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

# QUALITY NETWORK MEETING

Tuesday, December 10th, 2019 at 9:30 A.M.
Ryan White Part A Program Office Room A-337
115 S. Andrews Ave., Ft. Lauderdale 33301

## Minutes

**PROVIDERS PRESENT**
Amy Pinter, AHF
W. (Billy) Gall, AHF
Natasha Markman, BRHPC
Dr. Joshua Caraballo, Latinos Salud
Valery Moreno, Memorial
Alondra Machado, Memorial
Pamela Rodriguez, Memorial
Kaitlin Mooney, Nova
Ariel Williams, Care Resource
Alicia Lee-Clarke, Care Resource
Javier Sosa, Care Resource
Glynette Roberts, BCFHC
Diana Brown, Broward Health
Jamie Powers, Broward House
Janet Carter, FDOH-BC
Frank Young III, Poverello
Gary S. Hensley, Sunserve

**AGENCIES ABSENT**
Legal Aid

**GUEST**
None

**PART A RECIPIENT STAFF**
Edith Garcia

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

## I. Welcome/Introductions

The meeting was called to order at 9:30 a.m. CQM Support Staff welcomed everyone and individual introductions were made.

## II. Quality Improvement Project Check-In- PSDA Cycle Data

Quality Network Members presented preliminary data from their organization's PSDA cycles. After each presentation, Network members provided feedback and asked questions of each presenter. Network members also provided written feedback to presenters.

*Presented slides are attached.*

## III. Next Steps: Presenting Your QIP

CQM Support Staff discussed the future actions of the agencies Quality Improvement Projects (QIPs). The CQM Support staff will work with each agency to construct a formal presentation of each project.

## IV. Announcement(s)

None.

## V. Evaluations

## VI. Adjournment

The meeting was adjourned at 11:41 a.m.

**Next Meeting Date: January 8th, 2020 at 9:00 a.m.**

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# QUALITY NETWORK MEETING

**Date:** December 10th, 2019 @ 9:30am
**Location:** Governmental Building Room A-337
115 S. Andrews Ave
Ft. Lauderdale, FL 33301

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

## AGENDA

**I. Welcome/Introductions**

**II. Quality Improvement Project Check-In- PDSA Cycle Data**
*Quality Network Members will come prepared with preliminary data from their PDSA cycles and share it via a slide set the CQM staff sends out. Presentations will be 5 minutes or less and 2 minutes to write comments on papers to be given to presenter at end of meeting.*

**III. Next Steps: Presenting Your QIP**
*CQM staff will discuss the next steps for QIPs including presenting regarding their project at the All Networks Retreat and to Support Services next fiscal year.*

**IV. Calendar**

**V. Announcement(s)**

**VI. Evaluations**

**VII. Adjournment**

**Next Meeting Date: January 7th, 2020**

# AHF Preliminary QIP Data 12/6/19



# Aim Statement

AHF seeks to increase VL suppression in our youth population <25. We will target 24 active clients under age 25 with detectable viral loads with the goal that 50% will be virally suppressed by 12/31/19.

# Intervention

- Peer navigator will reach out to each client utilizing all contact information available (i.e. phone, emergency contact, text, email) in an effort to reach client.
- If unsuccessful, a second attempt will be made on a different date.
- If unsuccessful, peer will complete a search in Vinelink to confirm client is not incarcerated.
- If client is not found to be incarcerated or have moved, or engaged in care elsewhere, client will be referred to Broward County Linkage Program for assistance to locate client.

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# Intervention

- All outreach attempts will be documented in AHF EMR (CPS) and in PE as appropriate
- Once client is contacted either by phone or while at the HCC, the AHF Outreach Worksheet will be completed to identify barriers to treatment
  - Peer will ask open ended questions and guide the conversation as appropriate to allow client to identify and state barriers rather than asking every item on the checklist
- Peer will assist client to create a plan to address barriers as appropriate
- Peer will follow up with client at an mutually agreeable interval to assess progress
- VL values will be monitored by compliance manager throughout the project


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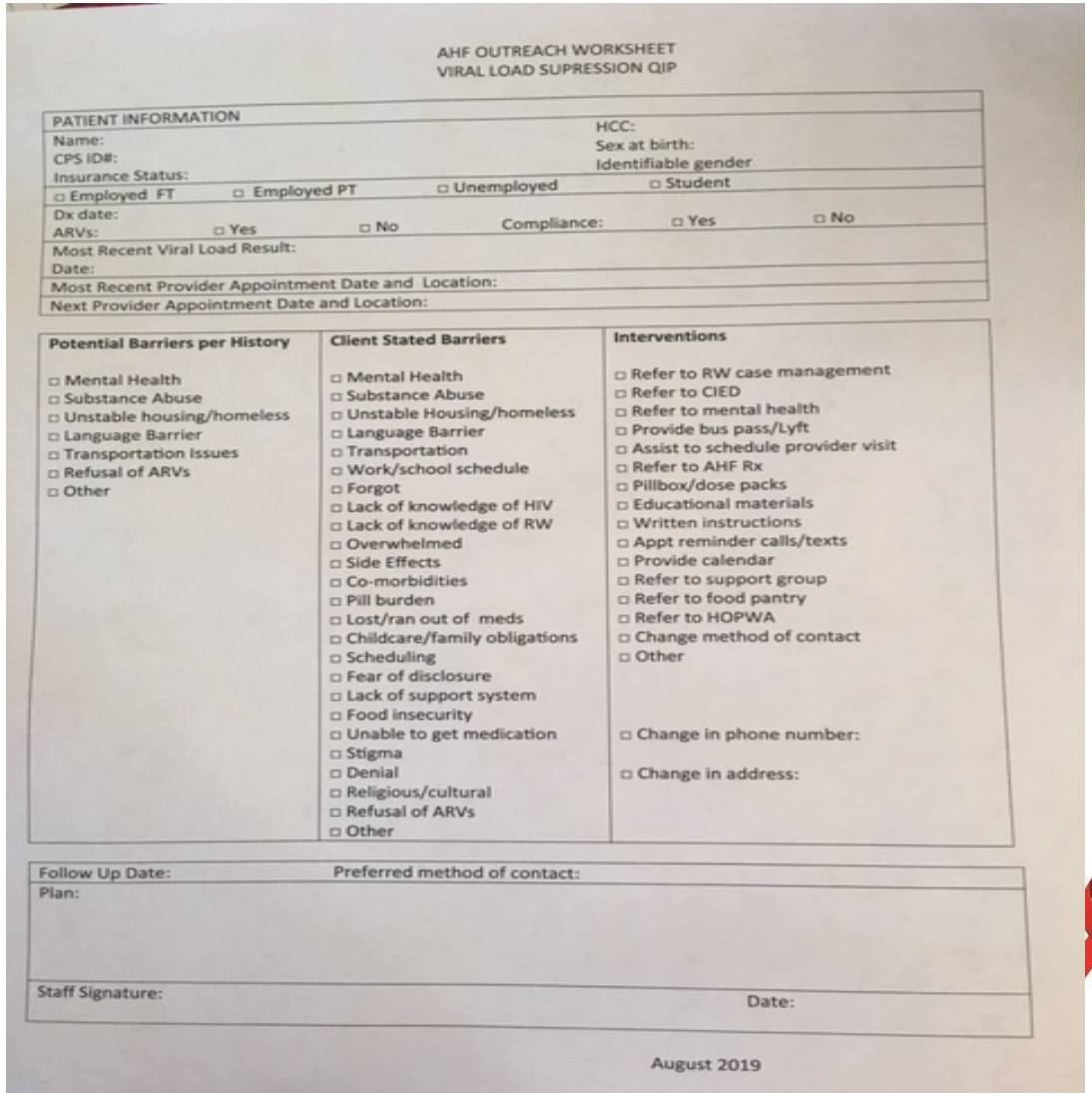
# Data Collection Tools

