Fort Lauderdale/Broward County EMA
Broward County HIV Health Services Planning Council
An advisory board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100 • Hollywood, Florida 33020 954-561-9681 • FAX 954-561-9685

Quality Management Committee Meeting

AGENDA

Date: April 19, 2021 at 12:30 p.m.
Location: WebEx Virtual Meeting Platform
Chair: Bisiola Fortune-Evans
Vice Chair: David Shamer

Facilitator: CQM Support Staff
quality@brhpc.org
(954) 561-9681 ext. 1343

QMC Purpose: To ensure quality, comprehensive care, and to positively impact the health of people with HIV at all stages of illness.

1. **Call to Order**
2. **Welcome & Public Record Requirements**
   a. Welcome
   b. Review Meeting Ground Rules, Public Comment and Public Record Requirements (Statement of Sunshine)
   c. Council Member, Guest, and Phone Introductions
   d. Moment of Silence
3. **Approvals**
   a. Meeting Agenda 04/19/2021
   b. Last Meeting Minutes 03/15/2021
4. **Public Comment (10 minutes)**
5. **Standard Committee Items**
   I. **CQM Work Plan Progress Review (Handouts A)**
   Work Plan Activity 4.1: Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.
   ACTION ITEM: Review QMC's FY2020 CQM Work Plan progress.
6. **Unfinished Business**
   None.
7. **Meeting Activities/New Business**
   I. **Quality Improvement Project Overview (Handout B)**
   Work Plan Activity 2.3: Identify and conduct systemwide quality improvement activities and operationalize strategies to evaluate outcomes.
   ACTION ITEM: Review and discuss QIPs completed by the Quality Network in FY2020.

II. **Ryan White Part A Data Review: FY2020 Quarter 4 (Handout C)**
Work Plan Activity 1.3: Identify and analyze health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC Committees and Networks to address findings.
ACTION ITEM: Review and discuss data regarding RWPA program outcomes in the fourth quarter of FY2020.

III. **CQM Performance Measures Overview (Handout D)**
Work Plan Activity 4.2: Review CQM Program performance measures for efficacy and relevance and make changes as needed.
ACTION ITEM: Discuss program performance as it relates to the FY2021 goal of closing the gap between linkage to care and retention in care.

8. **Recipient's Report**

9. **Public Comment (10 minutes)**

10. **Agenda Items/Tasks for Next Meeting**

a. Next Meeting Date: May 17, 2021 at 12:30 p.m. via WebEx Videoconference

b. Next Meeting Agenda Items

11. **Announcements**

12. **Adjournment**

FOR A DETAILED DISCUSSION ON ANY OF THE ABOVE ITEMS,
PLEASE REFER TO THE MEETING MINUTES.
Meeting Packets are available at: The HIV Planning Council Website
(http://www.brhpc.org/programs/hiv-planning-council/)

Please complete your meeting evaluations here
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

Meeting of the

Quality Management Committee

Monday, March 15, 2021
12:30 – 2:30 PM
By WebEx Videoconference

M I N U T E S

QMC Members Present: B. Fortune-Evans, H.B. Katz, N. Markman, Z. Muneton, D. Shamer

Ryan White Part A Recipient Staff Present: K. Giglioli, T. Thompson, N. Walker, W. Cius

Planning Council Support Staff Present: G. Martinez, V. Oratien, W. Saint-Fleur

Guests Present: K. Drummond, B. Mester, S. Williams, M. Rosiere

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Agenda Item #1: Call to Order, Welcome & Public Record Requirements

The *QMC Vice Chair* called the meeting to order at 12:30 p.m. The *QMC Vice Chair* welcomed all meeting attendees that were present. Attendees were notified that the QMC meeting is based on Florida's "Government-in-the-Sunshine Law" and meeting reporting requirements, including the recording of 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 *QMC Vice Chair*, committee members, Recipient staff, PCS staff, and guests by roll call, and a moment of silence was observed.

Agenda Item #2: Meeting Approvals

The approval for the agenda of the March 15, 2021, Quality Management Committee meeting was proposed by *N. Markman*, seconded by *Z. Muneton*, and passed unanimously. The approval for the minutes of the June 15, 2020 meeting was proposed by *H.B. Katz*, seconded by *N. Markman*, and approved with no further corrections.

Ms. Markman, on behalf of QMC, made a motion to approve the March 15, 2021 Quality Management Committee agenda as presented. The motion was adopted unanimously.

