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

Support Services QI NETWORK
Tuesday, December 4, 2018 at 9:30 A.M.
Ryan White Part A Program Office
115 S. Andrews Ave., Ft. Lauderdale 33301

MINUTES

PROVIDERS PRESENT
Patrick Saint Fleur – AHF
Roseline Labissiere – BCFHC
Tim Romero – BCFHC
Karen Whyte – Broward House
Vanessa Sooknanan – BRHPC
Stephanie Booth – Care Resource
Kara Schickowski – Legal Aid
Laurie Yadoff – Legal Aid
Edna Ferguson-Walker – NBHD
Amy Pont – SBHD

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Gritell Martinez
Marcus Guice
Anitha Joseph

PART A RECIPIENT STAFF
Richard Morris
Edith Garcia
Leonard Jones

GUESTS

I. Call to Order
The meeting was called to order at 9:35 a.m.

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

III. Improving the Client Referral Process: A Quality Improvement Approach
The presentation can be found within the meeting packet.

QI manager updated the group about the conversation with Palm Beach County and their referral process. CQM staff then presented a PowerPoint on referral system best practices.

Presentation Overview
Referrals in health systems across the country are often mishandled or dropped altogether, forcing referring providers, patients, or their representatives to mediate and undertake the referral process themselves. In fact, 68% of specialists in the U.S. receive no information from primary care physicians prior to referral visits. Common root problems within referral systems include a lack of standardization in referral protocols, reliance on a decentralized approach, lack of staff or personnel resources to manage client referrals, and mediocre portal/electronic systems to support referring providers' needs. Referral workflow technology, especially needs improvement.

Having a strong referral system and strengthening linkage helps clients adhere to and navigate the HIV care continuum better. The National HIV/AIDS Strategy's 2020 target is 90% of persons diagnosed with HIV infection retained in care. Retention in care for the Broward County Part A system and support services was 73% for FY2017.

Recommended processes that need to be in place for a successful referral system include: standard referral ordering process for all providers, partner agreements for feedback loops and accountability, standardized messaging and scripts for efficiency, adherence to a tracking mechanism, and clean-up guidelines.

Workflow Discussion
The ideal workflow is: provider/care navigator orders referral → referral created → electronically logged into PE → referral documentation sent to specialist or external agency → patient goes to specialist or external agency → specialist or external agency sends back note → note reviewed by provider/care navigator → referral completed and noted in PE.

Care Resource member noted that the workflow for them starts off successful but breaks down when they don't receive communication back from the provider that receives the referral. Another member stated that after logging the referral in PE, they have to do the follow up with the receiving provider/agency to make sure client went to the appointment. Members want PE to generate a notification for the receiving agency once a referral has been logged.

Recipient staff emphasized that **PE has the capability to send e-mails, links, and notes to referral agencies**, but the user must use the Tracking tab, and not simply enter notes in the Referral Notes tab. Staff cannot pull or track data on referral notes logged in the Referral Notes tab. This information has to be entered into the Tracking system. Additionally, the receiving agency/provider needs to have a system in place to receive and record the disposition. AHF member noted that in Palm Beach, each agency has an assigned staff person to receive and record referrals. He suggested that Broward County should have a similar process in place.

Recipients explained that PE's Tracking tab has the capability to not only send emails, but it can also log dispositions. So, it is up to the case manager's discretion to choose whether or not to use the Referral Notes tab for their own documentation purposes. However, they should absolutely be using the Tracking tab to log notes and dispositions.

Members stated they have no knowledge about PE's Tracking tab's email, tracking, and disposition capabilities. Members asked to have a training at the next meeting on PE system capabilities. Focus areas will be on how to use the Tracking tab in PE, best practices on usage, and insuring that there is a disposition. Moving forward, it's vital that referrals are being tracked, and not just in the progress notes log.

Recipient staff encouraged members to have internal training processes and procedures in place for inter-agency staff turnover. Since agencies receive an annual PE training, they should have an in house staff member that can communicate this knowledge to users that did not attend the general training and also new staff. Recipient encouraged developing a desk reference for staff to have on hand. **Asking for technical assistance on monthly provider calls is also a key resource for answering questions about PE**. Recipient staff holds weekly calls with the PE developer. If there are questions that staff can't answer, they can ask the developer and/or troubleshoot during the weekly call.

Prior to the next SSN meeting, each organization should start practicing the new referral process discussed. As a part of a PDSA around the referrals, staff suggested looking at the baseline, and where we are now. **Members can evaluate their current referral situation, as a baseline, by pulling a report and seeing how many referrals are out there and who the recipient is for those referrals.** Staff also encouraged investigating if the receiving agency has staff in place to receive and document referrals.

PE users that are listed within the agency are who can receive the email from PE. Note that some receiving providers are not Part A, so there needs to be a follow up process in place for those referrals. **If there is staff turnover, agencies should contact the program office to let them know which staff are no longer a part of the budget and who should not be a listed as a user on PE.**

Care Resource member asked Recipient to define staff roles. Omeid is the contracts and grants administrator. Neil and Richard deal with the quality aspect of the contracts. They can answer technical assistance questions related to the system and how the service delivery models should be implemented in the field.

