NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

The Use of a Statewide HIV Clinical Quality Group to Improve Viral Suppression in the State of Louisiana & Establishing Quality Performance Measures in Rhode Island for RW Part B

A Joint Presentation on Ryan White Quality Management

Disclosures

Presenter(s) has no financial interest to disclose.

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2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Presentation #1
Use of a Statewide HIV Clinical Quality Group to Improve Viral Suppression in Louisiana

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Co-Presenter Learning Objectives

- Discuss the key components, stakeholders, challenges faced, and lessons learned from the development of the Louisiana Statewide HIV Clinical Quality Group and the Rhode Island Clinical Quality Management program.
- Address the published evidence and best practices that support the different interventions that were used in the quality management programs to show generalizability to other clinics and non-medical settings in other locations.
- Explore how the Louisiana and Rhode Island programs have aligned HRSA requirements associated with quality management, quality improvement initiatives and performance measures .
- Stimulate an interactive discussion to add to the collective knowledge by including the successes and experiences of audience members to the forum.

Louisiana HIV Clinical Quality Group

- Background
  - Current iteration established in 2013
  - Ryan White cross-parts participation
  - QI assistance provided by CQII Coach
  - Supporting/Planning Committee agencies
    - Louisiana OPH STD/HIV Program
    - LSU HIV Outpatient Program (HOP)
    - CrescentCare
    - Open Health Care Clinic

Mission

To drive continual improvement of HIV clinical care by integrating quality improvement throughout agencies providing medical and support services for people living with HIV in Louisiana

Structure

- Quality management plan clearly defines mission, purpose, goals, infrastructure, leadership, membership, roles and responsibilities, performance measures, and work plan

- Basic structure
  - Group meets quarterly
  - Leadership plans meetings and sets agenda
  - Meetings
    - Updates
    - Hot topic issues presented by SME
    - New business
    - Peer exchange
  - Additional subcommittees and conference calls as needed

Leadership

- Leadership – roles filled on rolling bases for predefined term
  - Two co-leads: central role in planning and conducting meetings
    - one filled by LA Office of Public Health STD/HIV Program Quality Manager
    - one filled by agency member
  - Data liaison: collects needed data and aggregates it
  - QI facilitator: facilitates meetings
  - Secretary: records minutes at all meetings
  - Historian: committed member who provides context and guidance

Membership

- Membership – open to persons from agencies in Louisiana with an interest in ensuring PLWH in LA are receiving high quality HIV clinical care. Should primarily comprise persons from agencies providing HIV care and services.
- Member expectations
  - Attend and actively participate in at least 3 meetings
  - Participate in QI trainings
  - Submit data agreed upon by group
  - Plan and implement at least one QI project per year and share with group
  - Participate in additional calls as necessary

Louisiana Demographics

- >20,000 PLWH in LA
- 1,129 newly diagnosed individuals in 2016
  - New Orleans was highest in new diagnoses, followed by Baton Rouge
  - 71% Men, 27% Women and 2% Transgender Women
  - 22% had AIDS within 9 months of diagnosis
  - 73% African American
- Over the past ten years:
  - 53% MSM, 32% Heterosexual, 11% IVDA, 4% MSM/IVDA
- Significant Racial Disparities Exist
  - Driven by stigma, poverty, and incarceration disparities

Source: Louisiana Department of Health, Office of Public Health. 2016 STD/HIV Surveillance Report.

Viral Suppression by Participating Agency, 2015 - 2017

	2015	2016	2017	Interventions
AcadianaCares, Lafayette	N/A	N/A	88%	-Reminder interventions -Onsite case management -Health education and pill box assistance -Extending hours
CrescentCare, New Orleans	84%	85%	85%	-Rapid initiation of ART -Contact interventions
HIV Outpatient Program at University Medical Center, New Orleans	75%	84%	83%	-Targeted Contact Interventions -Support Services -Multidisciplinary workgroup to target unsuppressed patients
Lallie Kemp, Independence	74%	79%	90%	-Contact Interventions -Health education -Barrier/solution identifications

Viral Suppression by Participating Agency, 2015 - 2017

	2015	2016	2017	Interventions
Open Health Care Clinic, Baton Rouge	N/A	74%	79%	-Multidisciplinary workgroup to target unsuppressed patients -Onsite medical case management -Case conferences to assist with care plans
Our Lady of the Lake, Baton Rouge	70%	73%	77%	-Text reminders for appts -New provider
Tulane Clinic, Alexandria	72%	69%	78%	-Contact interventions -Health education with pill planners and adherence strategies
PLWH in Louisiana	56%	60%	62%	
PLWH In Care in Louisiana	78%	81%	83%	
RW Grant Recipients, Louisiana	76%	81%	*Data Not Available	

