COMMUNITY PARTNERSHIPS DIVISION
Health Care Services Section

115 S Andrews Avenue, Room A300 • Fort Lauderdale, Florida 33301 • 954-357-5390 • FAX 954-357-5897

MEDICAL/DISEASE CASE MANAGEMENT NETWORK MEETING MINUTES

Date: October 21st, 2019 @ 2:00pm
Location: Ryan White Part A Program Office
115 S. Andrews Ave., Room 302
Ft. Lauderdale, FL 33301

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

PROVIDERS PRESENT
Patrick Nuss, AHF
Marlena Salomon, AHF
Patrick Saint Fleur, AHF
Monica Liy, AHF
Dr. Erica Walton, AHF
Tyshan Oates, BCFHC
Denise Simpson, NBHD
Fabiola Boucicaut , NBHD
Diana Brown, NBHD
Javier Sosa Duran, Care Resource
Joshua Rodriguez, FDOH
Roody Lucius, FDOH
Amy Pont, SBHD
Paula Eckardt, SBHD

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

PART A RECIPIENT STAFF
Leonard Jones
Edith Garcia
Richard Morris

GUESTS
Elizabeth Ortega
Andre Juste
Marivil Castro Santiago

PROVIDERS ABSENT
None

I. Call to Order
The meeting was called to order at 2:10 p.m.

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

III. Ending the HIV Epidemic (EHE)
FDOH- Broward representative presented on the planning process for the Ending the HIV Epidemic grant for Broward County. A copy of this presentation can be found as handout A.

The FDOH-Broward representative urged the Network members to complete the End the HIV Epidemic survey at: getprepbroward.com/survey

This survey is an effort for the Department of Health to assess the public's education about pre-exposer prophylaxis (PrEP) as a tool for people who do not have HIV but are at high risk of getting HIV to prevent infection. This is in accordance to the Ending the HIV Epidemic initiative, which is a federal plan that seeks to reduce the number of new HIV infections in the United States by 75 years within five years, and by 90 percent within 10 years.

IV. Test and Treat Program Discussion

Providers discussed the difficulties of collaboration between agencies and how it impacts clients. Providers noted that they are often too busy with patient care to frequently collaborate with providers at other agencies.

V. Mentimeter Break I

What are the biggest challenges faced by providers caring for Test & Treat Program (TTP) patients?

11 participants answered this question.

- They don't come back
- No show on f/u
- Lack of transportation and ability to get medication from pharmacy beyond 30 days.
- Retention in care, info on Ryan White/ ADAP, no insurance
- Registration with Ryan White and ADAP within 30 days
- Patients abusing test and treat. Know they can rely on it and so falls out of care.
- Take advantage of the system
- Transportation I need some to go and physically get them, patients not willing to use telehealth
- Disconnected [phone] #s
- Have issues taking medications
- Don't like the provider

After this Mentimeter question, participants discussed the results. It was noted that online Ryan White program recertification may help reduce challenges faced by TTP patients staying in Ryan White. Providers discussed that they felt certain patients "took advantage" of the TTP to get medication or care quickly, without committing to staying in care. Participants noted the importance of having an open-door policy and providing care when clients request it. Some participants discussed concerns of individuals traveling to Broward for TTP who do not reside in Broward county. Participants discussed patients who utilize TTP to enter care multiple times; participants noted that these patients tend to have disorganized lives with substance abuse issues. One provider noted that peers could provide support in TTP. Recipient staff stated that starting 3/1/2020, Peers will be considered a part of medical services and could help with TTP. He noted, however, that there will be no additional funding offered for agencies choosing to utilize peers. Further guidance on this will come later. Participants discussed the TTP as a method of community harm reduction.

Participants discussed potential causes for patients leaving care and methods to help patients remain in care. Potential barriers include lack of cultural competency from providers, poor provider system coordination, and past trauma. Participants discussed the importance of trauma-informed care and not shaming patients for leaving care. Participants discussed using peers for care engagement, such as in the WHAM program (https://www.integration.samhsa.gov/health-wellness/wham/wham-training). Participants also suggested having walk-in availability for patients and the potential of home visits for extremely difficult to reach clients.

VI. Mentimeter Break II

At what frequency do you see TTP patients presenting to clinic who are very ill or have a CD4 value below 200?

