DC COLLABORATIVE DATA PRESENTATION

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A BRIEF HISTORY OF THE DC COLLABORATIVE DATASET

- **2011: The Beginning - Assigned measures from HRSA/HAB and NQC**
  - Self-reported and collected by Excel spreadsheet
  - This was better than previously (nothing)
  - Had limitations with integrity – a lot of manual manipulation was involved
  - Not client level – didn't align with RSR
- **2014: Introduction of DC CAREWare**
  - Reliability dramatically improved
  - Client Level Data in centrally located database
  - Use of spline interpolation to backfill 2011-12 data
- **2016: Advanced Analytics**
  - Disparities analysis
  - Tableau Report Cards for benchmarking
  - Control charts

WHO ARE OUR CUSTOMERS?

DEMOGRAPHIC DATA

While when we typically think about outcomes when we talk about quality, but a progressive view of quality improvement involves knowing the customer and crafting interventions to meet their needs.

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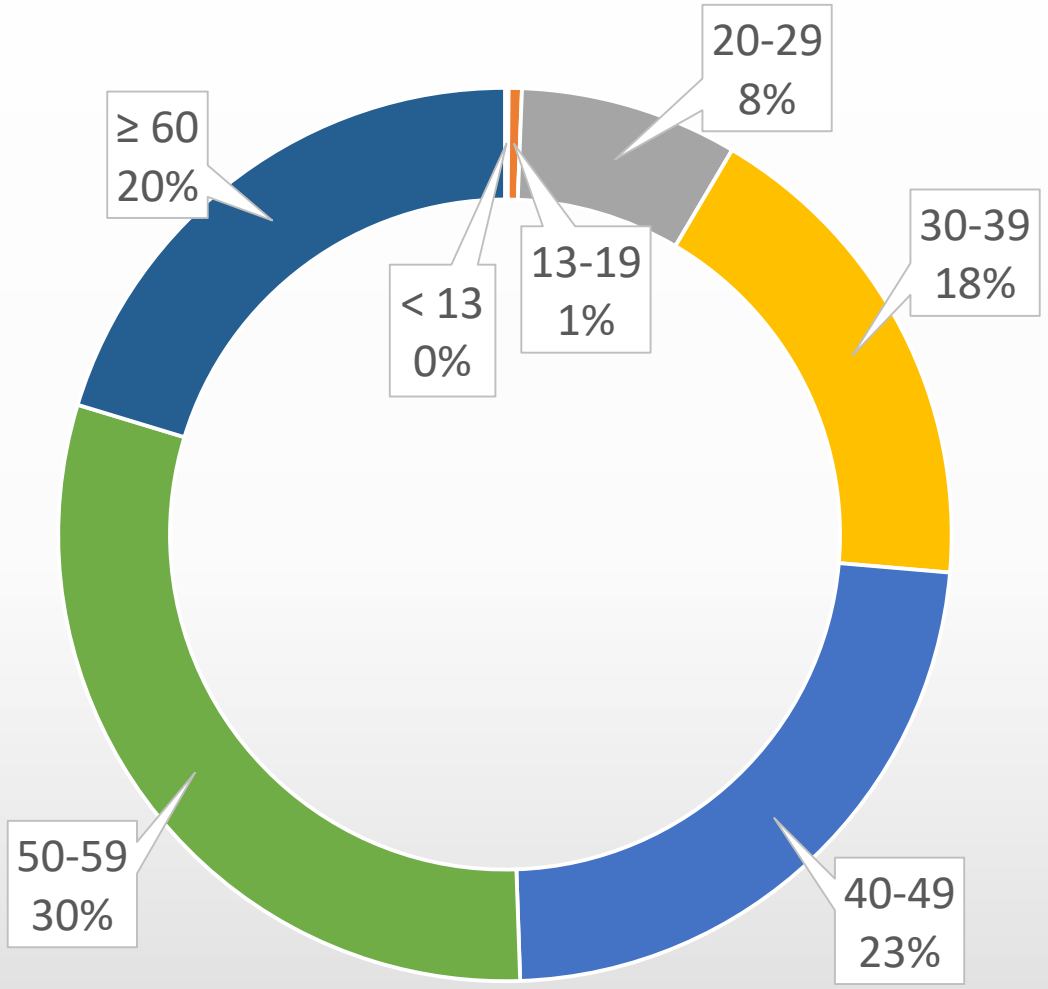
AGE - 2018



