Virtual Provider Learning Sessions for Latent TB Infection: Session 3 Transcript

- Again, for those of you who are just joining us, if you could take just a moment to introduce yourself into the chat, what is your name and preferred pronouns? What is your title and role at your organization? What organization you're from, and what is your favorite thing about winter? And I think I'm with Irving Atkins, I had a hard time thinking of something that I liked about winter myself, but. So good morning everyone, can we go to the next slide please? Welcome to our third Virtual Provider day session for latent tuberculosis infection, my name is Amy Sgueglia and I am a nurse and consultant at JSI who works on the TA4SI project. For those of you who are not familiar, well, I'm sure that many of you are, TA4SI stands for Technical Assistance for Service Integration, this project is funded by the Bureau of Infectious Disease and Laboratory Sciences and implemented by JSI. The project provides technical assistance to BIDLS-funded agencies with a focus on service integration both across infectious disease areas, such as HIV, hepatitis, STIs, and latent TB, and into primary care. So just again, if you joined us before the session started, we had a slide up regarding introductions for today's meeting, if you could just take a moment to introduce yourself in the chat box, including your name, your preferred pronouns, where you're from, what is your title? And what is your favorite thing about winter? Next slide please. So this is our third and final Virtual Provider Learning Session, we had two previous sessions in November, one was on risk assessment and testing, one was on adherence support, and one was on adherence support, and if you missed those sessions, recordings of the sessions and slides will be available shortly on the TA4SI website. Next slide please. The objectives of the Virtual Provider Learning Sessions are to update providers' knowledge and review resources that describe latent tuberculosis services, including risk assessment, testing, adherence support, and reporting, prepare agencies to plan for initiating or enhancing these services and to share lessons learned. Next slide please. So the agenda for today, the session today is gonna run from 10 to 12 p.m., we're going to start with some introductions momentarily, then we'll be listening to a presentation from Laura de Mondesert and Andrew Tibbs of MDPH about data reporting process, next we'll hear from Lisa Randall and Laura again from MDPH about quality improvement. After these two presentations, we'll have time for discussion and questions, then we'll have a brief break before we head into breakout rooms for a pre-process mapping exercise and two case study questions. Finally, we're going to regroup in the main room for a quick wrap-up session. Next slide please. So before we begin, we have some housekeeping items that we need to discuss. First, we recommend that you connect to this call using your computer's audio, to join this meeting using your computer's audio, please select the Computer Audio tab in the Zoom audio conference options box and select Join with Computer Audio. Next slide please. If you're unable to join by computer audio and need to join by phone, please select Join Audio, select the Phone Call tab, and select a phone number to dial. Once you are connected to Zoom, using the phone number you dialed please be sure to enter the correct meeting and participant ID numbers, these ID numbers can be found in the Audio Conference options pop-up that is shown on this slide. You will automatically be muted, and to mute or unmute yourself, please select the microphone icon on the bottom bar of your Zoom screen. If you have a webcam available, we're going to ask that you select the Start Video tab next to the mute feature on the bottom bar of your Zoom screen. Next slide please. As I mentioned when we were reviewing the agenda, there will be a discussion and Q&A session after today's presentations, please feel free to chat your questions throughout today's presentations, when we get to the Q&A portion of the presentation, we welcome you to raise your hand or chat your question as well. Next slide please. There

are several colleagues from MDPH in today's session, I'd like to spend a moment thanking them and those who were involved in the design of this program, we really truly couldn't have done it without you, we really appreciate the time and the effort you put into this, we certainly do. I'd like to hand it off for a moment to Lisa Randall from MDPH for a few words and to introduce her team. Lisa? Lisa, you're muted. There you go.

- You think that I would have learned how to use this by now. Good morning everyone, thank you so much for joining us, I'm happy to see many of you again. Again, my name is Lisa Randall, I'm the director for the Bureau's Office of Healthcare Planning among other responsibilities of our office, capacity building, technical assistance, but also monitoring and evaluation for the contracted services, so many of you, I've had interactions with, I think. One of our priorities in engaging community-based service providers, including the agencies that are participating in this endeavor today, we support to integrate across HIV, hepatitis, tuberculosis, and STI within your respective organizations, and BIDLS similarly is working to be fully functionally integrated and integrated across the various disease areas, and so similar to the work that we do or that you do, we are also doing, and this series of virtual learning opportunities was developed by JSI in collaboration with multiple units, divisions and offices within the Bureau, including the Office of HIV/AIDS, the Division of Global Populations and Infectious Disease Prevention, as well as the Office of Healthcare Planning, and the individuals from those different units within BIDLS are listed on your screen, and I also think that we have some additional staff that are participating today that may not be listed, and so I hope that we have an opportunity to see them and have them participate as well. Thank you.