Summary of Interventions Implemented

- Contact Interventions
  - Reminder calls/letters
  - Intensive Outreach
- Health Education and Pill Boxes
- Rapid Initiation of ART
- Multidisciplinary Workgroup
- Co-location of Services
  - Social work
  - Case Management
- Clinic design
  - extended hours
  - new providers

Guidelines

IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents.

International Advisory Panel on HIV Care Continuum Optimization: Zuniga JM et al. JIAPAC 2015:1-32.

Guidelines Related to Our Interventions

18. Immediate Offer of ART regardless of CD4 count or Viral Load- A1

24a. Viral Suppression is recommended as the primary adherence monitoring measure- B2.

26. Patient education about and offering support for medications adherence and keeping clinic appointments is recommended. - A1

26A. Pill box organizers are recommended. - B2

28. Proactive engagement and reengagement of patients who miss visits is recommended. - B2

28A. Case Management to retain patients in care is recommended. –B2

1=excellent, 2=high, A=strong, B=moderate

Contact Interventions Improve Viral Suppression

Intensive Contact Interventions: Navigation Programs

- Study of 4 programs that enrolled patients with HIV not fully engaged in care or at risk of falling out of care
- Navigators were peers or paraprofessionals
  - Performed appointment coordination and medical referrals
  - Often accompanied the patient to the appointment
  - Intervention period was over a year
- Data collected from client interviews and medical record review
- Statistically significant improvements in:
  - Undetectable VL (35% to 53%)
  - Attendance of 2 or more visits in past six months (64% to 79%)

Bradford JB, Coleman S, Cunningham W. HIV System Navigation:An Emerging Model to Improve HIV Care Access. AIDS Patient Care STDs 2007;21:49-58.

Enhanced Contact Intervention Improves Retention

- Enhanced Contact: dedicated person who saw patient at face-to-face visits, and made interim, appointment reminder, and missed visit calls.
- 1838 patients randomized to:
  - Standard of Care- appointment reminder calls
  - Enhanced contact(EC)
  - EC plus 1 hour skills session with support and behavioral skills training

Visit Constancy (1 visit in each four month interval)

- SOC 46%, EC 56%, EC plus skills 56%
- Enhanced contact improved retention in care

Gardner Li, Giordano TP, Marks G et al. Enhanced Personal Contact with HIV Patients Improves Retention in Primary Care: A Randomized Trial in 6 US HIV Clinics. Clin Infect Dis 2014;59:735-34.

Pillbox Organizers Improve Viral Suppression

-269 people living with HIV in San Francisco were observed from 1998 through 2005

- Recruited from homeless shelters, free meal programs, and low income hotels

-Every 3-6 weeks they received unannounced adherence-monitoring visits (3,170 total)

-Pillbox organizer use showed statistical improvement in adherence (4.1%–4.5%)

- Decrease in viral load (0.34–0.37 log10 copies/mL)
- Higher probability of achieving a viral load ≤400 (14.2%-15.7%; OR 1.8–1.9)

Peterson ML et al. Pillbox organizers are associated with improved adherence to HIV antiretroviral therapy and viral suppression: a marginal structural model analysis. Clin Infect Dis. 2007;45(7):908-915.

Co-location of Services

Services associated with increased retention in care:

- Case management
- Mental health services
- Substance abuse treatment
- Drug assistance programs
- Food assistance
- Nutrition
- Housing assistance
- Transportation assistance

1. Ashman JJ, Conviser R, Pounds MB. Associations Between HIV-Positive Individuals' Receipt of Ancillary Services and Medical Care Receipt and Retention. *AIDS Care*. 2002;14(Suppl 1):S109-118.
2. Cabral HJ, Tobias C, Rajabiun S, et al. Outreach Program Contacts: Do They Increase the Likelihood of Engagement and Retention in HIV Primary Care for Hard to Reach Patients? *AIDS Patient Care STDS* 2007;21(Suppl 1):S59-67.
3. Horstmann E, Brown J, Islam F et al. Retaining HIV-Infected Patients in Care: Where Are We? Where Do We Go from Here? *CID.* 2010;50:752-761.
4. Sherer R, Steiglitz K, Narra J et al. HIV Multidisciplinary Teams Work: Support Services Improve Access to and Retention in HIV Primary Care. *AIDS Care.* 2002;14(Suppl 1):S31-44.