Mr. Katz, on behalf of QMC, made a motion to approve the June 15, 2020, Quality Management Committee meeting minutes as presented. The motion was adopted unanimously.

Agenda Item #3: 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 pertaining to HIV/AIDS and services in Broward County. There were no public comments.

Agenda Item #4: Standard Committee Items

CQM Support Staff reviewed the progress made in completing the FY2020 CQM Work Plan (Handout A1 on file). The Committee, Networks, and CQM Support Staff completed all goals despite the difficulties experienced as a result of the coronavirus pandemic. In lieu of the annual Network Retreat, CQM Support Staff hosted a virtual Network Appreciation Week in September of 2020. Following the review, CQM Support Staff reviewed the FY2021 CQM Work Plan (Handout A2 on file). Of note was the addition of a fifth goal. Titled, "Examine current patient satisfaction strategies and initiate a new evaluation system that will allow for consistent review of the patient experience in receiving Ryan White Part A services," it separates patient satisfaction from the data collected in Goal 1. Members discussed the potential challenge of accomplishing work plan goals during the pandemic. In FY2020, QMC and CQM Support Staff worked around myriad challenges to accomplish tasks. There were no recommendations to change the FY2021 Work Plan, and it was subsequently approved.

The approval for the FY2021 Work Plan was proposed by *H.B. Katz*, seconded by *N. Markman*, and passed unanimously.

Mr. Katz, on behalf of QMC, made a motion to approve the FY2021 CQM Work Plan as presented. The motion was adopted unanimously.

Agenda Item #5: Unfinished Business

There was no unfinished business for committee members to discuss.

Agenda Item #6: Meeting Activities/New Business

CQM Support Staff reviewed the proposed Service Delivery Models (SDMs) with the Committee. The Non-Medical Case Management (NMCM) SDM (Handout B on file) was approved by the HIV Planning Council in September of 2020. At that time two points were omitted from the SDM in error. It was returned to the Committee to make the correction.

The approval for the revised NMCM SDM was proposed by *H.B. Katz,* seconded by *Z. Muneton*, and passed unanimously.

Mr. Katz, on behalf of QMC, made a motion to approve the Non-Medical Case Management Service Delivery Model as presented. The motion was adopted unanimously.

CQM Support Staff reviewed the proposed Central Intake and Eligibility Determination (CIED) SDM (Handout C on file). The SDM was updated to include more methods of recertification for clients, including the recently implemented online portal, as well as an annual marketing plan for sharing information about the Ryan White Part A Program with the community. There were no recommendations to change the CIED SDM, and it was subsequently approved.

The approval for the revised CIED SDM was proposed by *H.B. Katz,* seconded by *Z. Muneton*, and passed unanimously.

Mr. Katz, on behalf of QMC, made a motion to approve the Centralized Intake and Eligibility Determination Service Delivery Model as presented. The motion was adopted unanimously.

CQM Support Staff reviewed the proposed Disease Case Management (DCM) SDM (Handout D on file).
The DCM Network reviewed changes to this SDM, and members provided their insights during the model's development. This service is focused on re-engaging clients in care, and Disease Case Managers have expressed interest in the addition of specific items now included in this revised SDM. One addition is the acuity scale for developing the Individualized Care Plan. The scale features a scoring component that provides management and client contact guidance based on the acuity level.

The provider will enter acuity information into Provide Enterprise (PE) at the initial assessment, and acuity will automatically be updated based on scoring. The provider still has the authority to maintain the appropriate level of contact and/or guidance, but this information must be noted in the client's file. There were no recommendations to change the DCM SDM, and it was subsequently approved.

The approval for the revised DCM SDM was proposed by *H.B. Katz,* seconded by *Z. Muneton*, and passed unanimously.

Mr. Katz, on behalf of QMC, made a motion to approve the Disease Case Management Service Delivery Model as presented. The motion was adopted unanimously.

CQM Support Staff reviewed the proposed Integrated Primary Care & Behavioral Health (IPCBH) SDM (Handout E on file). This SDM was developed in keeping with the Department of Health & Human Services guidelines as well as with input from Dr. Jefferey Beal, Medical Director of the Florida Department of Health.

The approval for the revised IPCBH SDM was proposed by *N. Markman,* seconded by *H.B. Katz*, and passed unanimously.