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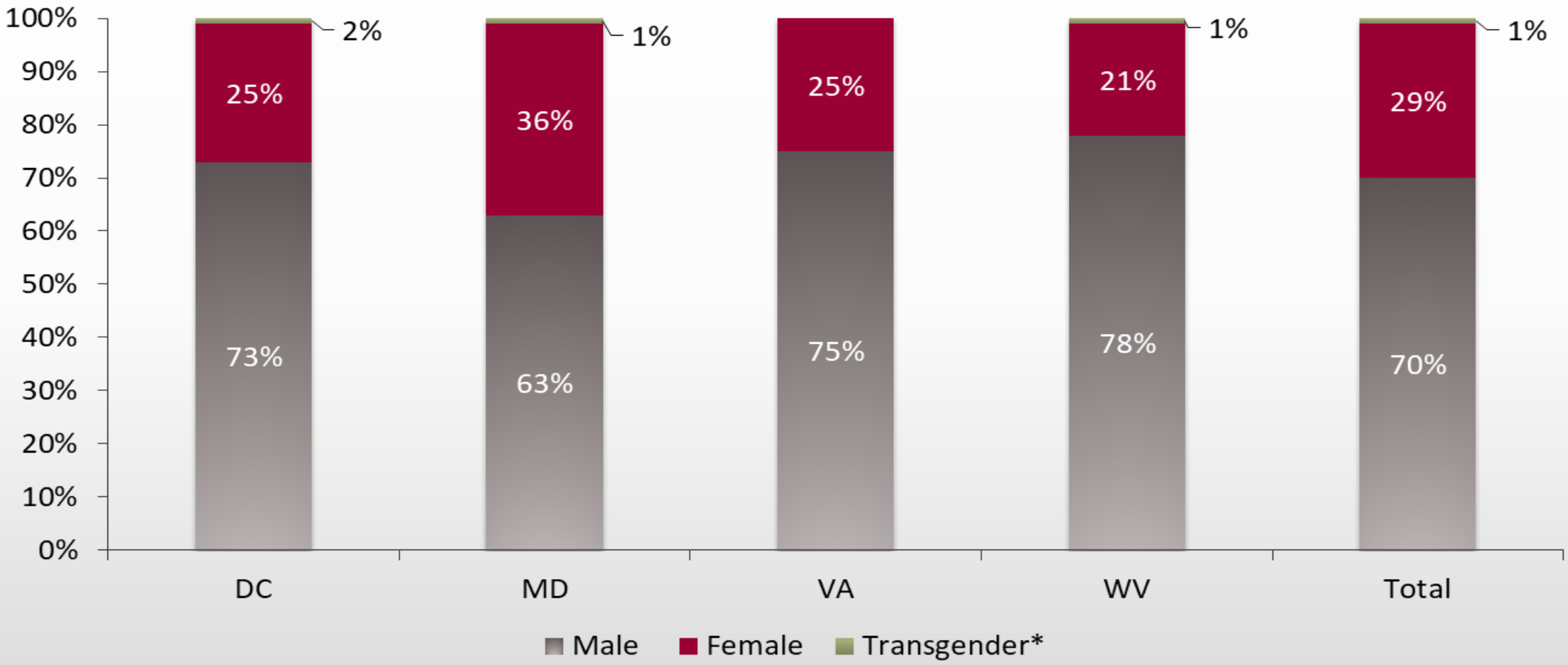
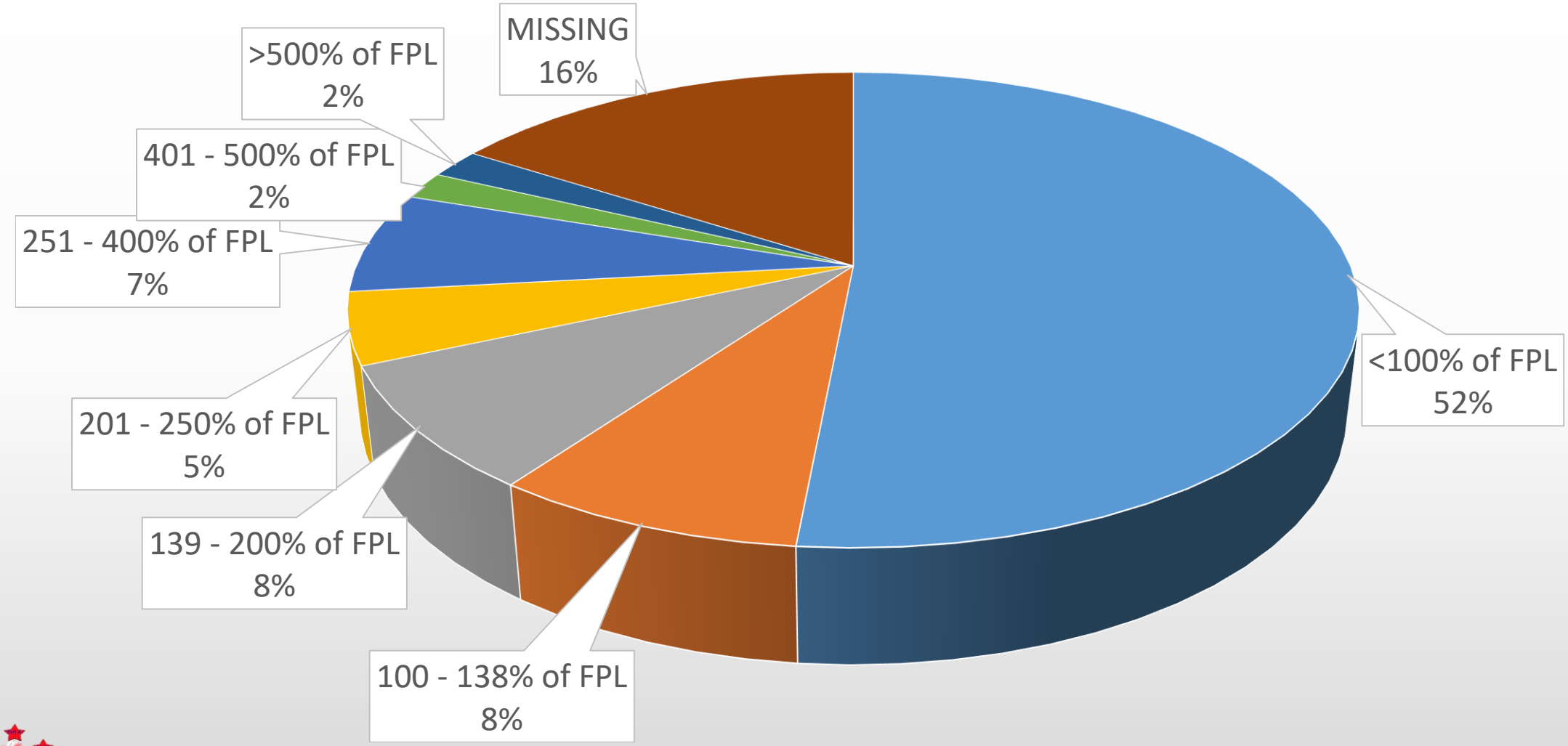
GENDER - EMA