Conclusions: How can we improve viral suppression?

- Measure and identify at-risk patients
  - Population at risk may vary based on clinic population and location
- Co-locate services known to improve retention in care
- Immediate ART
- Consider navigators and case management for newly diagnosed and poorly engaged patients
- Hire providers who facilitate connections with patients
- Use health education and pills boxes to assist with ART adherence

University Medical Center New Orleans-HIV Outpatient Program (HOP)

Demographics (n=1652)

- Race: 77% African-American, 22% White
- Ethnicity: 3% Hispanic
- Sex/Gender: 67% Male, 32% Female, 1% Transgender
- 61% below the 100% poverty level
- Risk Factor: 31% MSM, 44% Heterosexual, 7% IVDU
- VL < 200 in 83%
- CD4 >200 in 83%

UMC QI Project Background

Multidisciplinary team-based intervention among non-suppressed patients to resolve unmet needs

- Measurement was impact on VL suppression after 12 months of follow up
  - VL Suppression defined as <200 copies
- April 2017 –March 2018
- **Patient Inclusion**: Patients with at least one primary care visit in previous year with persistent VL > 5000 copies/ml.
  - N=37 (2% of total population)
- **Goal:** To increase the number of patients with suppressed viral loads from 0 % to 20% by April 2018

Determination of Root Cause

Among unsuppressed selected patients:

- **Chart review/verification of key causes**

Risk Factor	%
Recently re-established care	46.4
Psychiatric diagnosis	33.9
Active substance abuse	26.8
Recent hospitalization	25
Incarceration	8.9
Medication acquisition from pharmacy	8.9
Difficulty with med Instructions	5.4
Language barriers	1.8
Transportation needs	1.8
Number of co-morbidities (mode)	0 - 9 (7)

Intervention over 12 Months

- Provide all patients a referral to health education session(s) to:
  - learn skills for medication adherence
  - receive support with pill box preparation
  - improve knowledge on importance of adhering to ARV regimen
- Provide all patients weekly/monthly contact follow up by patient navigator or social worker after the PC visit to:
  - check on adherence to appointments and medications
  - assess psychosocial unmet needs to resolve in a timely manner

Results/Lessons Learned

Out of a cohort of 32 patients with sustained VL > 5000 copies/ml

- **14/32 (44%)** suppressed VL in period 4/1/17 – 3/31/18;
- 18/32 (56%) were not suppressed by 3/31/18

- **8/16 (50%)** patients attended health education adherence intervention sessions and suppressed their VL;
- **6/16 (37%)** did not attend health education sessions and suppressed their VL

- Root causes for viremia varied
- Intervention required a multidisciplinary team to address the problem

Challenges Faced

- Required a flexible approach (one size did not fit all)
- Patient subset with significant barriers related to social determinants of health (lack of housing, transportation, poverty); health education session not a priority
- Some health education visits had to be on the fly
- Staff shortages limited the intensity at times

CrescentCare Intro and Demographics

Federally Qualified Health Center in New Orleans

Demographics (n=3473)

- Race: 64% African-American, 36% White
- Ethnicity: 7.5% Hispanic
- Sex/Gender: 72% Male, 26% Female, 2.2% Transgender
- 58% below the 100% poverty level
- Risk Factor: 53% MSM, 42% Heterosexual, 5% IVDU
- VL < 200 in 83.7%
- CD4 >200 in 84%

CrescentCare QI Project background

Existing approach prior to intervention: reactive – triggered by provider, quality meetings, etc.