12 participants answered this question

- 1-2 times per month- 42%
- Every few months- 58%
- Every 6 months- 0%
- Every year- 0%
- Every few years- 0%

Participants discussed that the hospitals tend to see sicker patients. The representative from SBHD noted that she sees 4-5 ill HIV clients per week through the Emergency Department. The SBHD representative noted that HIV testing is offered on an opt out basis for Emergency Department patients and that new cases or patients out of care are often discovered this way.

What opportunistic infections are you seeing in TTP patients upon enrollment?

10 participants answered this question. Participants ranked the following options in the order detailed as follows:

1. Candidiasis
2. Pneumocystis carinii pneumonia (PCP)
3. Wasting syndrome due to HIV
4. Kaposi's sarcoma (KS)
5. Herpes simplex (HSV): chronic ulcers(s)
6. Tuberculosis (TB)
7. Other
8. Histoplasmosis

Participants noted that not all providers test for HIV, so patients enter care sicker. It was noted that oral health services are seeing patients with Kaposi's sarcoma, Herpes simplex virus, and candidiasis.

What STIs are you seeing in TTP patients upon enrollment?

13 participants answered this question. Participants ranked the following options in the order detailed as follows:

1. Syphilis
2. Gonorrhea
3. Chlamydia
4. Hepatitis

5. Human Papillomavirus (HPV)
6. Other

Participants noted that high STI rates indicate that patients are not having safe sex. This is concerning for patients who have a detectable viral load.

VII. Announcements

- The FDOH-Broward Representative announced that the Test and Treat Formulary includes all single tablet regiments at this time; a provider noted to be careful with certain medication in patients that may have Hepatitis B.
- STI treatment guidelines are being reviewed at the national level

VIII. Next Meeting Agenda

IX. Meeting Evaluation

X. Adjournment

The Meeting was adjourned at 3:47 p.m.

The next Medical and Disease Case Management Network Meeting is scheduled for January 29th, 2020 at 2:00pm in A-337.

Department of Health

ENDING THE HIV EPIDEMIC (EHE)

PS19-1906 CDC

Rapid Planning Process

Department of Health

Joshua Rodriguez
HIV AIDS Program Coordinator
Florida Department of Health

“Without knowledge action is useless and knowledge without action is futile!”

Abu Bakr

ENDING THE HIV EPIDEMIC (EHE)