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25%
73%
2%
36%
63%
1%
25%
75%
21%
78%
1%
29%
70%
1%
DC
MD
VA
WV
Total
Male
Female
Transgender*

FEDERAL POVERTY LEVEL - EMA



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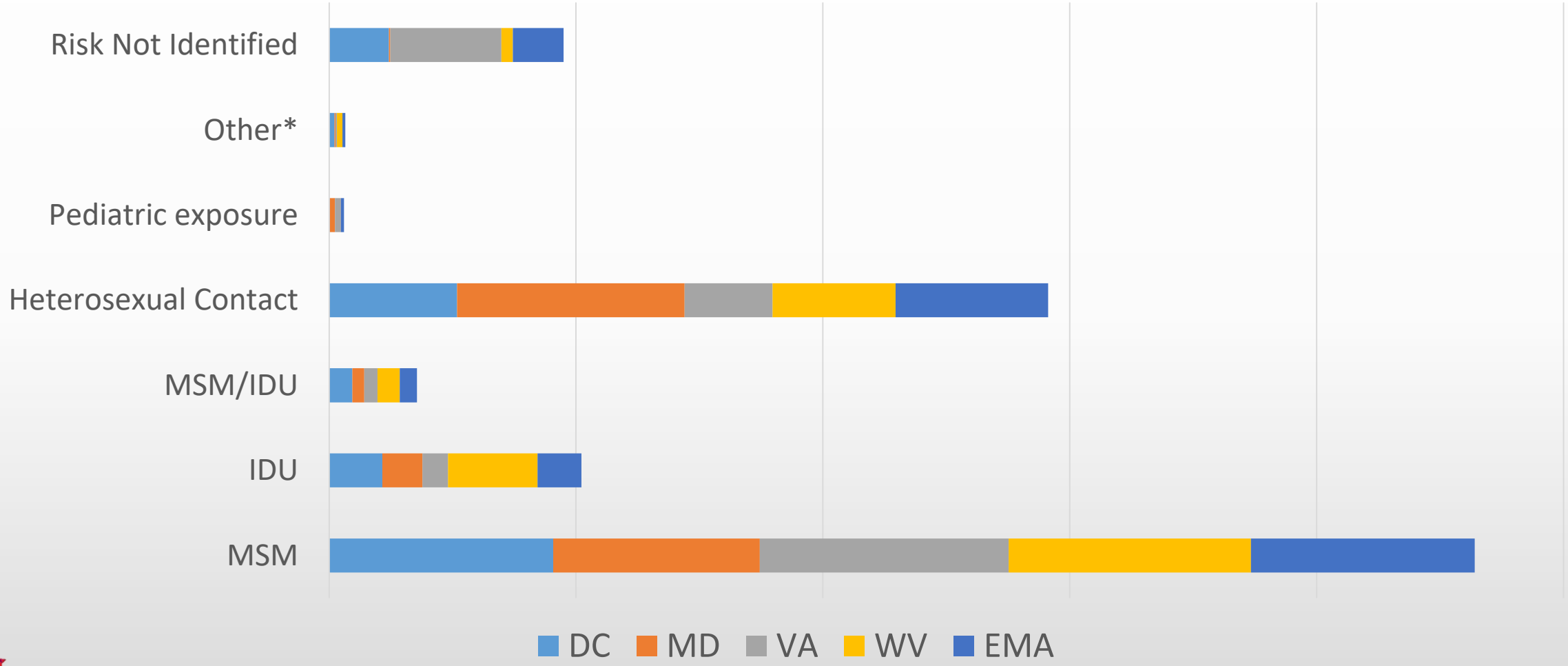
RISK FACTOR EMA



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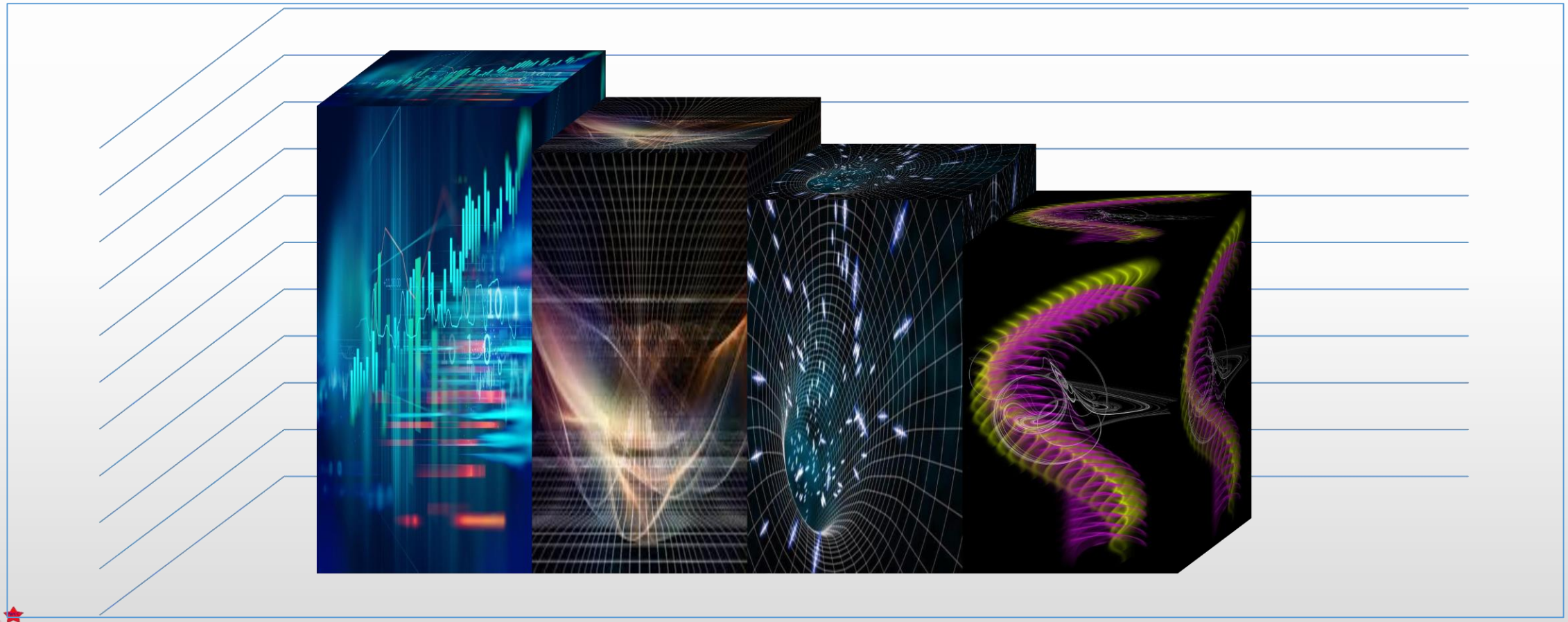
CARE DYNAMICS