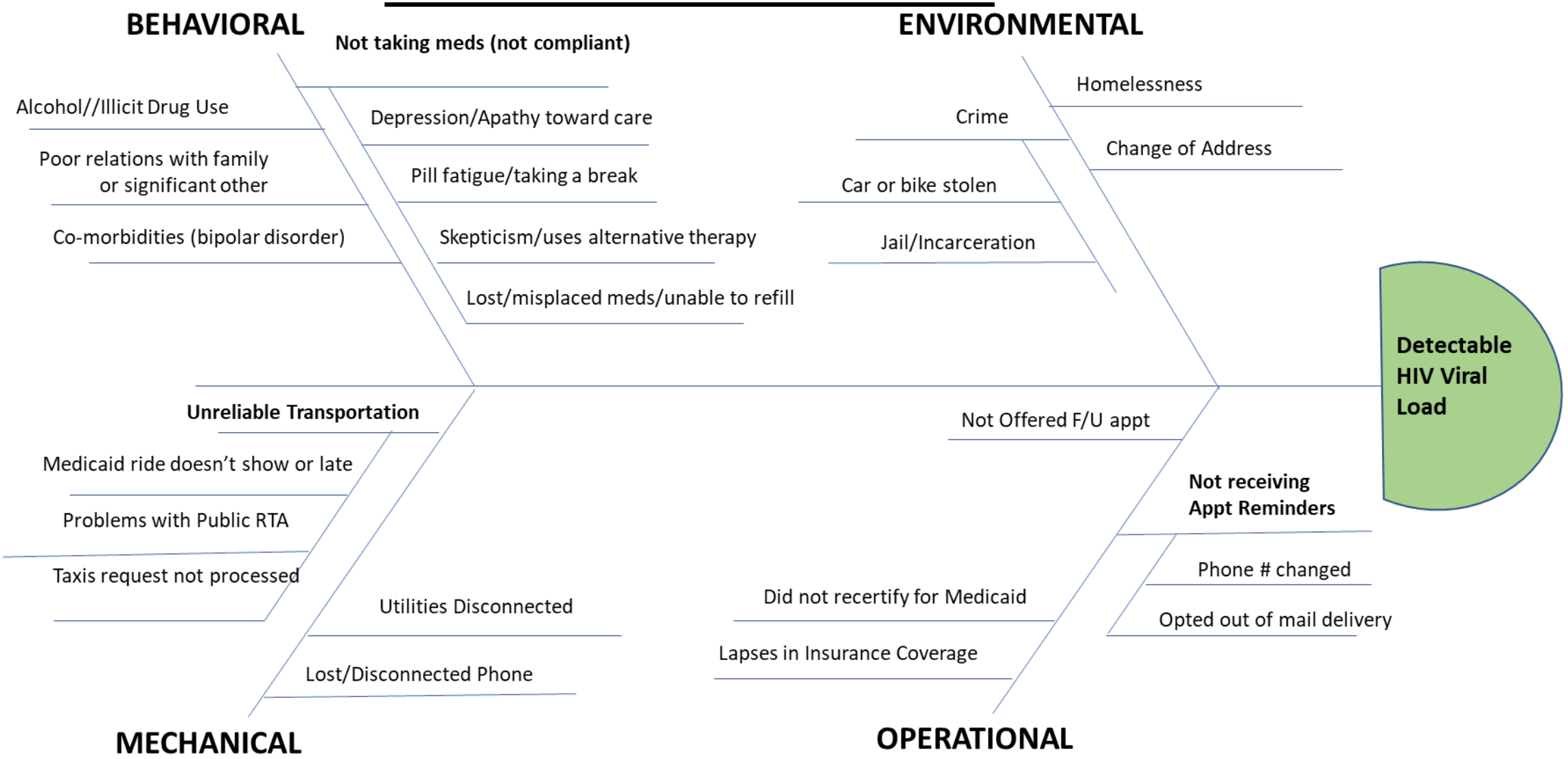
Changing to a proactive system:

- CrescentCare Start Initiative framework
  - Weekly huddles to run lists, contact patients who miss visits, or are not suppressed

