FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING
COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

System of Care Committee Meeting

Thursday, March 2, 2023 - 9:30 – 11:30 AM
Meeting at Broward Regional Health Planning Council and via WebEx

Chair: Andrew Ruffner • Vice Chair: Jose Castillo

https://browardregionalhealthplanningcouncil.my.webex.com/browardregionalhealthplanningcouncil.my/j.php?MTID=mc22adf30db2e721639e066e2a7530375

Join the meeting via phone: 1-408-418-9388 US Toll (access code: 2632 371 8733)

This meeting is audio and video recorded.

Quorum for this meeting is 5

DRAFT AGENDA

ORDER OF BUSINESS

I. Call to Order/Establishment of Quorum
   a. Welcome from the Chair
   b. Meeting Ground Rules
   c. Statement of Sunshine
   d. Introductions & Abstentions
II. Moment of Silence
III. ACTION: Approval of Agenda for March 2, 2023
IV. ACTION: Approval of Minutes from February 2, 2023
V. Public Comment
VI. Unfinished Business
   a. None.
VII. New Business
   a. Review/Update “How Best to Meet the Need Language” for FY 2024-2025 **(Handout A)**

Workplan Activity 1.5: *Develop How Best to Meet the Need (HBTMTN) language based on findings annually.*

b. Update on Ryan White Part A Providers' Quality Improvement Projects FY 2022-2023 **(Handout B)**
Workplan Activity 2.4: *Receive presentations on Quality Improvement Projects (QIPs) taking place among service providers as needed.*

c. Update on Ryan White Part A approved service delivery models (SDMs) FY 2023-2024.
Workplan Activity *2.6: Conduct annual review and present findings to QMC for potential updates to service delivery models (SDM) as needed.*

d. Update on Ryan White Part A Broward Outcomes and Indicators FY 2022-2023. **(Handout C)**
Workplan Activity 1.2: *Analyze utilization trends for the HIV population in the Ryan White Part A system of care on an ongoing basis.*

e. Discussion on the status of system mapping.

Workplan Activity *2.1 Develop targeted strategies and interventions for vulnerable populations who may not seek care or who may have fallen out of care as needed/recommended.*
Workplan Activity *2.2 Identify barriers and facilitators to retention in care for HIV-related services on an ongoing basis.*

VIII. Recipient Report

IX. Public Comment

X. Agenda Items for Next Meeting

XI. Next Meeting Date: April 6, 2023, at 9:30 a.m. Location: BRHPC and via WebEx Video Conference

XII. Announcements

XIII. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website

Please complete your meeting evaluation.

Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

Vision: To ensure the delivery of high-quality, comprehensive HIV/AIDS services to low-income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal

governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

Broward County Board of County Commissioners

Mark D. Bogen • Lamar P. Fisher • Beam Furr • Steve Geller • Robert McKinzie• Nan H. Rich • Tim Ryan •Hazelle P. Rogers• Michael Udine

Broward County Website

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

HIV HEALTH SERVICES PLANNING COUNCIL MEETING GROUND RULES

1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.

2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.

3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.

4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.

5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.

6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.

7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.

8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.

9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.

10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.

11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

Revised 7/24/14

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH REGLAS BÁSICAS DE LA REUNIÓN

1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.

2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.

3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.

4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.

5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.

6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.

7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.

8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.

9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.

10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.

11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

Revised 7/24/14

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV
RÈGLEMAN RANKONT-YO

1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.

2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.

3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.

4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priyorite sou lòt manm-yo.

5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.

6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.

7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respektè menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.

8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.

9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.

10. Vye langaj, menas vyolans, oswa posesyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.

11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.

Revised 7/24/14

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
HAB: HIV/AIDS Bureau
HHS: U.S. Department of Health and Human Services
HICP: Health Insurance Continuation Program
HIV: Human Immunodeficiency Virus
HIVPC: Broward County HIV Planning Council
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development
IW: Integrated Workgroup
IDU: Intravenous Drug User
JLP: Jail Linkage Program
LPAP: Local AIDS Pharmaceutical Assistance Program
MAI: Minority AIDS Initiative
MCDC: Membership/Council Development Committee
MCM: Medical Case Management
MH: Mental Health
MNT: Medical Nutrition Therapy
MOU: Memorandum of Understanding
MSM: Men Who Have Sex with Men
NBHD: North Broward Hospital District (Broward Health)
NGA: Notice of Grant Award
NHAS: National HIV/AIDS Strategy
NOFO: Notice of Funding Opportunity
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University
OAHS: Outpatient Ambulatory Health Services
OHC: Oral Health Care
PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

PROACT: *Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward's treatment adherence program.*

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

Recipient: Government department designated to administer Ryan white Part A funds and monitor contracts.

Planning Council Support (PCS) Staff/'Staff': Provides professional staff support, meeting coordination and information to the HIVPC, its standing and ad-Hoc Committees, Chair, and Recipient.

Clinical Quality Management (CQM) Support Staff: Provides professional support, meeting coordination and technical assistance to assist the Recipient through analysis of performance measures and other data with implementation of activities designed to improve patient's care, health outcomes and patient satisfaction throughout the system of care.

Provider/Sub-Recipient: Agencies contracted to provide HIV Core and Support services to consumers.

Consumer/Client/Patient: A person who is an eligible recipient of services under the Ryan White Act.

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(954) 561-9681 • FAX (954) 561-9685

System of Care Committee

Thursday, February 2, 2023 - 9:30 AM
Meeting at Broward Regional Health Planning Council and via WebEx

DRAFT MINUTES

SOC Members Present: A. Ruffner (Chair), J. Castillo (Vice-Chair), V. Biggs, E, Chrispin, T. Pietrogallo, A. Murphy, F. De'Amore

SOC Members Excused: None

Ryan White Part A Recipient Staff Present: T. Thompson

PCS/CQM Staff Present: G. Berkley-Martinez, B. Miller, D. Liao

Guests Present: J. Shirley

Call to Order, Welcome from the Chair & Public Record Requirements

The SOC Chair called the meeting to order at 9:30 a.m. The SOC Chair welcomed all meeting attendees that were present. Attendees were notified that the SOC meeting is based on Florida's "Government-in-the-Sunshine Law and meeting reporting requirements, including recording minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the SOC Vice-Chair, Committee members, Recipient staff, PCS & CQM staff, and guests by roll call, and a moment of silence was observed.

- Public Comment

  The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters about HIV/AIDS and services in Broward County. There were no public comments

- Meeting Approvals

  The approval for the agenda of the February 2, 2023, System of Care Committee meeting agenda was proposed by J. Castillo, seconded by V. Biggs, and passed unanimously. The approval for the minutes of September 1, 2022, meeting was proposed by J. Castillo, seconded by V. Biggs, and passed unanimously.

  Motion #1: Mr. Castillo, on behalf of the SOC made a motion to approve the February 2, 2023, System of Care Committee meeting agenda with the addition of an agenda item to discuss access to care. The motion was adopted unanimously.

  Motion #2: Mr. Castillo, on behalf of the SOC, made a motion to approve the September 1, 2022, System of Care Committee meeting minutes as

presented. The motion was adopted unanimously.

- Standard Committee Items

  There were no standing committee items on the agenda for this meeting.

- Unfinished Business

  There is no unfinished business.

- New Business

  G. Martinez reviewed the current SOC work plan for the 2022-2023 fiscal year with the committee. The SOC work plan was on track for the fiscal year except for Objective 2.5 and 2.6. These two objectives are for the committee to recommend areas of inequities for review and present data findings for potential updates to the Service Delivery Models (SDMs) to the Quality Management Committee (QMC). G. Martinez stated that QMC was able to review the SDMs for the upcoming 2023-2024 fiscal year.

  The FY2023-2024 SOC work plan was reviewed to be approved by the committee. The action steps of Objective 2.1 were changed to reflect the language of the 2022-2026 HIV Integrated Plan in the new work plan. This action step for Objective 2.1 includes language for the committee to identify ways to engage/reengage people living with HIV who are not in care or are not virally suppressed and provide recommendations for QMC and the Ryan White Part A Office. There were no other changes to the FY2023-2024 SOC work plan.

  The approval for the FY2023-2024 SOC work plan was proposed by J. Castillo, seconded by F. De'Amore and passed unanimously.

  Motion #3: Mr. Castillo, on behalf of the SOC, made a motion to approve the FY2023-2024 SOC work plan as presented. The motion was adopted unanimously.

  The CQM Support Staff gave a presentation to discuss and review the FY2022-2023 Quarter 3 (Q3) health outcomes data. The reporting period for Q3 is from September 1, 2022 – November 30, 2022. CQM Support Staff updated SOC to make them aware of quality assurance issues with the systemwide retention rate of the Broward EMA. They stated that they have been working with the Recipient Staff and Provide Enterprise (PE) tech support to resolve underlying data discrepancy issues. The CQM Support Staff noted that they have been closely monitoring the retention rate and observed a decrease in the numbers over the past three quarters. Currently, the systemwide retention rate of the Broward EMA is at 63.1%. They stated that they will work with PE to rerun the FY2023-2023 Q3 data for the HIV Care Continuum/Broward Outcome & Indicators once the issues are resolved and report back to SOC with the new information.

  Although data discrepancies have been present with the retention rate, the CQM Support Staff noted that the Ever In Care, In Care, Prescribed ARV, and Viral Suppression service categories have been consistent over the past three quarters. CQM Support Staff stated that the In Care service category for Q3 is currently at 91.6%, which shows that Broward Ryan White clients have been documented to receive at least one medical care service within the Q3 reporting period. Additionally, the prescribed ARV service category for Q3 is currently at 95.9%, which shows that clients have been documented to receive medication at any time during the reporting period as well. The viral suppression rate for Q3 is at 87.2%, which leaves 12.8% of clients who may not be consistent with their treatment or experiencing a barrier in receiving their ARV medication. CQM Support Staff stated that this discrepancy has been consistent in the HIV Care

Continuum for a while. Once the retention rate issue is resolved, the CQM Support Staff will drill down the data to discover any process issues related to data entry that may be affecting these numbers in PE.

CQM Support Staff also reported on three subpopulations within the HIV Care Continuum, gender, race/ethnicity, and age. CQM Support Staff restated that given the current retention issues with PE, the staff will have to rerun Q3 data to verify any changes within the system. The subpopulations that were recommended to monitor were: female clients, Black (Non-Hispanic) clients, Hispanic/Latinx clients, 18-28 and 59+ aged clients. CQM Support Staff specifically noted that the 18-28 age range showed the biggest drop in retention from FY2021-2022 to FY2022-2023 Q3 (65.28% to 56.89%). CQM Support Staff stated that they will be doing data drill downs in PE to discover any logistical barriers or health disparities that the 18-28 age range may be experiencing.

Next, the CQM Support Staff fulfilled a data request by SOC to analyze and report on FY2022-2023 Q3 Broward EMA clients who are not virally suppressed. Viral suppression rates were reported by subpopulation including gender, race/ethnicity, age, sexual orientation, and poverty level. For the gender subpopulation, transgender and female clients were subgroups to monitor with 14.94% and 11.73% not virally suppressed. Additionally, 13.94% of Black (Non-Hispanic) clients are shown to not be virally suppressed in comparison to the 9.06% of White (Non-Hispanic) clients. For age, the 18-28 age range had the highest percentage (17.96%) of clients not virally suppressed. CQM Support Staff noted that this subpopulation is being monitored throughout the current fiscal year. Clients who identify as bisexual (15%) and heterosexual (9%) were shown to be the top two subgroups with the highest percentages of clients not virally suppressed. Lastly, clients within the 0%-50% poverty level had the highest percentage of clients not virally suppressed (16.18%) within the subcategory.

After the data presentation, a discussion followed about the possibility of a correlation between clients who have a lower federal poverty level percentage, housing status, and viral suppression rates. CQM Support Staff stated that they can drill the data down further to report on a possible correlation if SOC requests it. Additionally, there was a data request by a member of SOC to review the FY2022-2023 Q3 service utilization report for Broward Ryan White service categories. CQM Support Staff stated that they would discuss these data requests with Recipient staff and report back to SOC.

Lastly, the CQM Support Staff reviewed the FY2022-2023 Q3 Broward Outcome and Indicators with the committee. The categories that met or exceeded their outcome/indicator goals are: Oral Health, Integrated Primary Care & Behavioral Health, AIDS Pharmaceutical Assistance, and Legal Services. Given the data discrepancy issues with PE, CQM Support Staff stated that they will rerun the report and present the updated information at the next SOC meeting.

- Recipient Report

  There was no Recipient report for this meeting.

- Public Comment

  The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters about HIV/AIDS and services in Broward County. There were no public comments.

- Agenda Items for Next Meeting

  There will be an update on the FY2022-2023 Q3 health outcome data. The data requests will be clarified at the next meeting. The next SOC meeting will be held on

March 2, 2023, at 9:30 am. Location: BRHPC and via WebEx Video Conference.

- Announcements

  The 2022 Provider Appreciation Week will be held virtually on Zoom from Monday, February 6, 2023 – Friday, February 10, 2023, from 1 PM – 2 PM. For more information, members and guests can contact the CQM Support Staff.

  The Black AIDS Advisory Group gala for National Black HIV/AIDS Awareness Day will be held at the Urban League on Friday, February 3, 2023 at 7 PM. The HIV Planning Council Chair, Lorenzo Robertson and Vice-Chair, Von Biggs, have been nominated for several awards. Contact the Chair, Lorenzo Robertson for more information.

9. Adjournment

   There being no further business, the meeting was adjourned at 11:24 a.m.