- Thank you, Lisa. Next slide please. We also have several members of the TA4SI team joining us today, besides myself, we have Sabrina Eagan, technical advisor, Molly Rafferty, project associate, Mira Levinson, project director, Molly Higgins-Biddle, project manager, Mikey Davis, consultant, and Christine Luong, consultant. Next slide please. TA4SI developed a series of Fact Sheets on latent tuberculosis infection services, the Fact Sheets address key considerations of each component of testing and treating individuals with latent tuberculosis infection, these Fact Sheets were developed for use by clinical and nonclinical providers in agencies that are receiving funding from the Bureau of Infectious Disease and Laboratory Sciences to provide TB testing and latent TB infection services. Next slide please. Thank you. So this graphic depicts the components for testing and treating individuals with latent tuberculosis infection, it gives an overview of the cascade of care for latent TB infection and includes the steps to deliver each component to the individuals that you work with. It's important to remember that individual agencies may offer all of these components, or they may offer some of these components, only offer some of these components in a menu of services. Next slide please. I wanna show a close-up of the bottom half of this document, so this shows the steps that are listed under treatment, adherence support, and reporting and analysis, so as I was saying, we've developed all of these Fact Sheets and they are on the TA4SI website, if you look at the slide that's up right now, you can see the link to that website and it will bring you to this general TA4SI page, if you click on, there's a link underneath the latent tuberculosis section, it will bring you to a list of all of these Fact Sheets. Can I have the next slide please? So again, just as a reminder, although I think we've probably lost all of our chatted introductions, but if you've just joining us for the first time, if you wouldn't mind chatting your name and

preferred pronouns, what is your title/role, where you are from, and what your favorite thing is about winter. Next slide please. So before we begin with our content today, we would like to get a sense of where the agencies are that are joining us, with the agencies that are joining us are with their data reporting activities. So a poll just popped up on your screen, the question is, how would you describe your agency's MDPH BIDLS data reporting activities? And if you could choose one of these, awesome, we're very good at reporting data, great, because I figure someone else is taking care of reporting, pretty good, because we do okay with reporting data, so-so, reporting data is a challenge, or help. So if you could just take a moment to the agencies that are with us today to answer that question. Okay, why don't we end the poll and we'll see what the results are. Great, so it looks like most of you are awesome, you're doing a very good job at reporting data, 44%, 13% said, "Great, because I figure someone else "is taking care of the reporting." 31% said, "Pretty good, we do okay reporting data." 13% said, "Eh, so-so, reporting data is a challenge." And nobody is desperate for help, it looks like, screaming for help, so thank you. Next slide please. So now we'd like to turn the presentation over to Laura de Mondesert and Andrew Tibbs of MDPH. Laura is an epidemiologist with the Office of Healthcare Planning while Andrew is the Surveillance and Epidemiology team leader for the Division of Global Populations and Infectious Disease Prevention. Welcome, Laura and Andrew, and Laura's going to share her screen with us and her slides.

- Good morning. Thank you, Amy, for that introduction, can everyone hear me?

- Yes, I can hear you.

- Yes, okay, great. I'm gonna go ahead and share my screen. Let's see. All right. So welcome again, and thank you all for joining. Today we'll be discussing LTBI reporting and reporting processes, and we'll just go ahead and jump into it. So as you just saw in one of Amy's previous slides, these are the components for testing and treatment of individuals with latent TB infection, you may have seen this in a different format, but this is just the broad overview of the components and we'll kind of dive in deeper as we move along the presentation. So these components that are highlighted in blue call attention to data that can be reported using the Integrated Testing and Linkage Services form, also known as the ITLS form, and then the components, or the one component highlighted in green references data that can be reported using the ITLS Syringe Services Short-Term Health Navigation and PrEP form, and for the purposes of this ITLS form and Short-Term Health Navigation form, so DPH will follow up directly. Oh, I'm getting a notice that internet is unstable again, can everyone still hear me?

- Yes, I think that was at your end, Laura, so I think the rest are okay at the moment.

- Okay, just let me know if something goes wrong.

- We sure will.