Ms. Markman, on behalf of QMC, made a motion to approve the Integrated Primary Care & Behavioral Health Service Delivery Model as presented. The motion was adopted unanimously.

Agenda Item #7: Recipient Report

- The Recipient's Office had a virtual site visit with HRSA to review Ending the HIV Epidemic (EHE) progress.
- The Notice of Funding Award was released for EHE and includes an additional $800,000 for Broward County to utilize. The recipient's Office is working to expand its current programming based on this increase.
- The Part A Notice of Funding Award is anticipated. This will be discussed in more detail during the Priority Setting & Resource Allocation process.

Agenda Item #8: 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 pertaining to HIV/AIDS and services in Broward County. There were no public comments.

Agenda Item #9: Agenda Items/Tasks for Next Meeting

The next QMC meeting will be held on April 19, 2021, at 12:30 p.m. via WebEx Videoconference.

Agenda Item #10: Announcements

- CIED Staff have returned to Poverello as of March 15, 2021. CIED Staff are outposted at all previous locations except the Florida Department of Health – Broward County and Children's Diagnostic & Treatment Center.

Agenda Item #10: Adjournment

There being no further business, the meeting was adjourned at 1:16 p.m.

QMC Attendance for CY 2021

Consumer	PLWHA	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date	C	C	15										
0	0	0	**1**	Fortune-Evans, B. V. Chair			X										
1	1	0	**2**	Katz, H.B.			X										
0	1	1	**3**	Barnes, B.			A										
0	0	0	**4**	Markman, N.			X										
0	0	0	**5**	Muneton, Z.			X										
1	1	0	**6**	Shamer, D.			X										
				Quorum = 4	0	0	5	0	0	0	0	0	0	0	0	0	

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

Broward EMA CQM Annual Work Plan FY 2021-2022

Goals and Objectives	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Responsible Party
Goal 1: Use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, gaps in care, and integration of services.													
1. Analyze and report on performance measures including client demographic and utilization data, HHS/HAB measures, and locally adopted outcomes and indicators.	X			X			X			X			CQM Staff, QMC, Quality Network
2. Review and analyze findings from the annual needs assessment including focus groups, client and provider surveys, and network member evaluations and recommendations.				X			X			X			CQM Staff, QMC, Quality Network
3. Identify and analyze health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC Committees and Networks to address findings.	X			X			X			X			CQM Staff, QMC, Networks
Goal 2: Implement quality improvement activities that enhance systemwide service delivery and improve client treatment, care, health outcomes, and satisfaction.													
1. Review Service Delivery Models as part of the system-wide QIP and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.												X	CQM Staff, QMC, Networks
2. Determine annual CQM Program goals and identify and leverage strategies to achieve goals.											X		CQM Staff, QMC
3. Identify and conduct systemwide quality improvement activities and operationalize strategies to evaluate outcomes.	X			X			X			X			CQM Staff, QMC
4. Ensure the development, implementation, and evaluation of at least one quality improvement project per agency during the fiscal year.	X			X			X			X			CQM Staff, Quality Network
5. Organize and conduct evidence-based trainings for providers, staff, the QMC, and the SOC to enhance knowledge on health disparities, HIV treatment and care, person-centered care, client access to eligible services, and quality improvement strategies.			X			X		X			X		CQM Staff
6. Provide technical assistance to providers as needed.	X			X			X			X			CQM Staff
Goal 3: Communicate CQM Program updates, data, and activities to the QMC, Networks, and community stakeholders.													
1. Distribute the annual CQM Program Report.		X											CQM Staff
2. Disseminate Ryan White Part A Program data and activities to the HIVPC and Committees, providers, and community stakeholders.	X				X			X			X		CQM Staff
3. Provide Network updates to the QMC and gather feedback/suggestions for the Quality Network.			X			X			X			X	CQM Staff
4. Provide routine CQM Program updates to the HIVPC.	X				X			X			X		CQM Staff
5. Plan and implement an annual Network Member Education and Appreciation Week focused on virtual learning and celebration of agency accomplishments.								X					CQM Staff
Goal 4: Routinely evaluate the CQM Program and identify areas for improvement.													
1. Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.												X	CQM Staff, QMC
2. Review CQM Program performance measures for efficacy and relevance and make changes as needed.													CQM Staff, QMC, Networks
3. Conduct surveys of all meetings and make suggested improvements.						X						X	CQM Staff
4. Collaborate with the Recipient following their review of the agency-specific quality management plans for compliance with HRSA CQM Program guidelines and provide TA when indicated to agencies that require assistance in developing a compliant quality management plan.				X									CQM Staff
5. Survey efficacy of CQM Program communication methods.						X						X	CQM Staff
Goal 5: Examine current patient satisfaction strategies and initiate a new evaluation system that will allow for consistent review of the patient experience in receiving Ryan White Part A services.													
1. Review consumer feedback data from 2019-present looking for strengths and weaknesses of current evaluation system.													CQM Staff
2. Research best practices in obtaining consumer feedback about patient experience.													CQM Staff
3. Plan, initiate, and implement a client satisfaction/client experience plan and provide training as indicated.													CQM Staff