*All outreach attempts, referrals, and completed outreach form were documented in EMR*



AHF OUTREACH WORKSHEET
VIRAL LOAD SUPRESSION QIP

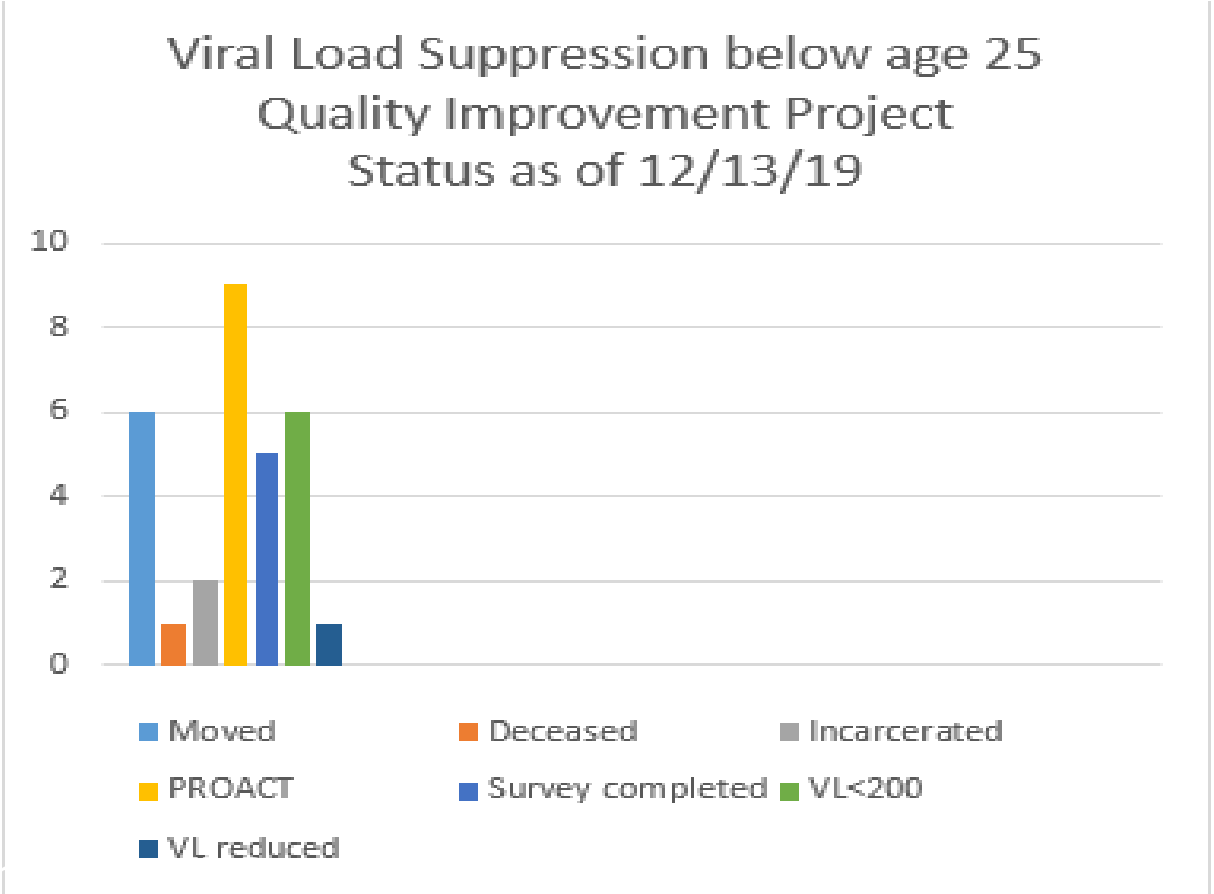
PATIENT INFORMATION
Name: HCC:
CPS ID#: Sex at birth:
Insurance Status: Identifiable gender
□ Employed FT □ Employed PT □ Unemployed □ Student
Dx date:
ARVs: □ Yes □ No Compliance: □ Yes □ No
Most Recent Viral Load Result:
Date:
Most Recent Provider Appointment Date and Location:
Next Provider Appointment Date and Location:

| Potential Barriers per History | Client Stated Barriers | Interventions |
|---|---|---|
| □ Mental Health | □ Mental Health | □ Refer to RW case management |
| □ Substance Abuse | □ Substance Abuse | □ Refer to CIED |
| □ Unstable housing/homeless | □ Unstable Housing/homeless | □ Refer to mental health |
| □ Language Barrier | □ Language Barrier | □ Provide bus pass/Lyft |
| □ Transportation Issues | □ Transportation | □ Assist to schedule provider visit |
| □ Refusal of ARVs | □ Work/school schedule | □ Refer to AHF Rx |
| □ Other | □ Forgot | □ Pillbox/dose packs |
| | □ Lack of knowledge of HIV | □ Educational materials |
| | □ Lack of knowledge of RW | □ Written instructions |
| | □ Overwhelmed | □ Appt reminder calls/texts |
| | □ Side Effects | □ Provide calendar |
| | □ Co-morbidities | □ Refer to support group |
| | □ Pill burden | □ Refer to food pantry |
| | □ Lost/ran out of meds | □ Refer to HOPWA |
| | □ Childcare/family obligations | □ Change method of contact |
| | □ Scheduling | □ Other |
| | □ Fear of disclosure | |
| | □ Lack of support system | |
| | □ Food insecurity | |
| | □ Unable to get medication | □ Change in phone number: |
| | □ Stigma | |
| | □ Denial | □ Change in address: |
| | □ Religious/cultural | |
| | □ Refusal of ARVs | |
| | □ Other | |

Follow Up Date: Preferred method of contact:
Plan:
Staff Signature: Date:

August 2019

# Results


Viral Load Suppression below age 25
Quality Improvement Project
Status as of 12/13/19
10
8
6
4
2
0
Moved
Deceased
Incarcerated
PROACT
Survey completed
VL<200
VL reduced

# Next Steps: Successes

- AHF will hold the final internal project discussion meeting on 12/20/19. The final results of the project will be analyzed after project completion 12/31/19.

**Project successes include:**

  - 9 active referrals to PROACT in an effort to re-engage clients
  - 40% of clients are now undetectable (6/15); however, these results cannot all be attributed to the interventions of this project

# Next Steps: Barriers

**Project barriers include:**

- Variance in level of engagement and participation by staff
- Inability to reach the clients to actually complete the assessment
- Mixed responses from clients to “cold calls”
- Disconnect with front desk being aware that CM or peer needs to speak with client
  - At project discussion 11/8/19 decided to flag superbill with colored note indicating CM/peer needs to meet with client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# *Care Resource* Preliminary QIP Data

*2019, Ariel Williams, MHA, Quality Assurance Associate*

# Aim Statement

*The viral load suppression rate for MSM of Color has decreased to 3.7% between FY 2017 and FY 2018. Care Resource would like to see a 2.5% improvement in the viral load suppression rate by 12/31/19.*

# Intervention

- *An acuity scoring system was created in order to assess the risk factors and barriers related to falling out of care, as well as the social determinants of health that could have an effect on client engagement.*