- Thank you. So DPH will follow up with agencies directly to collect data for these other components that are not reportable through the ITLS or Short-Term Health Navigation forms. Data through other components should be collected by your agencies through internal databases or information systems in whatever mechanism that you collect your data. So you guys should be fairly familiar with the ITLS forms by now and Short-Term Health Navigation form, we'll move on to a demonstration to kind of show you how you should fill these forms out for using a specific scenario, I'll also highlight relevant LTBI changes that were made to the form, which was distributed last week to your program managers. Changes were only made to this first form, the ITLS form, not the Short-Term Health Navigation form. So again, we just saw this in Amy's slides, but these are the reporting components and kind of a broad overview of what is involved in each of the components, so for the first one, risk assessment, as implied by its title, it involves identifying individuals who may be at risk for latent tuberculosis infection or active TB disease, and in performing these activities, it would be helpful to refer to the DPH risk assessment tool, which is online on the DPH website and I believe on the TA4SI website as well, and it's essentially a guide for knowing how to identify individuals at risk, and so here we can see individuals at risk, or at increased risk for infection, they would include anyone who's immunocompromised or born outside of the US in countries with high transmission. So for the purposes of our demonstration, we will identify an individual born in Haiti who is HIV positive, so both born outside the US in a high-transmission country, and immunocompromised. So then the next component would be testing, and once you've identified the individual who may be at risk, you would then move on to this phase which would involve choosing the appropriate TB test, which could be the interferon gamma release assay, the IGRA test, or the tuberculin skin test, TST, you would confirm and document the test result on the ITLS form and provide the result to the individual as you do with some of the other diseases that are reported through the ITLS form, and so for the purposes of our demonstration, we'll say that you all used the IGRA test on this individual and they, indeed, were positive. From there, you would move on to the evaluation component, which would rule out active disease, active TB disease, this may not be relevant for all agencies involved on the call, but we'll kind of dive deeper into that as we move along in the presentation. Once you have identified whether the patient, the individual has a latent TB infection, or TB disease, you would then move onto the treatment component, and the treating provider would identify what the appropriate regimen would be for the individual. So for the purposes of our demonstration, we'll say that the individual was referred to an ID specialist and successfully linked to their treating provider, which may be the extent of what your agency is able to do with this individual in this component. Moving on, the next component would be adherence support, which would be reported through the Short-Term Health Navigation form, and using our demonstration, we'll say that the individual may require assistance in scheduling her appointment with her treating provider or getting linked to a specialist, she may require transportation assistance and an appointment reminder on the day before her appointment. And then reporting and analysis would involve reporting cases of latent TB to MDPH and reporting those treatment outcomes and assessing the quality of services. So, sorry, we will jump into the demonstration before we'll jump into Andy's component, just let me share. So again, this is the ITLS form, you'll see this is version three, so this will include the relevant updates that were made to the form last week, I've gone ahead and filled out the demographic information following the demonstration that was listed in the presentation. So using the information listed on the

slides, we'll go ahead and say that the client was only tested for TB, and so then we'll go here, and we said that the client had tested positive through IGRA, so IGRA positive, and these are the changes that were made to this section of the form, previously it just said positive or negative, and now we have this distinction between the two types of tests that may be available at your agency. So IGRA positive, we'll say that, "Yes, we provided the result to the client." And then we'll ask for you to provide a date for when that result was provided. And then for the care status, so using the demonstration, we said they were referred to an ID specialist and successfully attended the appointment, so referred to care, attended appointment, you would then include the appointment date if you know it, and then where that appointment took place, and this is just a list of all of our contracted agencies, and at the bottom, there's a section for other, so for example, if the client was referred to an ID specialist at the Brigham, other would be the appropriate choice. I'll remind you that as you're making changes to the form, please remember to save often because you'll send the third page of this form, which includes the barcodes, through the fax number, and the barcode is encoded by saving the form, and you'll notice that the Form Unique ID is auto-populated based off of the information that you provide in the demographic section, it will also carry over to that second page if relevant. So we'll move onto the second page, which is the Short-Term Health Navigation form as we're calling it for the purposes of this presentation, all of the demographics and risk information will also be auto-populated from what you had listed in the first page, and so then moving on to the component of adherence support, the individual received LTBI treatment navigation, so we'll indicate the date using the date calendar function, and then it's important to, we don't consider the navigation complete until there is an end date and an outcome associated with the start date of that navigation, so let's say we know the end date, whoops, sorry, all right, and then the outcome was linked to treating provider, but then here, you would go on to check all of the boxes to kind of detail the type of navigation and work that was involved in navigating this client, so we can indicate that transportation assistance was provided, and appointment reminders and any appointment accompaniments that may be relevant to the person's navigation. So that's just kind of a brief overview of how to fill out the form, of course if other services happen in conjunction with the navigation or testing, you would fill out those sections as well, but just using our demonstration for testing and short-term health navigation, that's basically how you would fill it out. Again, remember to save often that way you can ensure that all of the data is properly encoded in this third page, which is the barcode page, and this is exclusively the page that you would fax to the MDPH fax number. Then we'll jump back into the presentation. And I will hand it off to Andy.

- Hi everybody. Thanks Laura, thank you for getting us going. So I just have this one slide, which is full of text, and I apologize for that, but there's a few things that I'd like to point out relevant to kind of how this process works. So for both clinical and nonclinical sites that are participating in this project and then who are expected to complete the ITLS forms, they are expected to complete them for each client who is tested for IB using IGRA or TST, whether the result is positive or negative, and so that would take care of your reporting requirements, the Massachusetts reporting requirements for every patient you fill out that form for for your LTBI reporting needs. And so depending on your facility's capacity, non-clinical sites are required to report any treatment adherence support, just like Laura just demonstrated, for latent TB infection on the short-term form, health navigation form, and then again, as I mentioned, as long as you submit the ITLS form you're not expected to complete any additional surveillance forms. If there's any additional testing done at your facility through other mechanisms for TB for patients who