SOC Attendance for CY 2022 - 2023

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	5	2											
0	0	0	1	Chrispin, E.	CX	X											
0	1	0	2	Pietrogallo, T.	CX	X											
0	0	0	3	Ruffner, A. *Chair*	CX	X											
0	1	0	4	Biggs, V.	CX	X											
0	1	0	5	Castillo, J. V-Chair	CX	X											
0	1	0	6	DeAmore, F.	CX	X											
1	1	0	7	Murphy, H.A.	CX	X											
				Quorum = 5													

Legend:	
X - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	Z - resigned
CX - canceled due to quorum	R - removal letter

HANDOUT A

How Best to Meet Priority Needs

HRSA Requirements

Broward County HIV Health Services Planning Council
Broward County Health Care Services Ryan White Part A Program
Broward County Board of County Commissioners
Presented to System of Care: 3/02/2023

HRSA Requirements

- The planning council has the right to provide directives to the recipient on how best to meet its identified service priorities.

- The council may direct the recipient to fund services in particular parts of the EMA.
- To use specific service models.
- It may tell the recipient to take specific steps to increase access to care (for example, require that Medical Case Management providers have a bilingual staff or that primary care facilities be open one evening or weekend a month).
- It may also require that services be appropriate for subpopulations—for example, it may specify funding for medical services that target young gay men of color.

HIVPC
Broward County HIV Health Services Planning Council

HRSA Requirements

- The planning council **cannot** pick specific agencies to fund or make its directives so narrow that only one agency will qualify.
- The planning council may review sections of the Request for Proposals (RFP) the recipient develops for RWHAP Part A services, to ensure that directives are appropriately reflected, but it cannot be involved in any aspect of contractor selection (***procurement***) or in managing or monitoring RWHAP Part A contracts. *These are recipient responsibilities.*

Resources: HRSA Ryan White Part A Manual/ Ryan White Planning Council Primer 2018 (pg. 22)

HIVPC
Broward County HIV Health Services Planning Council

QUESTIONS?

DISCUSSION

Broward County Ryan White Part A
HIV Health Services Planning Council
HOW BEST TO MEET THE NEED LANGUAGE
Approved by HIVPC 7/2022 for
FY 2023-2024

Submitted to SOC for review and provide recommendations to the PSRA Committee for FY 2024-2025.
Items in red were new recommendations during the July 2023 review process.

ALL SERVICES
Recommended Language
1. Develop a formal client orientation program that includes a visual tour and access procedures explained by a Community Health Worker or Peer when they are linked to treatment. (2021-2022 Broward County HIV Community Needs Assessment). 2. Develop and ensure that all Part A Providers receive Educational Tools that support a more caring and culturally competent workforce (2021-2022 Broward County HIV Community Needs Assessment and CEC Community Conversations). 3. Ensure collaboration and sharing of knowledge between Providers and Peers in delivering HIV treatment and care. (2021-2022 Broward County HIV Community Needs Assessment). 4. Increase after-hours/ non-traditional hours across all services to ensure clients have access to care (CEC) 5. Ensure Part A Providers document collaborative agreements with all and other organizations within their continuum of care, and across systems to help clients get all their needs addressed. 6. Provide Care Coordination across multiple service categories. 7. Ensure high client satisfaction with services through consistent feedback opportunities such as surveys or focus groups, annual customer service trainings for staff, and provide follow-up as needed. 8. Collaborative agreements with treatment adherence programs and other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care. 9. Enhance the emphasis on adherence and retention in medical care inclusive of sub-populations not achieving viral load suppression, including but not limited to: a. Black heterosexual men and women b. Black men who have sex with men (MSM) 18-38 years of age 10. Integrate care collaboration with members of the client's service providers. 11. Collect client-level data on stages of the HIV Care Continuum to identify gaps in services and barriers to care. 12. Implement formal policies addressing referrals amongst internal and external providers to maximize community resources. 13. Co-locate services where applicable, to facilitate a medical home for Part A clients.
CORE MEDICAL SERVICES
Outpatient Ambulatory Health Services (OAHS)
Services Criteria: (≤ 400% FPL)
Recommended Language
1. Educate clients beginning at age 64 and at least four months before they turn 65 about Medicare enrollment guidelines, especially those pertaining to late enrollment penalties. (CEC Community Conversations -Long Term Survivors Awareness Day) 2. Create more information about the food services eligibility for medical provider clinical team and case managers. (2021-2022 Broward County HIV Community Needs Assessment). 3. Test and treat as well as the integration of behavioral health screenings into primary care increase access to OAHS and may require increased funding due to additional staffing and provisions of services. 4. Integrated Primary Care & Behavioral Services funded agencies to provide Outpatient

Ambulatory Medical Care, Behavioral Health, and Care Coordination services.

5. Providers are responsible for providing assessments, brief therapy interventions, and referrals for clients that require a higher level of care.
6. Integrate care provider collaboration with members of the client's treatment team outside of the organization.
7. Establish shared clinical outcomes and data sharing to maximize coordination and tracking of client health outcomes.
8. Care Coordinators will monitor the delivery of care; document care; identify progress toward desired health outcomes; review the care plan with clients in conjunction with the direct care providers; interact with involvement departments to ensure the scheduling and completion of tests, procedures, and consult track and support patients when they obtain services.
9. Provide after-hours services availability to include Crisis Intervention.
10. Coordinate referrals with other service providers; conduct follows with clients to ensure linkage to referred services.
11. Ensure providers are knowledgeable regarding the management of patients co-infected with HIV and Hepatitis C Virus (HCV).
12. Incorporate prevention messages into the medical care of PLWHA.
13. Report clients who have fallen out of care to DIS Outreach workers to determine if clients are not in care or have moved away/to a different payer source.

AIDS Pharmaceuticals (Local)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. No recommended language for FY2023-2024.
2. Drugs used for Test and Treat.
3. Report clients who have fallen out of care to DIS Outreach workers to determine if clients are not in care or have moved to a different payer source.

Oral Health Care (OHC)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. No recommended language for FY2023-2024
2. Make provision for the increased demand for services due to increase in service locations.
3. Maintain specialty oral health care services and provide care beyond extractions and restoration to include, but not be limited to, full or partial dentures and surgical procedures, periodontal work, and root canals.
4. Increase Oral Health Care collaboration with mental Health providers.
5. Expand and separate Oral Health Care services funding into two components: Routine maintenance care and Specialty Care.

Health Insurance Continuation Program (HICP)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. No recommended language for FY2023-2024
2. Increase in clients with access to health insurance.
3. Develop materials for clients to use as quick references.
4. Provide assistance with prior authorizations and appeals process.
5. Maintain routinized payment systems to ensure timely payments of premiums, deductible, and co-payments.

Mental Health Service (MH)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. No recommended language for FY2023-2024
2. Report clients who have fallen out of care to medical team when there is a missed mental health

appointment to quickly reengage the client in care for mental health services.
3. Integrated service may be impacting utilization in this service category.
4. Provide Trauma-Informed Mental Health Services referring clients to the prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.
5. Provide after-hours availability to include Crisis Intervention.

Medical Case Management (Disease Case Management)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. Provide case managers and other service providers with information on the linkage between HIV treatment and management and the various support services. (2021-2022 Broward County HIV Community Needs Assessment).
2. Educate clients beginning at age 64 and at least four months before they turn 65 about Medicare enrollment guidelines, especially those pertaining to late enrollment penalties. (CEC Community Conversations -Long Term Survivors Awareness Day)
3. Coordinate referrals with other service providers; conduct follow-ups with clients to ensure linkage to referred services.
4. Report changes in viral load status as clients progress through the program.

Substance Abuse/Outpatient

Services Criteria: (≤ 400% FPL)

Recommended Language

1. Ensure that substance abuse treatment services are offered to all consumers with an active substance use disorder. (2021-2022 Broward County HIV Community Needs Assessment).

SUPPORT SERVICES

Case Management (Non-Medical)

Services Criteria: (≤ 400% FPL)

Recommended Language

1. Educate clients beginning at age 64 and at least four months before they turn 65 about Medicare enrollment guidelines, especially those pertaining to late enrollment penalties. (CEC Community Conversations -Long Term Survivors Awareness Day)
2. Implementation of test and treat increases demand for more services.
3. Specially trained personnel to ensure client education about transitioning to insurance plans, including medication pick up, co-payments, staying in network, etc.
4. Provide education to reduce fear and denial and promote entry into primary medical care.
5. Educate clients on the importance of remaining in primary medical care.
6. At least 30% of Non-Medical Case Management funded personnel be dedicated to Peers.
7. Incorporate prevention messages into the medical care of PLWHA.
8. Educate consumers on their role in the case management process.
9. Provide initial/ongoing training and development for HIV peer workers.
10. Overview of health care plan summary benefits (coverage and limitations).
11. Educate the client on the different types of health care providers (i.e., Primary Care, Urgent Care, and Specialty Care).

Centralized Intake and Eligibility Determination (CIED)

Services Criteria: HIV+ Broward County Resident (All Clients)

Recommended Language

1. Educate clients beginning at age 64 and at least four months before they turn 65 about Medicare enrollment guidelines, especially those pertaining to late enrollment penalties. (CEC Community Conversations -Long Term Survivors Awareness Day)
2. Participate in future Part A/B dual eligibility determination.
3. Ensure the locations and service hours target historically underserved populations that are disproportionately impacted with HIV.
4. Maintain collaborative agreements with treatment adherence programs and other key points of entry to facilitate rapid eligibility determination for the newly diagnosed and for clients who have fallen out of care.
5. Distribute client handbook to provide an overview of the purpose of Ryan White Part A services and includes the following: 1) Client rights and responsibilities, 2) Names of providers complete with addresses and phone numbers, and
    a. 3) Grievance procedures.
6. Always offer dedicated live operator phone line during normal business hours.
7. Ensure that intake data collected for transgender clients is sufficient to make full use of transgender related categories in PE.
8. Follow-up with all newly diagnosed clients within 90 days of certification to ensure they are engaged in care.

Emergency Financial Assistance

Services Criteria: (≤ 400% FPL)

Recommended Language

1. No recommended language for FY2023-2024
2. Drugs used for Test and Treat.
3. Provide limited one-time or short-term pharmaceutical assistance for Ryan Part A clients.

Food Services

Services Criteria: (≤ 400% FPL)

Recommended Language

1. Create more information about the food services eligibility for medical provider clinical team and case managers. (2021-2022 Broward County HIV Community Needs Assessment).
2. Increase communication with client primary care physicians and nutrition counselors to ensure client nutrition needs are being met.
3. Provide workshop and training forums focused on improving Clients' knowledge of healthy eating and nutrition as related to management of their health.

Legal Services

Services Criteria: (≤ 400% FPL)

Recommended Language

No recommended language for FY2023-2024

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

Programs at 400% FPL (or Below)

Integrated Primary Care and Behavioral Health (IPCBH)

Disease Case Management (DCM)

Non-Medical Case Management (NMCM)

Oral Health Care

AIDS Pharmaceutical Assistance (APA)

Health Insurance Continuation Program (HICP)

MAI Trauma-Informed Mental Health

MAI Substance Abuse Services - Outpatient

Programs at 300% FPL (or Below)

Part A Trauma-Informed Mental Health

Part A Substance Abuse Services - Outpatient

Food Services

Legal Services

HANDOUT B

Broward EMA Ryan White Part A Program

FY2022-2023

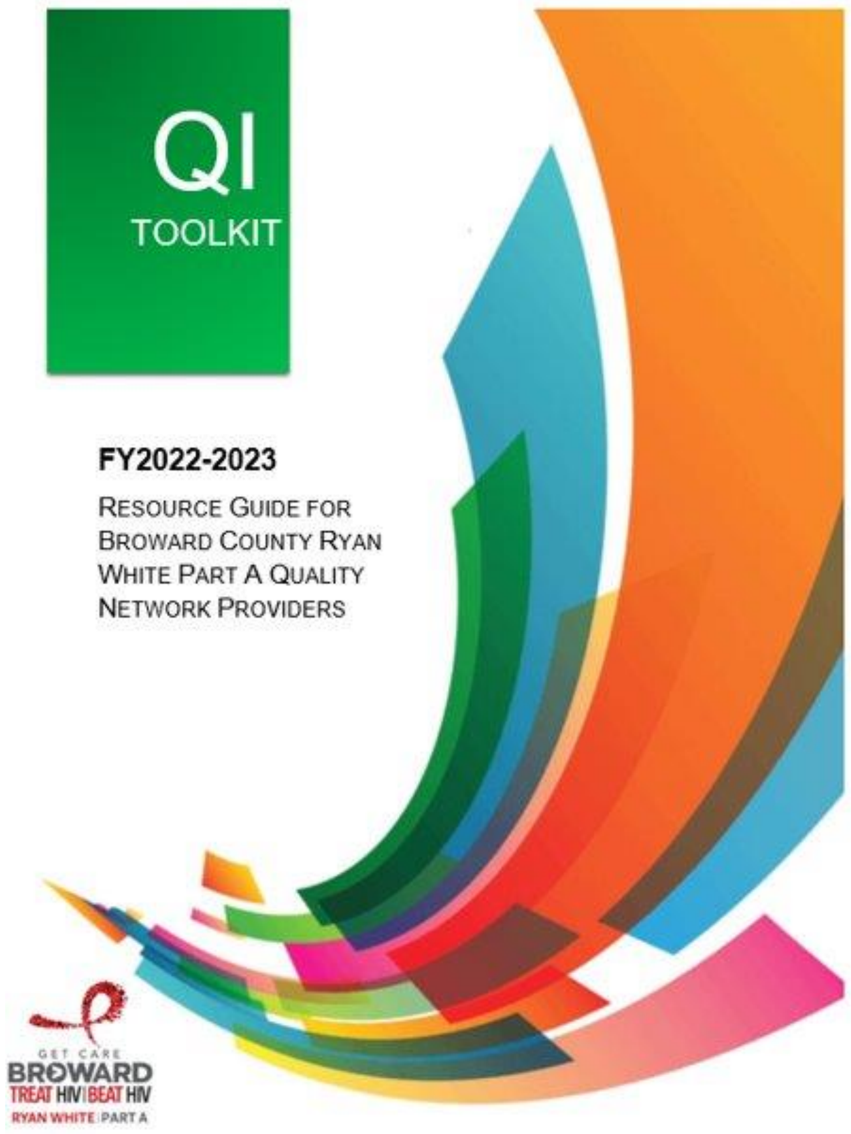
Ryan White Quality Network:

Quality Improvement Project Presentation

PRESENTED BY
BRIANNE MILLER, MPH, CHES & DANIELLE LIAO, MPH

FY 2022-2023 QIP Review

The purpose of this presentation is to discuss and review selected Quality Improvement Projects from the Quality Network within the 2022-2023 fiscal year.