When clients are attached to providers by relationship, there are certain actions that need to be completed to change their relationship status prior to a provider leaving. Action plans need to be closed, service goals need to be closed, even before a new provider takes place. There is no one button that is going to cancel out everything because it is tied to billing.

If a provider has set up a billing relationship with their clients and have not completed the proper closure protocol, then the relationship will remain open. It will not automatically close when a provider leaves the system. In fact, the provider is still active until the Recipient gets a notice of leave from the agency. Only then can the Recipient enter on the user side and change the provider's status to inactive. Recipient staff mentioned that they will try to set up a training to get everyone on the same page by January or February.

IV. End+disparities ECHO Presentation: Using QIPs to increase viral load suppression outcomes by 10% among African American Latina Women

The presentation can be found within the meeting packet.

The CQM Staff presented an overview of the end+disparities ECHO collaborative. The presentation includes information regarding Broward's analysis of the Black/African American and Latina women subpopulations, the National Collaborative Aims, structure of the program, and Program Performance Measurements. Staff will provide the recent trends of African American/Latina viral suppression improvement within the updated presentation in the meeting packet.

The CQM team emphasized the focus of how improved health outcomes and quality improvement projects can stem from addressing the disparities within these subpopulations in the ECHO Collaborative. There have been previous QIPs focused on addressing the barriers of women of color living with HIV in accessing treatment and achieving viral suppression. Viral load suppression for Black/African American and Latina women has improved within the EMA over that last few years. Barriers to care in the past has included transportation, housing, and mental health. There are a host of external variables that affect clients' ability to show up such as being able to make it to the agency before the facility closes and prioritization of family roles and self-sacrifice of personal health. Agencies demonstrated mixed no-show rates with some experiencing high volumes of client no-shows and others having a low volumes of no-shows.

There are different techniques used to compensate for the client no-shows such as case managers being available as needed, agencies opening early, keeping facilities open until 7pm, or even being open on weekends. Agencies have developed contracts with Lyft or other transportation services in efforts to alleviate the barrier of transportation. There was discussion of how an agency could account for client waiting times. Providers have made efforts to create "safe-spaces" and provide activities that subvert the stigma and mental stresses associated with positive HIV status. These activities from various agencies have included museum tours, painting activities, public forum, and providing food.

The network discussed interventions focused around making clinics more accessible for clients who experience unstable housing. Some of the interventions discussed were:

- a promotion of personal health and hygiene for women,
- having food available, testing and screenings,
- having cell phone charging stations, and
- connecting clients to pertinent community groups.

Additionally, an AHF provider mentioned that the agency has an annual Thanksgiving event in which they provide meals, have on site testing, and offer other services. The Legal Aid provider emphasized the importance of asking clients about external factors aside from health status and direct services given at the agency. Assessing needs and applying client-focused services, being flexible and allowing clients to choose times of appointment, and communicating in a personable manner are all imperative for connecting with clients and promoting their well-being.

V. Case Study: Care Resource

Case study can be found attached in the meeting packet.

The member read through the client's history. The client's criminal history is unknown. Because aggressive history and drug record, housing is going to be a particular challenge. A provider noted that the client may have Social Security Disability Benefits as an option if physician diagnoses some of his health conditions. This would help partially eliminate his financial burden. There will be communication with the CIED provider in re-initiating his Ryan White eligibility. One member noted that the client should consider seeking behavioral health care at Henderson Mental Health Center due to his drug and behavioral record. There was emphasis placed on determining the goals of the client instead of the goals of the case managers for the clients. Clients must have clear defined goals for what they want to accomplish in seeking care. Additionally, there should be support provided to the case manager to relieve the pressure from the client. The client currently has a dependence to his case manager and the longitudinal affects of their client-provider relationship has caused mental exhaustion. Keeping the latest of the client's documentation for whenever personal documents and identification are lost or misplaced would be beneficial in allowing the client a safety net in maintaining current personal information. It is important to keep documentation current in PE in situations where clients need this information.

VI. Complete Meeting Evaluation Discussion

VII. Adjournment

The meeting was adjourned at 11:25 a.m.

Next Meeting Date: March 5, 2018
Reminder: Breakfast Potluck; An email reminder will be forwarded.

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

SUPPORT SERVICES NETWORK MEETING

Date: December 4th, 2018 at 9:30A.M.
Location: Ryan White Part A Program Office
115 S. Andrews Ave. A-337
Ft. Lauderdale, FL 33301