# Data Collection Tools

- *Based on a brainstorming session with the Clinical Manager, Medical Compliance Manager, and the Disease Case Manager, the current Ryan White RN Disease Case Management Assessment was used to create an acuity scoring system.*
- *75 total acuity indicators attributed to falling out of care were highlighted within the existing assessment*
- *The Patient Assigned Acuity Risk Categories are as follows:*
  - *Low Acuity Risk: 1-25 Points*
  - *Medium Acuity Risk: 26-50 Points*
  - *High Acuity Risk Level: 51-75 Points*
- *The acuity scoring system was completed for 10 MSM of Color patients*

# Data Collection Tools

**CARE RESOURCE - RW RN Disease Case Management Assessment**

| ASSESSMENT DATE: | CLIENT ID: |
|---|---|

**CLIENT INFORMATION – UPDATE IF NEEDED**

| First Name: | Last Name | DOB: |
|---|---|---|
| Cell Phone: | Work Phone: | SS#: |
| Address: | | |
| City: | Zip: | County: |
| E-Mail: | | |

**ALTERNATE CONTACT / HEALTHCARE CONSENT INFORMATION**

| Emergency Contact Person: (If No Emergency Contact Person) | Relationship: |
|---|---|
| Address: | City/State/Zip |
| Aware of HIV Status: YES: NO: | Phone: |

I give permission for the above emergency contact to be called or contacted by the health center with matters pertaining to my health care. Client Signature:_____ Date:_____

**CLIENT DEMOGRAPHIC INFORMATION**

| Marital Status | Race | Gender | Housing |
|---|---|---|---|
| Single | Caucasian | Male | Alone |
| Married | African American | Female | With Spouse |
| Widowed | Haitian | Transgender M>F | Spouse and Children |
| Separated | Hispanic | Transgender F>M | Domestic Partner |
| Divorced | Other: | | Shared/Roommate |
| Other: | | | Shelter |
| Other: | | | Homeless |

| Dependents | Primary | Sexual Orientation | Education |
|---|---|---|---|
| Children (If 2+ Children) | English | Heterosexual | None |
| Age:_____Sex:__ __ | Spanish | Bisexual | K-6th Grade |
| Age:_____Sex:_____ | Creole | Gay | 7-12 Grade |
| Age:_____Sex:_____ | French | Lesbian | College Graduate |
| Age:_____Sex:_____ | Other: | Pansexual | Graduate School |
| Age:_____Sex:__ __ | | Trans: M T F | Reader: |
| Mother / Father | | Trans: F t M | Non Reader: |
| Siblings | | | |
| Other: | | Sex Worker | |



| Income | Mailings | | |
|---|---|---|---|
| Working | All materials OK | | |
| SSI | Thrive Only | | |
| Disability | Education/PHC | | |
| O: | No Mail | | |

**PROVIDER AND MEDICAL VISIT ADHERENCE**

| | | YES | NO |
|---|---|---|---|
| 1 | Do you have an HIV doctor? | X | |

Doctor's Name:
Clinic/Agency Name: CARE RESOURCE
Last Appt Date: Next Appt Date:
Appointment Frequency: (qmthly, q3mths, q6mths, other)

Have you been hospitalized or visited an ER within the last three months? YES or NO
If YES, please explain:

When was your last provider visit(if never had one):

| | | | |
|---|---|---|---|
| Have you missed more than two provider visits in the last year? | YES | NO | N/A |
| Have you missed more than two Behavioral Health visits in the last year? | YES | NO | N/A |
| Have you missed more than two specialist visits in the last year? | YES | NO | N/A |

**SCREENINGS – SEXUALLY TRANSMITTED DISEASES AND OTHERS**

| 2 | Have you been screened for: | Y /N /NA | DATE | RESULT (risk if positive) |
|---|---|---|---|---|
| | Syphilis | | | |
| | Gonorrhea | | | |
| | Chlamydia | | | |
| | Tricomonas | | | |
| | HPV (Genital Warts: Penis, Vagina)) | | | |
| | Condyloma acuminatum (Rectal Warts) | | | |
| | Hepatitis A | | | |
| | Hepatitis B | | | |
| | Hepatitis C | | | |
| | Anal/Rectal Pap (Male) | | | |
| | Tuberculosis Test | | | |



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# Data Collection Tools

| | | | | |
|---|---|---|---|---|
| | Toxoplasmosis | | | |
| | Cytomegalovirus (CD4 < 50mm) | | | |
| | Colonoscopy (M/F over 50) | | | |
| 3 | **HIV Disease Progression, Risky Behaviors, Prevention Methods, Safe Sex Practices** | Choose Applicable | | |
| | CONDOMS USE ALWAYS | | | |
| | CONDOMS MOSTLY | | | |
| | CONDOMS SOMETIMES | | | |
| | CONDOMS NEVER | | | |
| | Understands the risk of unprotected sex? | YES or NO | | |
| | Best form of prevention is abstinence, condoms, non risky behaviors. | YES or NO | | |
| 4 | **Immunizations - Have you had following** | Y / N / NA | DATE | |
| | Influenza (Flu Vaccine) | | | |
| | Pneumovax / Prevnar | | | |
| | Hepatitis A | | | |
| | Hepatitis B Series – Shot 1 | | | |
| | Hepatitis B Series – Shot 2 | | | |
| | Hepatitis B Series – Shot 3 | | | |
| | Tetanus | | | |
| 5 | **FOR WOMEN ONLY** | Y / N / NA | DATE | RESULT |
| | PAP Smear / Cervical Cancer Screening | | | |
| | Mammogram / Breast Cancer Screening | | | |
| | Pregnancy Test | | | |
| | **FOR MEN ONLY** | Y / N / NA | DATE | RESULT |
| | Colonoscopy | | | |
| **HIIV/AIDS Screening Questions** | | | | |
| 6 | Most current CD4 lab results? | | | |
| 7 | Most current VL lab results? | | | |
| 8 | Are you having any related symptoms? | | | |
| | Have you discussed with doctor? | | | |
| | List: | | | |
| | List: | | | |
| | List: | | | |
| 9 | Ever been hospitalized for AIDS related illness or opportunistic infections (OI)? | | | |
| 10 | Are you on prophylaxis treatment for AIDS? | | | |
| | | | | |



| MENTAL HEALTH / PSYCHOSOCIAL ASSSESSMENT | | | |
|---|---|---|---|
| Does patient have a PQH9 Depression Screening completed in EHR? YES: NO: | | | |
| Have you ever been a victim of domestic violence or family abuse? | | | |
| Are you currently in a violent or abusive relationship? | | | |
| Are there any life crises or issues other than HIV/AIDS that we have not discussed that you need to talk about? | | | |
| **SUBSTANCE ABUSE/DEPENDENCE and TOBACCO ASSESSMENT** | | | |
| Have you used alcohol in last 12 months? | Are you an alcoholic? | | |
| Are you currently drinking? (risk if yes) | Are you receiving treatment? (risk if no) | | |
| Is your alcohol use preventing you from carrying out your daily activities? (risk if yes) | | | |
| Have you used drugs in last 12 months? (risk if yes) | Are you an addict? (risk if yes) | | |
| Are you currently using?(risk if yes) | Are you receiving treatment? (risk if no) | | |
| Is your drug use preventing you from carrying out your daily activities? (risk if yes) | | | |
| Are you an Intravenous drug user? (risk if yes) | | | |
| Do you practice safe injection drug use? (risk if no) | | | |
| Has alcohol/drug use continued despite social/personal problems?(risk if yes) | | | |
| When using drugs/alcohol do you remain adherent to your ARV regimen? (risk if no) | | | |
| Do you smoke? | | | |
| Would you like to stop smoking? | | | |
| **VISION CARE** | | | |
| Are you having trouble with your vision? | | | |
| If yes, specify: | | | |
| Do you wear glasses? | | | |
| Last Dilated Eye Exam? | Date: | Result: | |
| Would you like a referral to eye doctor? | | | |
| Any HIV/AIDS Related Complications? | | | |
| | | | |
| **DENTAL/ORAL CARE** | | | |
| Do you have a dentist? | YES or NO | | |
| **If NO; Consider Dental Services Referral** | | DATE | TREATMENT |
| How many visits in last 12 months? | | | |
| Do you have/had OI: Oral Thrush | YES or NO | | |
| Do you have/had OI: Candida | YES or NO | | |
| Have/had Canker Sores/Herpes Simplex? | YES or NO | | |
| Other: | | | |
| **DIET & NUTRITION** | | | |
| Current Weight: | Height: | | |
| Recent Weight Loss: | How much: | Period of time: | |