Fiscal Year 22-23

The Broward EMA Ryan White Part A Program quality improvement focus for FY 2022-2023 is closing the gap between linkage to care and retention in care, specifically among subpopulations, including:

- Black-African American Non-Hispanic/Latinx Cis-Gender Adolescent Adult Male and Female who acquired HIV infection due to heterosexual contact
- Hispanic/Latinx Adolescent Adult MMSC
- White Non-Hispanic/Latinx Adolescent Adult MMSC

Quality Improvement Projects (QIPs) should focus on addressing this gap.

QIP PLANNER 2022-2023

This planner is a recommended timeline for deliverables related to the QIP process.

Checkpoint check-ins are one on one virtual check ins and provide an opportunity to check in with the CQM team. Time slots are available from 10am to 3pm

QIP PHASE	STARTING	ENDING
STEP 1: GEARING UP FOR QIPS	3/1/22	4/11/22
STEP 2: IDENTIFYING THE PROBLEM	4/12/22	5/2/22
STEP 3: AIM STATEMENTS	5/3/22	6/20/22
STEP 4: PDSA CYCLES	6/21/22	10/3/22
STEP 5: PRELIMINARY DATA REVIEW AND EVALUATION	10/4/22	11/28/22
STEP 6: QIP POSTER	11/9/23	1/9/23

CHECKPOINT CHECK-INS	DATE 1	DATE 2
IDENTIFY FOCUS AREAS FOR QIPS	3/29/22	3/31/22
DRIVER DIAGRAM	4/21/22	4/28/22
AIM STATEMENT	5/16/22	5/18/22
DRIVERS/CONTRIBUTING FACTORS	6/10/22	6/14/22
PDSA CYCLE PLANNING FORM	7/25/22	8/30/22
PRELIMINARY DATA REVIEW & EVAL	11/8/22	11/15/22
QIP POSTER	1/23/23	2/6/23

Checkpoint due dates are in highlighted.

MARCH

M	T	W	T	F	S	S
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APRIL

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JUNE

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DECEMBER

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JANUARY

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FEBRUARY

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Medication Adherence In Clients 59 & Over

AGENCY B

BACKGROUND

- Improving viral suppression rate in clients over the age of 59.
- During the pandemic, **AGENCY B** noticed an increase in viral load amongst our older client population. The highest V/L reading being 852,000 copies

AIM STATEMENT

AGENCY B aims to increase viral suppression rates from 71% to 73% through medication adherence interventions by December 2022 for Ryan White clients aged 59 and over.

MEASURES

Process Measures

- **AGENCY B** used appointment codes and a tracking spreadsheet for all appointments relating to education and monitoring.

Outcome Measures

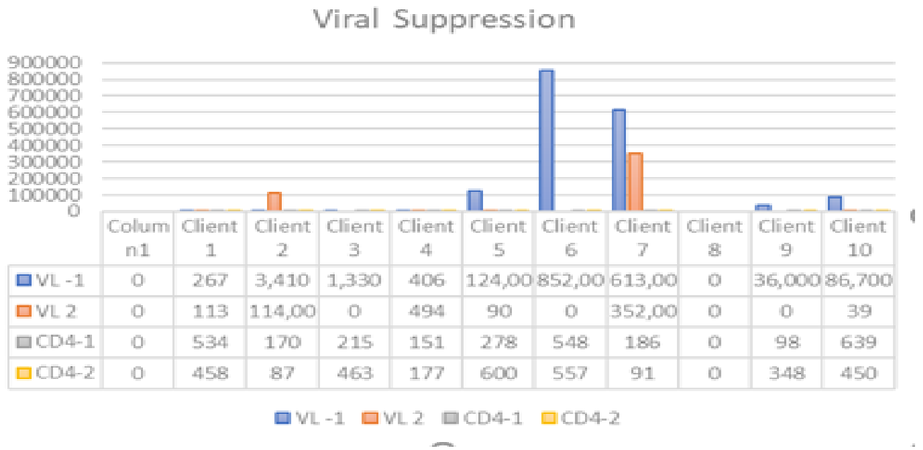
- Clients were tested on their knowledge of their antiretrovirals by name/color as well as having access to their list of medications.

PDSA CYCLES

Cycle 1 Medication adherence through education & Health Literacy.
Plan: Test clients' knowledge about meds.
Do: Clients shared their medication card with providers.
Study: Significant improvement in viral load analysis reading. Results were confirmed from the two most recent readings within the last 6 months.
Act: Successful implementation of the medication card. Clients were engaged in helping fill out their card and it gave them a sense of empowerment.

Cycle 2 Improve pharmacist-patient relationship & med review.
Plan: Ensure all meds are going to one pharmacy; it helps if its community based.
Do: Encountered resistance from outside pharmacies. Different understanding of patient needs.
Study: Better communication/coordination from onsite pharmacy. Pharmacist makes direct contact with providers, CM's and nurses. Timely med refills and lower risk for contraindications.
Act: Better account of what is being prescribed and picked up by the clients through med review visits

RESULTS



Column1	Client 1	Client 2	Client 3	Client 4	Client 5	Client 6	Client 7	Client 8	Client 9	Client 10
VL -1	0	267	3,410	1,330	406	124,00	852,00	613,00	0	36,000	86,700
VL 2	0	113	114,00	0	494	90	0	352,00	0	0	39
CD4-1	0	534	170	215	151	278	548	186	0	98	639
CD4-2	0	458	87	463	177	600	557	91	0	348	450

Viral Load and CD4 Chart

RW QIP Tracking List 2022

DOB	Age	VL	CD4	Commorbidities	Pharmacy	Support	Nationality
11/19/1949	72	571	397	Diabetes Militus	DOH	Daughter	Jamaican
3/1/1952	70	3410	147	Anorexia, Hyperten	Walgreens	None	Haitian
11/2/1941	80	215,000	215	Type 2 Diabetes	Walgreens	None	Haitian
10/22/1957	64	406	151	Type 2 Diabetes	DOH	None	Haitian
7/6/1952	69	124,000	278	Essential Hypertension	DOH	Son	Haitian
8/24/1949	72	852,000	548	Type 2 Diabetes	Walgreens	Daughter	Haitian
9/11/1956	65	625,000	104	Pre-diabetes	DOH	None	Haitian
2/28/1958	64	4,300	66	Anemia, Smoker	CVS	None	American
7/18/1944	77	36000	98	Latent Syphilis	DOH	Daughter	Haitian
1/24/1949	73	867,000	365	Hypertension	DOH	Son	Haitian

SUCCESSES, CHALLENGES, & NEXT STEPS

- The medication card and patient-pharmacist relationship were a success. **AGENCY B** concluded the project with 8, leaving us with a viral suppression rate of 86%.
- During Cycle two we lost the use of the appointment codes.
- Moving forward we plan to continue the project by establishing or strengthening family involvement.

Accurate Data leads to Proactive Care

AGENCY E

BACKGROUND

The inability to pull accurate data reports, inhibits direct care staff from being able to proactively identify individuals at risk of, or having already fallen out of medical care.

AIM STATEMENT

AGENCY E aims to improve the quality of data entry into PE to improve reportability of client's VL suppression,CD4 Count, Client/Provider Relationships, and Retention in care.

MEASURES

Process Measures

AGENCY E aimed to maintain an active census to track caseload acuity, follow-up rates, and lab values/kept appointments.

Outcome Measures

Their CM's tracked by hand, as well as pulled reports to confirm accuracy/inaccuracy of reporting system.

PDSA CYCLES

Training and Implementation

Plan: Train staff to ensure they are knowledgeable as to where to enter/confirm data for accuracy

Do: Scheduled/Facilitated training to prepare for implementation

Study: Once staff were comfortable with implementation, monthly reports were run to assess effectiveness

Act: Follow-up with staff in monthly meetings to identify barriers to gathering/entering appropriate data

Outcome: We found that although data was entered by CM when available, some data was required to be obtained via Medical Providers. Additionally, run reports did not match data input into PE.

Relationship Building across Network Providers

Plan: Pick one medical provider to forge a clear path of obtaining needed information

Do: Management team met with medical provider representative and outlined test points within agency for access

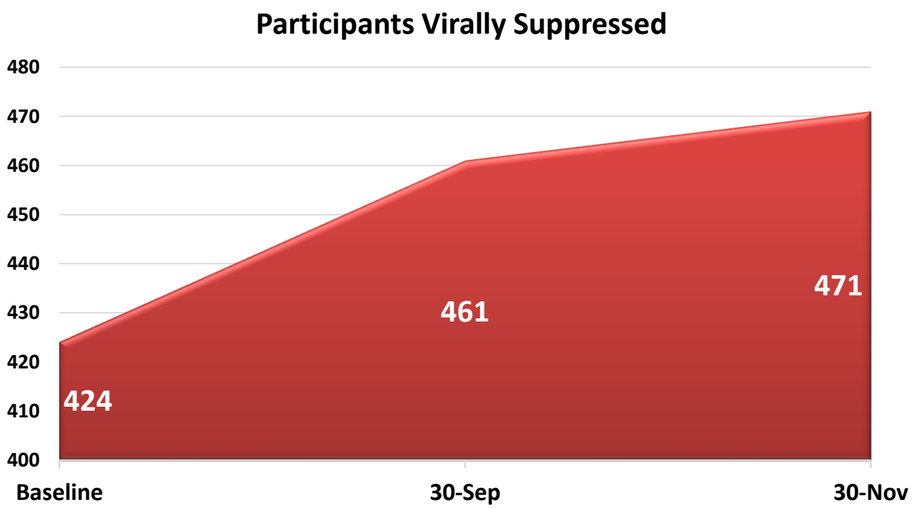
Study: Utilize those checkpoints to ensure PE data was updated

Act: Rerun reports to confirm accuracy.

Outcome: We found that PE reports did not match data input into portal.

RESULTS

Although their outcome percentages did not increase to the goal of 92% virally suppressed, **AGENCY E** were successful in increasing our viral suppression rates from 424 individuals to 471 individuals (difference of 47) .



SUCCESSES, CHALLENGES, & NEXT STEPS

AGENCY E attribute their success of increasing their VL Suppression rates for 47 individuals to their staff's dedication to hand tracking and identification of higher acuity clients, to ensure that they did not fall out of care. They will continue to work with PE to identify ways to improve reporting around data entered in the portal.

Increasing Utilization Through Awareness and Access

AGENCY I

BACKGROUND

Will utilization of Ryan White-funded legal services increase by raising awareness of and access to available services?
Why? Data show clients that utilize support services generally have a higher rate of retention and better viral suppression

AIM STATEMENT

AGENCY I aims to increase utilization from FY21-22 Qs 2 & 3 (June -Nov) by 6% by end of FY22-23 Q 3 (11/30/22) in clients utilizing Legal Services support service category.

MEASURES

Internal case management software (*LegalServer*)
- Track outreach efforts
- Client utilization
- Client surveys

Provide Enterprise
- Client utilization
- Contract utilization (monthly invoicing)

PDSA CYCLES

Increase client awareness of and utilization of available Ryan White legal services

Cycles 1, 2 and 3:

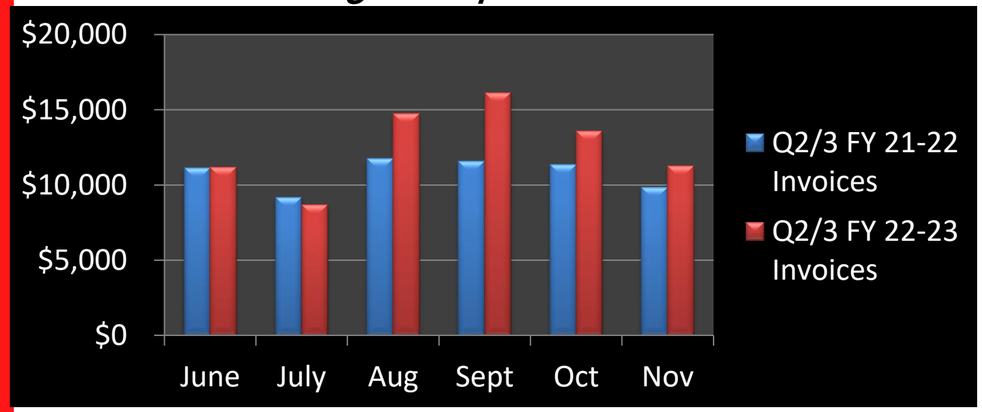
Plan: *purposeful and coordinated outreach to case managers and case management agencies to inform of most up-to-date legal service available at Legal Aid*
Do: (1) emails and direct phone calls // (2) via other sources - announcements during RW meetings (PSRA, SFAN, Quality Network, etc.), increased social media posts // (3) in-person and/or via video conference
Study: Track activities through Legal Server; Legal Server and PE client utilization and new client reports
Act: Adopt

Cycle 4

Plan: Provide options for remote and in-office appointments
Do: track client preference; survey for barriers; poll case managers
Study: results in LegalServer client files and case notes
Act: Adapt/Adopt

RESULTS

Increase in August/September client utilization



FY 2021-22 Q3 Retention in Care: 75%

FY 2022-23 Q3 Retention in Care: 80%

SUCCESSES, CHALLENGES, & NEXT STEPS

Data tracking issues
--Unable to track results of outreach for clients served through other (non-Ryan White) units at Legal Aid
--Outreach takes time to see results (delay in agencies distributing info to clients; client not seeking assistance right away after receiving info, etc.)

