COMMUNITY PARTNERSHIPS DIVISION
Health Care Services Section
115 S Andrews Avenue, Room A300 • Fort Lauderdale, Florida 33301 • 954-357-5390 • FAX 954-357-5897

Support Services Network
December, 2019 at 2:30 p.m.
Broward Governmental Building
Conference Room GC-302
115 S. Andrews Ave., Ft. Lauderdale 33301

MINUTES

PROVIDERS PRESENT
Marlena Solomon; AHF
Patrick Saint Fleur; AHF
Roseline Labissiere; BCFHC
Karen Whyte; Broward House
Patricia Falco; Broward House
Natasha Markman; BRHPC
Stephanie Thomas; Care Resource
Richard Ortiz; Latinos Salud
Amanda Sorge; Legal Aid
Amy Pont; Memorial
Guerline Verger; Memorial
Olga Garcia;Memorial
Frank Young III; Poverello
Edna Ferguson-Walker; Broward Health

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Marcus Guice
Jessica Seitchick

PART A RECIPIENT STAFF
Edith Garcia
Richard Morris

PROVIDERS ABSENT
None

GUESTS
None

I. Call to Order
The meeting was called to order at 2:38 p.m.

II. I. Welcome/Introductions
CQM Support Staff welcomed everyone, and individual introductions were made.

III. II. QI IQ Assessment
Members filled out an assessment that asked foundational questions about their experience and acuity with Quality Improvement. The assessment was a follow-up to an initial survey and the scores will be compiled to measure the progress the Network has made in increasing their adherence

IV. Young Adult's Engagement in Care: What Does the Data Tell Us

Data presented during this meeting can be found attached in the meeting packet.
The CQM Support Staff presented data on the Viral Suppression trends of Young Adults (Ages 18-28) and composition of Young Adult in the EMA by year since FY 2011. This presentation was followed by a discussion of surrounding the delivery of care to young clients.

Providers discussed social indicators for client health, social risks for the young MSM population, and the perceptions of HIV Care from the young adult perspective. Some of the indicators discussed included stigma, economic stability, education, sexual behaviors, and family report. One best practice discussed by the group was differentiated service delivery tailored to this population. A member noted that, as a case manager, it is important to not approach the clients in an authoritative or paternal manor.

IV. Case Study Discussion

A Network member representing South Broward Hospital District gave a case study presentation on a client who had been in care through her young adulthood and is currently in her early 30s. The case study describes the success of a client who, through years of HIV care and social barriers, was able to become undetectable for the first time in 5 years. Providers gave supportive feedback to the member's case study,

V. Building Futures: Supporting Youth Living with HIV, Technical Assistance Toolkit

The CQM Support staff presented a toolkit developed by HRSA HIV/AIDS Bureau. The toolkit describes activities agencies can undertake to enhance delivery of HIV care to youth living with HIV. Each section includes strategies to address the specific topic, and resources are provided to support implementation. Providers can use some or all information in the toolkit to enhance their programs to better meet the needs of youth living with HIV.

VI. Announcements

VII. Adjournment

The meeting was adjourned at 4:14 p.m.

Next Meeting Date: TBD

HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION
115 S Andrews Avenue, Room A360 • Fort Lauderdale, Florida 33301 • 954-357-8647 • FAX 954-357-8204

SUPPORT SERVICES NETWORK MEETING

Date: December 3, 2019 at 2:30 pm
Location: Ryan White Part A Program Office
115 S. Andrews Ave., GC-302
Ft. Lauderdale, FL 33301

Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1250

AGENDA

Meeting Theme: Engagement in Care Among Young Adults (18-28) with HIV

I. Call to Order

II. QI IQ Assessment

III. Welcome/Introductions

IV. Young Adult's Engagement in Care: What Does the Data Tell Us?

V. Case Study Discussion

VI. Building Futures: Supporting Youth Living with HIV, Technical Assistance Toolkit

VII. Community Resource Broward House's Clear Paths Program

VIII. Announcements

IX. Next Meeting Agenda

X. Meeting Evaluation

XI. Adjournment

Next Meeting Date: TBD

COMMUNITY PARTNERSHIPS DIVISION
Health Care Services Section
115 S Andrews Avenue, Room A300 • Fort Lauderdale, Florida 33301 • 954-357-5390 • FAX 954-357-5897

Support Services Network
Monday, October 14, 2019 at 2:00 p.m.
Broward Governmental Building Annex
Conference Room A-337
115 S. Andrews Ave., Ft. Lauderdale 33301