you would not normally submit an ITLS form for, you would still be required to report those cases to Mass DPH, as is required by law on the TB Infection reporting form, so again, you can submit one or the other, you don't have to submit both, so if you're submitting an ITLS form for a patient already that you're navigating through your system, that's it, that's all you have to do, if you are seeing a patient for a non ITLS-related procedure or if you're testing them for some other reason, you would still have to submit the reporting form to DPH through the normal mechanism. And then if an individual tests positive at your site, that piece at the end of the care cascade where you would talk about outcomes where there's no place to fill that in on the form, that's because an epidemiologist from DPH may contact you if additional information is needed and will discuss the processes of evaluation and treatment completion relevant to your site and will help walk you through the next steps, so if you're a treating provider, if you're treating those patients, we'll talk to you facility-by-facility about how we're gonna get the information on treatment completion from you, which makes sense for your facility, what makes sense for your facility and for DPH, and if you're a non-treating provider and you've successfully navigated the patients to someone who can treat them for LTBI, your process basically ends at that point, so doesn't make sense for you guys to fill out more forms at that time, and I'm happy to answer any questions about that during the question and answer session at the end, or during the breakout sessions. Moving on.

- Great, thank you, Andy. So then we'll move on to using DPH reports to understand your data, and specifically, how to identify where components may be reported in some of the reports that we generate and some of the reports that you've hopefully seen by now. So this is the ITLS Dashboard report, don't worry, you don't need to analyze this at the moment, it's just in case you're not familiar with its title or how we call it, that is the report, and it's generated monthly at aggregate agency and site levels. This should be distributed to you all by your contract manager on a monthly basis, and hopefully you all will look at this and review it with your contract manager during your monthly calls. So specifically as it relates to LTBI, it contains an overview of latent tuberculosis infection linkage to care in a cascade format, it also contains information on short-term health navigation, specifically latent tuberculosis infection treatment navigation with its outcomes along with priority populations that are tested, race/ethnicity for those tested, and of course, other components for other diseases for which we capture data. And then this is the monthly ITLS summary report, also generated monthly and available at the aggregate agency and site levels, distributed by your contract manager, and again, this is hopefully one of the many reports that you all will review frequently with your contract manager to see your data as it's been reported to us reflected on a month-to-month basis, and specifically with this report, it reports the number of tests, either through IGRA or TST, conducted by your agencies and the number of positives that resulted from those testing sessions. Other reports that are generated by the Office of Healthcare Planning are the quarterly ITLS reports, fondly known as the long report, this is generated quarterly, and it contains a detailed breakdown of every field included on the ITLS form, so an example of data that you may find there would include TB tests conducted by your site, stratified by age, race/ethnicity, and other demographics listed in the demographics and risks section of the form, it would also include linkage to care outcomes, so for example, number of individuals who tested positive and were linked to care or already in care, declined assistance, lost to follow-up, et cetera. And then we also have the Short-Term Health Navigation reports which are generated quarterly, and they contain a detailed summary of all of the navigation services and the populations receiving these short-term health

navigation services along with their outcomes, so an example of data that you may find here would be the number of LTBI treatment navigations initiated during the fiscal year by target population, also by some of the other demographic breakdowns such as risk, gender identity, et cetera. And so we'll kind of dive in to--

- Laura, excuse me for a minute, we lost a couple minutes during the technical issues so you have about five more minutes to go, just so you know.

- Okay, we'll just kind of breeze through these components, some of them may be redundant as they're listed on the form, so here's component A for the risk assessment, so what's listed here is the priority population table for the Dashboard, so while this indicator may not be explicitly worded in the reports, the ITLS report in this format, so for the individuals who were deemed to be at risk and received a test be reported in this section of the report. For component B, testing can be calculated using the data reflected on the ITLS Dashboard report along with the monthly summary report, so these would be the sections where you would find the numbers for this specific indicator for number of individuals tested for TB infection by your agency, and here is where we'd find the numbers for individuals who test positive using IGRA or TST. Component C is the evaluation component, it's currently a component for which we do not collect data for on the ITLS forms, however, you should record this information in your internal databases as it will be information that you may need to report to the surveillance epidemiologists, as Andy mentioned. Then component D for treatment, the Dashboards only report the number of individuals who tested positive and went on to attend their referral appointment, so if adherence treatment, sorry, adherence support is provided, treatment status can be reported using the Short-Term Health Navigation form. And so here's where we would find information for this indicator for individuals who initiate treatment using the cascade, if they attended their appointment, we kind of use that as a proxy for treatment initiation, it can also be found here in the Short-Term Health Navigation form where you may be able to list explicitly that treatment was completed through short-term health navigation. Adherence support, so again, using the Short-Term Health Navigation forms, this is where you would find this indicator on the Dashboard report. And then finally, component F, which is reporting and analysis, so as mentioned under component C, the evaluation component, this distinction of LTBI versus active disease diagnosis are indicators for which we do not collect on the ITLS forms, however, you should be collecting them internally. What our reports do count are the number of individuals who tested positive at your facility, and here's where you would find those counts, again, just reiterating, on the monthly and Dashboard reports, similar metrics are reported in the quarterly report as well, and just to reiterate, we count the number of positives on all of the reports generated by the Office of Healthcare Planning, however, we don't know how many of those positives, just by looking at the reports, will go on to receive active TB disease diagnosis or latent TB infection by just reviewing these reports, and so we'll reserve questions for the end and I will pass it off to Lisa.