NEXT STEPS:
- Continue various outreach methods
- Poll clients as to how they came across our services as another way to determine if outreach efforts are working to increase utilization of Ryan White legal services
- Expand on PDSA Cycle 4 (accessibility; barriers) for future QIP?

Increase Retention of Virally Uncontrolled Black Women

AGENCY J

BACKGROUND

- The number of Black women, between the ages of 36 and 45, tend to have an uncontrolled viral load compared to our other patient populations.

AIM STATEMENT

To increase in-care retention rates among Black Women between the ages of 36 and 45, from 88% to 90% by December 2022.

MEASURES

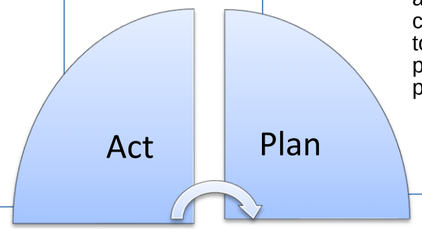
Process Measures
- Followed up with patients to ensure that they kept Medical Appointments.
- Rounded with Case Managers and the outcomes of their sessions with the patient.

Outcome Measures
- Use of the EMR
- Patient interviews (in-person and phone)

PDSA CYCLES

- **AGENCY J** adopted the cycle as we noticed the patient was able to become re-engaged and/or more compliant. Therefore, leading to the patient to become virally controlled.

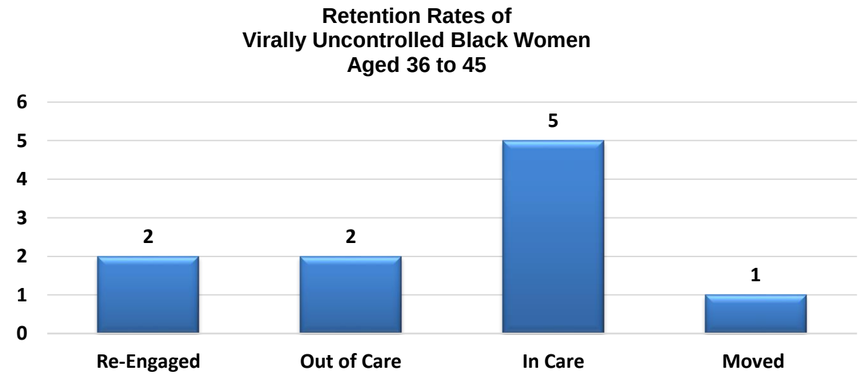
- To improve non-compliance and adherence to medical care. Therefore, leading to a virally controlled patient within this patient population.



- We found that patients have been more compliant in their medical care. This is leading us to have a virally suppressed patient.

- Identify any barriers that lead to non-compliance within this patient population.
- Refer to and provide mental health, case management, and/or transportation services.

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

Successes:
- Patients were willing to connect to their case workers.
- Patients showed up to their appointments.
- Patients utilized **AGENCY J'S** transportation option to come to appointments.

Challenges:
- Patients not wanting to disclose personal barriers to care.
- Difficulty reaching the patient for initial assessment.
- Mental/Substance Abuse issues.

Next Steps

- Continue to monitor the retention rate of Black Women between the ages of 36 and 45, who are virally controlled.
- Continue to engage patients in Case Management, Mental Health Services and Substance Abuse Services

Any Questions?

Thank you!

The services provided by Broward Regional Health Planning Council, Inc. is a collaborative effort between Broward County and Broward Regional Health Planning Council, Inc. with funding provided by the Broward County Board of County Commissioners under an Agreement.

HANDOUT B

Broward Ryan White Part A FY2022-2023 All Agency Quality Improvement Projects

Retention and Mental Health

BACKGROUND

- Retention at **"a specific clinic"** was lower than the other clinics.

AIM STATEMENT

[redacted] aims to increase retention in care from 71% to 74% at " a specific clinic" by December 2022.

MEASURES

Process Measure
Mental Health utilization

Outcome Measures
Annual Retention in care

PDSA CYCLE

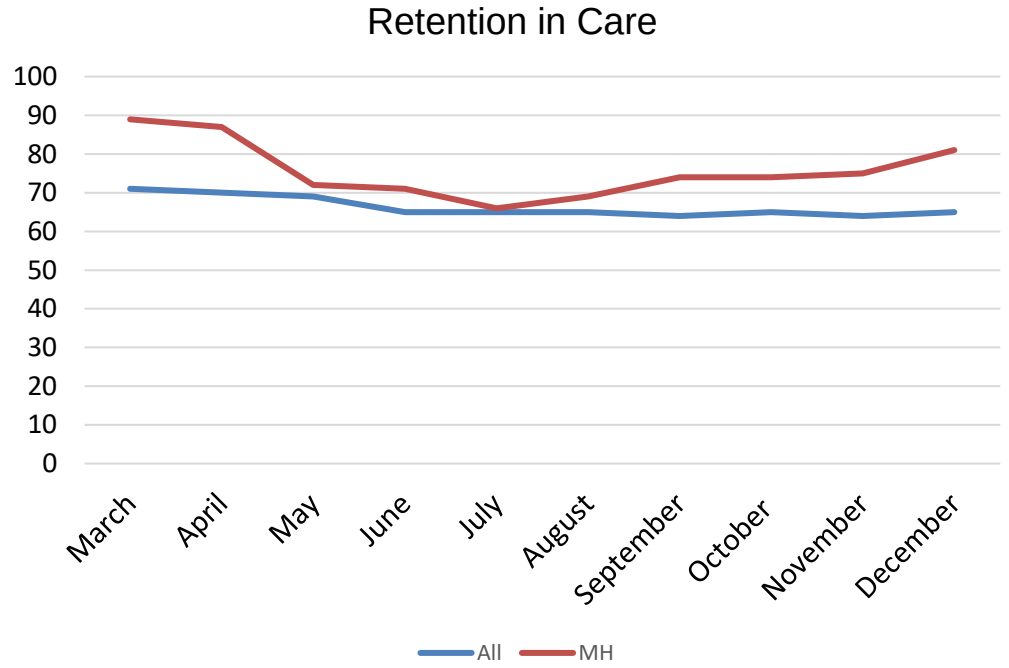
Plan: Determine whether clients receiving MH services increases overall retention in care.

Do: LCSW to offer and provided clients with [redacted] services.

Study: Overall retention has not increased.

Act: Adapt to focus more broadly on increasing retention in care.

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

- Clients in [redacted] have consistently higher retention.
- Substance use and stigma are barriers to RIC.
- Continue to attempt to address barriers and provide [redacted] services.

ACKNOWLEDGEMENTS

Medication Adherence In Clients 59 & Over

BACKGROUND

- Improving viral suppression rate in clients over the age of 59.
- During the pandemic we noticed an increase in viral load amongst our older client population. The highest V/L reading being 852,000 copies

AIM STATEMENT

[redacted] aims to increase viral suppression rates from 71% to 73% through medication adherence interventions by December 2022 for Ryan White clients aged 59 and over.

MEASURES

Process Measures

- We used appointment codes and a tracking spreadsheet for all appointments relating to education and monitoring.

Outcome Measures

- Clients were tested on their knowledge of their antiretrovirals by name/color as well as having access to their list of medications.

PDSA CYCLES

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Cycle 2 Improve pharmacist-patient relationship & med review.
Plan: Ensure all meds are going to one pharmacy; it helps if its community based.
Do: Encountered resistance from outside pharmacies. Different understanding of patient needs.
Study: Better communication/coordination from onsite pharmacy. Pharmacist makes direct contact with providers, CM's and nurses. Timely med refills and lower risk for contraindications.
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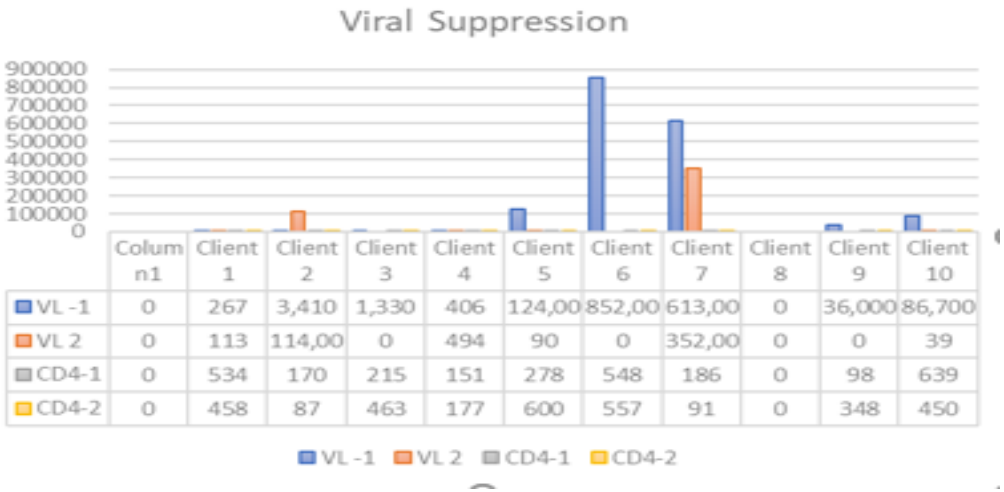
RESULTS



	Column1	Client 1	Client 2	Client 3	Client 4	Client 5	Client 6	Client 7	Client 8	Client 9	Client 10
VL -1	0	267	3,410	1,330	406	124,00	852,00	613,00	0	36,000	86,700
VL 2	0	113	114,00	0	494	90	0	352,00	0	0	39
CD4-1	0	534	170	215	151	278	548	186	0	98	639
CD4-2	0	458	87	463	177	600	557	91	0	348	450

Viral Load and CD4 Chart

RW QIP Tracking List 2022

DOB	Age	VL	CD4	Commorbidities	Pharmacy	Support	Nationality
11/19/1949	72	571	397	Diabetes Militus	DOH	Daughter	Jamaican
3/1/1952	70	3410	147	Anorexia, Hyperten	Walgreens	None	Haitian
11/2/1941	80	215,000	215	Type 2 Diabetes	Walgreens	None	Haitian
10/22/1957	64	406	151	Type 2 Diabetes	DOH	None	Haitian
7/6/1952	69	124,000	278	Essential Hypertension	DOH	Son	Haitian
8/24/1949	72	852,000	548	Type 2 Diabetes	Walgreens	Daughter	Haitian
9/11/1956	65	625,000	104	Pre-diabetes	DOH	None	Haitian
2/28/1958	64	4,300	66	Anemia, Smoker	CVS	None	American
7/18/1944	77	36000	98	Latent Syphilis	DOH	Daughter	Haitian
1/24/1949	73	867,000	365	Hypertension	DOH	Son	Haitian

SUCCESSES, CHALLENGES, & NEXT STEPS

- The medication card and patient-pharmacist relationship were a success. We concluded the project with 8, leaving us with a viral suppression rate of 86%.
- During Cycle two we lost the use of the appointment codes.
- Moving forward we plan to continue the project by establishing or strengthening family involvement.

Journey to Successful Viral Load Suppression

BACKGROUND

- New client will obtain Viral Load Suppression during FY 22-23.
- Clients required initial support to navigate the RW Network and ensure access and retention in care.

AIM STATEMENT

[redacted] will monitor and evaluate viral suppression of new clients to undetectable during FY 22-23, while ensuring access to and retention in care through December 2022.

MEASURES

Process Measures

- Viral Load Lab Results
- Client /TEAM Feedback

Outcome Measures

- Client Feedback and Viral Load Results
- Kept Appointments
- Independent Navigation and Compliance

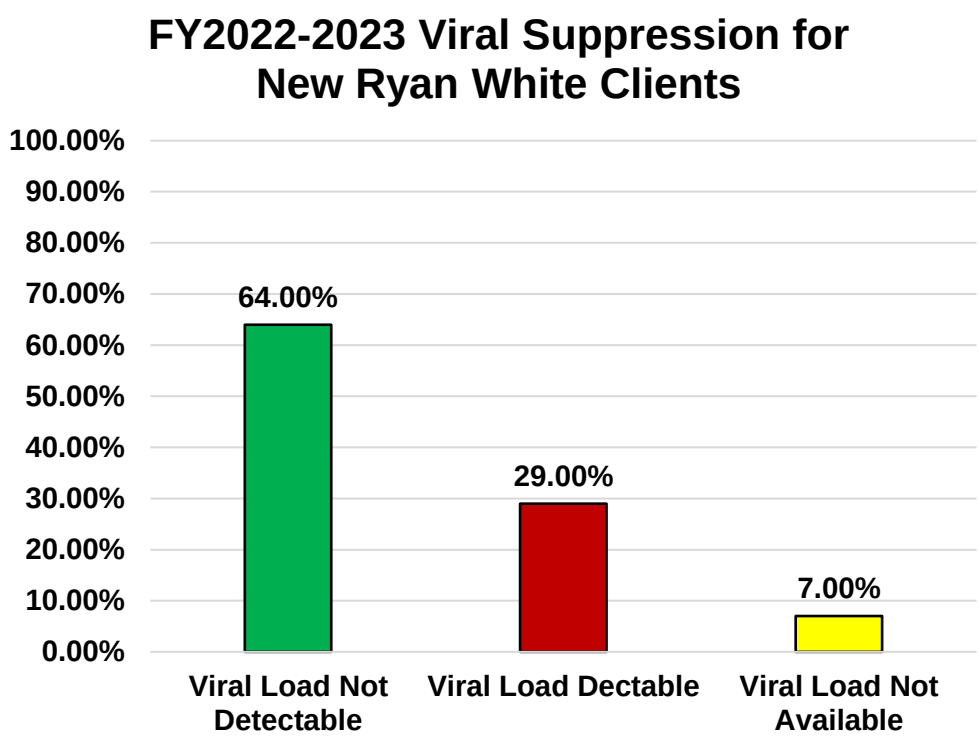
PDSA CYCLES

Cycle 1
Plan: Identify 28 new clients
Do: Weekly engage clients
Study: Client feedback accepted
Act: Move to three-month interval engagements; accepted notable client feedback; assist with rescheduling lab and medical appointments and navigating RW network for additional supportive services.

