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

MEDICAL/DCM NETWORK MEETING

Date: July 24, 2019 at 2:00 pm
Location: Ryan White Part A Program Office
115 S. Andrews Ave., A-337
Ft. Lauderdale, FL 33301

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

AGENDA

I. **Call to Order**

II. **Welcome/Introductions**

III. **Mentimeter Break I**

IV. **Disease Case Management**

V. **Mentimeter Break II**

VI. **Provider Communication**
- Access to Care schedule

VII. **Announcements**
- Peers
- Data to care workshop update

VIII. **Next Meeting Agenda**

IX. **Meeting Evaluation**

X. **Adjournment**

Next Meeting Date: October 23rd, 2019, 2:00 p.m.

Broward County Board of County Commissioners
Mark D. Bogen • Beam Furr • Steve Geller • Dale V.C. Holness • Chip LaMarca • Nan H. Rich • Tim Ryan • Barbara Sharief • Michael Udine
Broward.org

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: June 5th, 2019 @ 2:00pm
Location: Ryan White Part A Program Office
115 S. Andrews Ave., GC-320
Ft. Lauderdale, FL 33301

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

PROIVDERS PRESENT
Monica Liy, AHF
Marlena Solomon, Broward Health
Patrick Saint Fleur, AHF
Patrick Nuss, AHF
Glynette Roberts, BCFHC
Karen Pierre, BCFHC
Benge Nelson-Pierre, Care Resource
Gwendolyn Bennett, Care Resource
Amy Pont, Memorial Healthcare
Paula Eckardt, Memorial Healthcare
Cherise Martin, Memorial Healthcare
Kimberly Holding, Broward Health

PROVIDERS ABSENT

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

PART A RECIPIENT STAFF
Edith Garcia
Teisha Fender

GUESTS
Lisa Robinson
Vanessa Rojas
Roody Lucious
Elizabeth Ortega

I. Call to Order
The meeting was called to order at 2:20 p.m.

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

III. Activity: QI IQ Survey Completion
Members filled out a short paper assessment that asked foundational questions about their experience and comfort with Quality Improvement.

IV. Mentimeter Introduction

Mentimeter is a tool that the CQM team is using to build interactive presentations and add questions and polls to engage and draw feedback from the Network

members. The audience uses their smartphones, tablets, or laptops to connect to the presentation where they can give responses to queries from the CQM team. Results from Mentimeter breaks are recorded in the meeting minutes.

V. Mentimeter Break I

The members of the Network were asked how familiar they are with evidence-based Test & Treat models. The answers were given on a scale of 1 to 5 with 1 being not familiar at all to 5 being very familiar or an expert on the topic.
With 16 people responding, the average score among the providers was 3.7.

VI. Test & Treat Analysis

The CQM Staff began the discussion by detailing and reviewing evidence-based programs that have involved connecting patients to care. The Network was asked for recommendations and ideas of how the Broward EMA's CQM team can work with providers to increase sustainable engagement within our Test & Treat model.

A physician commented that there are many clients who do not recertify for Ryan White and ADAP. Often, these clients seek care through Test & Treat because they have not gone through the recertification process. She mentioned that there was a study conducted at her agency in which, between May 2017 and January 2019, the Comprehensive Care Center saw 116 Test & Treat patients. Of these patients, roughly half were new patients and the others were formerly diagnosed clients who were reengaging in care. Moreover, 60% of the Test and Treat patients fell out of care during the study period. She cited the fragmented nature of services (i.e. ADAP separate from Ryan White) as one possible barrier to Test & Treat patients disengaging from HIV care. Group discussion on these reported findings resulted in the recommendation that a needs assessment be conducted to trace the causes of why test and treat individuals fall out of care.

A CQM staff member detailed that the U.S. Department of Veteran Affairs has reported reduced retention in HIV care outcomes within their system. They have started an HIV Telehealth program to retain patients who are being rapidly engaged into HIV treatment. A physician from Memorial Healthcare announced that they have begun a similar Telehealth program at their clinic. There are limitations, however. Appointments are made after the initial Test & Treat visit. These appointments take place about a week from the point in which the initial visit occurs to monitor how the patient is responding to medication and treatment. A telehealth challenge is that patients often do not connect to their telehealth appointment on time and, when called, they are frequently in public settings, preventing the physician from initiating the follow-up appointment. The provider noted that the telehealth program began early in 2019.

