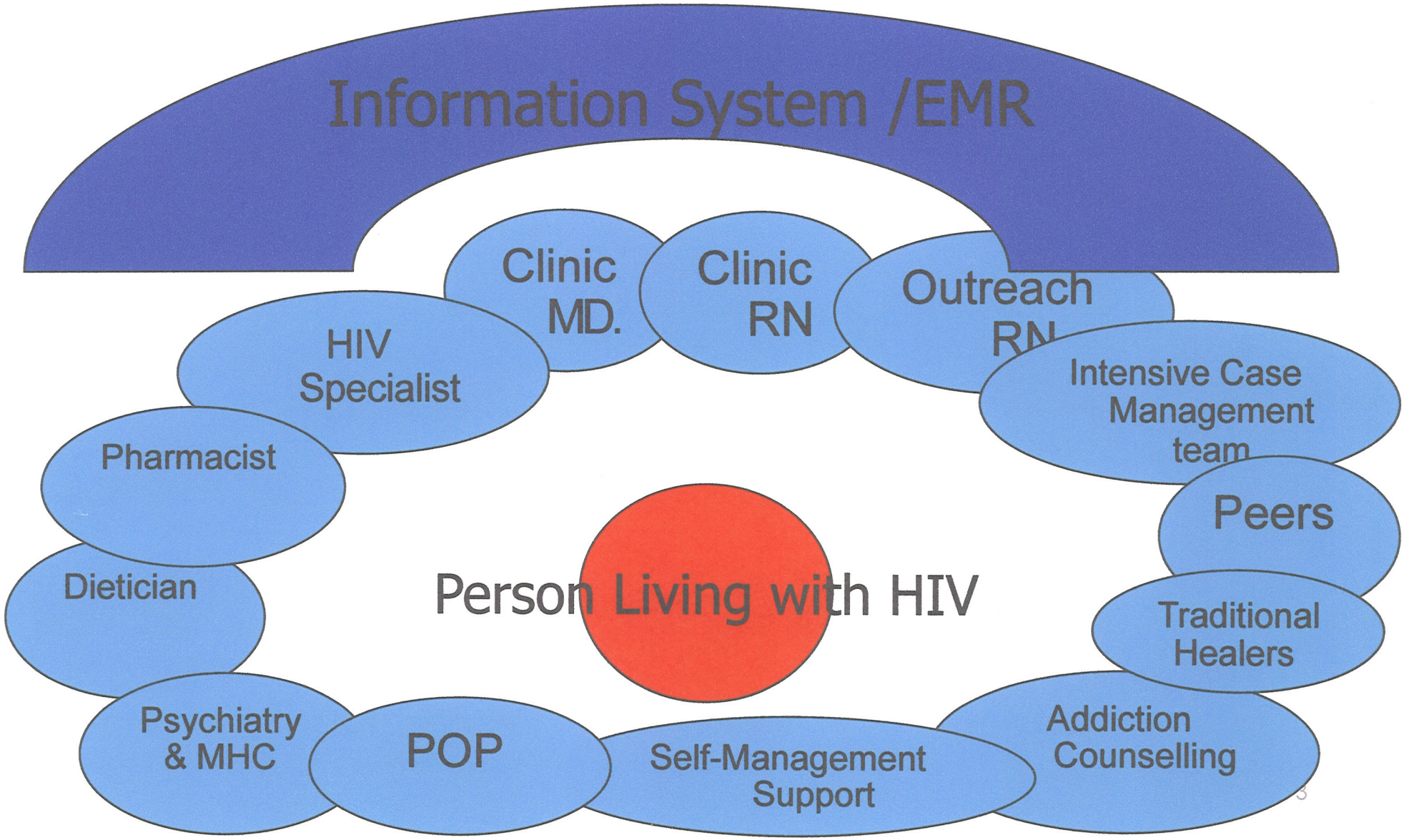
Specific Objectives (con'd)

7. >95% of patients have been screened for TB
8. >95% of patients have an annual "social determinants" evaluation completed
9. Increase number of active patients in care at clinic to >280 by the end of 2011
10. Increase annual attendance in SMS program to 45 per year
11. Increase the number of HIV screening tests to 2000 by the end of 2011.