- Sorry, Amy, are you in charge, please? Who's in charge?

- Lisa, go ahead, I was just gonna introduce you. So for those of you who don't know, I'd like to introduce Lisa Randall, she's the director of Healthcare Planning and will be presenting about continuous quality improvement.

- All right, thanks, thanks so much. So Laura just foreshadowed the indicators, the program indicators that we're beginning to frame as a foundation for some enhancements in our quality improvement work, and we hope in your quality improvement work, I wanna spend a couple of minutes, not too much time, talking about quality improvement and our approach, I'm sure everybody on this webinar today is familiar with the term quality improvement or quality insurance or quality management, some variation of that, and I know that a lot of us tend to clench or get a little bit cranky when we hear we have to do some quality improvement activity, it could be because it seems complicated to go through some process, maybe it's not clear how it relates to your work, maybe you've had experiences in the past where you've gone through a lot of thoughtful process and it really didn't produce any improvements, or maybe it just feels punitive for some reason, but simply stated, quality improvement just really means engaging in an ongoing and a systematic process to review what you're up to, what you're doing in terms of the processes and the systems of your day-to-day work to determine where you might do better, and all of you, I know, are committed to doing the best work that you can to providing the highest of quality and most effective service that you can to the communities that you serve. So I think next slide, Amy. Molly, are you gonna do the polls?

- Sure. So yeah, so before we kind of get into QI principles, let's just do a quick poll everyone, and tell us, have you attended a training on quality improvement before? So I see some answers coming in here, we'll give it a minute. All right. Here we go. Okay, so a few say, "Yes, I'm a QI expert." The majority say, "Yes, but I could use a refresher." And a couple say, "No, not at all." So thanks everyone, and we can continue on, Lisa.

- It's really interesting how few folks, relatively speaking, have been through what they understand to be a quality improvement training. I would venture to guess that almost everyone has participated and learned a little something about quality improvement through your day-to-day work whether you realize it or not, and so I think it's really encouraging also that so many of you felt like you could use a little brushing-up. So there are a bunch of formal models and approaches for quality improvement and they're often used in healthcare, a lot of the QI models actually have their roots in manufacturing and industry. The PDSA, the Plan, Do, Study, Act model is one that is frequently used in healthcare, many of you are probably familiar with it, we've used it in the context of some of the work that we have done with Ryan White funded services, PDSA is often used in conjunction with sorting out and solving problems in complex organizations where there are multiple workloads and processes that impact on each other, and so that's where PDSA is often used. Closely related to PDSA is something called Six Sigma, and that's something that DPH uses quite a bit, it's the sort of core of PDSA is data-driven and it's intended to improve efficiency and reduce waste, so again, a lot of these, PDSA and Six Sigma both have some history in industry. The lean production, which actually used to be known in the day as the Toyota Production System, is really popular in healthcare, particularly for laboratories and pharmacies, it's

intended to find ways, it's really focused on findings ways that don't add value to what you're doing, so that, the lean production, or the lean, often goes with Six Sigma, maybe something that you're familiar with in your organizations, and the other one that tends to come up a lot in healthcare, particularly for laboratories and for healthcare functions where safety of employees or staff are often the focus, is something called human factors, and that's something that is intended to identify sort of the best match between the tools and the strategies and the processes and the human beings that will be enacting those. So those are just a flavoring of some of the models that are used in quality improvement, we don't particularly subscribe to one or the other, me personally, I take pieces of each of them as it sort of suits my needs for the particular issue or problem or group of individuals or organizations that I'm working with, but wanted to let you know that there are various ways of going about this. Next slide please. So regardless of the model or approach that you use, that we use for quality improvement, there are some general principles, I think, that are shared by all of them. One is that quality improvement is ongoing, you don't do it just once then stop, it's not a discrete one-off project, and the goal is always stimulating change, so that is the intent and the change doesn't have to be big, it can be incremental change, little baby steps, if you will. Quality improvement also focuses on processes and systems and fixing those, most of the time, we aren't seeing the outcome that we wanna see or something isn't working quite the way we want it to because some bit of our workflows or our communication strategies, or some operational process that we have just isn't working as well as it could, and so we're not trying to fix individuals, human beings, we're really trying to understand and adjust the processes that are used to do our work and the systems in which those processes run. Quality improvement should be data-driven, using data, various kinds of data, in my opinion, data from multiple sources is always better, and data can be both qualitative and quantitative, it's important to use that because it provides an objective view of what you're doing, how well you're doing it, and then it provides you the opportunity to measure any changes, the impact of any changes that you make, so the short version is, collect data and use it, don't be afraid of it. Quality improvement should be inclusive and it should facilitate accountability. Quality improvement is not the sole responsibility of someone in your organization with a title of QI manager, or the sole responsibility of the team of individuals in your organization that is referred to as the quality improvement team, everyone in your organization, and your clients or your patients, have a stake in this, and so it's important for you to think through how to obtain input and buy-in from all of your stakeholders through this process, so it should be embedded in the work that you do and your culture in some sort of way. And quality improvement doesn't have to be some big, grand process, some formalized process in the sense that you have the quality improvement meeting and you have a written plan, I like to think of it in terms of how you do the work you do each day and to take it in bite-sized pieces. I think Laura's slides about the indicators really illustrated that well because what it shows is that all of these indicators are, from our perspective, helping you to identify some key measurements, and then each of those measurements, or each of those outcomes, is looked at in a small sort of way, in a piece of a report, so you don't have to think about this as, "Oh, we have to have this big report "and we have to look at all of these data at one time "and make decisions based on that." You can take it in bite-sized pieces, and that's why I really like process mapping as a mechanism to sort of lay out your processes because those are the things that go wrong, those are the things that go sideways and make us all crazy in the end in terms of meeting the objectives or the goals that we want, but a process map can really help you, laid aside the data, suggest areas to focus your efforts, so if you use the reports that we provide to you, or reports that you generate on your own, you can identify those bits of a process, of your processes, that you might wanna focus on, and you might