A discussion followed regarding the social determinants of health attached to the population in which the Telehealth intervention is not impacting. A CQM staff member detailed her experience with a cell phone intervention in Africa. When the health staff issued mobile phones to a select group of young adults living with HIV

and initially began making check-in calls with these individuals, there were no responses to the calls. After speaking with the young adults, it was discovered that because an interpersonal connection was not made in the initial stage of the phone call check in, the young adults did not pick up when phone calls were made to them to check on their medication adherence. The health workers were initially calling to ask medical and/or health-related questions, but later learned from the young adults that because the workers never asked about the clients' personal lives and wellbeing the young adults made no attempt to answer the calls. After including more personal questions, engagement increased significantly in the program as did ARV adherence.

The Network was asked if peer navigators were used in the Test & Treat program at their agencies. A Memorial network member responded that although Peers are a part of the initial Test and Treat appointment, case managers have noted that Test & Treat clients continue to be lost to care after the initial visit.

A physician noted that every clinic must consider the demographic composition of their client population. She noted that there is limited clinical support staff at her clinic. A former staff member was a pivotal influencer of retaining a group of Caribbean men in care. However, once this staff member was no longer employed at the clinic, the Caribbean men were lost to care. HIV retention and engagement in care is often influenced by a person's culture, and clearly, that culture must be taken into consideration when initiating HIV treatment and care.

A member from Care Resource described a "pathway to care" roadmap that they created for clients. When Test and Treat clients did not progress through their pathways to care, then the Test & Treat team at the Florida Department of Health was alerted. The Care Resource member reported that she has maintained regular and consistent contact with the FDOH using this strategy.

There was a discussion of the saliency of what clinic a patient prefers to go to. One physician detailed that many clients want to go to the nearest or most convenient clinic to their home location. However, another physician stated that she had several clients in the past that sought care further away from their community due to fear of HIV-related stigma. . LRSs from the Department of Health are assigned to each agency and Test and Treat patients are navigated accordingly. The Department of Health plans to conduct visits with each agency to confirm that agencies are aware of their assigned LRS.
The Disease Case Managers were asked about their perspective with Test and Treat clients. A Memorial Network member remarked that Test and Treat patients are seen by non-medical case managers. Additionally, they have been trying to get authorization for peers to work with medical cases. She noted that disease case management is not a part of the Test & Treat process for her agency unless there is a comorbidity that must be addressed by a Disease Case Manager.

A member noted that the Service Delivery Models provided by the Broward EMA does not detail the criteria of who qualifies for disease case management. Disease Case Managers are generally RNs or LPNs, who are supervised by RNs. A provider noted that she heard that all new Test and Treat patients should see a Disease Case Manager. She noted that in order to document patients in Provide Enterprise, the case must be opened in a specific service category and to close the case there must be documentation. Without guidance from service delivery standards, she has been using her best judgement and admitting Test and Treat patients into disease case management based upon her perception of their needs.

A provider mentioned that she thinks that the Broward System has the greatest impact on the health outcomes of our clients. When compared to an EMA like New York, Broward has limited resources and began its focus on aggressively combatting HIV relatively recently. She cites that patients are virally suppressed elsewhere compared with Broward. Many providers voiced agreement that differences in practices and the unique culture of Broward County when compared with other cities in the United States, may be a factor that is influencing the Broward RW EMA Continuum of Care.

A representative from the Department of Health described the responsibilities of linkage retention specialists (LRS). Their responsibilities include, but are not limited to, making sure clients receive medical, social, and food services, helping clients complete applications, and delivering medications to clients' homes or other designated locations.

The CQM staff reinforced that quality improvement does not have to be a robust or system-level undertaking. Small, gradual changes in workflow could be a quality improvement project. These changes can be recorded along with any observations or results to complete PDSA cycles. Quality improvement aims and PDSA cycles inform practice and help to improve patient outcomes, including retention and engagement in HIV care.