X = goal for objective completion

= in progress

= completed

= planned

Quality Improvement Project Overview

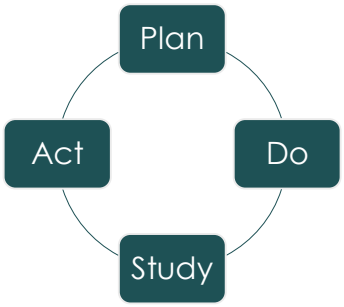
1

Quality Improvement

Quality Improvement

- **Motivation:** Continuously improving process and health outcomes
- **Attitude:** Proactive
- **Focus:** Processes and systems
- **Responsibility:** All staff

Quality Improvement Projects



2

RWPA QIPs FY2020 Topics

3

RWPA QIPs FY2020 System Navigation & Linkage Projects

Ensure Consistent Certification

PDSA Cycle: Clients who were not virally suppressed and were not recertified for Ryan White Part A services were contacted to schedule certification appointments

Result

More clients were recertified by the end of the project, but this did not result in increased viral load suppression

Caseload Assignments

PDSA Cycle: 10 clients assigned to 1 case manager were assessed using an acuity scale

Result

The PDSA cycle was hindered by staffing changes, but staff feedback was positive

4

RWPA QIPs FY2020
System Navigation & Linkage Projects

Increasing Access to Services

PDSA Cycle: Outreach and service delivery for clients were offered remotely to maintain service utilization during the pandemic

Result

More client case files were opened in FY2020 than in FY2019

Assessing Entry Points

PDSA Cycle: Client journeys into care were mapped to identify challenges

Result

Clients provided feedback to improve the process of accessing care

5

RWPA QIPs FY2020
Viral Load Suppression

Patient Engagement in Proactive Care Coordination

PDSA Cycle: Proactive Contact with 10 clients with high viral loads

Monthly contact from:

- Peer Educator
- Disease Cas Manager
- Case Manager

Result

Improved VLS and adherence to medical care plan

Of those clients with a second viral load since tracking began, 40% had a decrease in viral load

10% had an increase

Navigating Care During COVID-19

PDSA Cycle: When confirming appointments and at each appointment, patients were explained the protocols and procedures set in place to keep them safe during procedures.

Result

9% decrease in comfort level of patients having procedures during the pandemic

5% decrease in failed appointment rate

6

RWPA QIPs FY2020 Retention

Quality Assurance Tool Creation

PDSA Cycle: Establish monthly QA audit process to improve retention in care.

Alignment of service category-specific screening tool and QA tool for consistent documentation

Result

Improved client RW recertification rates

This project utilized a numerical percent score for selected charts as the outcome measure. The average score for selected charts was 91.4%

Continuing Client Support

PDSA Cycle: Continuous planning and evolving in the COVID-19 environment for clients to achieve and maintain a 92.1% viral load suppression rate

Result

Clients achieved the 92.1% goal client viral load suppression rate by February 2021

7

RWPA QIPs FY2020 Adherence & Telehealth

Adherence

Connecting with Clients to Achieve Viral Load Suppression

PDSA Cycle: 4 Black female clients enrolled in Disease Case Management to develop personalized medication adherence plans. The project aimed to have 3 of the tracked women achieve viral load suppression by February 2021

Result

2 clients achieved viral load suppression with undetectable status

Telehealth

Decreased Telehealth No-Show Rate

PDSA Cycle: To decrease the no-show rate for telehealth visits from 27% to 15%, this project focused on making virtual appointments more accessible.