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

AGENDA

I. Welcome/Introductions

II. Improving the Client Referral Process: A Quality Improvement Approach

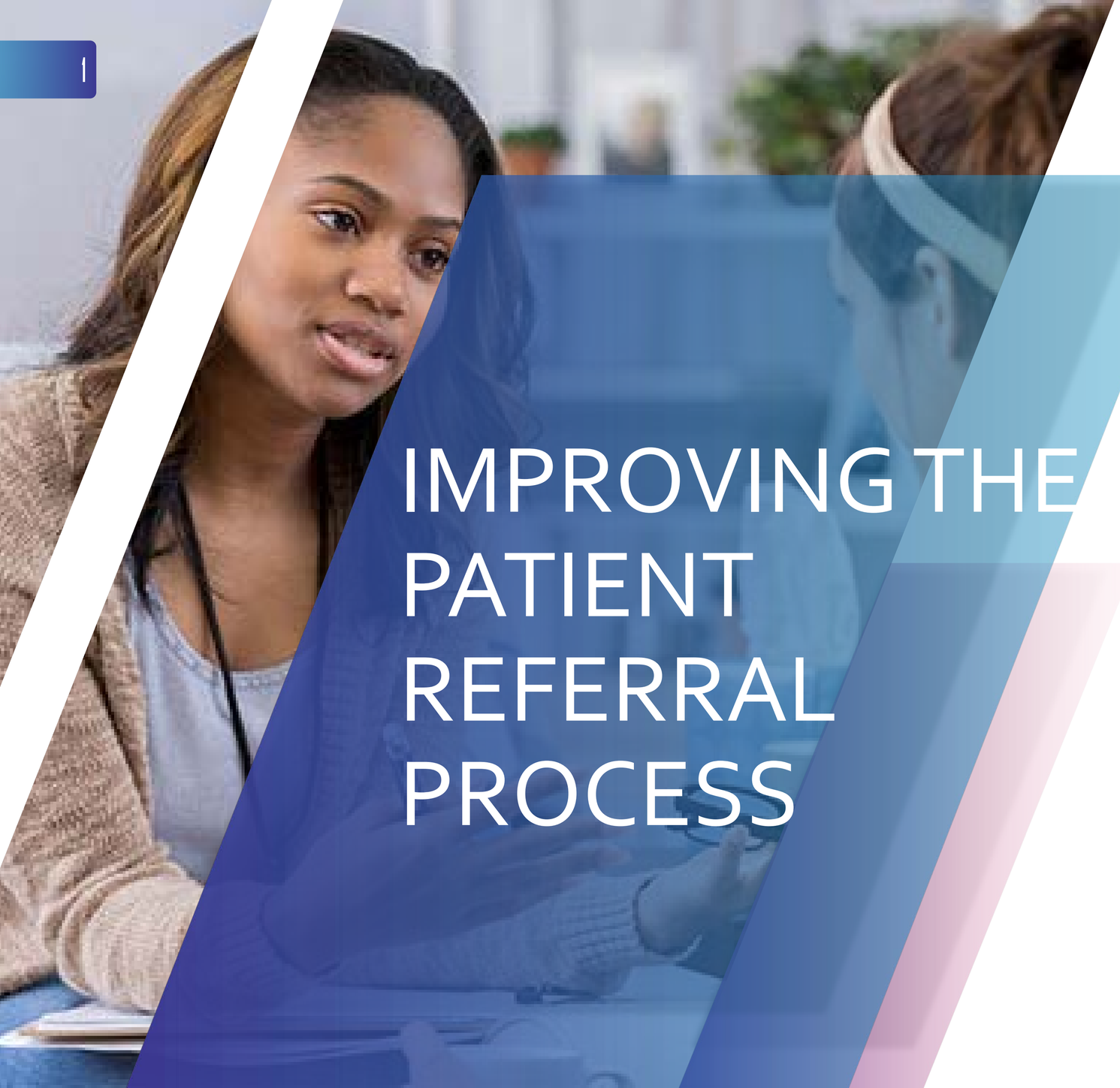
III. End+disparities ECHO Presentation: *Using QIPs to increase viral load suppression outcomes by 10% among African American and Latino Women*

IV. Case Study: Care Resource

V. Complete Meeting Evaluation

VI. Adjournment

Next Meeting Date: March 5th, 2019
Please see staff for a Governmental Garage Parking Validation ticket



IMPROVING THE PATIENT REFERRAL PROCESS

A QUALITY IMPROVEMENT APROACH

Support Services Network Meeting

Tuesday, December 4th, 2018

PATIENT REFERALS

A Common Problem

A vast majority of health care providers experience issues with their referral system

68% of specialists in the U.S. receive no information from primary care physicians prior to referral visits

Referrals in health systems across the country are often mishandled or dropped altogether, forcing referring providers, patients, or their representatives to mediate and undertake the referral process themselves

COMMON ROOTS

Typical Issues within referral systems

Lack of standardization in referral protocols

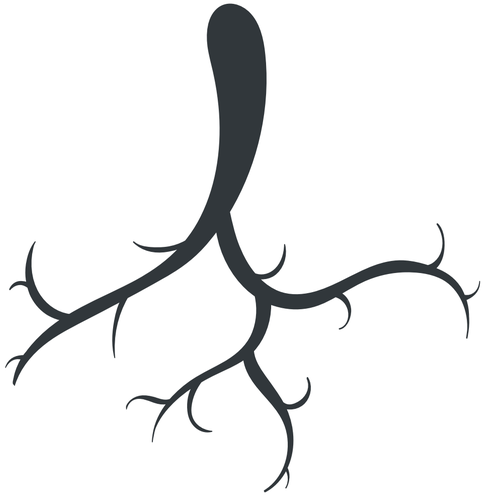
Reliance on a decentralized approach

- Individual agencies responsible for its own referral traffic

A need for a better portal (or electronic system) to support referring providers' needs

- 92% of providers note that referral workflow technology needs improvement.