wanna focus on it for two or three months and then on to something else. So next slide. So, Molly, I will turn it back to you.

- Great, thanks, Lisa. So hi everyone, we have a brief example to walk through together before we transition to the breakout rooms. So this slide shows some indicators related to the first two latent TB infection steps, risk assessment and testing, for three different example agencies, you can see the first row shows the number of individuals identified as at increased risk, the second shows the number of tests conducted, and the third shows the percentage. So we can see these three agencies have very different testing rates here, 5% for agency A, 50% for agency B, and 120% for agency C, which should certainly not be quite right when we're thinking about a percentage. So all three agencies have QI teams in place, they're reviewing data and are set to choose a topic for their next QI process, so let's do a poll. Which agencies do you think should consider a QI process related to TB testing rates? Is it agency A, agency B, agency C, A and C, or all of the above? And if you'd like to, go ahead and chat in why you chose the response that you did. We'll give everyone a minute to think about that one. Okay, thanks for participating in the poll, here we go, all right, so a couple said agency B, one said agency C, a handful said agency A and C, and then quite a few of you all said all of the above, which definitely I think any of these agencies could be thinking about a QI process related to their testing rates, and they have a few different reasons, right? So agency A's rate is really low, agency B's rate is better, but it's also low, agency C's data raises a whole lot of questions, what's going on? Is it related to how they're capturing data or their actual risk assessment and testing process itself? Is it something else? And that brings us to our next slide. Thanks. Okay, so continuing with this example, agency C decided to do a QI process and they have some funding to be able to make any adjustments they need to depending on what they find. So their first step is to form a QI team, the program manager contacted the infectious disease doctor, a medical case manager, and a community health worker providing patient outreach and navigation and asked them all to participate, so let's do a poll. So which questions should they try to answer with their QI process related to their testing rate? And this poll is check all that apply and there are quite a few options, so you can choose more than one, and if you choose other, enter your response into the chat. So the options to pick from are, why do we have more individuals tested than at risk? Whose fault is it? How do our risk assessment and TB testing teams share information? How soon can we finish the QI exercise? Do we test individuals for TB on the same day we do a risk assessment? What did the data look like for the previous month? How many individuals started latent TB treatment? Can we use funding to hire a nurse or buy some software to fix the problem? Have other agencies had a similar problem and what did they do? So those are some options to pick from, go ahead and submit your choice. Quite a few here coming in, that's great. Okay. All right, great. Thanks everyone. It looks like the majority said, "A, why do we have more individuals tested than at risk? "How do our risk assessment "and TB testing teams share information?" Quite a few said, "Do we test on the same day "as we do a risk assessment? "What did the data look like? "How many individuals started treatment?" And then most of you said, "Have other agencies had a similar problem "and what did they do?" So all of those are great, so I think some of the options we're looking to stay away from here, which it looks like nobody chose the first one, whose fault is it? So that one isn't super appropriate because QI is about systems, not individuals. How soon can we finish this QI exercise? Could be something you wanna explore if you're thinking about it in terms of a timeline rather than just finishing as quickly as possible. Let's see, option, how many individuals started latent TB treatment is certainly a great question for a QI process,

but it's not directly related to the testing rate issue that we saw in a previous slide. And in terms of using funding to hire a new nurse or buy some software, they could be good solutions, but it's hard to know at this early stage if that would actually help address their issue that they're trying to solve. So I see some great chats coming in, Martha says, "QI should be part of your program." Casey, "I don't think fault should ever be a factor, "QI should progress regardless of how long it'll take." Absolutely. "It may be too soon to look into a solution "before a problem is identified." Exactly. Great, thanks everyone. I think that wraps up this exercise, and I will turn it over to Sabrina.