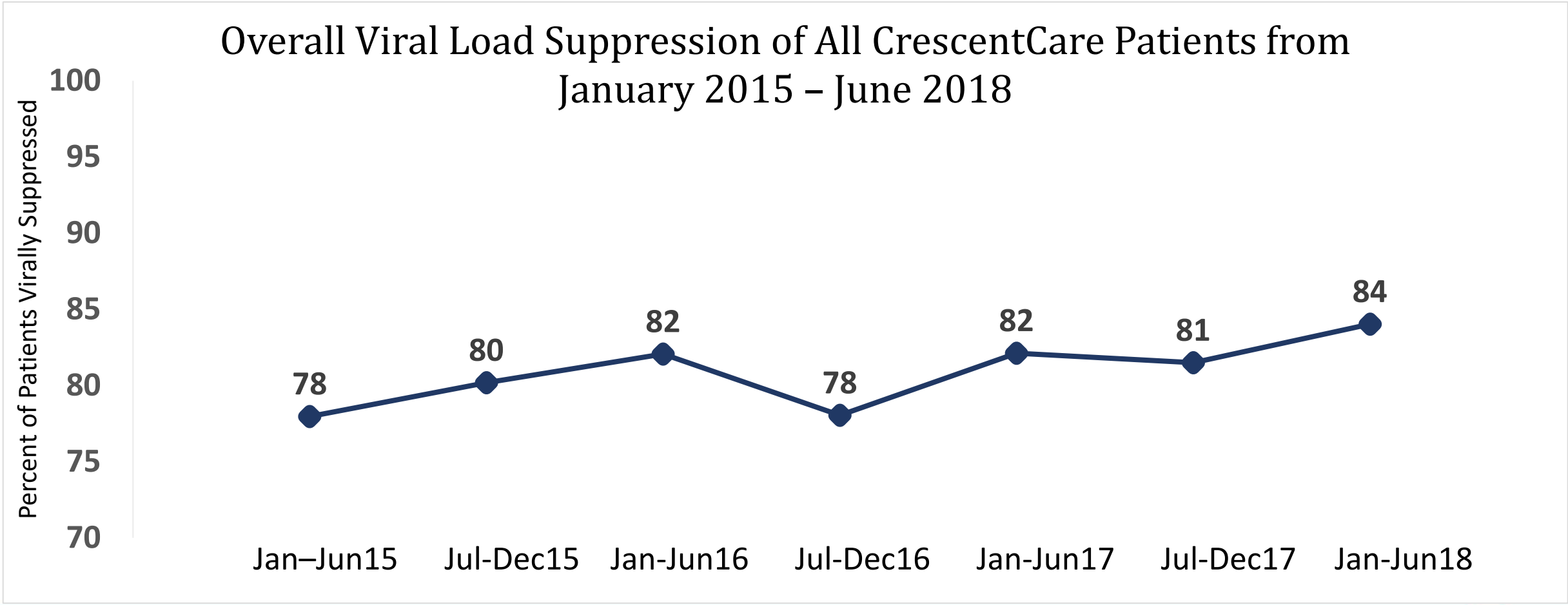
QI Project PLAN

1. CCSI Huddle Framework
    - Weekly huddle with the following:
        - Real-time updated list of all patients in the program
        - Provider leads from each main site (2), CHW Supervisor, Patient Navigator Lead in attendance
        - **Clients contacted by every means available in the system**
2. Providers at CrescentCare already encouraged to huddle with their Case Managers
    - Huddles done by most, but no defined agency-wide structure and not mandatory

ROOT CAUSE ANALYSIS



Evolution of Viral Suppression



Change in quality of care

Weekly meetings with CCSI Cohort (list running and enhanced contact):

- CCSI >90% suppression
- Provider with CM team >90% suppression

Transition this from pilot-structure to agency-wide

Lessons learned and next steps

Dedicated huddles with patient lists improves outcomes – yet, still not a completely proactive system

Texting > Calling; Human > EMR

After meeting with other RW programs in the South- phase II of the program:

- Move to text-based contact from a human *immediately* after a no-show or cancellation (front desk)
- Automated system to notify navigator (retention) for 2 or more missed visits