Cycle 2
Plan: Monitor 28+ clients
Do: Engagement intervals/observe
Study: SWOT analysis conducted
Act: Preliminary date evaluated; critical follow-up required for clients without case managers or peer support; Providers are not consistent with PE access and date entry of lab results.

Cycle 3
Plan: Monitor, data review, outreach
Do: Labs monitoring not successful
Study: Client monitoring of feedback and observations
Act: Lab results improving, client compliance and feedback is improving when results are trending appropriately

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

What went well/as planned?

- Outcomes improved 29% to 64% in viral load suppression.

What went wrong?

- Data availability and operational adaptability.

How will you move forward?

- The journey will continue 23/24.

REDUCING NO SHOW RATE

BACKGROUND

- Patient volume decreased during and after COVID pandemic.
- Patients that are scheduled for primary care services with medical providers do not keep their scheduled appointment which impacts their viral suppression.

AIM STATEMENT

Broward Health Comprehensive Care Center aims to decrease the no show rate from 24% baseline to 22% .

MEASURES

Process Measures

- No show rate (missed appointment without notice)

Outcome Measures

- Use NextGen to monitor appointments status (kept, no-show, cancel).

PDSA CYCLES

PDSA Cycle 1

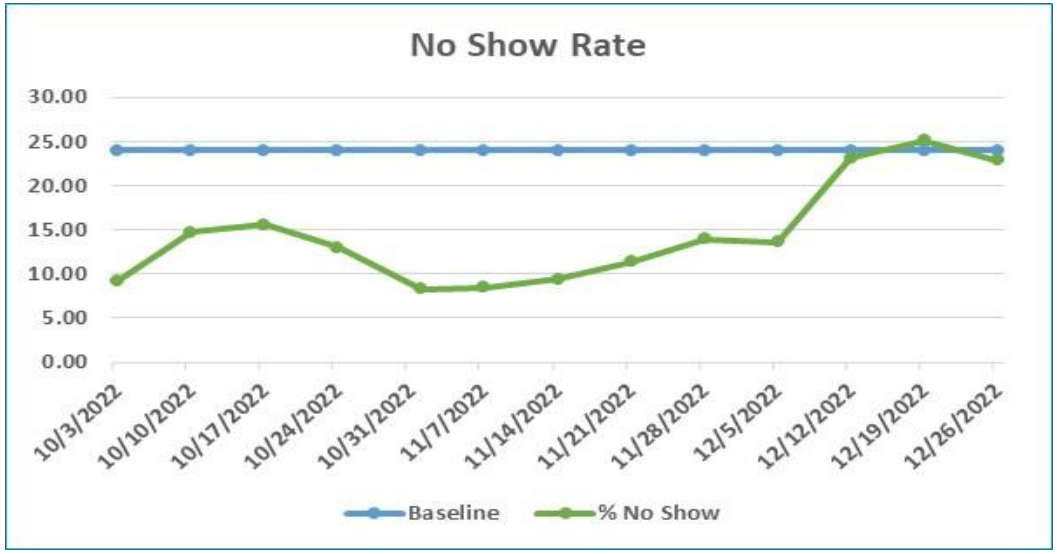
Plan: Make reminder phone calls to patients within 24 hours to prevent no-shows through December 2022.

Do: Front desk or designated staff call patients prior to their scheduled appointment.

Study: Track weekly no show rate in Nextgen for two primary care providers.

What we learned: Consistent reminder calls within 24 hours and following up with the patients the same day that they did not show to reschedule can reduce no show rate.

RESULTS



Average **no show** rate is 14.54% for the months reviewed and well below the baseline of 24%. Efforts are still ongoing to encourage patients to maintain all their scheduled appointments.

SUCCESSES, CHALLENGES, & NEXT STEPS

Successes

- Consistent reminder phone calls prior to the day of the scheduled appointment and follow-up calls to reschedule patient after missed appointments are essential to reduce no show and improve volume in the organization.

Challenges

- Staff limitations can impact the consistency in phone calls/process which negatively impacts the data.
- Provider unplanned leave, patient work schedule can impede no show rate.
- Holidays: Veterans Day, Thanksgiving, Christmas

Next Steps

- Continue to call patients to remind them of scheduled appointment.
- Text patients that have a valid mobile number on file.
- Create standardize policy on managing no show.

Accurate Data leads to Proactive Care

BACKGROUND

The inability to pull accurate data reports, inhibits direct care staff from being able to proactively identify individuals at risk of, or having already fallen out of medical care.

AIM STATEMENT

[redacted] aims to improve the quality of data entry into PE to improve reportability of client's VL suppression,CD4 Count, Client/Provider Relationships, and Retention in care.

MEASURES

Process Measures

We aimed to maintain an active census to track caseload acuity, follow-up rates, and lab values/kept appointments.

Outcome Measures

Our CM's tracked by hand, as well as pulled reports to confirm accuracy/inaccuracy of reporting system.

PDSA CYCLES

Training and Implementation

Plan: Train staff to ensure they are knowledgeable as to where to enter/confirm data for accuracy

Do: Scheduled/Facilitated training to prepare for implementation

Study: Once staff were comfortable with implementation, monthly reports were run to assess effectiveness

Act: Follow-up with staff in monthly meetings to identify barriers to gathering/entering appropriate data

Outcome: We found that although data was entered by CM when available, some data was required to be obtained via Medical Providers. Additionally, run reports did not match data input into PE.

Relationship Building across Network Providers

Plan: Pick one medical provider to forge a clear path of obtaining needed information

Do: Management team met with medical provider representative and outlined test points within agency for access

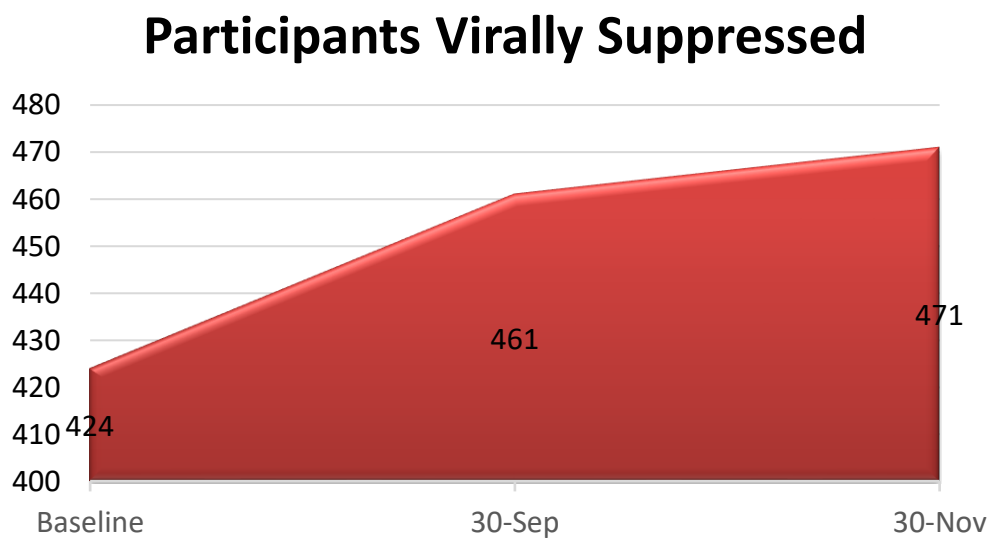
Study: Utilize those checkpoints to ensure PE data was updated

Act: Rerun reports to confirm accuracy.

Outcome: We found that PE reports did not match data input into portal.

RESULTS

Although our outcome percentages did not increase to the goal of 92% virally suppressed, we were successful in increasing our viral suppression rates from 424 individuals to 471 individuals (difference of 47) .



SUCCESSES, CHALLENGES, & NEXT STEPS

We attribute our success of increasing our VL Suppression rates for 47 individuals to our staff's dedication to hand tracking and identification of higher acuity clients, to ensure that they did not fall out of care. We continue to work with PE to identify ways to improve reporting around data entered in the portal.

Care to Re-engage

BACKGROUND

Bringing HIV+ Clients in the deck caseload back into care within the DCM Caseload

AIM STATEMENT

[redacted] aims to increase the compliance rate from 44% to 50% in Broward Ryan White clients from the disease case management case load by monitoring medical appointment visits, retrieving clients lost to care, and reviewing client viral load by December 2022.

MEASURES

Process Measures

- The providers will assess patient literacy and education using their QA tool

Outcome Measures

- Track appointments made and kept in EHR

PDSA CYCLES

Cycle 1

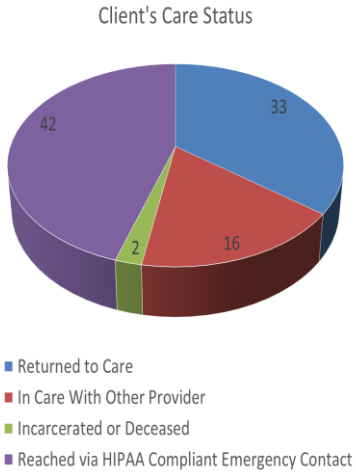
Plan: To identify cultural barriers and develop education to overcome those barriers and clarify misconceptions.

Do: Encountered clients with expired RW who did not renew. Transportation issues were identified as a barrier. Changes in providers for clients. Also, identified cultural barriers.

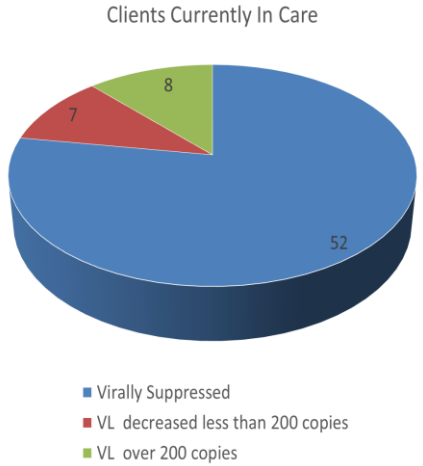
Study: Of 93 clients outreached, 33 returned to care. 16 of the 93 are in care with another provider. 2 of the 93 were unreachable due to incarceration or deceased. Of the 93, 42 HIPAA compliant emergency contacts were contacted. 41 pro-act referrals to the DOH were made.

Act: Identified several barriers to care and worked to overcome them in order to re-engage and retain patients in care.

RESULTS



Of the client case load of 93, we accounted for 100% of them in order to improve compliance. Attempts were made to contact and re-engage to bring back into care.



Currently, we have 67 clients in care. Out of the 67 patients enrolled, 52 are VL suppressed, that is 77.6 %. Out of those 67, 7 have VL count less than 200 copies, that is 10.44 %. The other 8 patients have VL over 200 copies, that is 11.9 %. We are working on achieving VL less than 200 copies with them.

SUCCESSES, CHALLENGES, & NEXT STEPS

- We are developing a standardized process for reminders and scheduling follow up appointments with all patients.
- We are using client feedback to develop educational materials to reduce barriers.

Caseload increased by using Outreach method

BACKGROUND

- HIV Population In Broward
  - ❑13 % are Haitian women
  - ❑13 % are Haitian men
  - ❑1 % are African-American
- More than 45% of our clients have had HIV within a two(2) year span
- Clients out of care are at risk for AIDS.

AIM STATEMENT

[redacted] aims to increase its case management caseload from 20 to 35 through outreach and engagement by December 2022.

MEASURES

Process Measures

- Announce services during provider meetings.
- Networking and attending partnership meetings.
- Outreach, Materials, and distribution

Outcome Measures

Use Provide Enterprise (PE) to see the number of new cases

PDSA CYCLES

Cycle 1

Plan: Contact other agencies, that do not provide the same services as [redacted] to obtain referrals.

Do: Conduct presentations to other agencies.

Study: [redacted] has contacted several agencies & [redacted] was still unable to obtain any new clients.

Act [redacted] has not obtained any clients during this cycle. As a result, [redacted] has decided to Adapt that tactic

Cycle 2

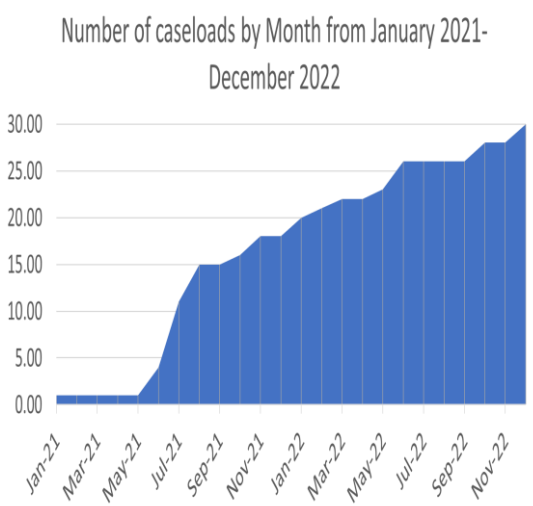
Plan: Increase outreach and engagement

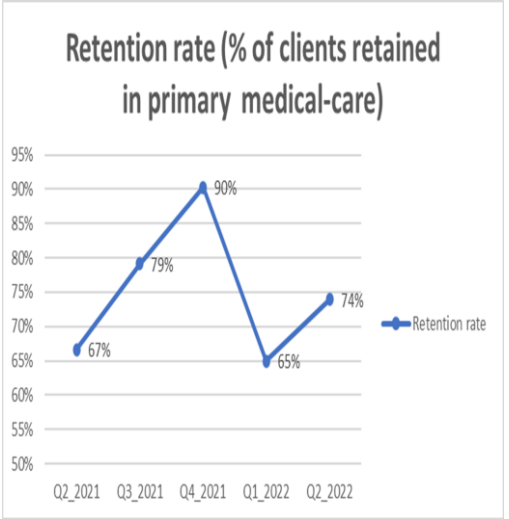
Do: Conduct presentations to other agencies and use social media to obtain new clients.

Study: Obtained a few new clients from the health department.