Population of Focus

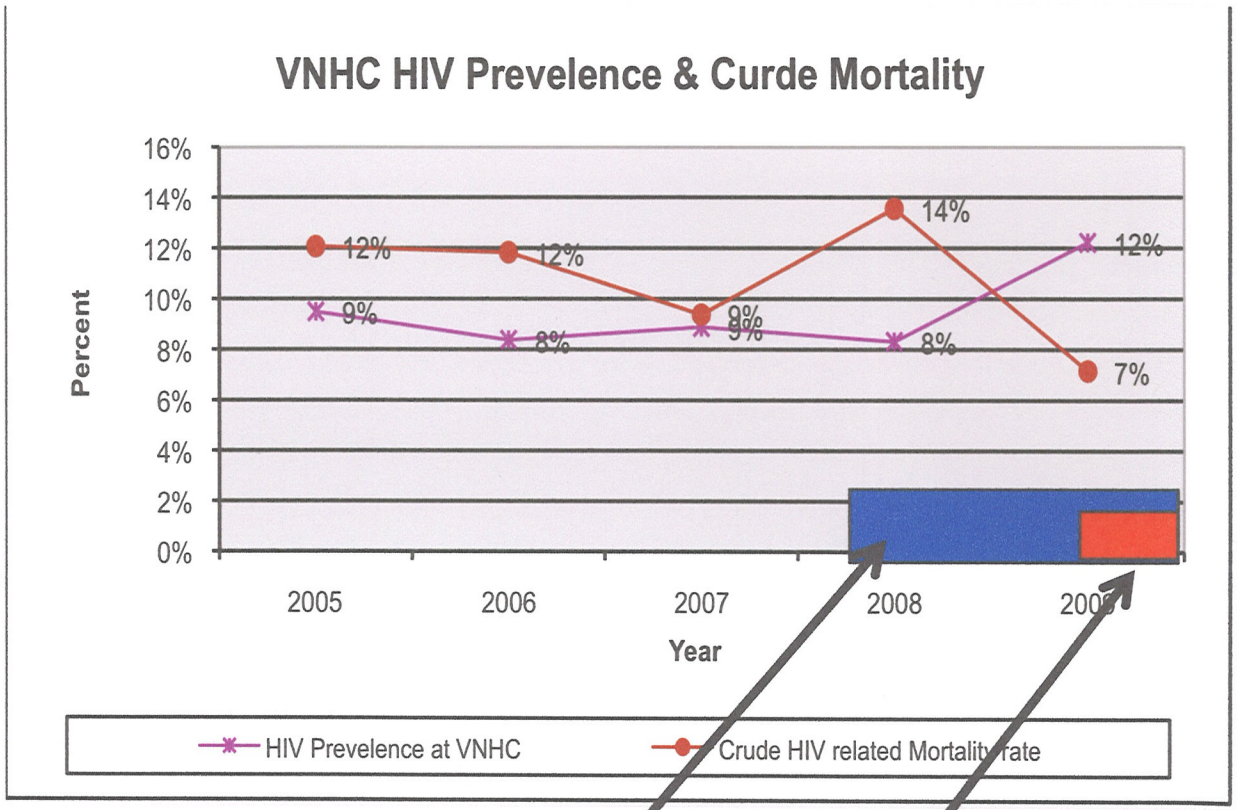
- The active VNHS clinic patients (220) + "unattached" patients of within POP & clinic (estimated at 60).

VNHS Inter-Professional Team Approach:



HIV at VNHC 2005-2009:

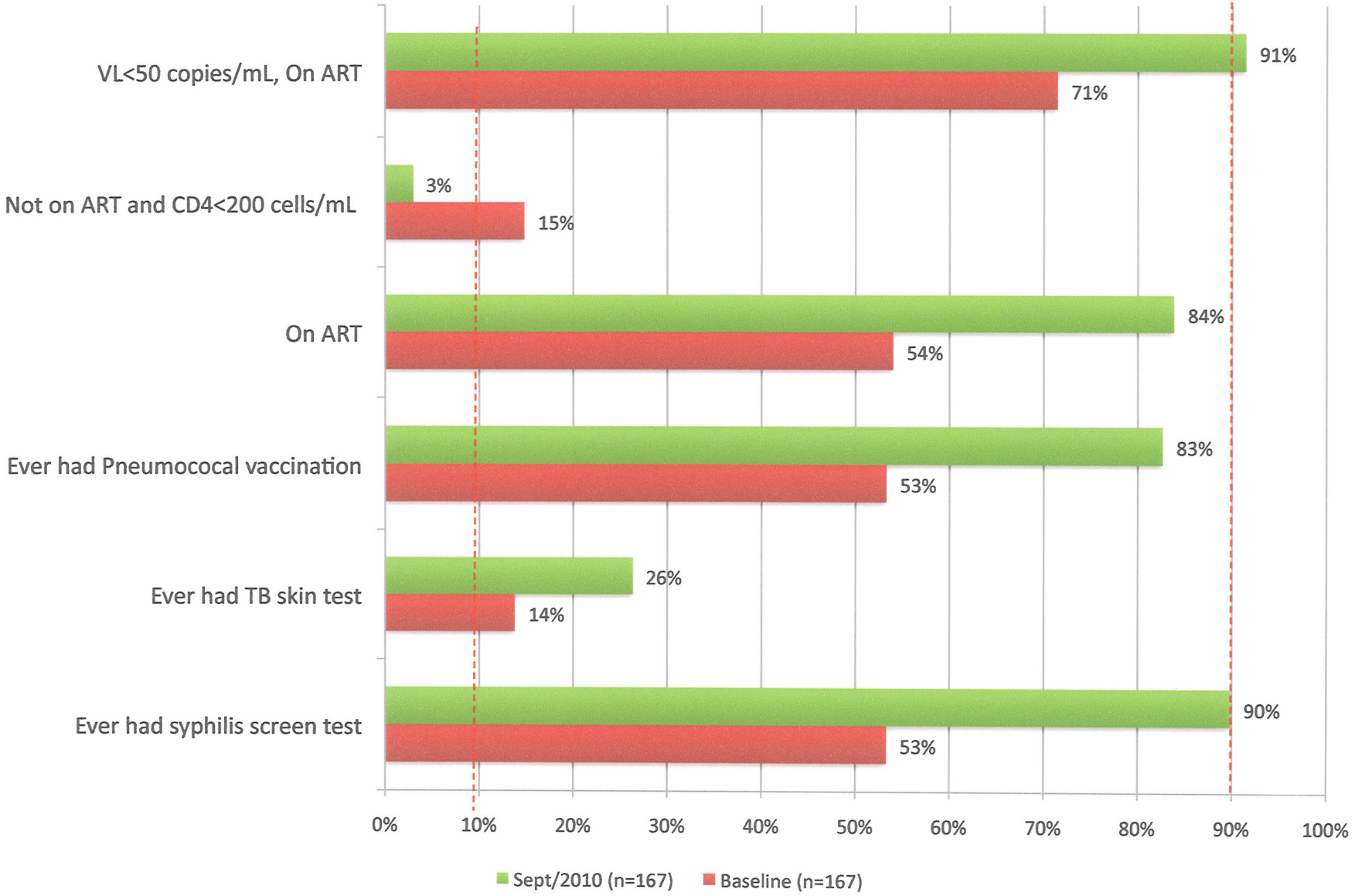
- HIV Prevalence: 9% (range 8-12%)
- 52% Aboriginal, 48% Non-Aboriginal
- Crude Annual Mortality rate: 11 % (range 7-14%