MINUTES

PROVIDERS PRESENT
Marlena Solomon; AHF
Patrick Saint Fleur; AHF
Tim Romero; BCFHC
Karen Whyte; Broward House
Oluwatosin Adeyeye; BRHPC
Kara Schickowski; Legal Aid
Laura Yadoff; Legal Aid
Amy Pont; Memorial
Frank Young III; Poverello

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Debbie Cestaro-Seifer
Marcus Guice
Jessica Seitchick

PART A RECIPIENT STAFF
Edith Garcia
Neil Walker
Leonard Jones

GUESTS
Zulma Muneton; CDTC

PROVIDERS ABSENT
Broward Health
Latinos Salud

I. Call to Order
The meeting was called to order at 2:08 p.m.

II. I. Welcome/Introductions
CQM Support Staff welcomed everyone, and individual introductions were made.

III. II. Health Literacy
CQM Support Staff shared a health literacy widget to the Support Services Network. The CDC Clear Communication Index is a research-based tool to assist in developing and assessing public communication materials. The Index contains 20 items, each with a numerical score of zero or one. The individual scores are converted to an overall rating on a scale of 100. The 20 items in the Index build on and expand plain language techniques described in the Federal Plain Language Guidelines. More information can be found at https://www.cdc.gov/ccindex/index.html.

IV. III. Case Study Discussion

Case study documents can be found attached in the meeting packet.

Children's Diagnostic & Treatment Center (CDTC)

The CDTC provider discussed a client who was perinatally transmitted HIV. The client had not been in care for years until earlier this year after re-engaging in care through Test & Treat. Her viral load has improved, and the client received medications; however, the client is having issues with adherence to primary care.

One provider added that it is essential to let people who have been disengaged in care for a considerable amount of time that the scope of HIV care has changed. HIV treatment has become simpler to self-manage over time, and there may be a misadvised perception that intimidates or disengages a client from being in care. The CQM Support Staff Consultant expressed that current HIV Care advertisement campaigns do not promote self-improvement through engagement in care. Positive marketing could be beneficial for minimizing the stigma around HIV care.

A provider noted that fatigue could have played a role in the client's disengagement in care due to her growing up with HIV. Medication, when the client was in her childhood, could have embedded a negative perspective of HIV care on her.

Providers also attested that there is a lack of available information on HIV care. Misinformation and the lack of proper information limit the ability of the population to engage in prevention and treatment services.

One provider noted that it could be beneficial to discuss information with clients incrementally. For example, discuss viral load with a client during one visit then discuss CD4 during another.

AIDS Healthcare Foundation (AHF)

The provider discussed a client with a very high viral load and a history of low medical adherence. The client engaged in care when perceived he needed it. Additionally, the client suffered a history of trauma that was associated with being MSM and had little social support.

The disease case manager suggested eating with medication as a distraction from the act of taking medicine, which disassociates the client with negative connotations. The client's viral load decreased after the provider switches the medication along with side effect management. However, the disease case manager has not heard from the client since his last visit.

A provider recommended that the client be referred to PROACT so that the Florida Department of Health can reach out to return the client to care.

Centralized Intake & Eligibility Program (CIED)

The CIED member provided a case on how the Test and Treat program can work in tandem with other services. The client, in her case, entered care through Test & Treat

with a viral load. Through coordination with CIED and linkage through AHF, the client is now insured and undetectable.

Additionally, some clients do not understand that they do not have to pay copays and can utilize HICP services to cover costs. Perceived payment can be a barrier for clients to be retained in care or could decrease the client's overall care experience.

IV. Recipient Update

The EMA is currently working toward an eligibility initiative involving CIED. These initiatives include the ability for case managers to upload documents electronically to determine clients' eligibility, a pilot online eligibility portal, and dual eligibility with ADAP. Regarding the dual eligible initiative, Part A will complete 50 individual eligibility service units, and ADAP will complete 50 individual service units initially. The Recipient believes this will decrease the 3-week wait for CIED appointments and ease the ability for patients to schedule an appointment.

The Ending the Epidemic grant application was submitted on September 15th, 2019. The Recipient plans to utilize the additional funding to create initiatives in housing, engagement for new clients and clients who are out of care and hiring the staff necessary to implement these initiatives.

The staff has not yet begun preparations for ACA Open Enrollment due to the Recipient staff placing a priority on submitting the Annual Ryan White Part A EMA and Ending the Epidemic applications. A majority of clients who have private insurance have Blue Cross Blue Shield and are therefore automatically re-enrolled. The Recipient is not expecting any changes in processes from last year's Open Enrollment period. AHF is currently using peer s to enroll clients, a service not billable for Ryan White Part A funding. A Coast to Coast Legal Aid representative noted that if clients believe they are wrongfully denied ACA enrollment or needs advice regarding the ACA, they should contact the agency.

v.