- Yes, thank you, Molly, and thanks also to our other presenters, Laura and Andy and Lisa. I know there's a lot of information that's been presented and we wanted to sort of cover the spectrum from the sort of nuts and bolts of data reporting and data collection, all the way through to, "Well, why are we collecting this data? "What can we do with it that is interesting "and improves our services?" So I think that there may still be some questions that you guys may have, if you do have questions, please go ahead and put them into the chat, we have about, let's see here, 8 or 10 minutes for questions I think. As you guys are thinking through your questions, it might be helpful to go back to Laura and to the forms because I know sometimes with these forms, you look at them and you don't realize you have questions until you look at them again, so if Laura can post those forms again, and maybe she can just give any tips, but also as she posts the forms, go ahead and pipe up if you have questions specific to completing those forms and what categories mean what and where the right information goes.

- Thanks, Sabrina. So I'll just wait to see if there's any immediate questions, I can't see the chat box so if someone from JSI can alert me if there's a question there, that'd be great.

- Yes, we will.

- In the meantime, do you have any sort of tips or anything that is usually a point where people trip up that they should be aware of?

- Sure, so I mean, usually, you will receive now, there's a new system for delivering the QA reports and we're doing this monthly through a separate platform, which is called Interchange, and so you'll receive these if there's any kind of gaps in your reporting, so specifically, some of the more common ones will be, for linkage to care specifically, if there's gaps in linkage to care, so if you had just indicated that the result was positive and provided to the client, but we don't know the care status, that would be something that's included in your QA report and we'd ask that you try and update the form and resubmit so that those updates can be applied and we can see the most up-to-date information for the services for your agency.

- Okay, thank you. And we did have a question come in from Ellen, she wants us to confirm that if ITLS is reporting a positive TB incidence, then a separate form does not need to be used to report to DPH. Can you respond to that?

- Yeah, I'll actually take that one.

- Okay, great.

- So yes, that's true, so if the patient meets the criteria for an ITLS form, so as Laura mentioned, the risk criteria including, for TB, born outside the United States and you're seeing them in your facility and you're testing them for TB, the ITLS form is sufficient, you don't have to send in a TB case reporting form or the initial form for the evaluation, just the ITLS form is sufficient.

- Great, thank you. Are there any other questions about this form or about the STHN form before we move on from the forms? Okay.

- While we're waiting for questions, another just comment that I'll say is, we've kind of learned through having different iterations of the form, so there is some functionality that's important to consider when filling out this form, so for example, if this checkbox is not checked, so indicating that that is one of the diseases that you're testing for in this encounter, it won't let you populate these fields, and that's just kind of like a data quality check for you all to make sure that there's appropriate logic in some of the things that you're reporting and it doesn't lead to other gaps that may be identified in the QA report, so if you're having issues filling out the ITLS form and you're going to this section and you're saying, "Oh, I'm trying to indicate a positive "but it's not letting me." I would first check here to make sure that you're indicating the test that you're wanting to report a result for, and that would probably be the answer to your question.

- Izzy had a question or a comment, I think related to the poll, around what were the questions that should be asked around the testing data, and his question specifically was, "Are there any cultural differences?" And I wanted to say two things, yes, that is absolutely a relevant question to raise in the context of your quality improvement processes that may be implicated in what you are observing in terms of testing uptake and/or linkage to care, whatever the service piece is, you may be suspicious now that our attention right now to reporting and quality improvement and process indicators has a particular underlying rationale or agenda, you would be right about that, we wanted to talk about that a little bit today in part because we wanted to support you in terms of some of the process mapping that we are asking you to do in conjunction with implementing LBTI services, but also we are thinking through how to expand or enhance our support, both internally within the Bureau and for the agencies that we contract with around quality improvement, and we're developing some tools to help you with

that, one of those being sort of a menu of questions to ask about the various components of services, and it has completely fled from my mind, Sabrina, where we are at with packaging that up, and I don't mean to put you on the spot, but you might want to, if possible, we might want to say a little something about that, I think it's a Fact Sheet.

- Are you talking about the process mapping questions that people can ask themselves?

- Yeah, yeah.

- Yep, I'm so glad you asked, those are on our website, we actually have a link that, if we can't chat it out right now, it will be chatted out during the breakout rooms so that you guys also have that link as well.

- So thank you for the question, Izzy, and allowing me to yap some more.

- Okay, it doesn't seem like there are any other questions coming in on the chat box, but I like where Lisa's sort of taken it and talking about the next steps that DPH wants to take with QI and the fact that they are really interested in this, and I feel like they're also quite open to you reaching out to them if you have questions about data, if you have questions about QI process, that kind of thing. I do see that Mira did chat out the link to the process mapping.