Result

The no-show rate for telehealth visits was achieved and sustained

8

Broward EMA RW Part A Program

FY 2020-2021 Q4 Update

Broward EMA HIV Health Services Planning Council (HIVPC)
Quality Management Committee (QMC)
Presented by BRHPC CQM Support Staff - Whitney Saint-Fleur, MPH and Vanessa Oratien, MPH

1

Overview

Data Reporting

- Data is pulled through the end of the fourth quarter of the fiscal year (3/1/20-2/28/21)
- All HIV Care Continuum data only include clients who are HIV+ and have utilized at least one service unit
- Service Utilization Data only include *billed* and *paid as billed* services

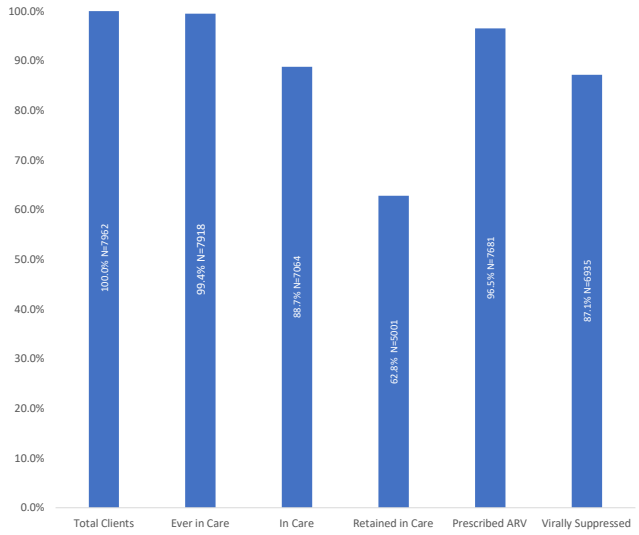
Limitations

- Data values from this quarter may differ from final reported values for the fiscal year
- Broward Outcomes and Indicators data encompasses available data for Q4 FY2020 as of 4/19/21 and may not reflect final values

2

Broward Part A HIV Care Continuum

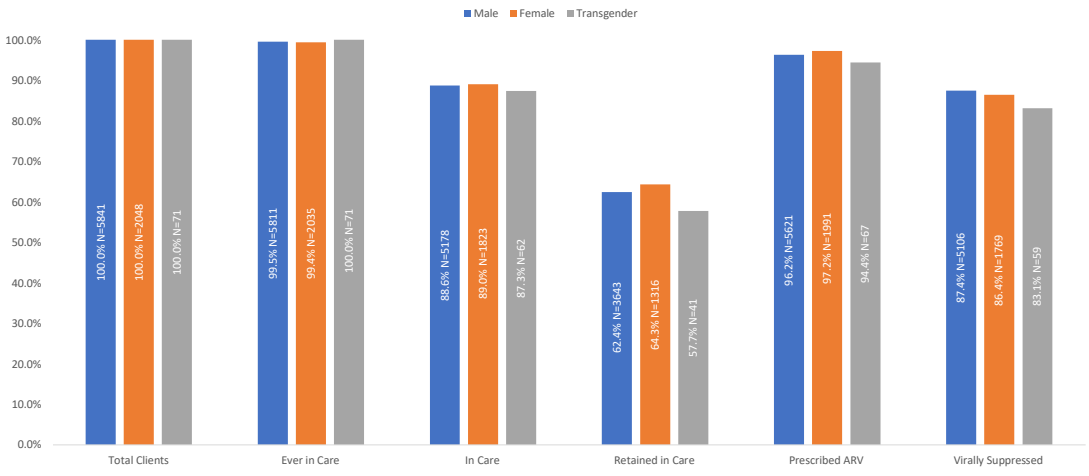
- A total of 7,962 clients are included in the HIV Care Continuum for FY2020-2021*
- Viral Suppression is 87.1%
  - Most recent FL-DOH data** (2019) report 68.5% viral suppression in Broward County (Ryan White and non-Ryan White clients)



*Data Source: Broward County Ryan White Part A Care Continuum Provide Enterprise Report 3/1/2020-2/28/2021, data pulled through end of Q4
**HIV Integrated Epidemiological Profile, Florida, 2019

3

Broward Part A HIV Care Continuum FY2020-2021 - Gender



Data Source: Broward County Ryan White Part A Care Continuum Provide Enterprise Report 3/1/2020 - 2/28/2021, data pulled through end of Q4