Initiation of Chronic Disease Management Approach

Initiation of Self-Management Support Study

Baseline vs. Most Recent Analysis



VNHS Change Team: Baseline Quality Measures
January 5, 2011

		04-Jan-11	Percentage	Target
1	**Primary care visits** # of Patients with Primary Care Visit in the last four months over total number of patients	**187** **216**	87%	>95%
2	**HIV Viral load** # of Patients with PVL Test in the last four months:	**156** **216**	72%	>95%
3	**Antiretroviral Uptake** # of Patients with CD4<200 and on ART over total number of patients with CD4<200	**38** **41**	93%	>95%
4	**Achieving maximal HIV virologic control if prescribed ART** # of Patients with PVL<200 and on ART >6 mths over total number of patients on ART >6mths	**110** **117**	94%	>95%
5	**"lost to follow up" by the end of 2011** # of Patients without Primary Care Visit in the last twelve months over total number of patients	**7** **216**	3%	<1%
6	**Up to date for immunizations (pneumovax)** ? HEP A/B/FLU	**148** **216**	69%	>95%
7	**TB Screening** # of Patients with documented TB screening over total number of patients	**53** **216**	25%	>95%
8	**Social Determenants Screening** # of Patients with documented SD assessment over total number of patients	**n/a** **216**	n/a	>95%
9	**Total Number of Active Patients** # of Patients in the HIV registry that have not moved or gone elsewhere for care (MOGE) over total number of patients in the HIV registry	**216 active care** **435 in database**	216 77%	280
10	**Attendance in SMS Porgram** # of patients enrolled in SMS program	**10** **45**	22%	45
11	**HIV Screening Tests** (? How are we going to measure this?)	**n/a** **2000**		2000

Version Jan 17,2010

Minutes – VNHS "HIV CHANGE TEAM" MEETING

JANUARY 18, 2010, 8:30-9:30 AM

In attendance: Doreen, Tina, Cherry, Glen, Rebecca, David. Regrets: Steve.

Agenda Item	Discussion	Decisions / Action Points
1) WELCOME / REVIEW AGENDA / REVIEW MINUTES FROM LAST MEETING	Minutes & Agenda were approved. See documents.	
2) REVIEW BASELINE PERFORMANCE MEASURES	Baseline Performance measures data was reviewed. See Documents. It was discussed that flu shots are important but logistically difficult to measure. The number of HIV screening tests will be measured using the "STD screening measures" in OSCAR. An MOA or clinic nurse will enter the test result when a paper copy is received from the lab. [Point of Care test results will also need to be recorded in this way]. The social determinants annual review tool is still not developed, and hence no data is available yet. [We do not have a patient Satisfaction goal, which is a "core measurement" of the collaborative.	(David) Flu shots will be removed from the list of performance measures. (Cherry) Clinic Nurse/MOA to continue entering HIV screening test results into OSCAR. David/Denise/Doreen- to meet on Wednesday at 1:00pm to work on modifying Tahah tool. (David) Add "patient satisfaction" to the list of performance measures.
3) STRATEGY DISCUSSION FOR SPECIFIC OBJECTIVES	1) HIV Screening: Target is about 150 tests/mth a. POC testing: could be incorporated into Women's clinic / Men's group / and weekends. Need posters. b. Lab Testing: Add reminder for HIV tests to all eligible patients. Consider "pre-ticking" HIV serology on all lab forms. Need to make sure appropriate counseling/consent accompanies	(David) To get POC posters from VCH. (Who?) To develop systematic offering of POC testing on weekends/women's/men's group. (Cherry) To start adding reminders to OSCAR for HIV tests

	each test. c. Education: update for staff at WW lunch on HIV screening recommendations. Update at Feb 10 dinner for HIV screening recommendations. 2) TB Screening a. Set up TB testing Blitz at POP two times this year. In conjunction with CXR, to include TB Spot test. b. POP staff could follow up TB skin test results. c. New RN/MOA will enter backlogged TB screening data. d. Education: need lunch time Med-Staff update on HIV and TB screening. Men's/Women's/Youth/SMS groups to discuss importance of TB and HIV screening. 3) HIV SMS uptake: a. Clinic Physicians to identify lists of patients to invite.	(Group) To discuss changing lab form at next meeting. (Doreen) Coordinate TB screening blitzes (Who?) Coordinate follow up of TB skin tests at POP. (NEW RN) To enter backlogged TB data into OSCAR (David) To coordinate March 23 VNHS lunch time testing talk (15 min). (Cherry) To organize VNHS clinical staff lunch update on HIV testing/ TB screening. (Who?) To coordinate introducing TB/HIV testing into patient groups (Rebecca) To provide Cherry lists of patients who have participated in SMS. (Cherry) To approach physicians to identify invitation list.
4) PLANNING FOR LEARNING COLLABORATIVE	Rebecca/Denise/David /Steve / Cherry will attend.	(Group) to bring pictures & annual report of VNHS for storyboard.
5) PLAN FOR NEXT MEETING	Next meeting is Feb 1, then Feb 15 at 8:30 am.	