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# Data Collection Tools

| | |
|---|---|
| Eating disorder: | |
| **Questions/Comments:**<br>Appetite:<br>Do you have access to food?<br>Do you have problems eating due to other sources?<br>Do you see a nutritionist?<br>Comments: | |
| Food Allergies: | |
| Herbals Taken: | Frequency: |
| Herbals Taken: | Frequency: |
| Over the counter diet supplements: | |
| | |
| | |
| | |

**CURRENT HEALTH STATUS - MEDICAL ASSESSMENT**

| |
|---|
| **CURRENT HEALTH STATUS:** |
| **Are you working? YES NO If yes, does it interfere with your HIV related appointments?** |
| **Do you have a disability that prevents you from working?** |
| **Does client need home visits / home health based on assessment?** |
| **MEDICAL ALLERGIES:** |
| **RECENTLY DEVELOPED HEALTH/WELNESS CONCERNS:** |
| **PREVENTIVE HEALTH MEASURES TAKEN SINCE LAST ASSESSMENT: (When applicable)** |

**HIV / AIDS HISTORY** (AIDS: CD4 < 200mm)

| | |
|---|---|
| First HIV Positive Date: | Source: Patient self-report Western Blot<br>Document Scanned In NextGen: YES or NO |



**OPPORTUNISTIC DISEASES / COMPLICATIONS**

| Current | Resolved | Condition | Current | Resolved | Condition |
|---|---|---|---|---|---|
| | | PCP – Pneumocystis Carinii Pneumonia | | | HIV Encephalopathy |
| | | Recurrent Bacterial Pneumonia | | | Neuro: Peripheral Neuropathy |
| | | Tuberculosis | | | Cardiomyopathy |
| | | Esophageal Candidiasis | | | Nephropathy leading to Chronic Renal Failure |
| | | Kaposi's Sarcoma | | | Chronic Herpes Simplex |
| | | HIV Wasting Syndrome (>10% wt loss) | | | Cervical Cancer |
| | | MAC-Mycobacterium Avium Complex | | | Thrombocytopenia (Platelets < 40K, with spontaneous bleeding) |
| | | Cytomegalovirus (Eyes) | | | Diarrhea lasting > 1 month, resistant to Tx |
| | | Cytomegalovirus (GI) | | | Cholesterol Abnormalities |
| | | Cryptosporidiosis | | | Triglyceride Abnormalities |
| | | AIDS Dementia Complex | | | Fat Maldistribution |
| | | Toxoplasmosis | | | Non-Hodgkin's Lymphoma |
| | | Diabetes | | | Lactic Acidosis |
| | | Insulin Dependence | | | Histoplasmosis |

**MEDICAL HISTORY - COMORBID CONDITIONS**

| | | | | | |
|---|---|---|---|---|---|
| | Abnormal PAP | | Depression | | HEPATITIS C |
| | Anemia | | Diabetes Type I | | Paralysis |
| | Arthritis | | Diabetes Type II | | Peripheral Neuropathy |
| | Asthma | | Diabetic Retinopathy | | Psoriasis |
| | Bronchitis | | Eczema | | Seizures |
| | CHF | | Erectile dysfunction | | Sleep Problems |
| | Chronic Kidney Failure | | ETOH use | | Thyroid Abnormalities |
| | Cirrhosis | | GERD | | Urinary Incontinence |
| | Constipation | | HEPATITIS A | | O: |
| | COPD | | HEPATITIS B | | O: |

Other Medical Conditions:

**MEDICATIONS - CURRENT PROFILE**
**IF Medication List is current in NextGen, Copy and Paste into P.E.**

| MEDICATION | DOSE | FREQUENCY | START DATE | DC REASON |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |



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# Data Collection Tools

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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| MEDICATION ADHERENCE |
|---|
| Are you taking all medications as prescribed? (risk if no) |
| Are you keeping all your medical appointments? (risk if no) |
| Do you have any barriers to treatment? (risk if yes) |
| Are you capable of making therapeutic lifestyle changes to become adherent? (risk if no) |

| LABORATORY RESULTS | | | |
|---|---|---|---|
| If CURRENT LABS (WITHIN 3-6 MONTHS) ARE IN EHR, IMPORT TO P.E.<br>Record the most recent test available and date done<br>HIV LABS / BMP / CBC with differential / CMP / UA annually) / Liver Function Test | | | |
| OTHER TESTS TO CONSIDER | RESULT | DATE | Frequency or Note |
| HLA-B*5701 | | | Starting Abacavir |
| Tropism Test (CCR5 Antogonist) | | | Starting SELZENTRY |
| HEP A (HAVA total antibody) | | | |
| HEP B (HBcAb core antibody) | | | |
| HEP B (HBsAb surface antibody) | | | |
| HEP B (HBsAg surface antigen) | | | |
| HEP C (HCV Ab antibody) | | | |
| RESISTANCE TESTING (Genotype/Phenotype) | | | |

| PATIENT ASSIGNED ACUITY RISK CATEGORY | | |
|---|---|---|
| LOW (1-25 Points) | MODERATE (26-50 Points) | HIGH (51-75 Points) |
| Total Risk Score: | | |

| DISEASE CASE MANAGER ASSESSMENT COMMENTS |
|---|
| |
| |
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| |

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# Results

- *Based on the risk level of falling out of care, the number and type of client interactions were established:*
  - *Low Acuity Risk: One face to face contact every three months, and at least one telephone patient or service-related contact per month.*
  - *Moderate Acuity Risk: Once face to face contact every two months and at least two telephone patient or service-related contacts per month.*
  - *High Acuity Risk: Once face to face and at least three telephone patient or service-related contacts per month.*
- *Total average Acuity Score of MSM of Color: 8.5 (Low Acuity Risk Score)*

# Next Steps

- *Take a deeper dive into individual acuity indicators to see if some indicators could be more weighted than others*
- *Increase sample size to be more representative of the population served*
- *Complete a Plan, Do, Check, Act cycle to test if the established client interaction schedule affects the viral load suppression rate of MSM of Color*

# *Broward Regional Health Planning Council* Preliminary QIP Data

*2019, Natasha Markman*

# Aim Statement

*The Centralized Intake & Eligibility program will implement a Quality Improvement initiative to increase engagement among their BAAL populations who have missed an appointment for care within the last 60 days.*

# Intervention

- *Satisfaction Survey: Accessibility of Care*
- *Identify Challenges*
- *Online Eligibility Initiated*
- *24- hour follow up after a missed appointment*

# Data Collection Tools

- *Provided Enterprise Reports: Missed medical appointment within the last 60 days; missed CIED appointment with the last 60 days;  Monthly Satisfaction Survey Review*

