California Health Improvement Project (CHIP)
On-Site TB Clinic in Los Angeles Skid Row Homeless Shelter

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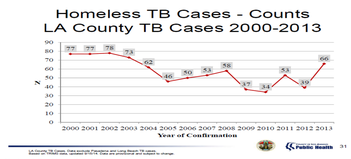
Problem Statement and Underlying Causes

Problem: Increasing transmission (outbreaks) of Tuberculosis with the G11610 Genotype in the LAC homeless shelters in South LA.

Underlying Causes: Epidemiologic linkages indicate ongoing transmission. Prevention is limited by difficulty with case finding and multiple barriers to screening, testing, treatment and completion of treatment to transient population.

Current State



Future Desired

Future Desired
Pathways to Home (P2H) on site TB Clinic

National Objective	Baseline (2004-2008)	National Performance Target 2015	P2H 2018 on site TB Clinic
Evaluation of contacts	68%	93%	95%
Screening of all clients upon arrival to and subsequent transitional housing in a high risk homeless shelter.	N/A	No Performance Target	100%
LTBI (Preventive Therapy) initiated	72%	88%	90%
LTBI started and completed in 12 months or less	47%	79%	93%

Note: Currently there are no specific NTIP objectives and performance measures for the homeless, homeless shelters or congregate settings.

Project Description

Develop and implement on-site TB Clinic at the Pathways to Home Homeless Shelter for the purpose of decreasing and ultimately eliminating the transmission of tuberculosis in this site.

Goal and Objectives

Goal: To reduce and eliminate transmission of TB in the Pathways to Home Homeless shelter by 2020.

Output-oriented Objective:

1. Draft DPH plan for the P2H on-site satellite TB clinic by June 2015.
2. Implement P2H TB Clinic which will provide comprehensive TB screening, case management and treatment services for P2H clients by September 2015.
3. Increase active TB case finding at P2H by 100% by 2018.
4. Develop data collection and E & M tool to be shared and utilized by all stake holders by September 2015.
5. Obtain countywide mandatory Homeless Shelter Annual TB Screening policy for all clients of homeless shelters by 2020.

Outcome-oriented Objective:

1. Increase P2H clients fully screened from 79% to 85% in 2016, 90% in 2017 and 100% in 2018.
2. Initiate and complete treatment on 40% of the Latent TB Infected clients by 2016, 60% by 2017 and 93% by 2018 in 12 months or less (NTIPS performance indicator).

Outputs & Outcomes

Outputs Achieved :

Outputs Achieved for CI and Active Case Findings at P2H after Phase I			
P2H Contact Investigation (recent exposures to active TB Case at PTH) 5/14/15 N=177		P2H Active Case Finding (All clients at P2H) 5/14/15 N = 223	
Contacts Identified	80/177 = 45%	Contacts screened	200/223 =90%
Blood/PPD TB Test given	70/80 = 86%	Blood /PPD TB test given	158/223 = 70.9%
(+) TB test	20/80 = 25%	(+) TB Test	35/223 = 15.7%
CXR w/ (+)TB test	9/20= 45%	CXR w/(+) TB test	25/223 = 11%
Fully evaluated	89/177= 50 %	Fully evaluated	177/223 =79.4
Total on Preventive Rxn	2/20 = 10%*	Total on Preventive Rxn	Data incomplete*
Total TB suspects on Rxn	Data incomplete*	Total TB suspects on Rxn	Data incomplete*

* Data incomplete due to: Unable to locate/ lost to follow-up. clients, initially and or after screening, clients refusal of screening, lack of transportation to outside clinic, no CXR screening equipment on site. inability of clients to follow up do to psycho-social issues, no treatment on-site, shelter staff's inability to hold client at shelter after shelter hours, mental health, inconsistent or incomplete data collection. Incomplete screening hinders ability to classify patients as TB suspects or those Latent TB infection needing preventive Rxn.