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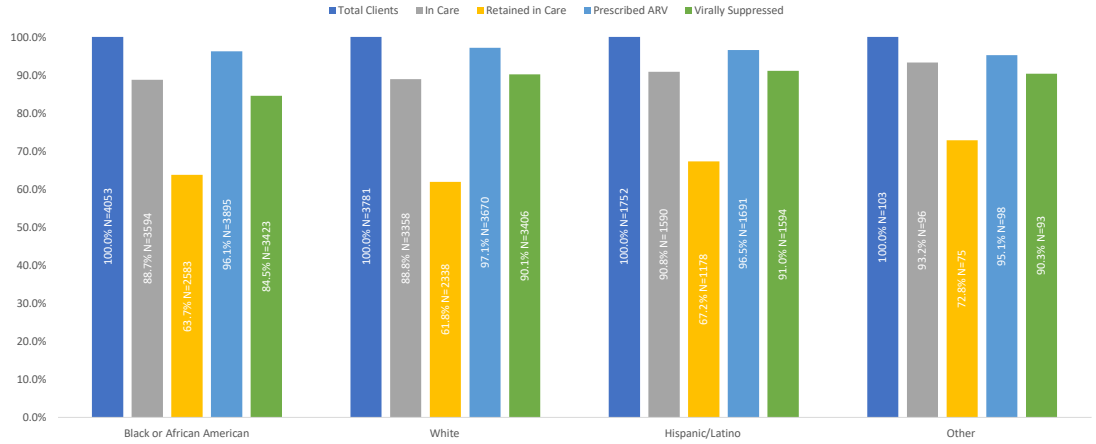
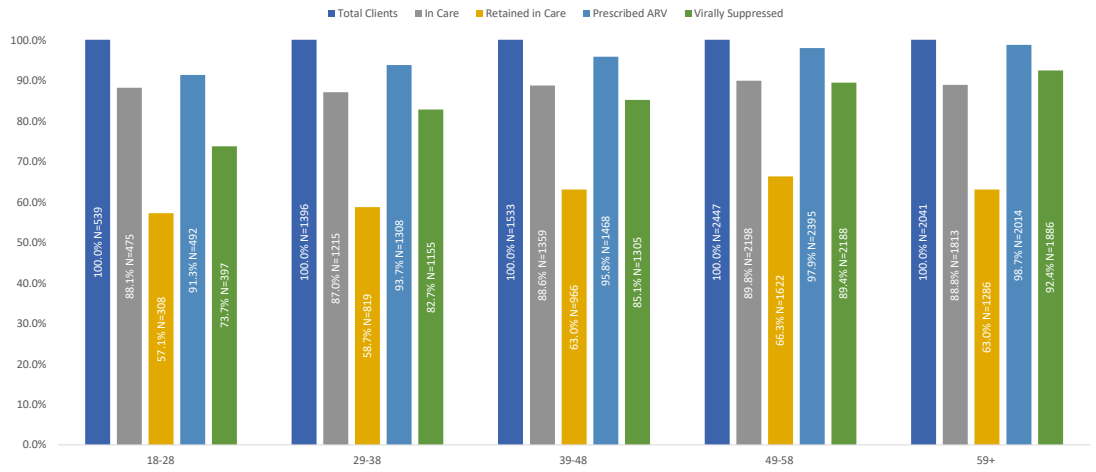
Broward Part A HIV Care Continuum FY2020 – Race/Ethnicity



***Data Source**: Broward County Ryan White Part A Care Continuum Provide Enterprise Report 3/1/2020 - 2/28/2021, data pulled through end of Q4*

5

Broward Part A HIV Care Continuum FY2020 – Age



***Data Source**: Broward County Ryan White Part A Care Continuum Provide Enterprise Report 3/1/2020 - 2/28/2021, data pulled through end of Q4*

6

HIV Care Continuum Notable Trends

- Transgender clients are 3.3-4.3% less likely to be virally suppressed than female and male clients.
- The Black/African American population is 5.6-6.5% less likely to be virally suppressed when compared to White, Hispanic/Latino, and Other populations.
- Individuals 18 – 28 years old are 1.6%-9.2% less likely to be retrained in care and 9-18.7% less likely to be virally suppressed than the other age groups.
- Viral suppression increases by age group.
  - The older the population, the more likely to be virally suppressed.