# Results

| Client PE | Missed Appointment Date | Expiration | Demo | Gender | Age | Last Lab Date | Recent Viral Load | AID Status | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | 10/14/2019 | 3/28/2019 | Black/African American | M-F | 52 | 8/11/2017 | <20 | Yes | |
| | 10/14/2019 | 10/18/2019 | Black/African American | M | 28 | 4/18/2019 | <=40 | No | |
| | 10/14/2019 | 10/16/2019 | Black/African American | F | 67 | 10/7/2019 | 35 | No | |
| | 10/14/2019 | 5/8/2019 | Black/African American | M | 49 | 7/25/2018 | <20 | No | Number might be disconnectd |
| | 10/14/2019 | 10/24/2018 | Black/African American | F | 48 | 11/1/2017 | <20 | Yes | |
| | 10/14/2019 | 10/12/2019 | Black/African American | F | 30 | 9/13/2019 | <20 | No | |
| | 10/14/2019 | 10/10/2019 | Black/African American | F | 35 | 4/10/2019 | 130 | No | |
| | 10/11/2019 | 10/10/2019 | Black/African American | M | 59 | 9/19/2019 | <20 | Yes | |
| | 10/11/2019 | 10/12/2019 | Black/African American | F | 49 | 8/12/2019 | 31 | Yes | |
| | 10/11/2019 | 11/10/2019 | Black/African American | M | 22 | NA | NA | NA | TNT-No Labs in the system |
| | 10/11/2019 | 10/4/2019 | Black/African American | M | 49 | 9/4/2019 | 90 | Yes | |
| | 10/11/2019 | 10/5/2019 | Black/African American | M | 37 | 6/21/2019 | <20 | Yes | |
| | 10/11/2019 | 11/7/2019 | Black/African American | M | 63 | 4/11/2019 | 82 | Yes | Rescheduled appointment for 11/5/19 |
| | 10/11/2019 | 10/16/2019 | Black/African American | M | 44 | 7/22/2019 | <20 | Yes | |
| | 10/11/2019 | 10/12/2019 | Black/African American | M | 57 | 2/7/2019 | 243 | Yes | |
| | 10/11/2019 | 10/4/2019 | Black/African American | F | 53 | 8/26/2019 | <20 | Yes | |
| | 10/11/2019 | 10/19/2019 | Black/African American | M | 36 | 9/19/2019 | 50 | No | TNT-Pending documents to complete eligbility |
| | 10/11/2019 | 9/1/2019 | Black/African American | F | | | | | |
| | 10/10/2019 | 10/17/2019 | Black/African American | F | | | | | TNT |
| | 10/10/2019 | 5/9/2019 | Black/African American | M | | | | | |
| | 10/10/2019 | 10/19/2019 | Black/African American | F | | | | | TNT-Recert |
| | 10/10/2019 | 10/18/2019 | Black/African American | F | 55 | | | | |
| | 10/10/2019 | 8/12/2019 | Black/African American | M | 22 | | | | |
| | 10/10/2019 | 10/12/2019 | Black/African American | M | 43 | | | | |
| | 10/10/2019 | 10/16/2019 | Black/African American | F | 40 | | | | |
| | 10/10/2019 | 9/20/2019 | Black/African American | M | 32 | | | | |
| | 10/10/2019 | 5/26/2019 | Black/African American and Latina | F | 57 | | | | |
| | 10/10/2019 | 10/10/2019 | Black/African American | F | 27 | | | | |
| | 10/10/2019 | 9/13/2019 | Black/African American | M | 25 | | | | |
| | | | | | | | | | |
| | Reviewed 48 last missed appointment in the last 3 business days. | | | | | | | | |
| | 29 of the 48 missed appointment who have not been rescheduled or completed recertification are BlackAfrican American. | | | | | | | | |
| | 60% of those who missed their appointment for recert in the last 3 working days are black | | | | | | | | |
| | | | | | | | | | |
| | Question (Goal: Acertain what is preventing client from making it to his appointment | | | | | | | | |
| | Question 1: What location is most convienet to complete eligbility | | | | | | | | |
| | Question 2: Will you be able to compelte eligbility if you are able to complete it online | | | | | | | | |
| | Question 3: How can we best assit in ensuring you make it to your next appointment | | | | | | | | |

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# Next Steps

- Weekly Review & 24 hour follow up after a missed appointment
- Monthly Review of Satisfaction Surveys
- Conversation with clients regarding challenges/accessibility/location
- Daily Review of submitted on-line assessments
- Monthly Review of Data

# *South Broward Hospital District, Memorial Healthcare System*

# Preliminary QIP Data

*2019, Valery Moreno, Alondra Machado, Pamela Rodriguez*

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# Aim Statement

- By December 31, 2019, Memorial Healthcare seeks to increase the number of black women living with HIV that are retained in care by ensuring at least one medical appointment within a 6 month period.

# Intervention

**Barrier Identified:**

- Work schedules are not flexible
- Childcare challenges

**Intervention:**

- Provide before and after hour appointments
- Complete the “scheduling preferences” tab in their EHR

**Barrier Identified:**

- Lack of healthcare literacy prevents patient from making educated medical decisions

**Intervention:**

- Link patient with peer specialist/case manager to help provide support and guidance on making informed medical decisions