Outcomes Achieved

Short term:
1) Screen and refer onsite with linkage to DHS as needed.
2) Obtain funding for mobile chest x-ray.
3) Secure dedicated space for the TB Satellite Clinic at P2H
4) Draft of P2H TB Policy and Procedure Manual
5) Link clients to ACA Cover California enrollment .
6) Enter Phase III of CHIP.

Long Term:
1) Increased policy discussion for annual mandatory TB screening of all homeless shelter residents.
2) Enter Phase III-V.

Guidance for outcomes section:

Phase I 2/2015-4/2015	Phase II 5/2015-7/2015	Phase III 8/2015	Phase IV 9/2015-10/2015	Phase V 11/2015-11/2018
CHIP Team (AMD, TBCP & P2H) create action plan for concurrent contact investigation & active case finding. ID priority areas. Develop goals, objectives, strategies, indicators, and activities.	**CHIP Collaborative Review** Action Plan materials & data shared with Collaborative. PDSA- Implement on-site TB clinic to merge CI and active case finding. ID new collaborative team members	**Confirm Resources and Responsible Parties** Finalize activites for On-sites TB Clinic. Discuss implementation planning with partners and stakeholders. Hold Collaborative recognition event.	**Finalize CHIP** Share CHIP with community and stakeholders. Begin implementation.	**CHIP Collaborative E & M** Quarterly PDSA Cycles with annual reviews to community and stakeholders.

National TB Program(NTPS) Objectives and Performance Targets for 2015*

National Objective	Baseline (2004-2008)	National Performance Target 2015
Evaluation of contacts	68%	93%
LTBI (Preventive Therapy) initiated	72%	88%
LTBI started and completed	47%	79%

Note*
1. The National Tuberculosis Indicators Project (NTIP) is a monitoring system for tracking the progress of U.S. tuberculosis (TB) control programs toward achieving the national TB program objectives. This system provides TB programs with reports to describe their progress, based on data already reported to the Centers for Disease Control and Prevention (CDC). In addition, these reports help programs prioritize prevention and control activities, as well as program evaluation efforts.
2. These NTIP objectives and performance targets are for the general population. No NTIP objectives and performance targets where found that relate specifically to the homeless population, homeless shelters or those in congregate setting. No NTIP performance measures were found for 2016 and above.

Lessons Learned

1. Identify passionate community partners.
2. Identify and involve key partners during planning.
3. Do not duplicate existing programs.
4. Continuously engage key stakeholders through routine engagement to ensure fidelity of shared vision, expectations and goals.
5. Work to develop shared data collection and E & M tool with key stakeholders.

This project helps my organization prepare for health care reform by simultaneously driving the triple AIM:

- Improving the experience of care by on-site TB active case finding in homeless shelters and mandatory screening of those who live in congregate settings
- Improving the health of this population by providing onsite TB screening and preventive therapy.
- Reducing per capita cost of health care by preventing the transmission of active TB and associated morbid conditions.

Homelessness

- At any given night as many as 58,000 people experience homelessness in Los Angeles County.
- Throughout 2013 over 190,000 people were without somewhere to sleep at some point during the year. More than 20% were veterans, and the number of homeless women and families is rising.
- TB is also on the rise in this transient population.
- "The good news is that miracles do happen on Skid Row" (Volunteers of America LA)

About My Organization

The Los Angeles County Department of Public Health (DPH)protects health, prevents disease, and promotes the health and well-being for all persons in Los Angeles County. Our focus is on the population (close to 10 million) as a whole, and we conduct our activities through a network of public health professionals throughout the community.

Community Health Service (CHS) is one of the 50 programs in DPH. CHS provides clinical services comprised of 14 public health centers in 8 Service Planning Areas. We conduct surveillance & medical case management of reportable communicable diseases, contains the spread of communicable diseases, & provides numerous outreach activities to engage the community as active participants to improve the health of residents.

Contact Me

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CHCF HEALTH CARE LEADERSHIP PROGRAM

To learn more about CHCF go to:
http://futurehealth.ucsf.edu/