Lack of staff or personnel resources to manage client referrals



STRENGTHENING LINKAGE

Using the Care Continuum

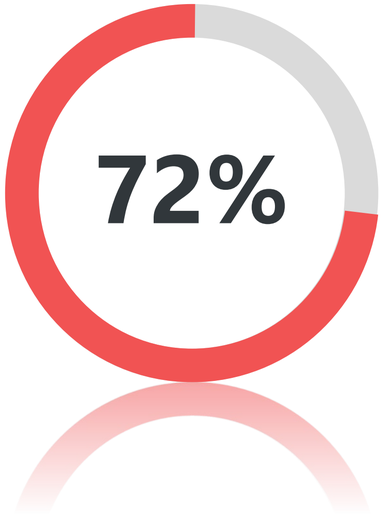
The HIV Care Continuum Outlines the series of steps that people living with HIV go through, from initial diagnosis through treatment with medication

To achieve the full continuum of care, our program requires strong linkages among testing, clinical care, and social support services.

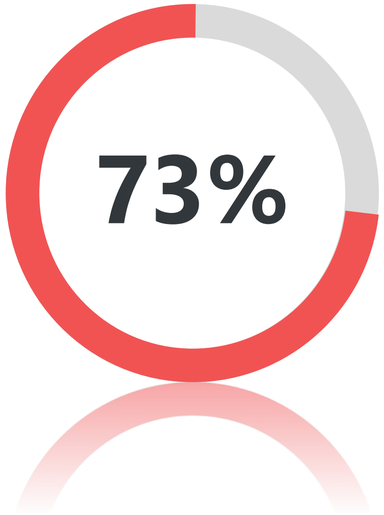
A suboptimal referral system could add barriers in care that specifically affect clients' retention rates

RETENTION IN CARE PERFORMANCE

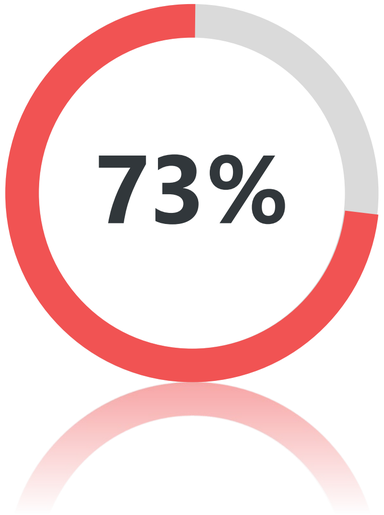
Support Services Thru Q3 FY2018



Support Services FY2017



System-wide FY2017



The National HIV/AIDS Strategy's 2020 target is 90% of persons diagnosed with HIV infection retained in care.

PROCESS NEEDED

Standard referral ordering process for all providers

Partner agreements for feedback loop, accountability

Number outreach attempts (to specialist and patient)

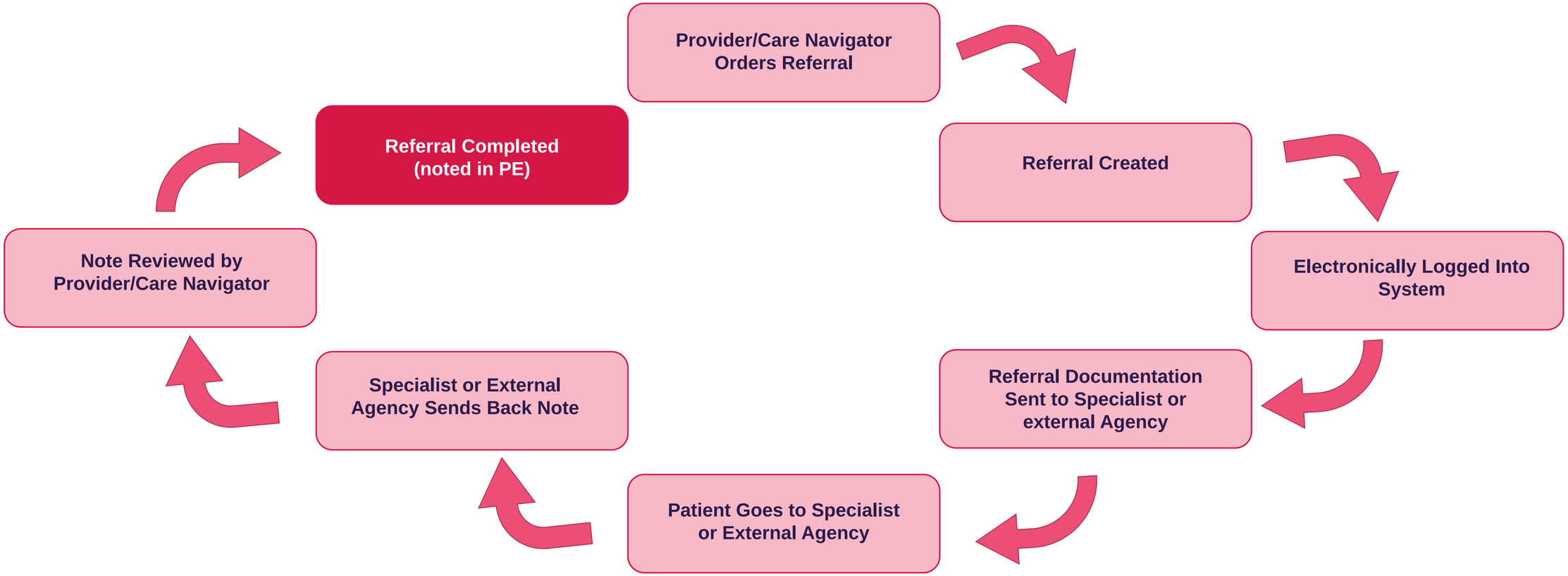
Create standardized messaging and scripts for efficiency