Act: [redacted] has obtained a few clients during this cycle. As a result, [redacted] has decided to Adopt that tactic

RESULTS





Increase rate: we increased our caseload by 50% for the year 2022, from 20 to 30 clients, using outreach

Our retention rate increased by almost 10% from quarter one(1) 2022 to quarter two (2) 2022

SUCCESSES, CHALLENGES, & NEXT STEPS

- It is challenging to do outreach and networking because the agencies have tight schedules.
- Many employees were involved and informed not only MAI employees we got a referral from an employee.
- Social Media we start working on reaching more people on social media

Increasing Retention Rate for Hispanic/Latinx Clients

BACKGROUND

- Retention in Care
- To ensure clients are In-Compliance with their HIV Care and Treatment and Medications.

AIM STATEMENT

To increase retention rate of clients from 88% to 90% by conducting a client call back protocol for Hispanic/Latinx Ryan White clients utilizing [redacted] services by December 2022.

MEASURES

Process Measures
Quarterly Reports

Outcome Measures
PE and Quarterly Reports

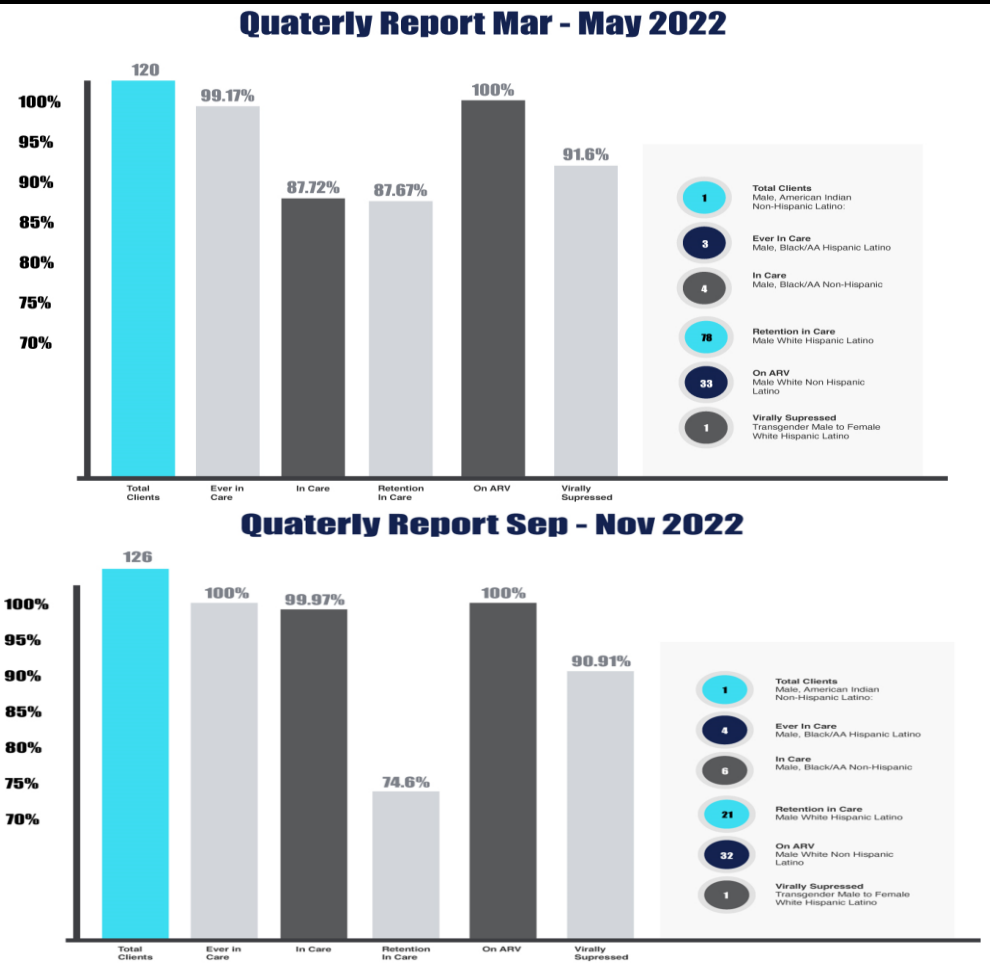
PDSA CYCLES

Cycle 1
Plan: Continue to divide my Supervisory duties & Non-Medical CM duties. F/U with assigned Testing Counselors
Do: Linked client with the Linkage Specialist to schedule an Initial Appt with HIV Care &Treatment with one of the [redacted] Facilities
Study: Quarterly Report Data show LS continues to be "In-Compliance"
Act: All services have been met & if the clients are in need of additional assistance

Cycle 2
Plan: Prioritize client's linkage to other RW services other than Medical & meds
Do: Link clients to specialists for HIV care/treatment
Study: Review FY22-23 Q2 data
Act: Adopt – continue to observe if clients need more services

Cycle 3 & 4
Plan: Client compliance & medical care maintenance
Do: Documents progress notes. Check Specific Goals within 3-6 months (i.e. Initial Appt, Follow-up, Review Lab Reports)
Study: Discussed with client the Specific Goals. Measure Outcome within 3-6 month if Action Plan Goals has been met Successfully
Act: Update Action Plan Goals and complete the Reassessment for the next 6 months

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

- **What went well/as planned?**
  - I have anticipated that the Retention of Care will increase.
- **Challenges:**
  - Timing and Day
- **Next Steps**
  - [redacted] will continue to Adopt

Increasing Utilization Through Awareness and Access

BACKGROUND

Will utilization of Ryan White-funded legal services increase by raising awareness of and access to available services?

Why? Data show clients that utilize support services generally have a higher rate of retention and better viral suppression

AIM STATEMENT

[redacted] aims to increase utilization from FY21-22 Qs 2 & 3 (June -Nov) by 6% by end of FY22-23 Q 3 (11/30/22) in clients utilizing Legal Services support service category.

MEASURES

Internal case management software (*LegalServer*)

- Track outreach efforts
- Client utilization
- Client surveys

Provide Enterprise

- Client utilization
- Contract utilization (monthly invoicing)

PDSA CYCLES

Increase client awareness of and utilization of available Ryan White legal services

Cycles 1, 2 and 3:

Plan: purposeful and coordinated outreach to case managers and case management agencies to inform of most up-to-date legal service available at [redacted]

Do: (1) emails and direct phone calls // (2) via other sources - announcements during RW meetings (PSRA, SFAN, Quality Network, etc.), increased social media posts // (3) in-person and/or via video conference

Study: Track activities through Legal Server; Legal Server and PE client utilization and new client reports

Act: Adopt

Cycle 4

Plan: Provide options for remote and in-office appointments

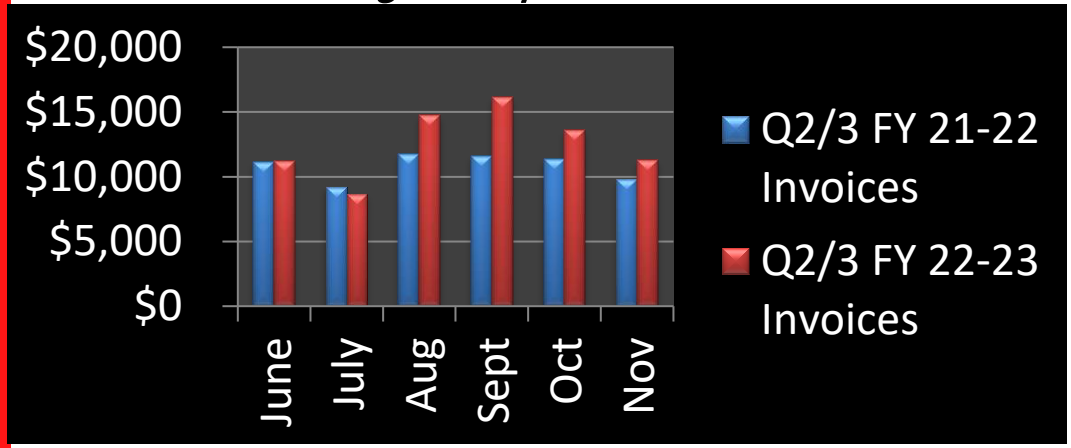
Do: track client preference; survey for barriers; poll case managers

Study: results in LegalServer client files and case notes

Act: Adapt/Adopt

RESULTS

Increase in August/September client utilization



FY 2021-22 Q3 Retention in Care: 75%

FY 2022-23 Q3 Retention in Care: 80%

SUCCESSES, CHALLENGES, & NEXT STEPS

Data tracking issues

--Unable to track results of outreach for clients served through other (non-Ryan White) units at Legal Aid

--Outreach takes time to see results (delay in agencies distributing info to clients; client not seeking assistance right away after receiving info, etc.)

NEXT STEPS:

- Continue various outreach methods
- Poll clients as to how they came across our services as another way to determine if outreach efforts are working to increase utilization of Ryan White legal services
- Expand on PDSA Cycle 4 (accessibility; barriers) for future QIP?

Increase Retention of Virally Uncontrolled Black Women

BACKGROUND

- The number of Black women, between the ages of 36 and 45, tend to have an uncontrolled viral load compared to our other patient populations.

AIM STATEMENT

To increase in-care retention rates among Black Women between the ages of 36 and 45, from 88% to 90% by December 2022.

MEASURES

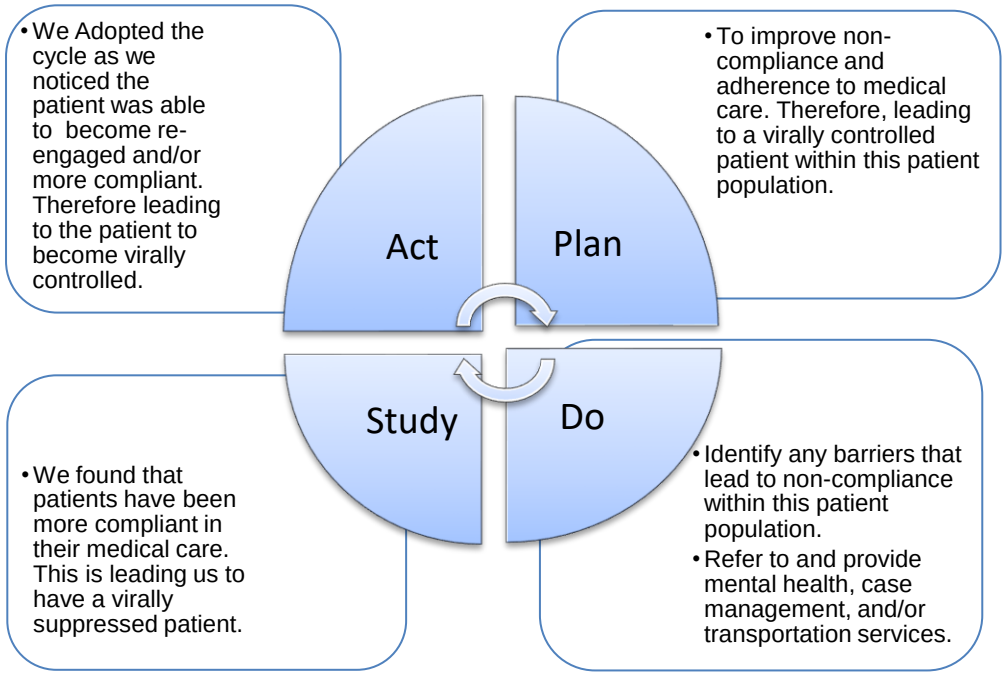
Process Measures

- Followed up with patients to ensure that they kept Medical Appointments.
- Rounded with Case Managers and the outcomes of their sessions with the patient.

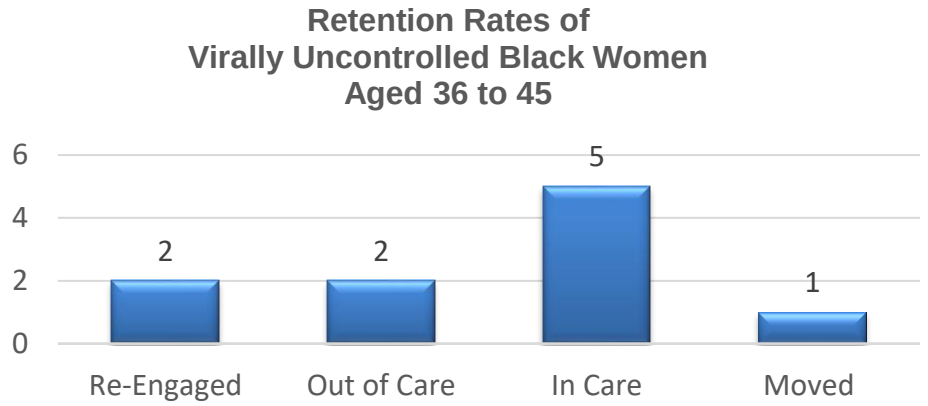
Outcome Measures

- Use of the EMR
- Patient interviews (in-person and phone)

PDSA CYCLES



RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

Successes:

- Patients were willing to connect to their case workers.
- Patients showed up to their appointments.
- Patient's utilized our transportation option to come to appointments.

Challenges:

- Patients not wanting to disclose personal barriers to care.
- Difficulty reaching the patient for initial assessment.
- Mental/Substance Abuse issues.

Next Steps

- Continue to monitor the retention rate of Black Women between the ages of 36 and 45, who are virally controlled.
- Continue to engage patients in Case Management, Mental Health Services and Substance Abuse Services

Increase Retention through Improving Overall Patient Experience

BACKGROUND

Retention in care is a problem many healthcare providers face with most dental offices having an average retention rate of just 41%. While [redacted] retention rate is currently at 91%, we strive for greatness and would like to improve our overall retention rate by 2%.

AIM STATEMENT

[redacted] aims to increase our retention rate from 91% to 93% by improving the overall patient experience. Patients will be given a survey at the operatory to discuss barriers or changes they feel should be made to improve our clinic and their experience.