7

Outcomes & Indicators Overview

- FY 2020 Quarter 4: December 1, 2020 – February 28, 2021
- CQM Support Staff track RW performance measures on a data dashboard

8

Broward Outcomes and Indicators	FY 2019-2020		FY 2020 - Quarter 4	
AIDS Pharmaceutical Assistance	**Num/Denom**	**%**	**Num/Denom**	**%**
Outcome 1: Improve access to medication. **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.	43/43	100%	3/3	100%
Outcome 2: Clients provided an opportunity to improve medication adherence. **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).	10/10	100%	0/0	-
CIED				
Outcome 1: N/A[1] **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.	92/95	96.84%	28/29	96.55%
Indicator 1.2: 80% of clients will not experience a lapse in Ryan White Part A eligibility.	7,863/7,863	100%	4,651/4,651	100%
Disease Case Management				
Outcome 1: N/A[1] **Indicator 1.1:** 85% of clients achieve one (1) or more action plan goals by the target resolution date.	254/290	87.59%	80/90	88.89%
Indicator 1.2: 90% of clients are retained in primary medical care.	493/543	90.79%	266/289	92.04%

Red - goal not met; Yellow - within 5% of goal; Green - goal met or exceeded

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 3/1/2019-2/28/2020, as of 4/15/2021*

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 12/1/2020-2/28/2021, as of 4/19/2021*

9

Broward Outcomes and Indicators	FY 2019-2020		FY 2020 - Quarter 4	
Food Services	**Num/Denom**	**%**	**Num/Denom**	**%**
Outcome 1: Increased access, retention, and adherence to Primary Medical Care. Indicator 1.1: 85% of clients are retained in primary medical care.	1,568/1,887	83.09%	719/1,061	67.77%
Outcome 2: Increased viral suppression. **Indicator 2.1:** 80% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	1,735/1,994	87.01%	983/1,104	89.04%
Health Insurance Continuation Program				
Outcome 1: N/A[1] **Indicator 1.1:** 85% of clients are retained in primary medical care.	125/163	76.69%	81/93	87.10%
Integrated Primary Care & Behavioral Health				
Outcome 1: N/A[1] **Indicator 1.1:** 85% of clients are retained in Integrated Primary Care and Behavioral Health services.	2,514/3,291	76.39%	1,832/1,856	98.71%
Indicator 1.2: 90% of clients on ART for more than six (6) months will have a viral load less than 200 copies/mL.	3,176/3,610	87.98%	1,740/1,949	89.28%
Legal Services				
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 case benefits and/or medical benefits thus improving their financial stability.	6/7	85.71%	5/5	100%
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.	55/63	87.30%	16/16	84.62%
Outcome 2: Increased access, retention, and adherence to primary medical care. **Indicator 2.1:** 85% of clients are retained in primary medical care	175/200	87.50%	94/105	89.52.%

Red - goal not met; Yellow - within 5% of goal; Green - goal met or exceeded

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 3/1/2019-2/28/2020, as of 4/15/2021*

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 12/1/2020-2/28/2021, as of 4/19/2021*

10

Broward Outcomes and Indicators	FY 2019-2020		FY 2020 - Quarter 4	
Non-Medical Case Management	**Num/Denom**	**%**	**Num/Denom**	**%**
Outcome 1: Continuity of oral health care. **Indicator 1.1:** 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1,608/1,825	88.11%	669/716	93.44%
Indicator 1.2: 85% of clients are retained in primary medical care.	1,494/1,733	86.21%	919/1,160	79.22%
Oral Health				
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.	1,963/2,092	93.83%	866/965	89.74%
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.	1,267/1,284	98.68%	466/467	99.79%
Substance Abuse - Outpatient				
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis. **Indicator 1.1:** 85% of clients achieve treatment plan goals by designated target date.	44/58	75.86%	8/9	88.89%
Outcome 2: Increased access, retention, and adherence to primary medical care. **Indicator 2.1**: 85% of clients are retained in Primary Medical Care.	49/59	83.05%	19/22	86.36%

Red - goal not met; Yellow - within 5% of goal; Green - goal met or exceeded

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 3/1/2019-2/28/2020, as of 4/15/2021*

Data source: *Broward County Ryan White Part A Care Broward Outcomes Provide Enterprise Report V2 12/1/2020-2/28/2021, as of 4/19/2021*

11

Questions?

Broward Regional Health Planning Council

BRHPC

HEALTH & HUMAN SERVICE INNOVATIONS

www.brhpc.org

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.