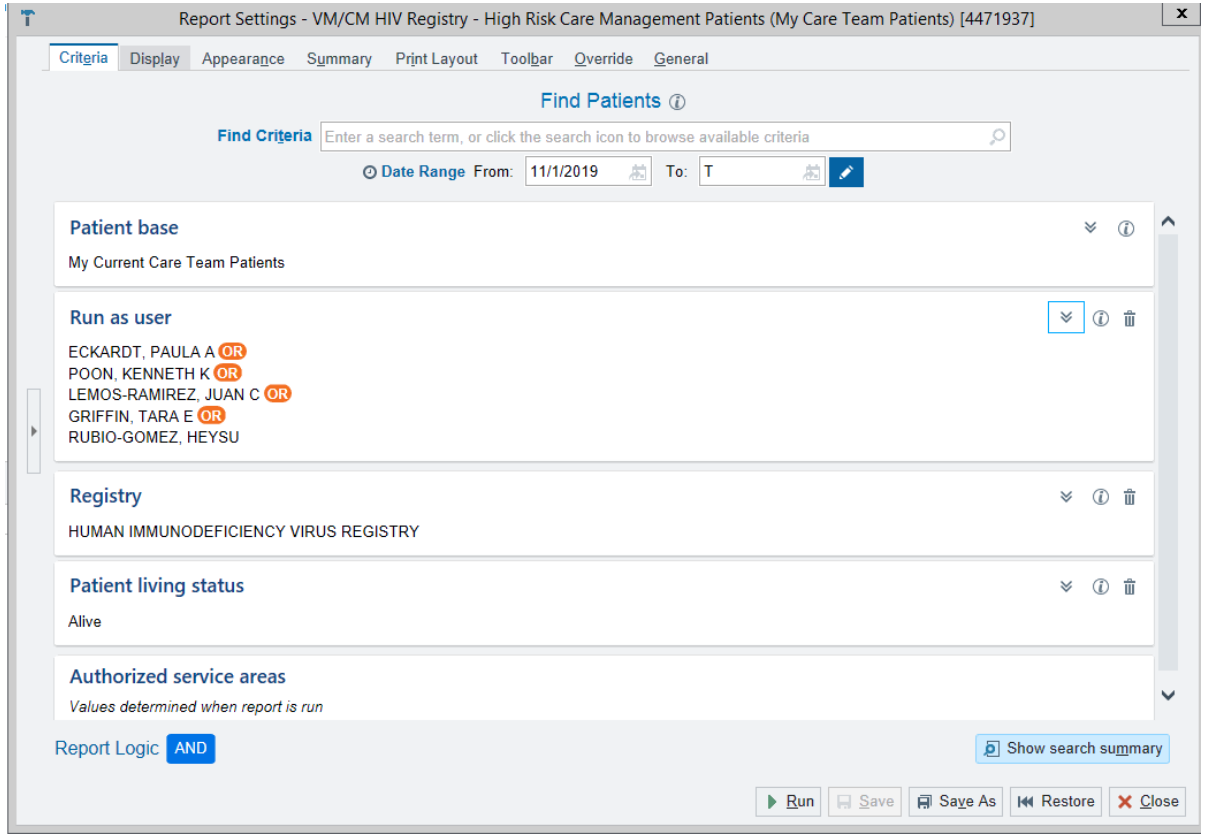
**Barrier Identified:**

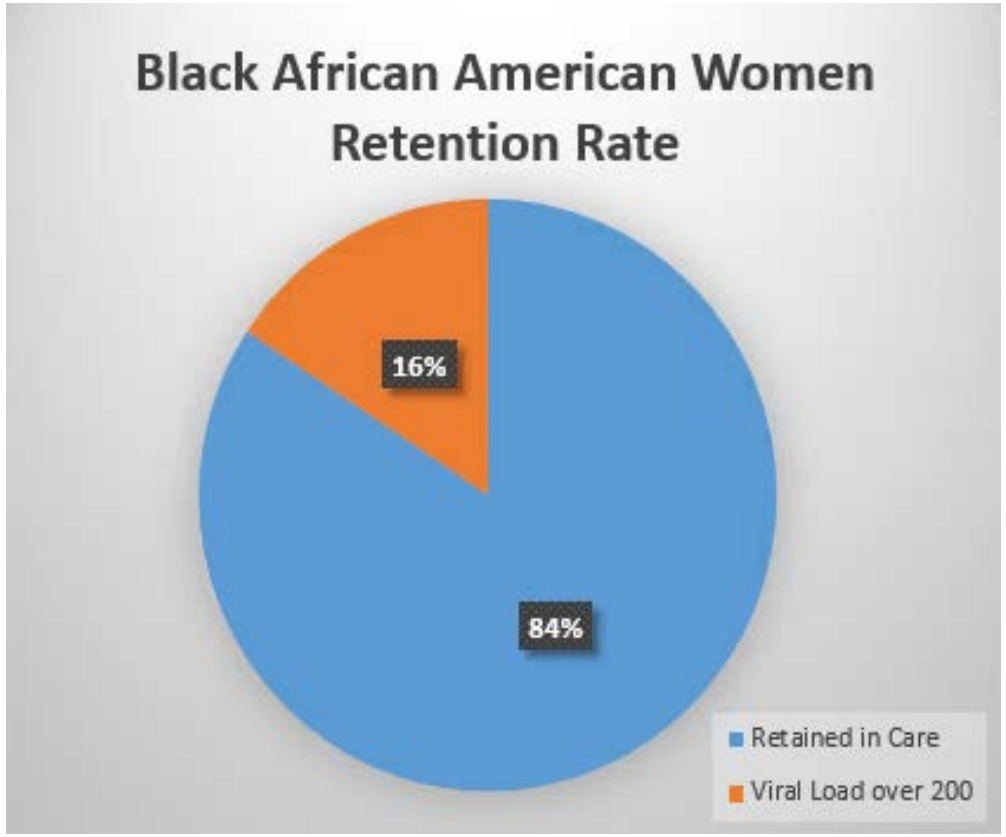
- Substance abuse/mental health issues

**Intervention:**

- Link patients with mental health and/or substance abuse provider.

# Data Collection Tools

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# Results

**Barrier Identified:**

- Work schedules are not flexible
- Childcare challenges

**Intervention:**

- Provide before and after hour appointments
- Complete the "scheduling preferences" tab in their EHR

**Barrier Identified:**

- Lack of healthcare literacy prevents patient from making educated medical decisions

**Intervention:**

- Link patient with peer specialist/case manager to help provide support and guidance on making informed medical decisions

**Barrier Identified:**

- Substance abuse/mental health issues

**Intervention:**

- Link patients with mental health and/or substance abuse provider.

Expected Outcomes:

- Increase in appointment retention rates
- Adherence to ARV's =
- Increase in viral load suppression rates

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# Next Steps

*What are you going to do next based on your results?*

- Continue to monitor patient adherence for needed intervention.
- Refer patients who do not adhere to interventions to our interdisciplinary staff meetings.

*Nova Southeastern University*

# Preliminary QIP Data

*2019, Dr. Mark Schweizer*

# Aim Statement

*What is your aim statement?*

NSU seeks to decrease the number of patients that no show their dental appointment by 2%. Currently our rate of patients not showing for their appointment(s) is around 17%.

# Intervention

- *What intervention or change did you make?*

We asked patients how far in advance they would like to receive their confirmation and the biggest complaint we had was that we were calling too far in advance (5 days prior to appointment). We decided to change this and we began calling 2 days in advance and the day of for patients that repeatedly fail their appointment.

# Data Collection Tools

- *What tools or methods did you use to collect data?*

First we evaluated the data and calculated our failed rate for a 3 month period to determine what our average percentage was of patients that failed their appointment. We then verbally surveyed patients asking "How far in advance would you like us to confirm your appointment?" We did this over a one week period and then evaluated the patient's answers to determine how far in advance most patients would like us to call to confirm. We then changed the confirmation process and began calling patients two days in advance based off patient's feedback. After one month, we calculated our failed rate data and determined the percentage of patients failing.

We also ran a PDSA cycle to determine if there was a link between patients failing their appointment and a high viral load. We ran a report in PE of all of the patients that are not virally suppressed and then evaluated each patient's chart. We looked to see if patients have kept a medical and dental appointment within the last year as well as their appointment history (did they fail often?).

# Results

- *On this slide share the results of your data collection, observations or other findings*
- Our failed rate decreased by 2% after the first month of changing our confirmation process. We still have patients that constantly fail appointments but we began scheduling them on standby so that if they don't show up, our schedule isn't affected by it.
- We did not find a correlation between viral suppression and patients failing their appointments.

# Next Steps

- *What are you going to next based on your results?*
- We are trying to get a process in place that will allow us to text patients to confirm their appointments. The system is very costly but it's something that NSU is trying to accomplish within the next year. Many patients ask us to text them for appointment reminders so we are hoping this will decrease our failed rate even more.

# *Broward House* Preliminary QIP Data

*2019, Jamie Powers and Gillian Cross Hogg*

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# Aim Statement

*What is your aim statement?*

**Broward House aims to increase the viral suppression rate in the youth population by 10% by identifying barriers to retention in care and effective interventions to increase engagement and retention in care and treatment.**

# Intervention

- *What intervention or change did you make?*

Broward House has implemented the use of the Triage Tool, triaging all clients to ensure that linkage to all needed services are provided at the time they are seeking assistance. This tool allows for us to work to address all of the clients' needs thoroughly, as a one stop shop. We have been tracking the use of this tool, capturing linkages made, and demographics of clients. We will take this data and further assess the effectiveness of engaging clients in care. We will review if the access to all needed service help to maintain client engagement within our target population, thus positively effecting viral suppression rates.

Additionally, we have completed a focus group with staff that meet the demographic age range, focusing on identifying basic barriers to care at all levels based solely on the age range we are targeting. With this information, we are examining additional interventions that we can begin to implement to increase client engagement in care to positively effect viral suppression within our targeted population.