OUR CARE CONTINUA



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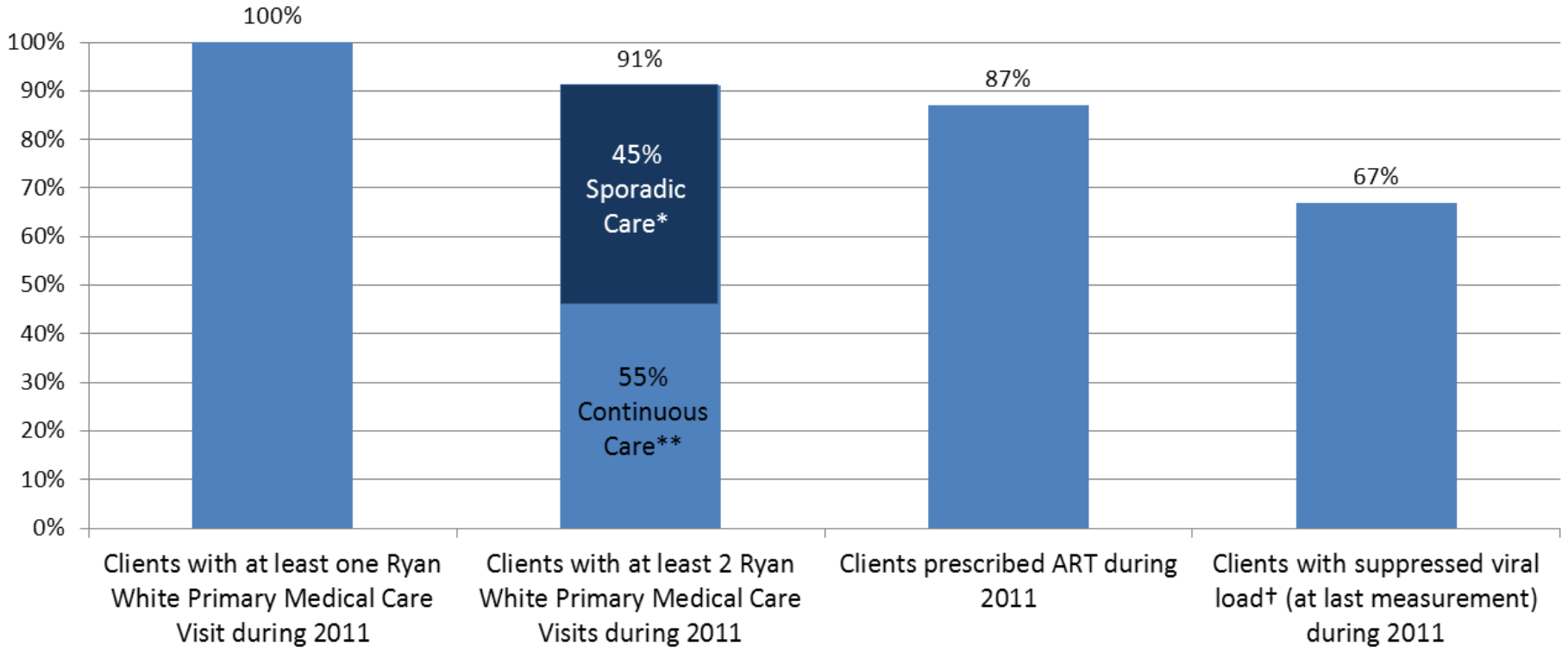
DC Collaborative Baseline - 2011



* Sporadic care is defined as having at least 2 primary care medical visits, however the visits were less than 3 months apart.
** Continuous care is defined as having 2 Primary care medical visits that are at least 3 months apart from one another
† Suppressed viral load is defined as viral load < 200 copies/mL