VII. Women of Child-Bearing Age Engagement and VL Suppression

The CQM staff queried the Network on current strategies they use to engage HIV-infected women of child-bearing age into the RW care system. A family medicine HIV provider stated that she is open to seeing pregnant women, however, they must come to her office and cannot call ahead for appointments. Women without insurance present challenges to engagement in care. After the Test & Treat or 90-day Medicaid period, it is often difficult to see these women, especially when they are undocumented.

Several providers stated that they do not know providers at other agencies and do not have a medical provider directory to assist them when referring patients.

Several providers made the recommendation that a RW Provider Directory be created for EMA providers.
It was clarified that Ms. Yvette Gonzalez is the Perinatal Coordinator for the Broward Department of Health.

VIII. Mentimeter Break II

Q: What can this Network do to improve Test & Treat Outcomes?
A:

- "Easier registration with Ryan White and ADAP at the same time."
- "Communication with other agencies."
- "List of Ryan White providers Dept of health services."
- "Maintain communication between agencies"
- "Streamline ADAP process. Create guidelines for who qualifies for Test & Treat. Give peers more latitude in which clients they can work with."
- "More communication between different networks."
- "Have the Test and Treat navigator at our office."
- "Streamline the ADAP and Ryan White eligibility process for a smoother transition, ADAP should come to the sites at least twice monthly."
- "Better communication with each and don't wait to reach to DOH."
- "Communicate to our congressman and senators the struggles we are all facing in addition to the difficulties the patients are facing."
- "Test and Treat needs to be more clearly defined. It seems patients are taking advantage of the system over and over."
- "Assigning case managers to the pediatric Test and Treat (population) has been very responsive. They attend all the follow-up appointments and really are engaged."

Q: What is your interest level (between 1 and 5 with 1 being not interested and 5 being very interested) in having a robust presentation on Data to Care strategies?

Results: Of 9 respondents, 100% of the network members answered that they were very interested.

IX. Announcements

- Peer Certification Program first class completion
- CQII Plus Consumer QI Training (AHF & Poverello participated)
- Quality Network Training Day June 12, 2019

X. Next Meeting Agenda

XI. Meeting Evaluation

XII. Adjournment

The Meeting was adjourned at 4:11 p.m.

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Health Care Services Section

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MEDICAL/DISEASE CASE MANAGEMENT NETWORK
MEETING MINUTES

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Facilitator: Clinical Quality Management Staff
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PROVIDERS PRESENT
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Karen Jean-Pierre, BCFHC
Tyshan Oates, BCFHC
Denise Simpson, Broward Health
Dr. Kimberly Holding, Broward Health
Douglas Steele, Care Resource
Joshua Rodriguez, FDOH
Roody Lucius, FDOH
Tara Griffin, Memorial
Cherise Martin, Memorial

PROVIDERS ABSENT

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Debbie Cestaro-Seifer
Marcus Guice
Anitha Joseph

PART A RECIPIENT STAFF
Leonard Jones
Edith Garcia
Richard Morris

GUESTS

I. Call to Order
The meeting was called to order at 2:15 p.m.

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

Broward County Board of County Commissioners
Mark D. Bogen • Beam Furr • Dale V.C. Holness • Martin David Kiar • Chip LaMarca • Stacy Ritter • Tim Ryan • Barbara Sharief • Lois Wexler
Broward.org

III. Mentimeter Break I

How often do you have formal and informal meetings with your QI manager?
The Broward Health representative stated that the QI manager position is currently vacant.

CQM Staff informed the Network that the Oral Health no-show quality improvement project (QIP) is currently in progress and the goal is to eventually expand the QIP to the rest of the Ryan White (RW) Part A networks. Each RW Part A agency is required to complete one QIP annually by HRSA requirement.

The Network discussed how difficult it is for their homeless clients, especially those that are unemployed, to adhere to medication and maintain RW certification. FDOH representative noted that Emergency Financial Assistance includes payment of first and last month's rent for eligible clients. Care resource and Sunserve offer housing case management. However, clients must be employed to get this case management.
Action Item: A request was made to invite a HOPWA representative to attend the next Network meeting.