V. Quality Improvement Health Disparities Discussion: Youth

What barriers exist in providing HIV treatment and care services to Broward Youth diagnosed with HIV?

It is challenging to form support groups for youth clients. Agencies have traditionally had little success in creating a social support setting for their youth clients. A provider suggested that youth support groups can be held in more recreational settings such as bowling alleys or restaurants instead of clinical settings. Additionally, transitions from youth to adult care are hard to manage. When patients turn 18, clients typically lose Medicaid, and navigating the client through care becomes more complicated.

Youth are similar to older populations in that common barriers to care are transportation, stigma, and housing.

What technology are you currently using to remind youth of their medical appointments?

Broward House has looked into using social media and digital platforms to target youth populations. Broward Health is restricted in using these platforms and restrictions on texting clients.

VI. Announcements

Peer Counselor Certification Program graduation

Developing Youth Leadership Teams: Creating a Space for Youth Experiencing Homelessness to Engage with Service Providers

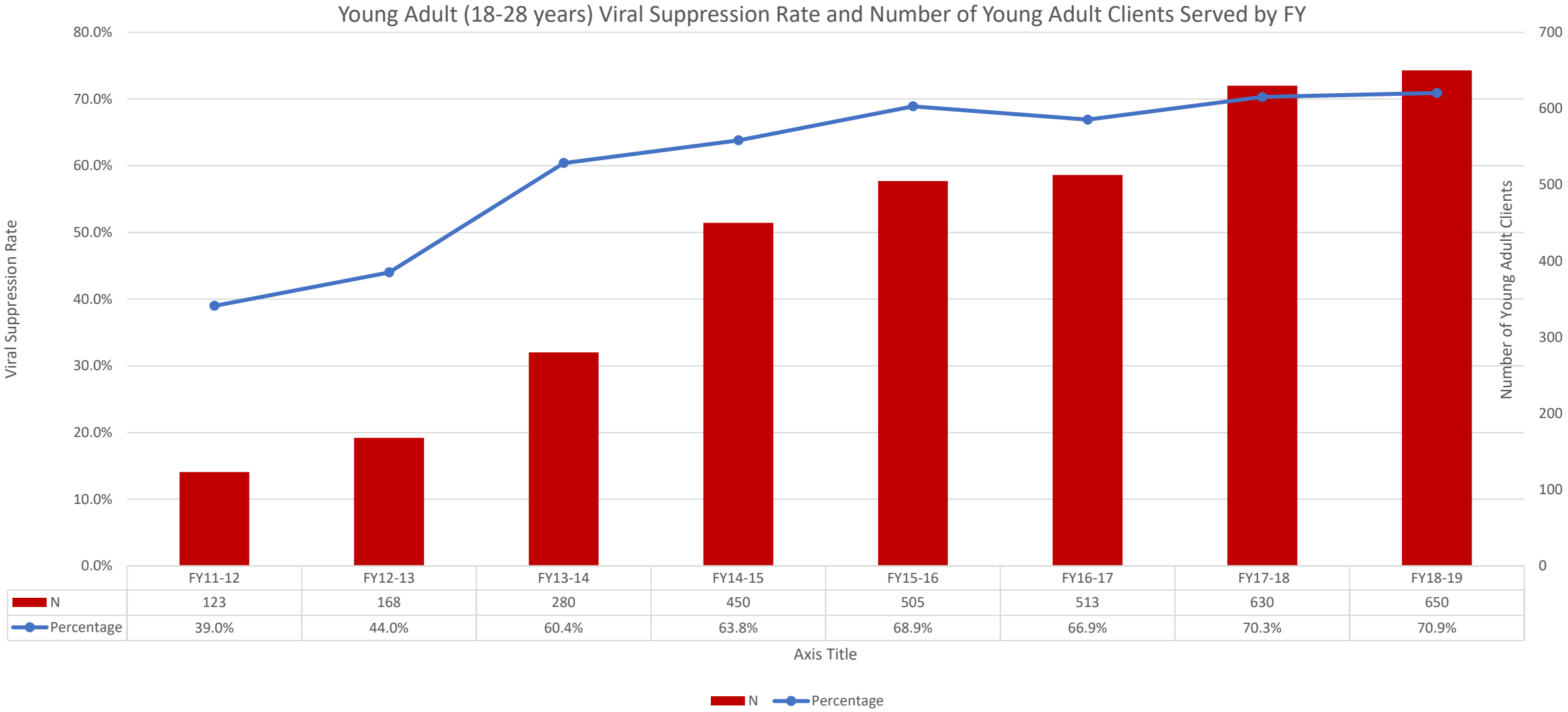
Resource Corner: The Impact of Substance Use on Persons with HIV

VII. Adjournment

The meeting was adjourned at 4:14 p.m.