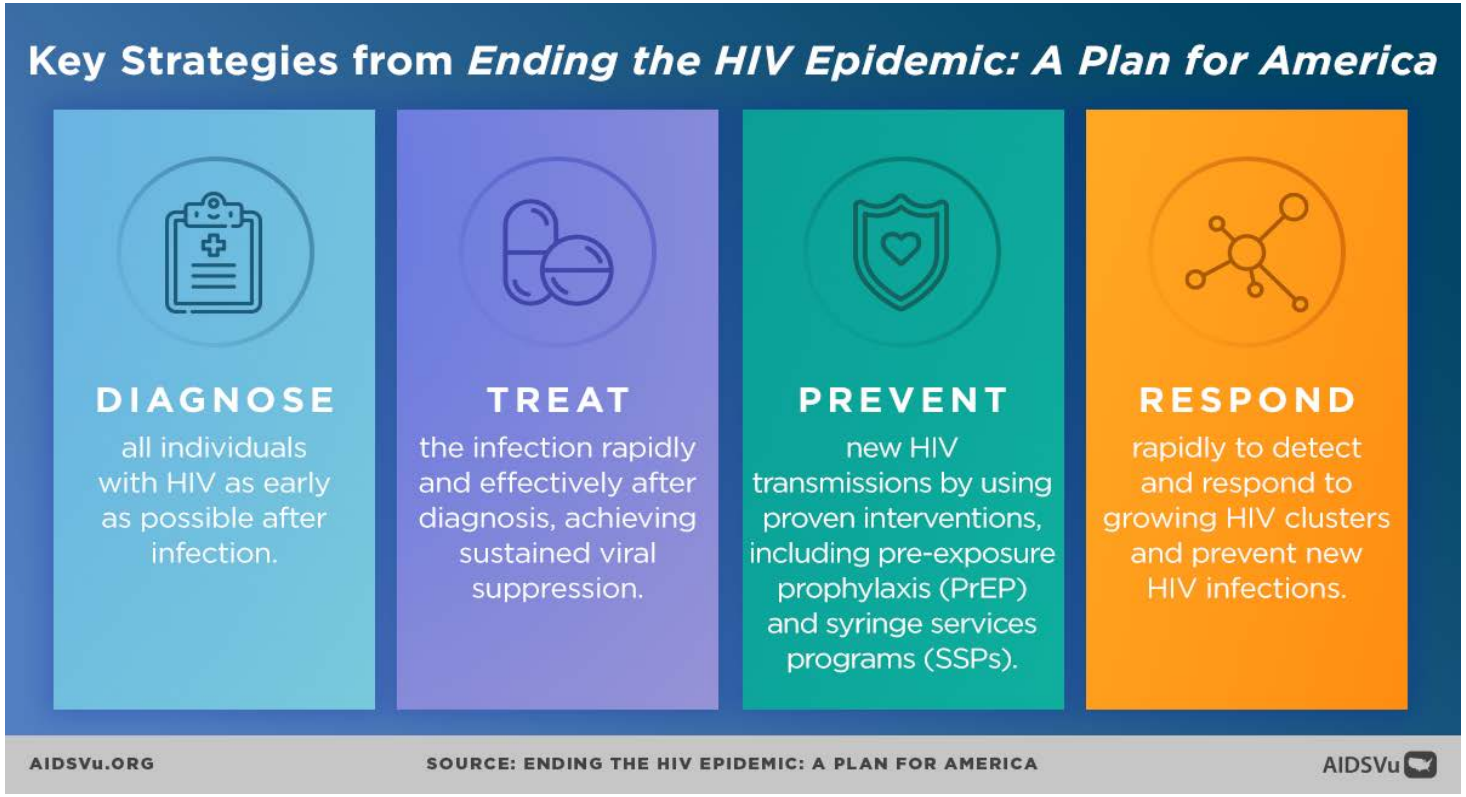
EHE SUMMARY

PLAN PURPOSE: Eligible health departments are to conduct rapid planning process that engages the community, HIV planning bodies, HIV prevention and care providers, as well as, other partners in aligning resources and activities to develop a End the HIV Epidemic (EHE) plan.

PHASE ONE: Planning to Plan “More Engagement & Innovation”

ENDING THE HIV EPIDEMIC (EHE)

EHE FOUR PILLARS



ENDING THE HIV EPIDEMIC (EHE)

THE INTEGRATED PLAN / EHE PLAN

INTEGRATED PLAN GOALS

Broward County, Florida

1. **REDUCE:** new HIV infections

2. **INCREASE:** Access to care and improve health outcomes

3. **REDUCE:** HIV related disparities and health inequities

4. **ACHIEVE:** more coordinated response to local epidemic

EHE PLAN

National Strategy

1. **DIAGNOSE:** all individuals with HIV as early as possible after infection

2. **TREAT:** the infection rapidly and effectively after diagnosis, achieving viral suppression

3. **PREVENT:** new HIV infections by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

4. **RESPOND:** to detect and respond to growing HIV clusters and prevent new HIV infections

ENDING THE HIV EPIDEMIC (EHE)

SDOH – EHE PRIORITY FOCUS

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

ENDING THE HIV EPIDEMIC (EHE)

Who do we need to involve who have not been involved in HIV/AIDS that should be there?

What do we need to change in order to get people in care, and remain in care?

Disruptively Innovative

Change Our Outlook

Change Our Approach

Change the Epidemic

ENDING THE HIV EPIDEMIC (EHE)

PLANNING TO PLAN
What is it?

EXPAND engagement to new community partners & develop more effective relationships to identify & address Social Determinants of Health (SDOH)

INCLUDE and go beyond the usual and engage new people, alliances, councils, providers, communities and…

ENDING THE HIV EPIDEMIC (EHE)

NEXT STEPS

Developed survey

Conduct focus groups and Key informant interviews

SWOT Analysis

Obtain planning bodies consensus

Develop final EHE Plan for Broward County

DISCUSSION

Rapid Planning Process

“Without knowledge action is useless and knowledge without action is futile!”

Abu Bakr