Adherence to tracking mechanism

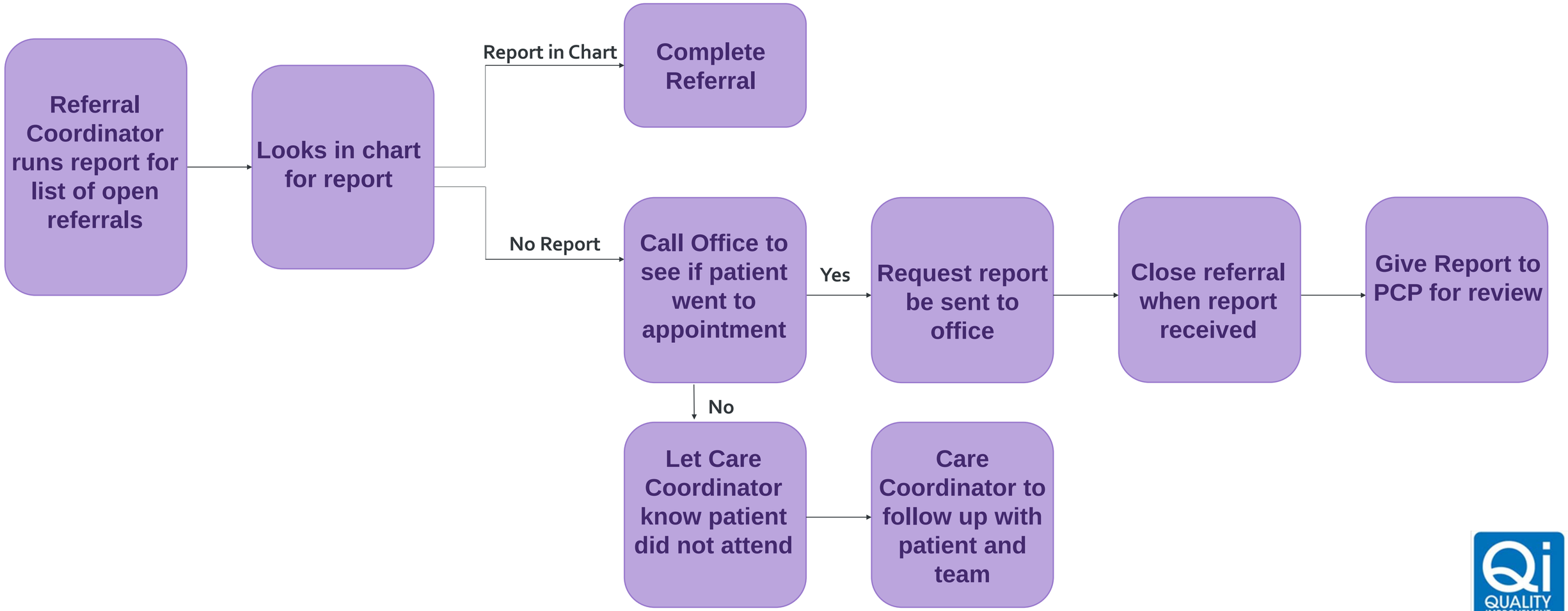
When is a referral considered complete?

Clean up guidelines (i.e. referral closed by the provider)

IDEAL WORKFLOW



EXAMPLE CLEAN-UP WORKFLOW



OBERSERVATION OF PALM BEACH COUNTY

The Palm Beach County utilize the Email referral component of Provide Enterprise

- Email referrals are sent to agencies for patient referrals
- Once clients visit the agency an email is sent back to referring agency
- There is a confirmation receipt activated whenever personnel opens referral emails.
- There are only a few (2 to 4) people at each agency who coordinate via the referral email account
- There is also a mass SMS capability for client notifications, however only one of their agencies are currently using this

Technical Difficulties

- Recently, there has been a technical problem with personnel being able see referral emails.
- They are currently troubleshooting this with PE

SMALL INTERVENTIONS PROVEN TO WORK

Offsite referral coordination with communication through inbox messaging

Service Integration

- Referrals made to agencies in which multiple needed interventions/services can be provided at time of visit

Patient-Centered Case Management

- Ask patients about things that may affect their ability to manage their health.
- Listen to what patients tell you about the challenges in their lives.