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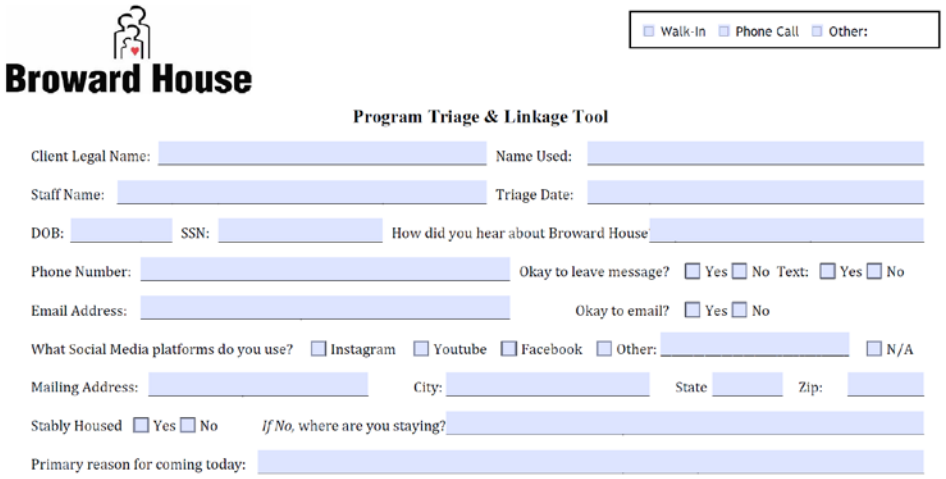
# Data Collection Tools

- *What tools or methods did you use to collect data?*
  - Triage tool implementation
  - Focus group



Broward House

Walk-In  Phone Call  Other:

**Program Triage & Linkage Tool**

Client Legal Name: _____ Name Used: _____

Staff Name: _____ Triage Date: _____

DOB: _____ SSN: _____ How did you hear about Broward House _____

Phone Number: _____ Okay to leave message? Yes No Text: Yes No

Email Address: _____ Okay to email? Yes No

What Social Media platforms do you use? Instagram Youtube Facebook Other: _____ N/A

Mailing Address: _____ City: _____ State _____ Zip: _____

Stably Housed Yes No *If No,* where are you staying? _____

Primary reason for coming today: _____

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# Results

- *Results of Triage Tool Implementation are Pending*
- *Results of Focus Group*
  - n=6 participants
  - Potential barriers identified included: Young and invincible, language or literacy barriers, unfamiliarity with navigating medical system, poor experiences with physicians
  - Potential interventions identified included: Pairing with peer, mentorship with older PLWHA, support groups for family and friends, accountability program, Intensive hands-on case management, workshop on developing skills and independence, providing a medical log book to aid with tracking medical history

# Next Steps

- *Next steps will include:*
  - Assessing the success of the Triage Tool to determine if engagement in care has increased
  - Selecting intervention(s) specifically targeted to youth

# *Legal Aid Service of Broward County, Inc. (Legal Aid)*

# Preliminary QIP Data

*2019, Kara Schickowski, Esq.*

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# Aim Statement

*Legal Aid seeks to increase the number of Black African-American Latina (BAAL) women utilizing Legal Aid's Ryan White services in Quarter 3 (as compared to Q3 Fiscal Year 2018-19).*

# Intervention

- Client (and case manager) outreach and education
  - *Identify case management (CM) and centralized intake and eligibility (CIED) agencies that historically serve a large percentage of BAAL women*
  - *Outreach (phone, email, in-person) to agencies identified to provide Legal Aid FAQs including direct contact  phone numbers for clients and detailed information regarding available services (both Ryan White-covered legal services and others provided at various other units at Legal Aid)*

- Schedule client appointments at case management and/or centralized intake and eligibility agencies, *as requested by clients*

# Data Collection Tools

- Track the number of informational outreach materials distributed in Q3
  - emailed three CM/CIED agencies
    - *request agency contacts distribute materials to all staff and clients*
    - *offer to present at agency staff meetings and/or arrange client workshops*
  - two on-site visits to agencies
    - *distribute 30 brochures per visit*

# Data Collection Tools

- Internal case management program reports *(LegalServer: "Ryan White funding code opened cases Q3 by client demographics")*
  - 13 **new** cases opened during FY2019-20 Q3 for BAAL women through the Ryan White unit
    - *Compare to 9 **new** cases opened during FY2018-19 Q3 for BAAL women through the Ryan White unit*
    - *Data Limitation: numbers do not include Ryan White-eligible clients that sought assistance and had case files opened through other units at Legal Aid; only accounts for those receiving services and billed-through Legal Aid's Ryan White program*

# Data Collection Tools

- Provide Enterprise client utilization reports (*Served Clients with Demographic Data*)
  - FY2019-20 Q3: 36/124 clients served identified as BAAL women (**29.03%**)
    - *Compare to 43/137 BAAL women clients in FY 2018-19 Q3 (**31.38%**)*
    - *Same data limitation as noted on previous slide (data only includes clients receiving Ryan White legal services at Legal Aid, not those that received services through other units)*

# Results

- Case Management and Centralized Intake and Eligibility agency staff happy to receive and distribute updated Legal Aid information to both colleagues and clients
  - *Emails are the most requested form of information because it can be easily forwarded; CMs also request hard-copy brochures to keep at their desk to give clients physical copies*
- Available space at partner agencies limit the opportunities to meet with clients in a private setting
  - *client closing survey finds that clients who receive legal services at Legal Aid don't generally find transportation to be a barrier to receiving the service*
  - *two clients requested legal services appointments off-site; eight clients requested services to be by phone conference (after initial applications either emailed or mailed to client)*
- Clients who receive Legal Aid presentations and/or information from CM/CIED agencies often take several months to follow-up and request an appointment for legal services; it may be next Quarter before data actually reflects any benefit of current outreach efforts

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# Next Steps

- Incorporate QIP (focused outreach efforts) into overall Quality Improvement/Quality Assurance Plan
  - *Continue outreach on a regular basis in an ongoing attempt to reach populations that underutilize legal services*
  - *Offer to provide certain legal assistance off-site to clients unable or unwilling to visit the main Legal Aid office*

# Intervention

- *What intervention or change did you make?*
  - *We wanted to know more about our clients' medication adherence practices (to assist in helping with viral suppression)*

# Data Collection Tools

- *What tools or methods did you use to collect data?*
  - *Ask-12 Taking Medicine – What Gets in the Way?*
- *You can include screenshots, pictures or questions from surveys or other tools*

# Results

- *On this slide share the results of your data collection, observations or other findings*
- *You can include tables, charts, and images to do this*
  - *N=5 (small n)*
  - *2/5 (40%) reported agreeing with the statements "I just forget to take my medicines some of the time." and "I run out of my medicine because I don't get refills on time."*
  - *All had strong, positive treatment beliefs*
  - *2/5 (40%) reported not having their meds when it was time to take it in the last 3 months*

# Next Steps

- *What are you going to next based on your results?*
  - *Collect more data*
  - *Look into refill issues*
  - *Helpful reminders (pill boxes, EDED app, phone calls, etc.)*

# *SunServe* Preliminary QIP Data

*2019, Gary S. Hensley Director of Quality Assurance*

# Aim Statement

- **SunServe would like to increase engagement in care for MSM ages 29-38 years old. Our goal is to increase viral suppression to 75% by December 31st.**

# Intervention

- **SunServe has obtained some emergency bus passes that will be extended to Ryan White Mental Health clients going forward.**