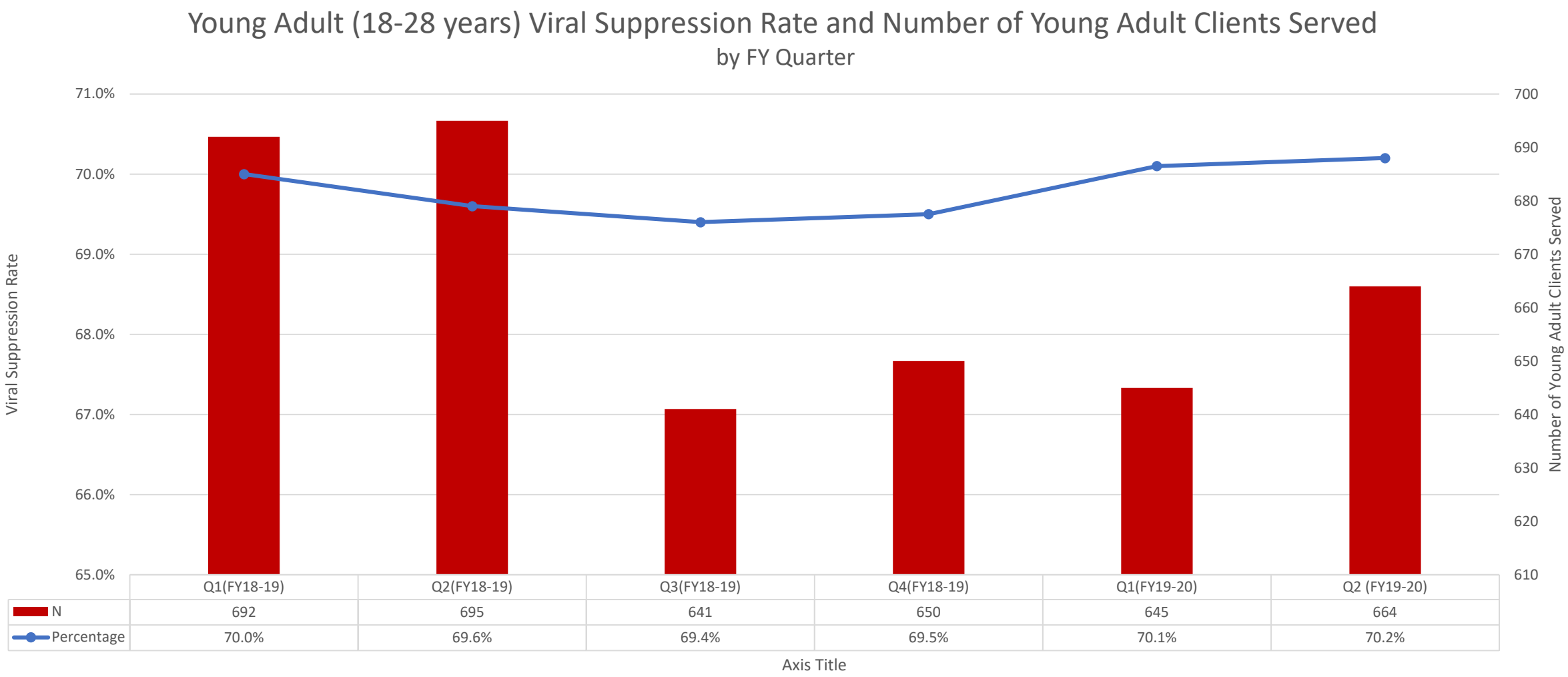
Next Meeting Date: December 3rd, 2019

Young Adult Viral Suppression Trend

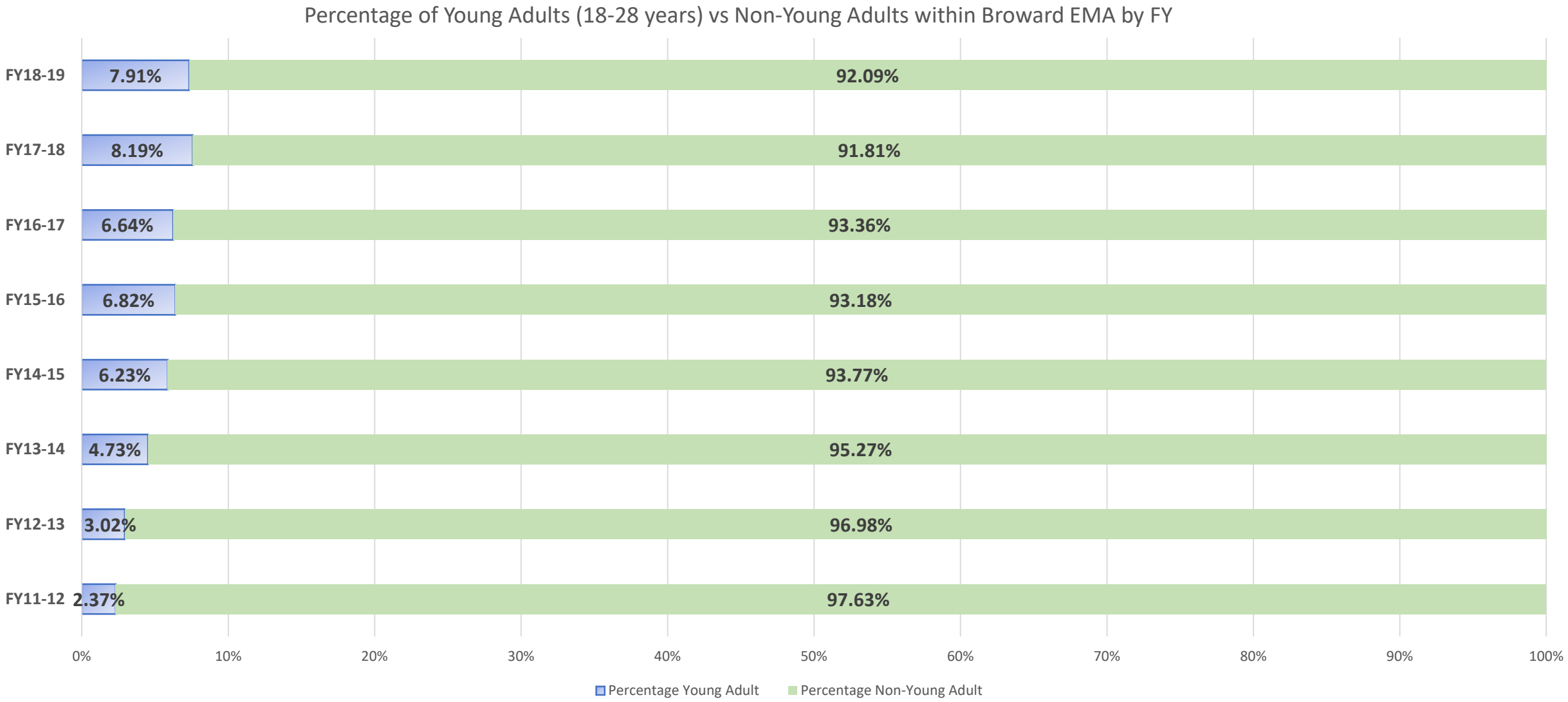


	FY11-12	FY12-13	FY13-14	FY14-15	FY15-16	FY16-17	FY17-18	FY18-19
N	123	168	280	450	505	513	630	650
Percentage	39.0%	44.0%	60.4%	63.8%	68.9%	66.9%	70.3%	70.9%

Young Adult Viral Suppression Trend- Quarters



Composition of EMA- Young Adults



HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS BUREAU

BUILDING FUTURES: SUPPORTING YOUTH LIVING WITH HIV

TECHNICAL ASSISTANCE TOOLKIT

Summary Slides- Created by Broward EMA CQM Team

Background

Toolkit developed by HRSA HAB to identify best practices for enhancing services to youth living with HIV (YLWH)

Toolkit is based on best practices from site visits, YLWH focus groups and interviews

This report considers youth 13-24 years; within the Broward EMA we consider a broader definition of youth/ young adults (18-28 years)

Within this presentation the youth and young adults are interchangeable

Topics Covered in Toolkit

Theme 1. Clinical Service Models	Topic 1.1 Youth-Centered Services Topic 1.2 Interdisciplinary Care Teams
Theme 2. Infrastructure Development	Topic 2.1 Staff Recruitment and Retention Topic 2.2 Improving Communication with Youth LGBTQ-Friendly Policies, Environment, and Culture
Theme 3. Informing Program Development	Topic 3.1 Gathering Structured Feedback from Youth Topic 3.2 Data-Driven Programing for Youth
Theme 4. Wraparound Services	Topic 4.1 Youth Support Groups Topic 4.2 Identifying and Addressing Support Service Needs Topic 4.3 Re-engaging Youth Lost to Care