MEASURES

Process Measures
Survey results were evaluated, and answers were tracked using Excel.

Outcome Measures
The Retention Rate report in Provide Enterprise.

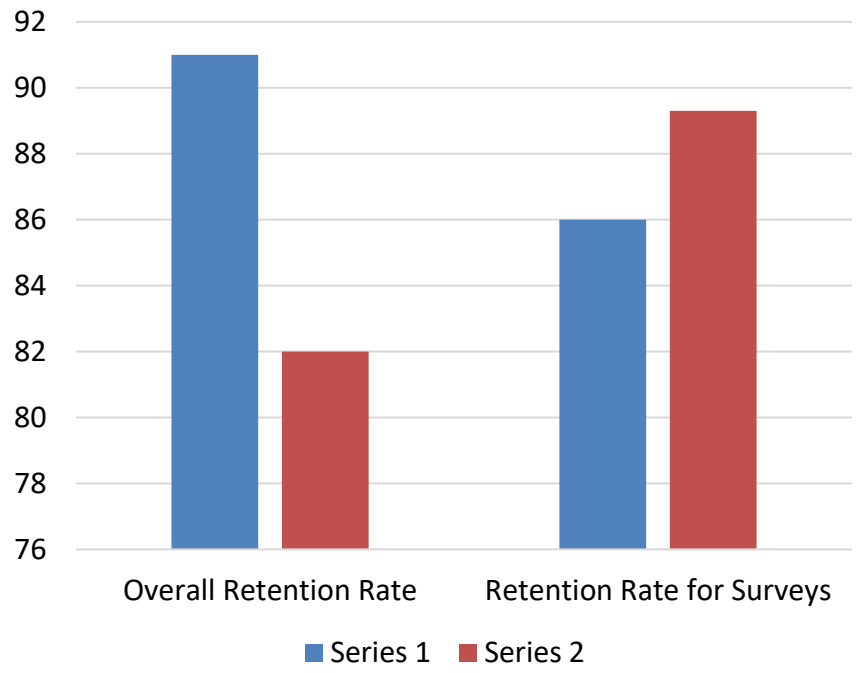
PDSA CYCLES

Cycle 1
Plan: 6 Question survey will be created to give to each non-new patient.
Do: Beginning 8/22/22, surveys were passed out in weekly increments to patients.
Study: Many patients did not answer question 6 which required them to write in an answer.
Act: Patients will be asked to complete this question when being given survey.

Cycle 2
Plan: Modified approach when handing out survey.
Do: Survey distributed week of 9/6/22, this time asking patients to complete question 6.
Study: Most answers were things like "Everything was great" rather than offering constructive
Act: Survey will remain the same.

Cycle 3
Plan: Continued using modified approach from cycle 2.
Do: Survey distributed week of 9/19/22.
Study: 86% of patients that completed survey were already considered "retained in care."
Act: Survey will not be adopted.

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

- Even though the survey was unsuccessful, 5 patients who were not retained in care previously are now showing up regularly.
- Our overall retention rate dropped by 9%.
- Moving forward, we have developed a new program that will focus on patients with severe caries to help them establish good oral health making it easier for them to remain in care.

10% Project

BACKGROUND

- Client not Virally Suppressed
- 90% of Clients are Virally Suppressed . [redacted] to have the last 10% of Clients to achieve Viral Suppressed

AIM STATEMENT

Increase Clients retention in care and Virally Suppressed for Client with high, unknow and not V.S.0% to 3%/ over all Clients 91% to 96% by February 28,2023

MEASURES

Process Measures

- Number of SBIRT Survey: Q1/30 Q2/40 Q3/15 Q4
- Number of Referrals: Q1/2 Q2/12 Q3/0 Q4
- Quarterly RW Part A LV Report:

Outcome Measures

Ahena Health and PE

PDSA CYCLES

Cycle 1

Plan: SBIRT Training
Screening/Referral/MI/ SBIRT
Phone, Online and office.
Do: Ongoing training
Study: one on one training
Act: SBIRT Surveys

Cycle 2

Plan SBIRT workflow
Do: Workflow for SBIRT by phone, online and in the office/ Referral and agencies logbook/ follow ups.
Study: updates on the workflow
Act: SBIRT Surreys

Cycle 3

Maximum Assist@Pov
Plan: 10% Clients have an intake with MAP MCM
Do: referral 10% Clients to MAP MCM
Study: Availability of MCM. More time needed to 10%Clients.
Act: Start up date moved to Q1 2023

RESULTS

Outcomes: 2022 March 1,2022 91%% clients are V.S/ December 1,2022 89% Client are V.S

Over a 14-month period, the two E2i sites conducted *SBIRT* screening with 943 clients with HIV. The E2i initiative measured HIV care continuum outcomes at the time of enrollment and 12 months later. Among the clients enrolled in *SBIRT*, the percentage with a prescription of ART and who reached viral suppression increased significantly. Engagement and retention in care rates also improved, although at non-significant levels

Category	Information
Evaluation data	Client medical data
Measures	Engagement in HIV care, retention in HIV care, receipt of ART, viral suppression
Results	• Engagement in care improved from 86% to 88% • Clients on ART increased from 92% to 99%* • Retention in care improved from 66% to 67% • Viral suppression increased from 76% to 91%

SUCCESSES, CHALLENGES, & NEXT STEPS

- **What went well/as planned?** Training/Workflow and staff input
- **What went wrong? Barriers** Number of clients willing for a referrals and agencies to RCO. Number of new Clients and lab work in PE
- **How will you move forward?**
- 10% Project with new QIP's using SBIRT has a Tool.

HANDOUT B

FY2022-2023

Quality Improvement Project (QIP) Summary per Agency

Agency A

Aim Statement: To increase retention in care from 71% to 74% at Oakland Park HCC by December 2022.

Summary: The goal was to determine whether increasing access to mental health services increases the likelihood of retention in care at the Oakland Park HCC. Annual retention in care and mental health utilization were the two measures used by this agency. The licensed clinical social worker (LCSW) attempted to increase client utilization of mental health services. The results as follows:

- 43% (40/94) of clients referred for mental health services did not respond or declined.
- 96% (90/94) of clients referred were warm handoffs in the clinic.
- 45% (42/94) of clients referred were seen by the LCSW.
- 67% (28/42) of the clients seen returned for a follow-up.
- Overall clinic retention decreased from 71% to 65% from March to December 2022
- Retention for clients accessing mental health services decreased from 89% to 66% March through July 2022, but then increased to 81% by December 2022.

Overall, there was no increase in retention in care after the intervention of the QIP. The LCSW identified primary barriers that affected this QIP such as substance use and the absence of in-house psychiatry for the whole term of the QIP. Agency A will continue to offer and provide mental health services to clients and attempt to address their barriers.

Agency B

Aim Statement: To increase viral suppression rates from 71% to 73% through medication adherence interventions by December 2022 for Ryan White clients aged 59 and over.

Summary: To increase medication adherence, there were a few measures put into place, such as improving pharmacist-patient relationship, increasing education, providing medication reviews at each visit, and helping with self-management efforts. For medication adherence, Agency B had their clients identify or name their medications during medical appointments. To improve pharmacist-patient relationship, the agency made sure all medications were going to one pharmacy and encouraged clients to build a good relationship with their pharmacist. They selected 10 clients to monitor throughout this process but lost two to follow-up. However, results showed that Agency B achieved a viral suppression rate of 86% at the end of their PDSA cycle, which exceeded the original aim of the QIP. Agency B was able to mitigate their appointment process issues by using a spreadsheet to track information. Lastly, Agency B evaluated the needs of their older clients and identified a need to focus on interventions focusing on aging and

managing HIV. By overcoming appointment process issues, they will continue to use this intervention for the next fiscal year.

Agency C

Aim Statement: To monitor and evaluate the viral suppression of 25 new Ryan White clients during FY22-23; ensure access to care, retention in care, and reduction in viral load to undetectable.

Summary: Agency C developed a QIP that monitored and evaluated the viral load suppression of "new to care" clients from March 2022 to December 2022. Their measures included: Process – viral load lab results/team feedback. Outcome – client feedback, viral load results, kept appointments, and independent navigation compliance. Agency C wanted to achieve their goals was improving communication, increasing client engagement, and multidisciplinary teamwork. The agency identified 28 clients new to care and not virally suppressed. Based on feedback from clients, they contacted these individuals in 3-month intervals. Agency C made sure that the clients were compliant with care and the viral load was suppressed. In total, the results showed 64% of the clients had no detectable viral load, 29% of clients had a detectable viral load, and 7% of client did not have any labs available. Agency C experienced some barriers such as client responsiveness, data availability, and operational adaptability. Throughout this process, retention in care remained constant. Based on results, the agency will adopt their PDSA cycles and continue this intervention for the next fiscal year.

Agency D

Aim Statement: To decrease the no-show rate from 24% baseline to 22%.

Summary: Agency D wanted to address the no-show rate and its impact on viral suppression. To decrease the no-show rate, they planned to make reminder phone calls to patients within 24-hours of their appointments. Their PDSA cycle was to make reminder phone calls to patients within 24 hours of their appointment to prevent no shows through December 2022. Agency D chose two providers and observed their no-show rates weekly. Between October and December 2022, the average no-show rate was at 14.54% during their PDSA cycle. However, Agency D noticed the no-show rate started to increase during the holiday season. By mid-December, the no-show rate increased to 25%. Agency D experienced other barriers including staff limitations, provider unplanned leave, patient work schedule, and holidays such as Thanksgiving and Christmas. For the next fiscal year, Agency D will continue this project and create a standardize policy on managing no-shows.

Agency E

Aim Statement: To increase the percentage of individuals who are virally suppressed or undetectable from 89% to 92% by December 31st, 2022, for all clients served within the agency.

Summary: Agency E wanted to increase viral suppression by improving their data entry into Provide Enterprises (PE), ensuring that all client lab values, appointments, and relationships are kept up to date. The improvement in the use of PE will allow Agency E to identify individuals who are not virally suppressed/undetectable and provide appropriate interventions to meet their needs

better. They trained staff and ensured data accuracy. Agency E also picked one medical provider from another agency to forge a clear path of obtaining needed information. Although they did not meet the goal of 92% being virally suppressed, they were successful in increasing their viral suppression rates from 424 individuals to 471 individuals (47 increase of individuals). The agency is expected to integrate new software to try and bridge the deficiencies. They will continue to monitor data and report any discrepancies to PE. Future implications will include a HIV education module for all participants and open discussions with medical staff about labs, medications, and how they work.

Agency F

Aim Statement: To increase the compliance rate from 44% to 50% in Broward Ryan White clients from the disease case management case load by monitoring medical appointment visits, retrieving clients lost to care, and reviewing client viral load by December 2022.

Summary: Agency F utilized two measures to help increase the compliance rate. The first measure identified cultural barriers and the second measure tracked appointments that were made and kept. During the process, they encountered clients with expired Ryan White eligibility who did not renew. Of the 93 clients, 100% were accounted for and attempts were made to contact clients and re-enter them into care. About 45% of those clients were reached via HIPPA Compliant emergency contact, 35% returned to care,17% are in care with another provider, and 2% were either incarcerated or deceased. Agency F currently has 67 clients in care and of those 67 clients, 77.6% are virally suppressed. Overall, Agency F surpassed their goal with a total compliance of 52.7%. They are currently developing educational materials to help reduce this barrier in the future.

Agency G

Aim Statement: To expand MAI services to Haitians and Caribbeans living with HIV in Broward County by increasing its case management caseload from 20 to 35 by December 2022.

Summary: Agency G wanted to increase the number of new caseloads, increase outreach attempts with prospective clients in-need, and obtain transportation services for clients to use for medical, CIED, and case management appointments. By utilizing outreach strategies, they were able to increase caseloads from 20 to 30 clients. The retention rate also went up by about 10% from quarter one 2022 to quarter two 2022 of the 2022-2023 fiscal year. The biggest challenge was networking with other agencies to obtain more clients due to scheduling. Agency G will be adopting this QIP, but they will need to improve on scheduling issues with other agencies and implement better tactics to network.

Agency H

Aim Statement: To increase retention rate of clients from 88% to 90% by conducting a client call back protocol for Hispanic/Latinx Ryan White clients utilizing agency H services by December 2022.

Summary: To increase the retention rate of clients, Agency H used Provider Enterprise (PE) quarterly reports to measure any changes at their agency. Agency H linked clients with Linkage Specialists to help schedule initial appointments with HIV care and treatment plans with other agencies. Agency H followed-up with clients checking specific goals within 3 to 6 months. The retention decreased from quarter one to quarter three during the 2022-2023 fiscal year. This change could be due to issues with PE that still need to be resolved. A representative from Agency H also stated difficulty in managing the client load as the only case manager at the agency. This agency has historically experienced barriers lack of sufficient staff and insufficient amount of time to dedicate to their QIP. Agency H will continue to adopt this QIP, and train newly arrived non-medical case managers for more assistance.

Agency I

Aim Statement: To increase utilization from Fiscal Year 2021-22 Quarter 2 and 3 (June through November) utilization by 6% by the end of FY 2022-23 Quarter 3 (11/30/2022) in clients utilizing Legal Services support service category.

Summary: In order to increase utilization and awareness of legal services, measures such as outreach activities, service accessibility, and identifying possible barriers to services were put in place. Some of the outreach activities included informing case managers of legal services, increasing social media activity, and in-person or video conferences. The results showed that the highest increase in utilization of services was for the months of August and September 2022. The retention rate also went up 5% from quarter three fiscal year 2021-2022 to quarter three fiscal year 2022-2023. Some challenges that they faced were delays in data, inability to track every client, and delays in outreach results. Moving forward, Agency I will adopt this QIP and continue to use various outreach methods to case management agencies.

Agency J

Aim Statement: To focus and increase in care retention rates among Black, Women, between the ages of 36 and 45 years old from 88% to 90% by December 2022.