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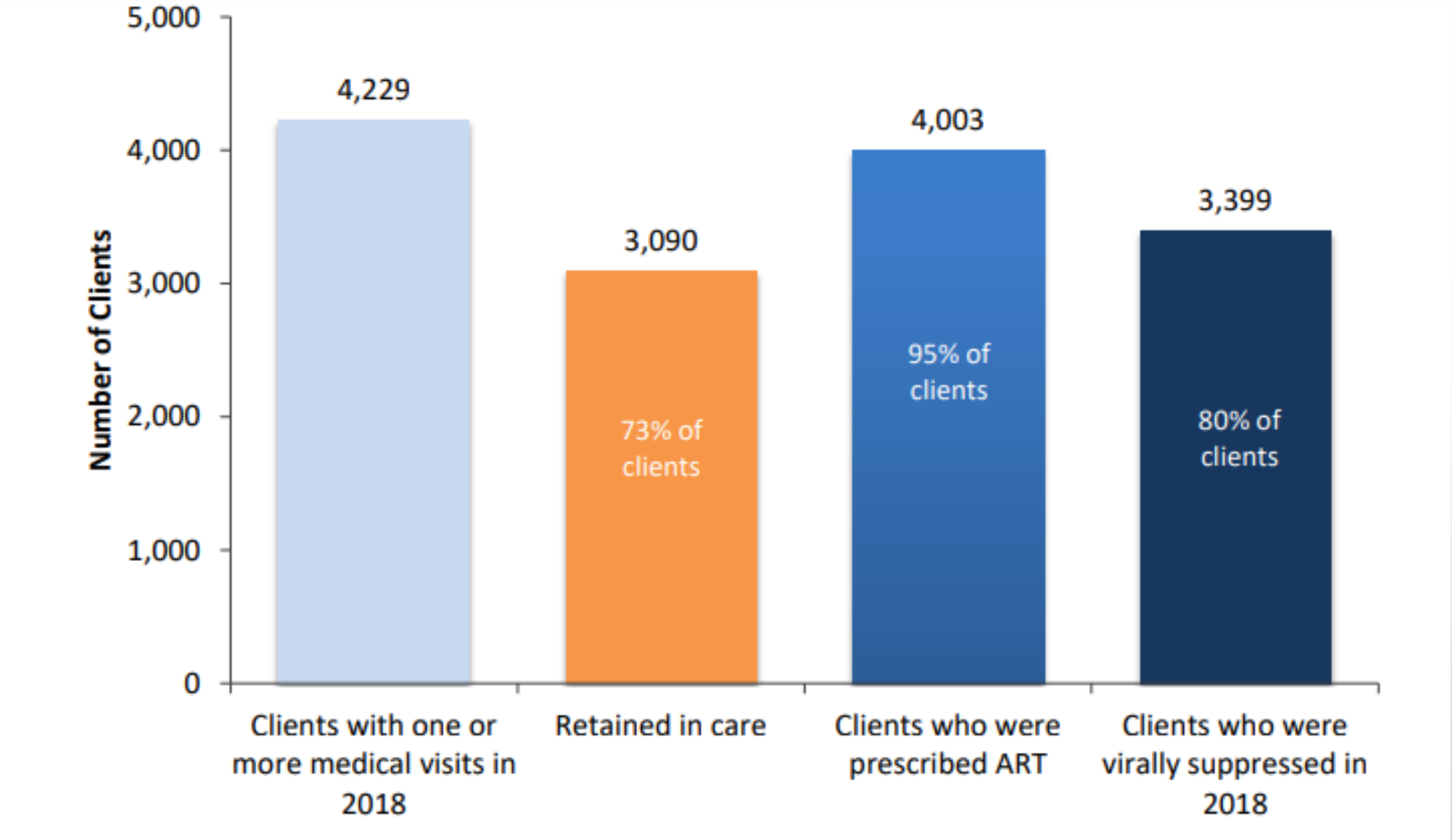
2018 DC Ryan White Continuum



Continuum by Age - 2018

Age Group	Retained in Care	Prescribed ART	VL Suppressed
0 - 12	64%	47%	31%
13 - 24	86%	87%	69%
25 - 34	82%	90%	76%
35 - 44	89%	95%	80%
45 - 54	89%	94%	84%
55 - 64	90%	96%	87%
65+	90%	96%	90%

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DISPARITIES ANALYSIS

STRATIFICATION OF DATA

- Gender
- Age
- Socio-economic Status
- Risk Factor
- Geography

How else should be looking at segments of the population? How can be use data to better improve social determinates of health?

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How do we Qualify a Health Disparity?

- Supreme Court of the United States and Disparate Impact
  - Disparate Impact examines ***Effect*** instead of ***Intent***
  - Applies to employment, housing, and other discrimination cases
  - ***Statistical tests*** built on decades of precedents
- Priority Populations: 2016 – 2020
  - MSM of Color
  - Black/African American and Latina Women (BAAL)
  - Youth (13-24)
  - Transgender

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DISPARITIES ANALYSIS

BEFORE AND AFTER ECHO COLLABORATIVE

HIV Viral Load Suppression (HAB) Overall Performance Average: 75.1%				
	B AA/L Women	MSM of Color	Trans	Youth (13-24)
Population Sample	2,036	1,952	187	363
Population Performance	75.05%	75.82%	68.98%	63.09%
Absolute Disparity	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY	YES DISPARITY
Relative Risk	NO DISPARITY	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY
Comparative Disparity	NO DISPARITY	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY
Odds Ratio	NO DISPARITY	NO DISPARITY	NO DISPARITY	YES DISPARITY