Clinical Service Models: Youth Centered Services

Adapting service delivery to better serve youth

Strategy	Definition	Relevance for….
Youth clinic	Separate, “full time” pediatric, youth and adult HIV clinics OR certain days/ hours dedicated to YLWH clients	Providers with large youth populations and resources to expand programing
Youth-focused hours, staff and physical space	Evening/weekend hours and an open attitude toward walk-ins; staff that specialize in youth; youth designated spaces (waiting rooms, etc.)	Providers with smaller youth populations and varying availability of resources to expand programing
Referrals to more youth-focused providers	Formal relationship with referral partner, involve YLWH in decision regarding the strategy, ensure YLWH are fully engaged with new provider, develop a reintegration strategy for when youth age back into adult care	Providers with small youth populations and no resources to expand programing

Clinical Service Models: Interdisciplinary Care

Continuity of care and comprehensive services are especially important for youth

-Co-location of services improves YLWH follow up on tests and procedures

Interdisciplinary Care Teams can help reduce fragmentation in care

-Teams should be a mix of clinical and non-clinical staff

-Teams should communicate regularly

Infrastructure Development: Staff Recruitment and Retention

- Youth interviewed stressed importance of relationships with staff
- Staff retention contributed to the feeling of safety at clinic for YLWH
- Based on interviews, youth want staff who:
  - Show dedication
  - Have patience
  - Practice a balance between hand-holding and accountability
  - Are coachable (responsive to client requests)
  - Demonstrate a non-judgmental attitude
  - Spend time on non-medical issues

Infrastructure Development: Improving Communication with Youth

- Phone call do not work well with youth
- YLWH tend to not have sufficient minutes, get phones disconnected or numbers change
- YLWH rely on free Wi-Fi
- Strategies

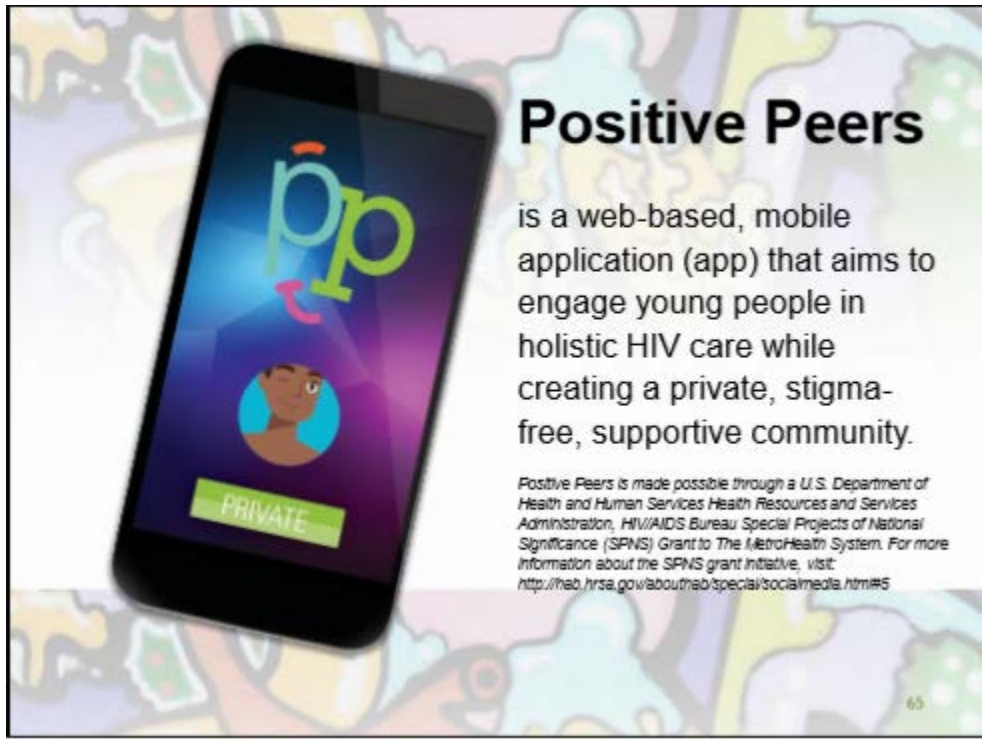
Text messaging

- HIPPA-compliant text messaging
- Secure messaging platforms

Using social media platforms

- Social media messaging
- Pushing content on social media
- Social media groups

Putting it to work: Positive Peers



- Users can create avatars and usernames
- Provides health management tools with a game-like feel, medication notifications , HIV and wellness education, private chat groups, messaging

More information at https://positivepeers.org/

Infrastructure Development: LGBTQ-Friendly Policies, Environment, and Culture

- LGBTQ youth face psychosocial and structural challenges such as: mental health issues, trauma, homelessness, substance use, stigma and discrimination
- 2 Components of LGBTQ-Friendly Agencies