OTHER THINGS TO CONSIDER WHEN MAKING REFERRALS

Referring Personnel must consider all available options to make the referral that is best for a specific client

The right referral requires a person to answer questions such as:

- Does the facility have the right staff, processes, and track record for this particular need?
- Is the referral clinically appropriate for this client?
- Is the facility conveniently located for the client?
- Are there nonclinical partners who can meet critical aspects of this client's care?

REFERENCES

- Olayiwola JN, Bodenheimer T, Dubé K, Willard-Grace R, Grumbach K. (2014). Facilitating Care Integration in Community Health Centers: A Conceptual Framework and Literature Review on Best Practices for integration into the Medical Neighborhood. *Blue Shield of California Foundation Report*. http://www.blueshieldcafoundation.org/publications/facilitating-care-integration-communityhealth-centers-conceptual-framework-and-literat
- Centers for Disease Control and Prevention. (2015). Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2013. *HIV Surveill Suppl Rep.* 20(2):70.
- Link Patients to Non-Medical Support: Tool #18. Content last reviewed February 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool18.html
- Schneider, M. (2018). 5 Steps to improve your patient referral processes. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/patient-engagement/5-steps-to-improve-your-patient-referral-processes.html

Qi QUALITY IMPROVEMENT

end+disparities ECHO Collaborative

Presented by:
Broward Regional Health Planning Council
Clinical Quality Management Office
Support Services Network -Broward EMA
December 4th, 2018

About end+disparities ECHO Collaborative

- National Quality Improvement Initative: March 2018 – October 2019
- Managed by the **HRSA Ryan White HIV/AIDS Program Center for Quality Improvement & Innovation (CQII)** and supported by the **HRSA HIV/AIDS Bureau (HAB)**
- Collaborative framework is based on the **Institute for Healthcare Improvement (IHI) Breakthrough Series model** with elements of virtual case presentations and discussions developed by the University of New Mexico's **Project Extension for Community Health Outcomes (ECHO)**

What is the end+disparities ECHO Collaborative?

- Mission: To promote the application of quality improvement interventions with the **ultimate goal** of **increasing viral suppression rates** for four **disproportionately affected HIV subpopulations**.
  - MSM of Color
  - Youth (ages 13-24)
  - Transgender People
  - African American and Latina Women

What is a health disparity?

- A difference in the incidence or outcomes of a health condition that is inequitable or unacceptable. In HIV there are several disparities related to race and gender.
- Disparities also occur AFTER diagnosis and linkage to care.

National Collaborative AIMS

- Aim 1: **Increase viral suppression rates** for people living with HIV by focusing on **four disproportionately affected HIV subpopulations** and increase the average viral suppression rate across all PLWH served by Collaborative participants
- Aim 2: **Implement and document effective improvement activities** to **reduce gaps in HIV care** for disproportionately affected HIV subpopulations
- Aim 3: **Sustain regional quality management networks** of **cross-Part RWHAP recipients and sub recipients** in local improvement groups

Broward EMA Subpopulation

- **Black/African American & Latina Women**
  - African American women are 20 times more likely to have HIV than white women
  - Black women are 18 times more likely to be diagnosed with HIV compared to White women
  - Latinas are 4 times more likely to be diagnosed with HIV compared to White women
  - More than 3 in 5 women diagnosed with HIV in 2015 were African American
- Next steps:
  - Focus local quality improvement efforts to reduce HIV disparities
  - Conduct improvement activities to meet the local & regional improvement needs
  - Collect performance data & track improvement efforts over time

South Florida Regional Group Members

Broward EMA

Orlando EMA

Palm Beach EMA

Tampa EMA

A Call to Action

- https://youtu.be/nJCbRTq_3zw

ECHO Performance Measurement

- The following list of measures, consistent with HAB measure definitions, are collected every other month:
  - % of HIV patients receiving outpatient ambulatory health services with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
  - % of Black/Latina Women with HIV receiving outpatient ambulatory health services with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Quality Improvement Projects - Discussion

- What do you see as barriers to viral load suppression, impacting the Black/Latina female community in Broward county?
- What projects are being conducted nationally and locally?
- Do you have ideas/suggestions for projects?

- GOAL: Increase VL suppression by 10% over the next year. Broward County is currently at 83%.

Common Causes For Detectable VL

1. Stigma
2. Mental Health/Trauma
3. Cultural Barriers/Social Support/Isolation
4. Staff Turnover

What barriers do you encounter with your clients?

ECHO Group QIP Preliminary Recommendations

- Reducing stigma: Find ways to make women feel welcome as soon as they enter the space
  - Eye contact
  - Handshake
  - Being offered coffee, water or a beverage when they check in
  - Being offered choices, such as wait here or there, do you want to see a case manager now or later? – any small choices that make it feel like the client is an honored guest and at the center of their own care.