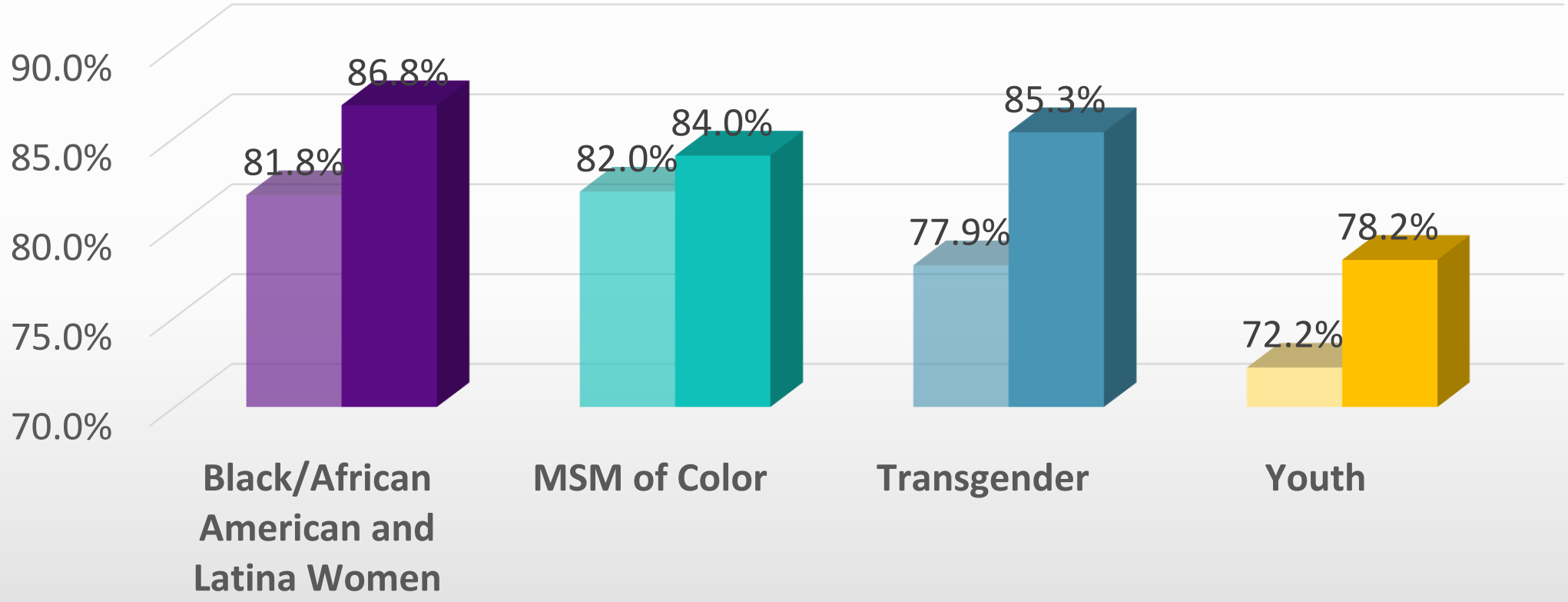
JUNE 2018

HIV Viral Load Suppression (HAB) Overall Performance Average: 78.24%				
	B AA/L Women	MSM of Color	Trans	Youth (13-24)
Population Sample	1,983	1,410	104	302
Population Performance	78.32%	75.96%	71.15%	65.89%
Absolute Disparity	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY	YES DISPARITY
Relative Risk	NO DISPARITY	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY
Comparative Disparity	NO DISPARITY	NO DISPARITY	NO DISPARITY	MAYBE DISPARITY
Odds Ratio	NO DISPARITY	NO DISPARITY	NO DISPARITY	YES DISPARITY

NOVEMBER 2019

RECAP OF ECHO COLLABORATIVE

NATIONAL OUTCOMES: JULY 2018 VS. NOV. 2019



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HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

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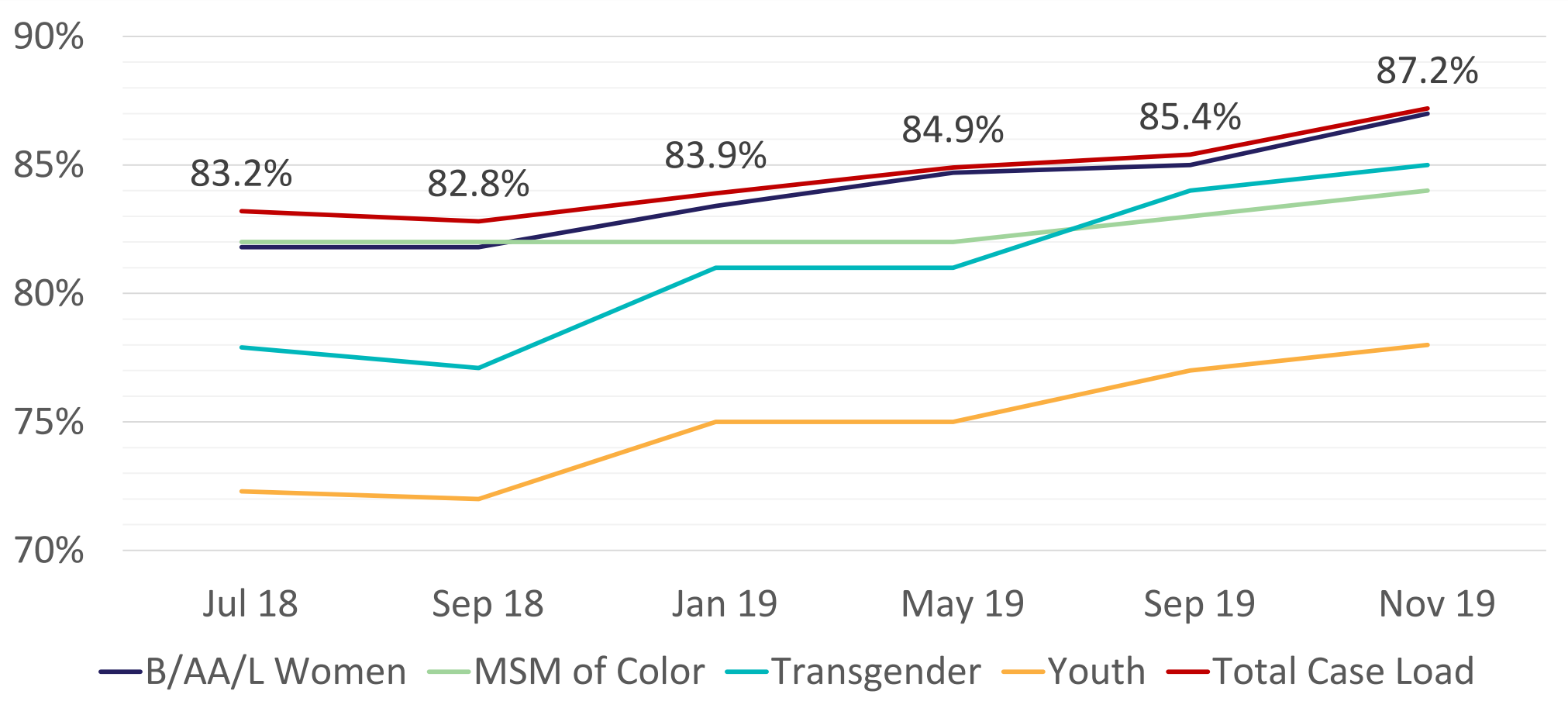
VIRAL LOAD SUPPRESSION TRENDS