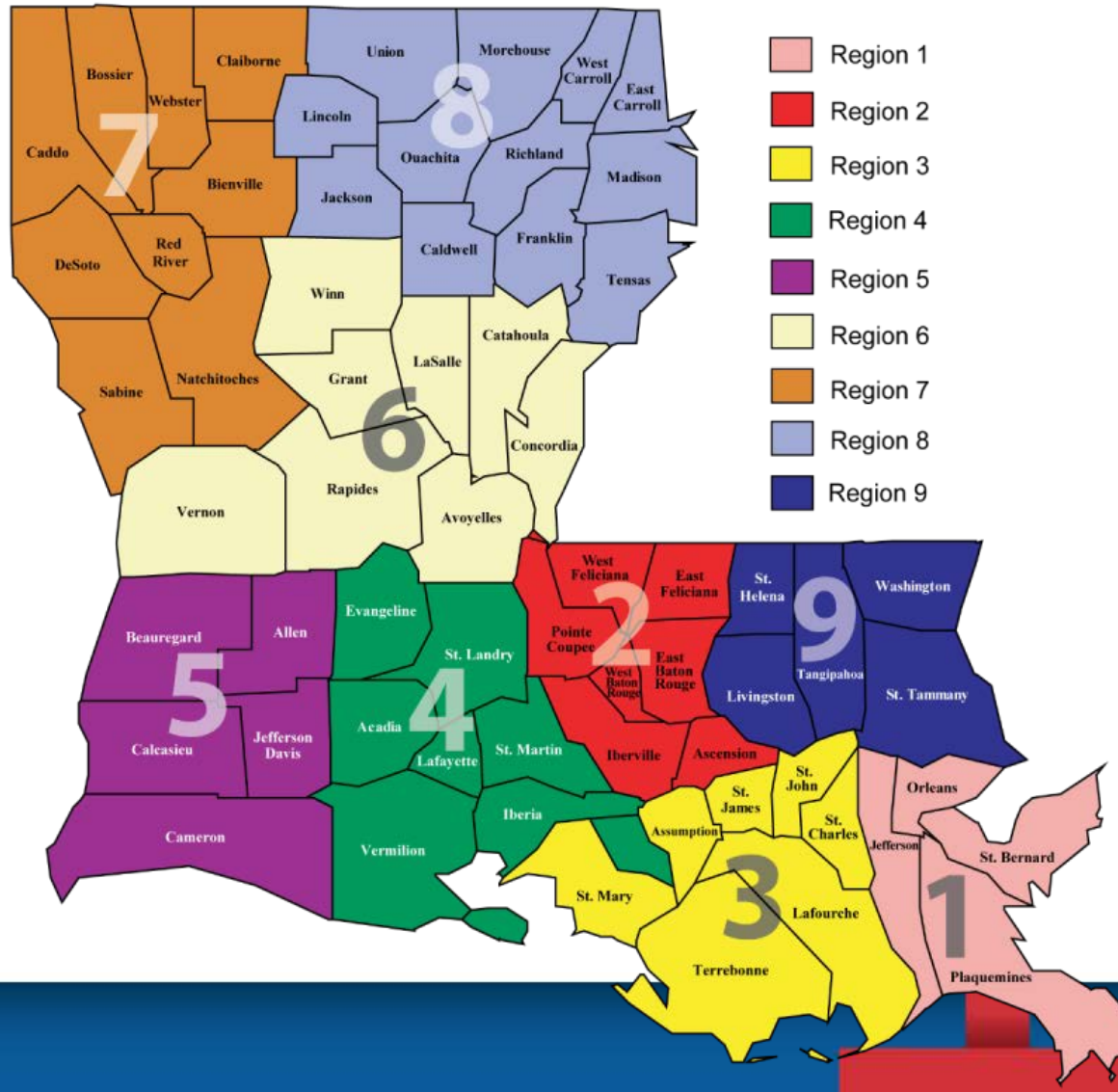
Tulane Alexandria - Demographics

Tulane Clinic serves Region 6 of Louisiana

(situated in Alexandria)

Total active patients (6/2018): 592

- Male = 67%, Female = 32%, Transgender = 1%
- African American = 69%
- White = 29%