IV. Disease Case Management (DCM)

Staff asked the Network to define and describe how DCM works in each of their agencies and how Network members qualify a client for DCM.

The Memorial provider stated that they refer clients to DCM when there is an uncontrolled co-morbidity. They measure success of DCM by seeing an improvement in clients' lab numbers (VL, etc.), if the client understands their disease process, adheres to medication, and can self-manage their disease. Memorial provider noted that if the co-morbidity is a behavioral health (BH) diagnosis, they refer the client to a BH provider, and not a disease case manager. Many of their clients in DCM have BH co-morbidity in addition to non-BH co-morbidity.

AHF uses an integrated approach, combining both medical and mental health services.

The BCFHC provider asked the Network, at what point is it appropriate to remove a client from DCM, especially if the client appears to be on the border of not needing the service. The Memorial provider cited the following example: a person that takes their medicine but does not know the name(s) of their medication, has controlled viral load numbers, but still needs education around medication management. These types of patients prove to be difficult for providers to definitively remove from DCM. It was noted that providers have the option of referring clients to their clinical pharmacist to aid in medication management. CQM Staff member informed the Network that Walgreens may be a resource, since the retail drug store now requires their pharmacists to complete HIV certification.

CQM Staff asked the Network if they are using a medical case management acuity assessment, the network responded yes but they are individual to the provider and agency. The Network does not use a standardized acuity assessment tool.

The Part A Recipient representative encouraged the Network to use an integrated approach to providing DCM. Integrated care is de-stigmatizing for clients and can reduce burnout among staff. Staff are typically happier when responsibility is shared, and not an individual burden. Furthermore, when care is integrated, clients are spared the ill effects of repeating their traumatizing medical, social and emotional histories, which promotes safety and engagement in treatment and care.

Prescriptive providers and/or non-medical case managers are typically the primary people referring clients to DCM.

V. Mentimeter Break II

What data do you look at to know your patients are doing well?
Labs and vital signs, PHQ2, PHQ9, Hedis measures, viral load suppression, vital signs, client satisfaction survey data, needs assessment, and communication with patients. The provider from BCFHC and Memorial both use a spreadsheet to track client progress. Sometimes important client information is documented in PE and in the EMR with no one system having all of the needed data. Some Disease Case Managers have found that creating a spreadsheet creates a type of "dashboard" for all patients in a practice so that the data can be reviewed daily/weekly to address patient needs prior to a scheduled appointment. Network providers also stated that they have huddles in the morning where they review the patient schedule, new patients, new test and treat patients, and referrals. The AHF huddle is conducted every morning and takes about 15 minutes to complete.

Among your patient population, what is your viral load suppression rate?
All responses were above 89%

How often are you reviewing your viral suppression rate?
Most Network members selected "weekly" or "monthly". Two members responded "never". One said "daily" and one selected "annually".

Identify a barrier to communicating internally within your agency about quality improvement and management of patients.
Broward Health has an internal messaging system called Cerner. AHF uses CPS. Care Resource uses internal tasking.

VI. Provider Communication

Identify a barrier to communicating externally within our EMA to make referrals, coordinate care, etc.

Broward Health member stated that it is especially frustrating when they leave voicemails, but never receive a return call. She specifies in these voicemails that it is her second/third/etc. message in hopes that the person will make a concerted effort to call back in a timely fashion.

It is difficult to acquire medical records from different service categories.

“Most people that work in the field do not know how the system of care works, or the differences between RW Part A, B, C, D, F. Staff are often unaware of what service categories exist or what is allowable.” A member responded that SFAN (South Florida AIDS Network) is a good resource (meet first Friday of every month at Holy Cross) to better understand the system.

VII. Announcements

- Peers seeking job opportunities
- Data to care workshop update

VIII. Next Meeting Agenda

IX. Meeting Evaluation

X. Adjournment

The Meeting was adjourned at 4 p.m.

The next Medical and Disease Case Management Network Meeting is scheduled for October 23, 2019 from 2-4 pm in GC-302.