12

CQM Performance Measures:

CLOSING THE GAP BETWEEN LINKAGE & RETENTION

1

Contents

2

The HIV Care Continuum

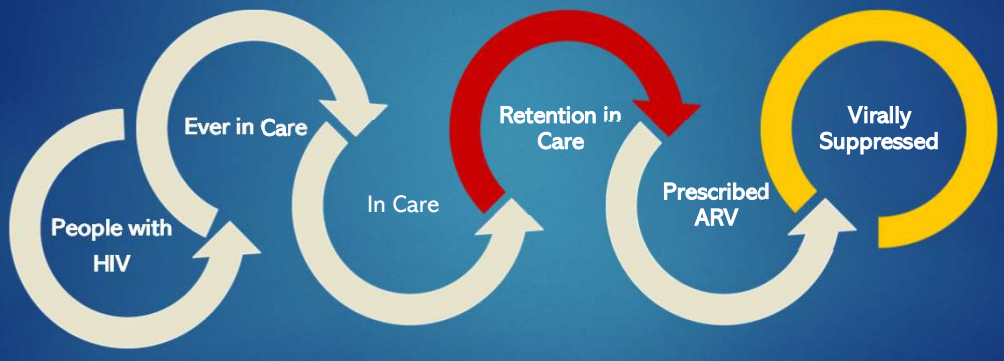
Performance Measure Definitions

People with HIV	Ever in Care	In Care	Retention in Care	Prescribed ARV	Virally Suppressed
Clients with positive HIV serostatus and received at least one service from the selected service category(s) in the reporting period.	Clients who ever had medical care documented.	Clients who had medical care within the reporting period.	Clients who had two or more medical care services at least three months apart in the reporting period.	Clients who have a documented prescription for ARV Therapy at any time during the reporting period as indicated in HIV treatment records.	Clients with a most recent viral load at the of end of reporting period that is less than 200 copies/mL.

3

The HIV Care Continuum

The Focus: Retention in Care



4

What the Data Say
About Retention in Care

Recent research shows that [people with HIV] who received ongoing, regularly scheduled care had **significantly lower viral loads**, higher CD4 cell counts, and reduced morbidity and mortality than those who missed even one medical visit over a 2-year period.

-Centers for Disease Control and Prevention

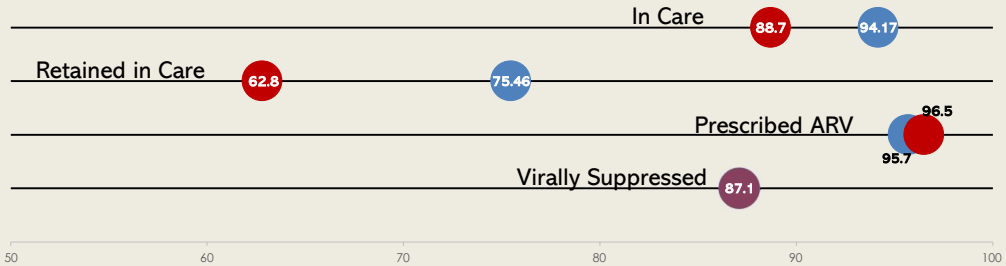
Other benefits of regular, ongoing HIV care included:

- Increased safer sexual behaviors
- Lower rates of progression to AIDS
- Decreased rates of hospitalization
- Improved overall health

5

What the Data Say
Performance Measures & Targets

Retention in care was furthest from its performance measure target along the Ryan White Part A continuum of care in FY2020.



	PWH	Ever in Care	In Care	Retained in Care	Prescribed ARV	Virally Suppressed
N=	7,962	7,918	7,064	5,001	7,681	6,935

6

How Retention is Being Addressed

FY2021 Goal:
Closing the Gap Between Linkage & Retention

7

How Retention is Being Addressed

Considering Retention

Support Services Network

- Non-Medical Case Management
- Client Intake & Eligibility Determination
- Substance Abuse
- Mental Health

Quality Management Committee

1. Review Data

Review data reports and QIPs with retention in mind

2. Ask Questions

Your questions & feedback will be shared with:
- System of Care Committee
- Support Services Network
- Quality Network

8

Retention in Care Strategies

Brainstorming Strategies for Increasing Retention in Care

1. From your own experience, what has ever prevented you from keeping an appointment?
2. What has incentivized you to return to a business or care provider?
3. What has disincentivized you from returning to a business or care provider?

9