- I see one more question has come in.

- Yep. So that link is there, and then we also have a question from Irving, "How do we track if an appointment has been made "but the client missed it? "How long do we need to track it for?" So I think that's a great question, I'm gonna ask Laura, Andy, and Lisa to sort of determine between you who's the best person to answer this.

- I can take it. So if an appointment's been made and it's internal, I would just kind of collaborate with your colleagues to figure out if the client missed their appointment, however, if you refer to an external agency, so using the example that we had, let's assume you referred the client to the Brigham, we would ask that you connect with the Brigham to see if the client had attended their appointment and make sure you make those relevant updates on the ITLS form or Short-Term Health Navigation form, whichever one is relevant.

- Irving, I see you nodding so I think that answers your question, correct?

- How long? Do we hold this record for a month? Do we hold this record for two months? I mean, if it takes us three or four times to get it successful, how far do we need to keep this record before we can send in the paperwork for matching documentation?

- So a general rule of thumb that we have is try and submit the form within 30 days of the testing session, and that would kind of include some of these additional components of linkage to care and whatnot, and so if after 30 days you're just not successful in figuring out where the client is along the care cascade, it's totally okay for you to put don't know on the form, or lost to follow-up, and you can then later go on to update the form if you do find out that they, in fact, attended the appointment, and we'll use that most updated form to update that information.

- So Irving, don't hold it forever, send it in no later than 30 days.

- Correct.

- Okay, great. Well thanks everybody, again, thank you to our presenters, and thank you to the participants, thanks for chatting in your comments and your questions in the chat box. Our next portion of this session is a breakout room, and for those of you who have participated before, you know that we will break you up into smaller groups so we can have a more rich, meaningful discussion.

- Okay, so welcome back everybody, I hope you guys had fruitful discussions in the breakout rooms. We are going to wrap it up, I think just one quick thing about the breakout rooms, we do have a document up on the website that has a list of process mapping questions, so if you wanna look at that and it will help generate more ideas, then you can take that back to your agencies, I think maybe some of you talked about that in your session, your breakout room, I'm sorry. So we just have a few minutes left and we're gonna wrap up and talk about next steps, I am going to turn it over to Lisa Randall for our wrap-up, before we do that, I wanna remind you to keep filling out the evaluation, please listen to Lisa, but don't forget to submit your evaluation at the end. So Lisa, do you wanna take it away? Did we lose Lisa along the line? There she is, you're on mute.

- Still on mute, always on mute. Thanks again Sabrina, I appreciate it. I just have a couple of quick remarks. So I hope that you all got the message from us today, and I don't think it is new to you, is that data reporting and analyses are really critical components of your program for LTBI services, and that we want to be able to support you in really using data and doing it in a way that helps you maintain the strongest programs that you can. In the past two sessions, I think we have articulated that we will be

asking you to develop process maps in advance of implementing any adjustments to your contracts relative to LTBI services, whether that is staffing plans or work plans or budgeting, that'll really help us understand what you plan to do, how you plan to do it, and will assist us in identifying areas that might need some additional attention from this team, from DPH, or other consultants, and so again, there is not a set date, we're not asking you to create a homework assignment to turn in to us, we'll want you to continue to work with your Office of HIV/AIDS contract managers as you are making adjustments to your services, and I really encourage you to reach out to any one of us as you begin the process mapping process, and certainly, as you begin to think through how you are going to implement LBTI services. Linda, is there anything else you want to add today? I don't mean to put you on the spot but you are closer to these services in some ways than I am, and these folks, so I wanted to give you that opportunity.

- No, I just think there are a few things that have come up in this session and previous sessions that we'll have to talk about internally and get back to folks about, but we just really appreciate your time, and from the breakouts, it's been great to be able to see the thought that you're all putting into moving ahead with this work, so thank you for all of that time and effort and for listening and participating today.

- And while Sabrina did mention that this is the last in the formal series that we have planned right now, that doesn't mean that that's the last time that we will gather in some fashion around TB and/or any of the other infections that we are interested in. Sabrina, anything else?

- No, I just, well, yeah, I shouldn't say no when I mean yes. So thanks to everybody, we really appreciate all of the presentations that have occurred in this session and in the preceding two sessions and that the participation from DPH has been fantastic, it's been nice to hear your thoughts on the way forward, but especially, I want to thank the participants themselves, you guys who are providers at agencies, I know you have really busy schedules and a lot to manage, so we appreciate you taking the time to attend these sessions and to comment and be really thoughtful about your next steps with latent TB services. So yeah, that's it for now, Mira has chatted out a link to the evaluation, which again, we encourage you to fill out, and even if you were dissatisfied, go ahead and let us know why so we can improve for next time, this seems to be a modality that we're gonna be using for a good while to come, and please use the TA4SI website if you need more information and please go ahead and reach out with any questions. Thanks to everybody and have a good rest of your day.