Informing Program Development: Gathering Structured Feedback from Youth

Systematic feedback gathering strategy

Strategies

- Formal feedback opportunities at check-out and remotely (surveys)
- Informal feedback (informal interviews by case manager or peer navigator)
- Invite youth to clinic planning meetings/ reviews
- Establish Youth Consumer Advisory Boards

Informing Program Development: Data-Driven Programing

Drilling down data for youth is important to understand issues that affect youth, youth are not a homogenous group

5 Steps

1. Select performance measures (i.e. retention, viral load, adherence)
2. Identify YLWH target populations (i.e. unstably housed, Spanish speaking)
3. Identify the data source (i.e. PE, EHR)
4. Build analytical tools
5. Develop quality improvement efforts based on findings(QIPS and PDSA cycles)

Wraparound Services: Youth Support Groups

- YLWH specific support groups with clear goals
- Variety of types of support groups
- Support groups could be paired with Youth friendly clinic hours or spaces

Wraparound Services: Identifying and Addressing Support Service Needs

Formal and informal assessments are essential

Forming partnerships for services not offered by Ryan White/ agency

Essential Support Services Identified

Transportation

Food Insecurity

Housing instability

Job training, clothing and school supplies

Economic issues

Wraparound Services: Re-engaging Youth Lost to Care

- YLWH often are more mobile than older clients

Steps For Re-engaging Youth

1.Identifying Out-of-Care Clients

a) Establish measures for identifying Out-of-Care that works for your clients
b) Quick identification of Out-of-Care Youth increases likeness of re-engaging YLWH
c) Maintain up to date contact info (ideally 3 types)

2. Intensive Outreach and Linkage

a) Utilizing a peer for outreach may be helpful with YLWH
b) Important to be non-judgmental and meet YLWH where they are
c) Plan for the first visit back – incorporate counselling and referral to support services

3. Encouraging Retention in Care

a) Enhance essential support services
b) Encourage YLWH autonomy
c) Celebrate victories, no matter how small
d) Take missed appointments seriously
e) More frequent clinic visits during new diagnosis or after re-engaging
f) Promote more regular contact

STEP 3: RETENTION IN CARE

Once YLWH are brought back into care, providers will need to develop strategies for retaining them. Findings on retention in care among providers that participated in the site visit portion of the HRSA HAB Building Futures: Supporting Youth Living with HIV project include:

1. **Enhance essential support services.** YLWH face many barriers in accessing care, especially in terms of housing stability, transportation, financial security, food, and clothing. These concerns are often more urgent to YLWH than medical care. Consider offering more intensive support services to YLWH to stabilize them, rather than focusing solely on medical outcomes.

2. **Encourage YLWH autonomy.** Providers reported that YLWH who felt engaged in their treatment plans were more likely to be retained in care. For example, some providers offered youth clients a choice of clinician, and some actively involved YLWH in selecting medication regimens to improve the likelihood of maintaining medication adherence.

3. **Celebrate victories, no matter how small.** For YLWH who are coming back to care, recognizing incremental progress can be a meaningful and powerful motivator. Responding to a text, attending an appointment, or improving adherence to medications are great opportunities to celebrate progress and support YLWH.

4. **Take missed appointments seriously.** Just one missed appointment might mean that the youth client is falling out of care. Don't just send an automated reminder for them to make another appointment. Instead, ask case management staff to make an immediate connection to schedule another appointment.

5. **Identify support staff who work well with YLWH.** Case managers and social workers play a particularly important role in connecting youth clients to support services and keeping them engaged in care. Clinics may wish to assign newly re-engaged youth clients to a case manager/social worker who has experience working with younger, hard-to-reach clients.

6. **Schedule more frequent clinic visits for newly re-engaged YLWH.** When youth clients are first re-engaged in care, providers may want to schedule them for more frequent medical and non-medical visits before gradually scaling back.

7. **Promote continual contact with youth clients.** Providers reported that contacting YLWH frequently about appointments, medications, medical issues, and general check-ins improved retention in care. Providers are encouraged to consider adopting strategies to keep in contact with youth clients electronically.

8. **Establish programming specific to YLWH who are newly re-engaged in care.** Providers may wish to develop programming that specifically targets YLWH who have recently returned to care. For example, providers should consider allowing drop-in visits for a period of time after re-engagement, even if the clinic does not normally allow drop-ins.