Summary: The four measures used to help reach this goal were tracking appointment no-show rates, linkage to case management and peer specialist, linkage to in-house licensed clinical therapist, and addressing any barriers that prevent patients from maintaining compliance. During the QIP cycle, Agency J referred and provided mental health, case management, and/or transportation services to the clients. Their results showed that they did not reach their aim; however, they were able to re-engage two out-of-care patients back into medical care, case management and mental health counseling. They learned that if they “are able to engage patients with case managers, disease case managers, and mental health counselors, the patient is more

apt to become compliant and open up to any barriers to care they may have". They plan to adopt the QIP cycle into their current patient care plans.

Agency K

Aim Statement: To increase our retention rate from 91% to 93% by improving the overall patient experience.

Summary: To reach this goal, patients will be given a survey at the office to discuss barriers or changes they feel should be made to improve the clinic and their experience. The two measures for this QIP will be the number of surveys completed and the retention rate. The patient will be given a six-question, Likert scale survey every other week for 3 weeks asking about overall satisfaction and suggested improvements in care. The survey questions were as followed:

1) Overall, how satisfied or dissatisfied were you with your last visit to our office?
2) How much do you trust your provider to make dental decisions that are in your best interest?
3) How well did your provider listen to your needs and answer your questions?
4) Overall, how would you rate the service you received from the staff at your office?
5) How well did the staff listen to your needs and answer your questions?
6) Is there anything we could have done to improve your last visit or experience at our office?

The results showed 150 surveys were completed. Of those completed surveys, 86% of clients were already considered retained in care. Out of the 21 clients not retained in care, 5 of them have returned for additional visits. The overall retention decreased from 91% to 82%. Because the survey data only reflected those classified as "retained in care", they have chosen to abandon this survey because it didn't really have an impact on the overall retention.

Agency L

Aim Statement: To increase client's retention in care and viral suppression (VS) for clients with high VS, unknown VS, and not virally suppressed. Overall, Agency L aims to increase viral suppression from 91% to 96% by February 28,2023.

Summary: To increase the viral suppression by 5%, the QIP measures are as follow: the number of Screening, Brief Intervention and Referral to Treatment (SBIRT) surveys completed, the number of client referrals, and the quarterly Ryan White Part A viral load reports. *SBIRT* is an early intervention tool designed to screen clients for alcohol and drug use. This intervention helps to connect clients to substance abuse treatment services and provide education on the risks of drug and alcohol usage. *SBIRT* is now being utilized for those living with HIV to help improve health outcomes. Agency L had to first train the staff on *SBIRT* and then develop a workflow. Once the staff was trained, they developed an agency logbook for referrals and follow-up plans. An online client portal was adapted to log all clients with high viral suppression. "Over a 14-month period, the two E2i sites conducted *SBIRT* screening with 943 clients with HIV. The E2i initiative measured HIV care continuum outcomes at the time of enrollment and 12 months later. Among the clients enrolled in *SBIRT*, the percentage with a prescription of ART and who reached viral suppression increased significantly. Engagement and retention in care rates also improved, although at non-significant levels." The results showed that there was improvement for existing

clients, but not for the new clients. Some barriers that they faced were the number of new clients, lab work not being reported into PE, and new staff members. They will continue to use *SBIRT* as a tool to help improve viral suppression.

HANDOUT C

Broward EMA Ryan White Part A Program

Health Outcomes

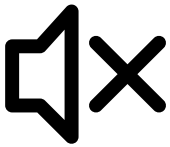
Systems of Care Committee Meeting

March 2, 2023

GET CARE BROWARD TREAT HIV | BEAT HIV RYAN WHITE | PART A

PRESENTED BY
BRIANNE MILLER, MPH, CHES & DANIELLE LIAO, MPH

Housekeeping Rules



Mute Microphone

Participants will be automatically muted to limit background noise

Identify Yourself

State your name and agency when speaking

Use the Chat Box

Type in the chat box to identify yourself and agency, ask questions, and request additional clarification

Raise Your Hand

The “raise hand” option will notify the presenter of any questions that may arise

Ask Questions

Please save questions until the end of each slide

HIV Care Continuum Definitions

- **Total Clients:** Clients who are HIV+ and received at least one service from the selected service category(s) in the reporting period.
- **Ever in Care:** HIV+ clients who ever had a medical care service documented.
- **In Care:** HIV+ clients who had a medical care service within the reporting period.
- **Retained in Care:** HIV+ clients who had two or more medical care services at least three months apart in the reporting period.
- **Prescribed Antiretroviral Drugs (ARV):** HIV+ clients who have a documented ARV at any time during the reporting period within HIV history records.
- **Virally Suppressed:** HIV+ clients with most recent viral load less than 200 copies/mL, as of end of the reporting period.

**Medical Care Service: Documented viral load or CD4 lab, medical visit, prescription filled and paid by Ryan White, or payment requests for co-pays made by HICP.*

HIV Care Continuum Definitions

- **Retention in Care:** Measure impact due to limited accountability for information from:
  - Clients who move, are incarcerated, or deceased during the measurement period
  - Clients with private insurance/doctors
  - The strict definition may exclude clients who received clinically indicated medical care during the reporting period
- **On ARV:** Includes self-reported data.
- Impact of COVID-19 on FY 2020 data.

FY 22-23 Q3 Data Review

The CQM Support Staff will review the Broward Outcomes and Indicators for the third quarter of the 2022-2023 fiscal year.

The data presented has been analyzed based on data entered in Provide Enterprise.

Broward Outcomes and Indicators	FY 2021 - 2022		FY 2022 – Quarter 3	
Oral Health	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Continuity of oral health care. **Indicator 1.1:** 75% of clients have a dental visit at least 2 times within the past 12 months.	**2,042/2,142**	**95.33%**	**1,029/1,214**	**84.76%**
Outcome 2: Screening of periodontal health is provided. **Indicator 2.1:** 75% of clients with a history of periodontitis who received an oral prophylaxis, scaling/root planning, or periodontal maintenance visit at least 2 times within the past 12 months.	**1,404/1,404**	**100%**	**680/680**	**100%**
Mental Health	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary mental health diagnosis. **Indicator 1.1:** 85% of clients achieve treatment plan goals by designated target date.	**0/0**	**-**	**4/4**	**100%**
Outcome 2: Increased access, retention, and adherence to primary medical care. **Indicator 2.1:** 85% of clients are retained in primary medical care.	**285/328**	**86.89%**	**174/192**	**90.63%**

Broward Outcomes & Indicators, FY22-23 Q3

Substance Abuse - Outpatient	Num/Demon	%	Num/Demon	%
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	**0/0**	**-**	**0/0**	**-**
Indicator 1.1: 85% of clients achieve treatment plan goals by designated target date.				
Outcome 2: Increased access, retention, and adherence to primary medical care.	**66/78**	**84.62%**	**35/43**	**81.40%**
Indicator 2.1: 85% of clients are retained in Primary Medical Care.				
AIDS Pharmaceutical Assistance	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Improve access to medication.	**14/14**	**100%**	**2/2**	**100%**
Indicator 1.1: Attempts will be made to contact 95% of clients who do not pick up medications within 7 to 14 days of filling the prescription.				
Outcome 2: Clients provided an opportunity to improve medication adherence.	**2/2**	**100%**	**0/0**	**-**
Indicator 2.1: 95% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence).				

Broward Outcomes & Indicators, FY22-23 Q3

Integrated Primary Care & Behavioral Health	Num/Demon	%	Num/Demon	%
Outcome 1: Increased access, retention, and adherence to primary medical care.				
Indicator 1.1: 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	**2,360/3,078**	**76.67%**	**1,612/1,629**	**98.96%**
Indicator 1.2: 90% of clients on ART for more than six (6) months will have a viral load less than 200 copies/mL	**2,936/3,314**	**88.59%**	**1,591/1,751**	**90.86%**
Legal Services	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Increased access to benefits for which the client is eligible.				
Indicator 1.1: 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of cash benefits and/or medical benefits or will have their case remanded for a hearing before an Administrative Law Judge.	**0/0**	**-**	**0/0**	**-**
Indicator 1.2: 80% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability.	**35/35**	**100%**	**3/3**	**100%**
Food Services	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Increased access, retention, and adherence to Primary Medical Care.	**1,737/2,078**	**83.59%**	**1,003/1,404**	**71.44%**
Indicator 1.1: 85% of clients are retained in primary medical care.				
Outcome 2: Increased viral suppression.	**1,948/2,201**	**88.51%**	**1,297/1,490**	**87.05%**
Indicator 2.1: 80% of clients on ART for more than six months will have a viral load less than 200 copies/mL.				

Broward Outcomes & Indicators, FY22-23 Q3

CIED	Num/Demon	%	Num/Demon	%
Outcome 1: Increase access, retention, and adherence to primary medical care.				
Indicator 1.1: 95% of Part A clients who have not had a primary medical care visit within the last six (6) months at the time of recertification have a primary medical care or disease case management appointment scheduled within one (1) business day.	**87/93**	**93.55%**	**15/32**	**46.88%**
Indicator 1.2: 80% of clients will not experience a lapse in Ryan White Part A eligibility.	**12,656/18,562**	**68.18%**	**1,870/1,876**	**99.68%**
Health Insurance Continuation Program	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Increased access, retention, and adherence to primary medical care.	**122/142**	**85.92%**	**29/39**	**74.36%**
Indicator 1.1: 85% of clients are retained in primary medical care.				

Broward Outcomes & Indicators, FY22-23 Q3

Non-Medical Case Management	Num/Demon	%	Num/Demon	%
Outcome 1: Increased access, retention, and adherence to primary medical care.				
Indicator 1.1: 85% of clients achieve one (1) or more action plan goals by the target resolution date.	**1,527/1,787**	**85.45%**	**593/637**	**93.09%**
Indicator 1.2: 85% of clients are retained in primary medical care.	**1,523/1,762**	**86.44%**	**960/1,202**	**79.87%**
Disease Case Management	**Num/Demon**	**%**	**Num/Demon**	**%**
Outcome 1: Increased access, retention, and adherence to primary medical care.				
Indicator 1.1: 85% of clients achieve one (1) or more action plan goals by the target resolution date.	**321/466**	**68.88%**	**85/119**	**71.43%**
Indicator 1.2: 90% of clients are retained in primary medical care.	**525/609**	**86.21%**	**263/292**	**90.07%**

Broward Outcomes & Indicators, FY22-23 Q3

MAI				
Integrated Primary Care & Behavioral Health	**Num/Denom**	**%**	**Num/Denom**	**%**
Outcome 1: Increased access, retention, and adherence to primary medical care. **Indicator 1.1:** 85% of clients retained in MAI Integrated Primary Care and Behavioral Health Services.	**32/40**	**80.00%**	**0/0**	**-**
Indicator 1.2: 90% of clients on ART for more than six (6) months will have a viral load less than 200 copies/mL.	**38/45**	**84.44%**	**0/0**	**-**
Mental Health				
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary mental health diagnosis. **Indicator 1.1:** 85% of clients achieve treatment plan goals by designated target date.	**0/0**	**-**	**0/0**	**-**
Outcome 2: Increased access, retention, and adherence to primary medical care. **Indicator 2.1:** 85% of clients are retained in primary medical care.	**31/35**	**88.57%**	**25/32**	**78.13%**

Broward Outcomes & Indicators, FY22-23 Q3

Non-Medical Case Management				
Outcome 1: Increased access, retention, and adherence to primary medical care.				
Indicator 1.1: 85% of clients achieve one (1) or more action plan goals by the target resolution date.	**137/173**	**79.19%**	**3/4**	**75.00%**
Indicator 1.2: 85% of clients are retained in primary medical care.	**176/203**	**86.70%**	**17/21**	**80.95%**
Substance Abuse - Outpatient				
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	**0/0**	**-**	**0/0**	**-**
Indicator 1.1: 85% of clients achieve treatment plan goals by designated target date.				
Outcome 2: Increased access, retention, and adherence to primary medical care.	**45/81**	**55.56%**	**25/49**	**51.02%**
Indicator 2.1: 85% of clients are retained in primary medical care.				

Broward Outcomes & Indicators, FY22-23 Q3

Broward Outcomes & Indicators:

Notable Trends FY2022-2023 Q3

Met or Exceeded Outcome/Indicator Goals:

- **Oral Health**
- **Integrated Primary Care & Behavioral Health**
- **AIDS Pharmaceutical Assistance**
- **Legal Services**

Broward Outcomes & Indicators:

Notable Trends FY2022-2023 Q3

Further Analysis:

- **Integrated Primary Care Behavioral Health**
  - Did meet Indicator 1.1 (**98.96%**)
    - Exceeded target goal by **13.96%**
- **Food Service**
  - Did not meet Indicator 1.1 (**71.44%**)
    - Did not meet Target goal by **13.56%**
- **CIED**
  - Did not meet Indicator 1.1 (**46.88%**)
    - Did not meet Target goal by **48.12%**
  - Did meet Indicator 1.2 (**99.68%**)
    - Exceeded target goal by **19.68%**

Broward Outcomes & Indicators:

Notable Trends FY2022-2023 Q3

Further Analysis:

- **Health Insurance Continuation Program**
  - Did not meet Indicator 1.1 (**74.36%**)
    - Did not meet Target goal by **10.64%**
- **Non-Medical Case Management**
  - Did meet Indicator 1.1 (**93.09%**)
    - Exceeded target goal by **8.09%**
  - Did not meet Indicator 1.2 (**79.87%**)
    - Did not meet target goal by **5.13%**
- **MAI Non-Medical Case Management**
  - Did not meet Indicator 1.1 (**75.00%**)
    - Did not meet target goal by **10.00%**
- **MAI Substance Abuse-Outpatient**
  - Did not meet Indicator 2.1 (**51.02%**)
    - Did not meet target goal by **33.98%**

Any Questions?

Thank you!

The services provided by Broward Regional Health Planning Council, Inc. is a collaborative effort between Broward County and Broward Regional Health Planning Council, Inc. with funding provided by the Broward County Board of County Commissioners under an Agreement.