ECHO Group QIP Preliminary Recommendations

- Client Engagement: Life is unpredictable. Women often have to think about many X factors like childcare, not missing work to attend an appt., making and keeping follow up appts., etc.
  - Effective & efficient appointments – start and end visits on time, patient-centered care, creating flexible appointment times for women
  - Incentives – gift cards, transportation voucher

ECHO Group QIP Preliminary Recommendations

- Creating space: Provide self-care opportunities to engage women into services and reduce stigma.
  - Examples: Health & beauty wellness days that can reduce stigma, focus on other health/wellness outside of HIV, and create safe spaces for support groups.

ECHO Group QIP Preliminary Recommendations

- What are some ideas/ways we can help patients identify support outside of the clinic?
  - Ask the client.
  - Own the responsibility.
  - Do the leg work to meet needs.
  - Know your area of expertise.
  - Help clients identify & build their own family and networks.

ECHO Group QIP Preliminary Recommendations

- How can we make clinic more accessible for patients who experience unstable housing or homelessness?
  - Keep key documents on hand: keep copies of ID, social security, Medicaid/health insurance cards, income, SSI/SSDI,etc.
  - Provide a safe space: cell phone charging station, “hang out” space
  - Collect & distribute hygiene products in unconventional ways: Have them readily accessible to all clients so that clients regardless of their current living situation can take products without feeling ashamed.

ECHO Group QIP Preliminary Recommendations

- Support group strategies – how to keep clients engaged.
- Recommendations:
  - Utilize staff peer counselors
  - Ensure meetings are focused on resilience and strength, not only on HIV or illness.
  - Incorporate beauty and wellness, food, transportation vouchers, socializing, and providing entertainment in the support group space.

What are your recommendations?

THANK YOU

Support Services: Case Study

Care Resource

Viral Load:	11/14/2018-2543
History of Viral Load	05/31/2018-68 01/25/2018-31 09/21/2017-21374 07/11/2017-16545 04/07/2018-46 01/27/2017-1299 11/21/2016-9287 06/29/2016-253261 03/13/2015-376 10/06/2014-391046 01/13/2014-20
Mode of Transportation:	31 day Bus Pass
Housing Status:	Boarding House
Insurance Status:	RW expired 11/30/18. Medicare Part A, B, D. Medicaid
Length of Time in Care:	01/16/2014
Other Medical Conditions:	Traumatic Brain Injury, Bi-Polar, Hip Replacement
Support System (Family, Friends, etc.):	None
Other Barriers to Care:	Drug Usage

Client History:

Client is a 50 year old Caucasian homosexual male who was diagnosed with HIV in 1997. Client reported having a left hip replacement and a traumatic brain injury which causes memory loss Client also diagnosed with bi-polar disorder. Client self-medicates with Methamphetamine and refuses treatment counseling and behavioral health. Client has discontinued psychotropic medications against MD. orders. Client has exhausted FTL. Hospital detox program stays. Client living at a boarding house. Reported history of being kicked out of sober living transitional facilities. Client cycles with HIV medication adherence as reflected in history of VL.

Client Issues:

Client reports always getting into fights or being attacked, as a results he has personal effects such as: Bus pass, documentation/ID stolen or lost. Client takes no accountability for his actions and blames others for his circumstances.

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Natasha Markman, BRHPC
Marie Hayes, Broward House
Stephanie Booth, Care Resource
Zulina Muneton, CDTC
Jorge Rodriguez, Latino Salud
Kara Schickowski, Legal Aid
Edna Ferguson-Walker, NBHD
Jean Alexandre, SBHD
Amy Pont, SBHD
Brad Barnes, Poverello Center

PROVIDERS ABSENT
BCFHC

GUESTS
None

PART A RECIPIENT STAFF
Richard Morris
Edith Garcia

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Gritell Martinez
Anitha Joseph
Marcus Guice

I. Welcome/Introductions

The meeting was called to order at 9:30 a.m. CQM Staff welcomed everyone and individual introductions were made. Additional meeting attendees arrived at 9:37 and reintroductions were made.

II. You Asked, We Listened!

Referral Process Between Part A Agencies

This meeting serves as a continuation of the discussions from the June meeting. *(The June Support Services Network meeting's minutes can be referred to for insight on what was previously discussed).* CQM staff turned the meeting over to the provider team to discuss referrals from an intra-agency perspective. Networks stated that there are issues with knowing if client referrals have been received or read in Provide Enterprise (PE). Another notable issue is that providers do not know where the follow-up notes should be documented. They noted barriers to the referral process such as localization of clients. An example given was the impact on keeping dental care appointments when the proximity of a client's home or place residence to provider

agencies combined with lack of means of transportation can make travel and fulfilling appointments difficult. The CIED provider also identified a lack of efficiency in PE to systematically translate whether a client referral has been completed. She indicated that the program lacks a tracking tool for the provider to know the status of a referral and notes difficulty in tracking follow-ups and mentioned the lack of time in an eligibility employee's day to check individual profiles and run various reports on clients.