NATIONALLY BY GROUP



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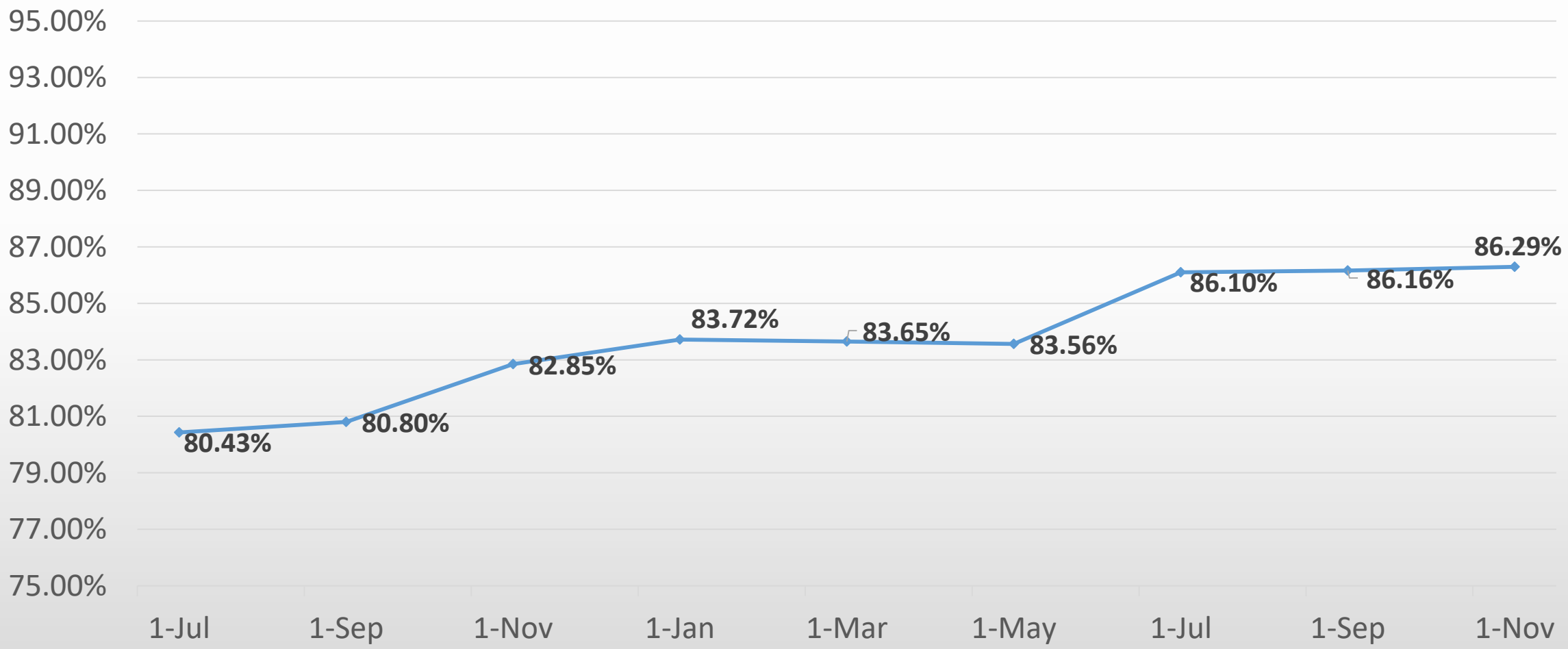
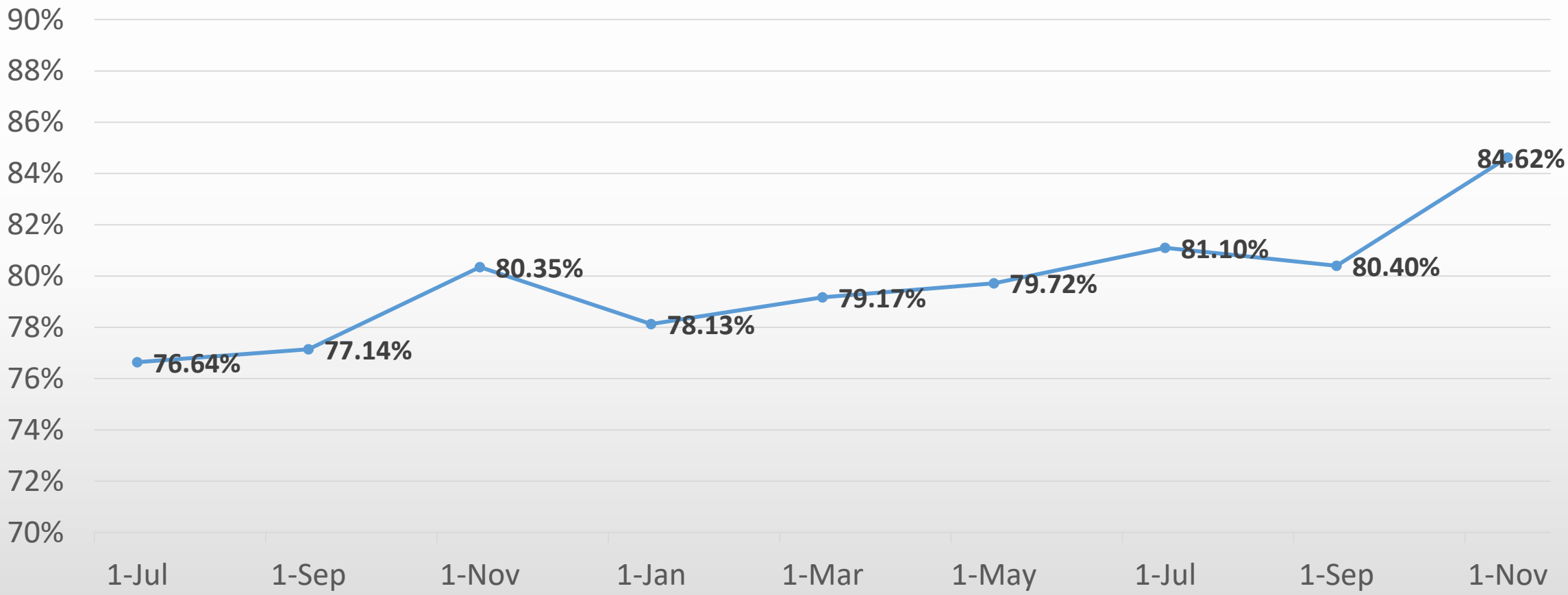
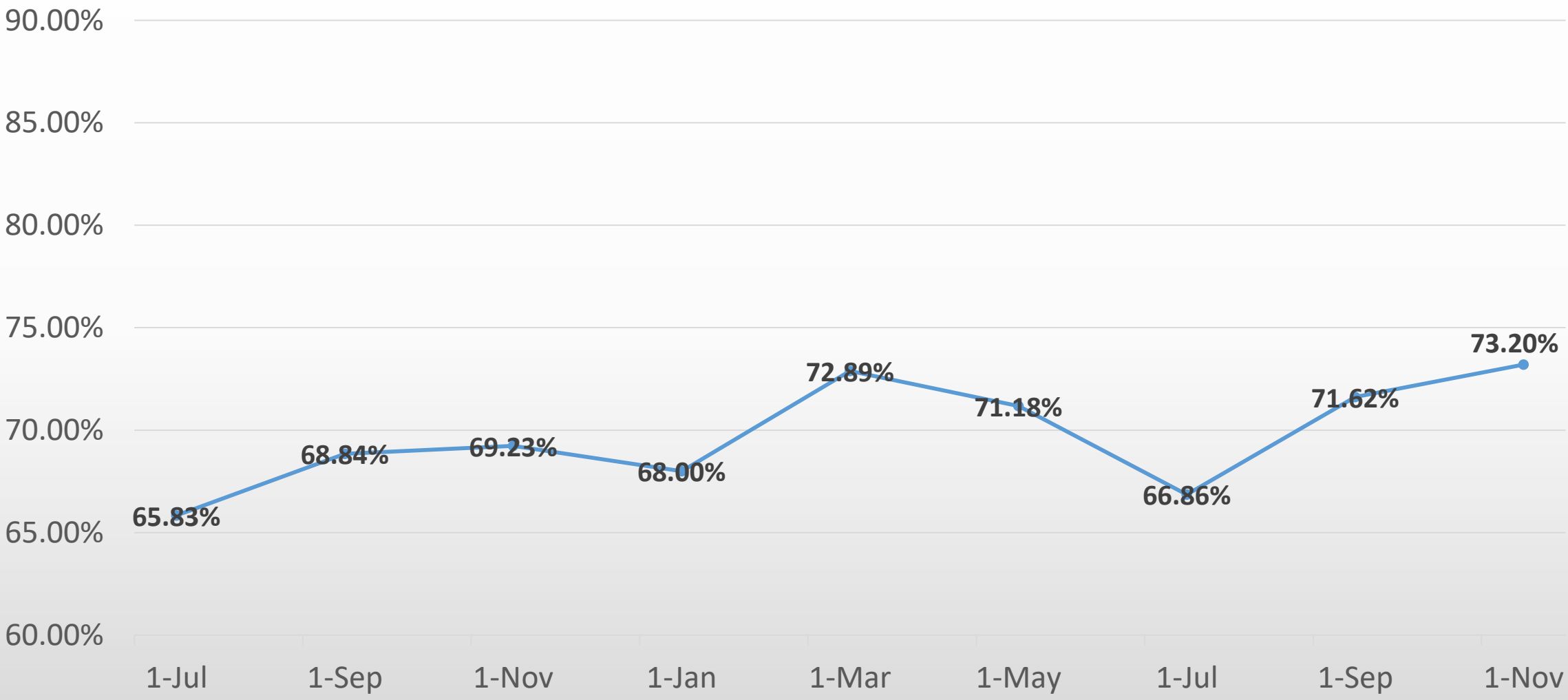
ECHO – DC Regional Group Data: Entire Caseload



ECHO: TRANSGENDER VIRAL LOAD SUPPRESSION



ECHO: YOUTH VIRAL LOAD SUPPRESSION



THIS IS YOUR DATA!

DISCUSSION

- What should be the top data priority of the collaborative?
- What assistance from HAHSTA has been most helpful to measuring your clinical outcomes?
- What has been helpful, but could be expanded or improved?
- What technical assistance for using your data is needed but has not been offered?
- What barriers exist to using data in quality improvement projects?
- How would you like us to share or analyze it to aid in CQM efforts?
- What other thoughts or questions do you have about your data?

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QUESTIONS

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