# Data Collection Tools

- ***Ryan White barriers to care survey will be administered which will be followed by a data drill down on survey data received back.***
- 1. What would make Mental Health Services at SunServe more accessible to you?
- 
- Comments_____
- 2. Do you have issues with transportation that affects your ability to make your appointments?
- **Yes**____ **No**____
- Comments_____
- 
- 3. Do you have issues with phone service that affects your ability to schedule appointments?
- **Yes**____ **No**____
- Comments_____
- 
- 4. Do you have issues with Housing that affects your ability to make your appointment?
- **Yes**____ **No**____
- Comments_____
- 
- 5. What gets in the way of you taking your HIV Medications? Lack of access?
- Comments_____
- 
- 6. Do you have any scheduling and or employment issues that keep you from keeping your appointments?
- **Yes**____ **No**____
- Comments_____
- 
- 7. If none of the above have kept you from not showing up for appointments are there other issues that are the barrier?
- Comments_____

# Results

- *Root Causes were determined to be: Lack of Transportation & Lack of Stable Housing*
- Barriers to Care Survey Results:
- 60% Lack of Transportation
- 40% Lack of Stable Housing
- Survey Demographics:
- 82% Male 18% Female 73% Non-Hispanic 9% Haitian 18% Other
- 9% 25-35 9% 36-45 36% 46-55 45% 56-65
- 55% White 36% B/AA 19% Other

# Next Steps

- *We are doing post bus pass program surveys with participants that have received bus passes to see if it has made a difference.*

# Intervention

- *What intervention or change did you make?*

1. *The distribution of pill organizers and/or key chain pill carriers to facilitate the taking of medications to help achieve viral load suppression.*
2. *Setting alarm on cell phones to remind when to take medications.*



# Data Collection Tools

- *What tools or methods did you use to collect data?*

➢ *We did interviews and surveys*

➢ *Questions from the interviews/surveys include:*

❖ *How many doses of your antiretroviral medication have you missed last week?*

❖ *How important is it for you to take your medication daily?*

❖ *When the medication is not in you body, what do you think the virus is doing?*

❖ *On a scale of 0-10, how helpful was this discussion for you?*

# Results

**Data Collection from 11/4/19**

- Client I.N. 5/20/19 VL = 2205. In 9/30/19 VL = 47.
- On 11/4/19 she opted for the cellphone alarm clock reminder
- Called her 11/14/19 to check-in. Said alarm reminder is helping
- Came for f/u apt w/MD 11/18/19. Said she missed the AM dose. She opted to take the pill organizer that day to help remember.
- Saw 12/9/19, said she missed weekend doses.
- Next lab appt. 2/10/20.

**Data Collection to Current**

- Has lab appt. for 2/10/20. Will review results then.

# Results

## Data Collection from 11/4/19

- Client M.G. 11/16/17 VL = 1191
- 3/15/18 VL = 3076
- 7/19/19 VL = 29
- 1/25/19 VL = 169
- 8/7/19 VL = 1085
- 10/18/19 VL = 2038
- 10/21/19 VL = 527
- Met w/pt 11/7/19. Said she's homeless. Opted to take weekday pill organizer versus using alarm clock.
- Met w/her again 11/18/19 on lab appt. Said she's taking meds daily.
- Kept f/u MD appt. 11/25/19.

## Data Collection to Current

- 11/18/19 = <20
- Next lab appt. 2/10/20

# Results

**Data Collection from 11/4/19**

- Client T.H. 5/12/17 VL = 89,241
- 6/7/17 VL = 251
- 6/19/18 VL = 113,743
- 10/4/18 VL = 53
- 2/4/19 VL = 163
- 5/30/19 VL = 227
- 11/6/19 VL = 25,952
- Was difficult to get pt in to talk to. Eventually came 11/25/19. She chose phone alarm as reminder.
- No-show for counseling appt. 12/5/19.
- Had genotype lab drawn 12/9/19. Said she hasn't missed taking meds since 11/25/19

**Data Collection to Current**

- Next follow up appt. with MD 12/23/19

# Results

**Data Collection from 11/4/19**

- Client W.M. 5/3/17 VL = 141,137
- 2/9/18 VL = 362,341
- 5/15/18 VL = 1267
- 8/18/19 VL = 64,994
- 10/15/19 VL = 154
- On 11/11/19 did home visit to pt's house due to inability to get her in. Said she's taking her meds daily. Did not need to set phone alarm or use pill organizer to take meds.
- No show for appt. 11/14/19 and 11/22/19
- Did walk-in 11/25/19. Was not able to be seen. Appt. rescheduled for 12/5/19. No show also. Called 12/9/19 to reschedule.

**Data Collection to Current**

- Awaits for pt to have labs drawn to determine viral load status now.

# Next Steps

- *What are you going to next based on your results?*

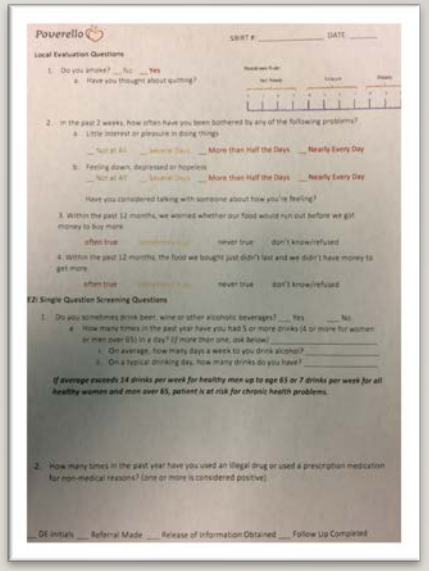
➢ *Awaits upcoming lab results for clients to determine effectiveness of intervention.*

# INTERVENTION

- ***Q: What intervention or change did you make?***
  - ***A: SBIRT (SAMSA) screening, brief intervention and referral to treatment***

# DATA COLLECTION TOOLS

- **Q:** ***What tools or methods did you use to collect data?***
  - **A:** ***PHQ2***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SWIFT # _____ DATE _____

Local Evaluation Questions

1. Do you smoke? ___ No ___ Yes
   a. Have you thought about quitting?

2. In the past 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things
   ___ Not at All ___ Several Days ___ More than Half the Days ___ Nearly Every Day
   b. Feeling down, depressed or hopeless
   ___ Not at All ___ Several Days ___ More than Half the Days ___ Nearly Every Day

   Have you considered talking with someone about how you're feeling?

3. Within the past 12 months, we worried whether our food would run out before we got money to buy more
   often true ___ never true ___ don't know/refused

4. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more
   often true ___ never true ___ don't know/refused

**EZ: Single Question Screening Questions**

1. Do you sometimes drink beer, wine or other alcoholic beverages? ___ Yes ___ No
   a. How many times in the past year have you had 5 or more drinks (4 or more for women or men over 65) in a day? (if more than one, ask below) _____
      i. On average, how many days a week to you drink alcohol? _____
      ii. On a typical drinking day, how many drinks do you have? _____

***If average exceeds 14 drinks per week for healthy men up to age 65 or 7 drinks per week for all healthy women and men over 65, patient is at risk for chronic health problems.***

2. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? (one or more is considered positive)

___ DE Initials ___ Referral Made ___ Release of Information Obtained ___ Follow Up Completed

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# RESULTS

- *The Poverello Center (TPC) has concluded as a result of the questionnaire that:*
  - *70% of our clients have self-reported that they are symptomatic to some form of mental health including but not limited to depression and/or anxiety*
  - *65% of our clients have self-reported that they are experiencing some form of present substance abuse*
  - *75% of our clients have self-reported that they are "food insecure"*

***Data pool: 768 participants screened through TPC PHQ2 program questionnaire.***

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# NEXT STEPS

- **Q:** ***What are you going to next based on your results?***
  - **A:** ***TPC is working to build a network of providers who offer a variety of services including but not limited to Mental Health and Substance Abuse specialties. TPC will refer clients to proper providers who specialize in the specifically identified issues of the individual client and engage in active and routine follow-up on our client's progress.***