The Poverello provider noted that their agency's process involves initiating referrals in PE, but mentions that they do not know if these referrals are being followed up on or tracked by other agency personnel. The provider also mentioned that client medical appointments within the past six months are the sole medical outcome being monitored. The county health department was mentioned to be the only agency that is effective in tracking and monitoring the client's referral process. A provider noted a recurring issue with the department of health, which is their criterion that clients are to be out of care for at least a year before action is initiated. This places a delay in clients' access to care. A consensus among the providers present during the meeting is that follow-ups are the most difficult part of the referral process. Many suggest that PE simply lacks a proper end-user component available to properly conduct follow-ups on clients. Providers' current methodology of conducting follow-ups on referrals is generally to call offices where clients have been referred and verify whether the client has fulfilled the appointments. Many providers are not utilizing PE reports.

Dental and Food Banks service providers' PE reports display medical summaries, unlike other services. This aspect has allowed these particular service organizations to more effectively track follow-ups. One provider mentioned that PCIS, the PE software's predecessor, employed an email system for referrals that was beneficial for providers as a tracking component. It was used as a two-way communication tool that was also used by the county health department to track as well. Another provider noted that a one call/one follow up methodology works for Legal services due to smaller number of clients.

It was also brought to the attention of the group that PE is being employed differently in Palm Beach County. There is email communication for referrals but no phone system. The provider suggested that we can contact Palm Beach County about implementing a similar email based system where referrals can be accepted or denied. Within this proposed methodology, referral acceptance denotes follow-up activity. Grantee staff noted that the capabilities of 100% use of email referrals are already within the current PE system. However, one issue in employing this methodology is that it does not automatically attach to email and agencies would need someone designated to go into the system to respond to referral task. Staff turnover could be a challenge to keeping email system updates. A suggested alternative is that providers can have their IT teams create one email account for staff to operate and use to conduct follow-ups. When using phone calls, appointments are relatively instantaneous. Further discussion revealed that employing a 100% email system may delay scheduling and create an additional barrier for clients in delivering them their scheduled time of appointment. Another identified challenge is within the referral process for CIED, as there is no documentation required for completing referrals.

Overall, providers simply cannot track the success rate for clients who have emergency or adverse situations that are occurring at this moment. The phone referrals give a sense of immediacy. However, there are oftentimes where clients simply do not adhere to referrals and this measure is outside of provider control.

The CQM Staff have agreed to work with Grantee staff in evaluating PE and the overall referral methodology. The follow-up is key component of clients' access to services, and the focus is to address the system of documentation and how follow-ups are navigated in PE.

III. Case Studies

a. Poverello

Received a Gilead grant to hire peer navigators to decrease barriers for clients. Although an old fashioned way of communicating, it was the daily person-to-person check-in that worked. The underlying problem for many of their clients is usually the housing situation. How do we work with clients that are no-show's and won't leave their "home" (i.e. cars, tents, etc.)? A CIED provider suggested doing home visits to more thoroughly analyze clients' environment and variables that may not be addressed during appointments. Perhaps mobile units can assist in meeting people where they are. Latino Salud has an Uber account for non-Medicaid patients (Note: Medicaid pays for transportation). Poverello has a client that is medically compliant/doing well but has no housing. Client sleeps at the airport; usually arriving with a suitcase every morning at 11am and leaving by 5pm. They know of around 10 clients that do this. Waiting lists at shelters have been a substantial barrier to adhering to care across our client population. The Network noted that client education is pivotal to increasing care compliance because many clients don't understand or are unaware of medically related terms such as CD4, viral load, etc. Providers discussed making messaging/education very basic and clear and the importance of linking patients to the Health Department as a tool to assist non-compliant patients with keeping appointments.

IV. Importance of Educating Clients on Viral Load Suppression

i. Staff asked the Network, "What is your process for monitoring viral load (VL) suppression?"

1. The North Broward Hospital Provider noted the importance of discussing Viral load / CD4 with patients. "*The case managers we work with address it – you never tell a patient that they are undetectable, because patients can translate that as being "cured"*. Based on their observations, these patients tend to return months or years later with a higher viral load. Providers suggested using language such as "your viral load is looking better, or keep doing what you have been doing to take care of yourself".
2. Discussion also ensued about addressing the stigma of HIV.
3. For those organizations that receive funding by grants, viral load education is important and a top priority. For aging populations, case managers have to be more educated about illnesses that are triggered by HIV.

4. Latino Salud supported education as the key point for the support services providers. Undetectable ≠ untransmittable (not the same thing as a cure). "*We have been taught all our lives that you take pills when you are sick. So if you tell them they are undetectable or "not sick", then they might stop taking pills.*"
5. Care Resource explained that they run reports on clients that have high viral loads weekly, and make contact with them to monitor their progress.

CQM Deliverables:

- Investigate the current PE referral tab and how referrals can be expanded to included email notifications and response indicating status of appointments
- Follow-up the Palm Beach County to determine the possibility of duplication the PE referral system
- Follow-up with the health department to determine their role in non-compliant client referrals and possible presentation at a network meeting

V. Complete Meeting Evaluation

Staff asked the providers to fill out the evaluation with any suggestions they would like to discuss in the next meeting.

VI. Adjournment

The meeting was adjourned at 10:55 a.m.

Next Meeting Date: December 4th, 2018