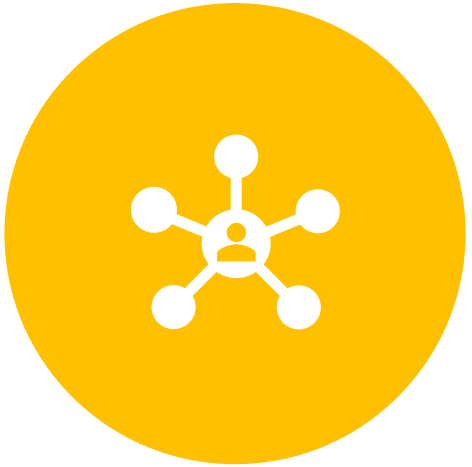
There are also many resources available to help providers choose the right intervention(s) for improving retention among YLWH. More information about interventions funded by the SPNS program for innovative strategies is available on the TargetHIV, formerly known as the TARGET Center and HAB websites. In particular, the SPNS initiatives Dissemination of Evidence-Informed Interventions and Outreach, Care,

Resources

- HRSA HAB Building Futures: Supporting Youth Living with HIV, Technical Assistance Toolkit- *extensive toolkit covering all themes and topics mentioned in PowerPoint*
- HRSA HAB Building Futures: Supporting Youth Living with HIV Collection – *toolkit, webinars, and slides*

Both resources can be found at https://targethiv.org and can be requested electronically from CQM staff by emailing quality@brhpc.org

Next Steps



BRAINSTORM WHAT STRATEGIES YOUR AGENCY UTILIZES TO ENGAGE YOUNG ADULTS/YOUTH

IDENTIFY POSSIBLE AREAS TO BE TARGETED WITH QIPS

Support Services: Case Study

Viral Load:	8/28/19 < 40 copies CD4 135
History of Viral Load	6/13/19 64 copies 5/20/19 131 copies 4/11/19 708 copies 2/27/19 187,788 copies 7/11/18 215,412 copies 5/16/18 306,258 copies 2/27/18 510,350 copies 11/29/17 804,281 copies 3/30/17 16,029 copies 6/30/16 239 copies (pregnant) 5/18/16 11,495 copies (pregnant)
Mode of Transportation:	Perinatal transmission
Housing Status:	Resides with her 3-year-old daughter
Insurance Status:	Medicaid or RW
Length of Time in Care:	Life
Other Medical Conditions:	Depression, Rheumatoid arthritis
Support System (Family, Friends, etc.):	Limited family support
Other Barriers to Care:	

Client History:

Pt is a 32 year old female; born with HIV. Pt has been in care at Memorial Healthcare System since the age of 22. She has limited family support and issues caring for an ill mother along with a young child. Fortunately, despite frequent illness, she has generally always been able to maintain employment. Due to a history of depression; throughout the years, she was often noncompliant with medical visits and treatment. She has been linked to Mental Health services many times in the past. In addition to addressing her mental health needs, she was counselled regarding risky behaviors. Other means to address her non-compliance included receiving Direct Observation Therapy (DOT) from the Broward County Health Department, but she continued to have a detectable viral load. As a result, she has developed multiple resistance to treatment over the years.

When she became pregnant at the age of 28 years old; her Viral Load over 11,000 and she was not taking her medications. During her pregnancy she was referred to CDTC and returned to Memorial a year later. Fortunately, despite not taking her medications and having a detectable viral load during her pregnancy, her child has tested negative. Throughout the time we have managed her, she has never been able to get her viral load controlled. In Feb 2019; her VL was 187,788 with a CD4 of 7. She had several admissions to the hospital, including one for pneumonia. During a medical visit with the provider in March, she admitted to not taking medication as prescribed. She expressed a desire to get better stating her motivation was to live for her daughter, but stated she needed help with reminders to take her medication. After a long discussion, the Case Manager offered the client her personal phone number to call the CM daily, even on the weekends at any given time. Afraid of forgetting, the client requested the CM call her daily. They agreed on a time of 6pm daily for the CM place a reminder call. After a week of phone calls; CM inquire if pt was willing to do video calls, using WhatsApp to verify that the client was taking her medications and she agreed. Once she started taking her medications; she developed several complications related to the treatment and became discouraged. With the CM's daily encouragement and explanations as to the reasons behind the side effects, the patient remained adherent to her treatment. In August, the client reached an undetectable VL for the first time in well over 5 years. Eventually, the calls were weaned down, to increase client's independence in managing her own care and now the client and CM speak once every 3 weeks. She continues to verbalize taking her medications as prescribed. The client is due for new labs later this week and we are confident that she is on a path to better health.

Current Treatment:

- Tivicay
- Descovy
- Prezcobix

Client Issues:

- History of Non-adherence to meds
- Medication Resistance
- Lack of Family Support