Baseline Data at Beginning of Project

Baseline data from 1st Qtr, 2017

560 – Active Patients

486 – Patients with at least one OAMC visit

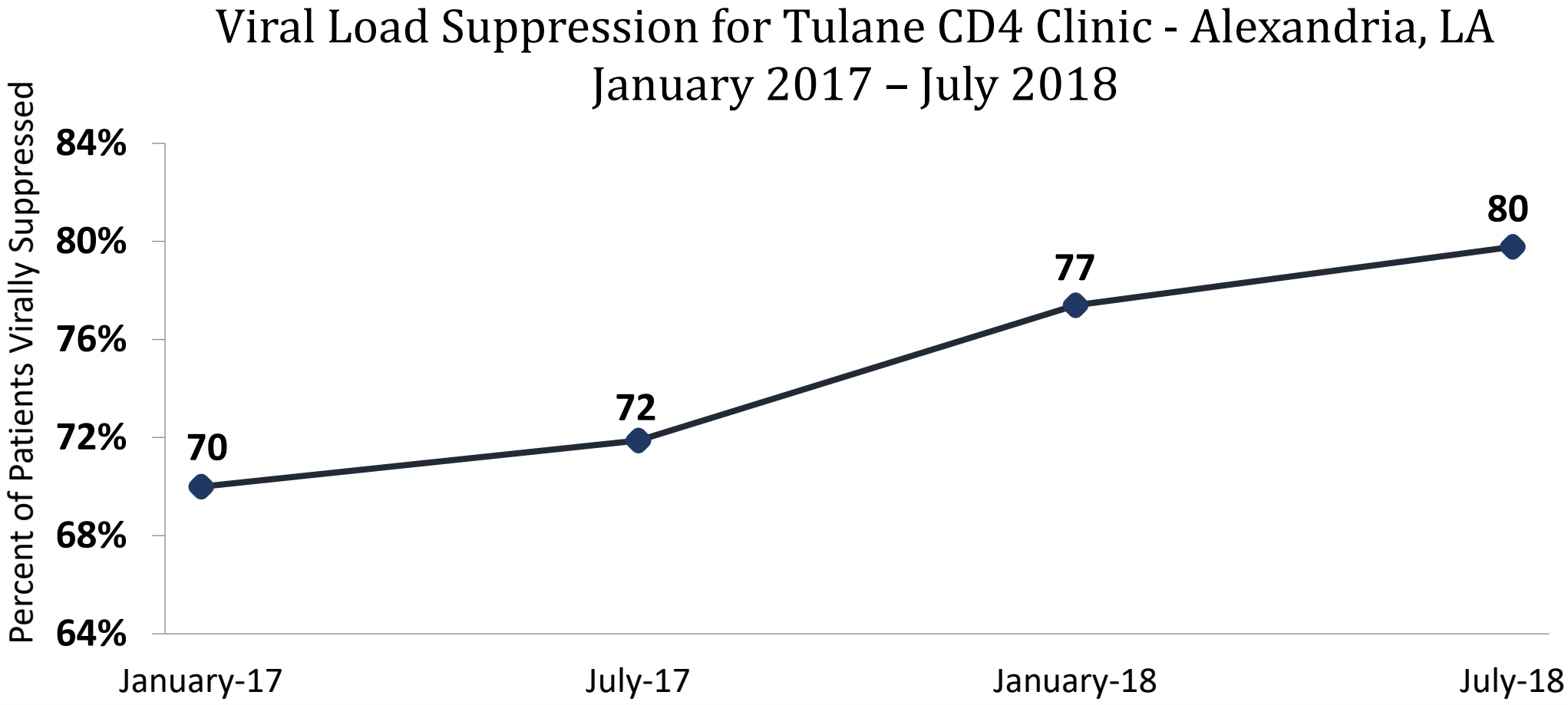
389 – 80% Viral Suppression goal

338 – 69% of patients virally suppressed

Intervention Steps to Viral Suppression

- Drill down on non-suppressed patients
  - Barriers? Housing, Substance use, Transportation, Med Confusion, Resistance
- Collaborate with OPH for out-of-care patients
  - Moved out of area?
  - Still in area & need to be re-linked?
- Phone & Med Planner campaign
  - See all new patients w/in 6-weeks of starting or re-starting meds
  - Call all numbers on profile, mail letter if unable to reach
  - Increase Med Planner visits for those needing help
- EMR integration + Huddles
  - “Electronic Post-Its” created in the EMR to notify all staff of patients involved in the QI project
  - VL results posted and updated whenever clients came back in
  - Monthly huddles to review QI clients (existing and new)

Progress to VL Suppression



Lessons Learned

Consistency and persistence required for successful VL project

Buy-in of all staff

- Combat fatigue (project never ends, numbers keep growing)
  - Celebrate successes!

Logistics

- Housing and substance use options not always easy to overcome in Region 6 (as is the case in many areas)

Lallie Kemp Medical Center

Tangipahoa Parish

- Rural communities between New Orleans and Baton Rouge, LA
- 127,115 residents
  - 63.8% White
  - 29.3% African American
  - 3.91% Hispanic
- Poverty Rate 22.3% (National Average Poverty Rate 14.1%)
- Unemployment Rate: 4.3%

(July 1, 2017) United States Census Bureau: Tangipahoa Parish, La. Retrieved from www.census.gov/quickfacts/TangipahoaParishLouisiana

Lallie Kemp Medical Center

LSU Health Care Services Division- dedicated to serving the health of Louisiana citizens through its public hospital and clinics at Lallie Kemp Regional Medical Center

Serves rural communities located between New Orleans and Baton Rouge, La

Lallie Kemp Medical Center

Specialty Clinic Demographics

279 Total HIV Clients in Care

101 HRSA Clients (Ryan White Part D) in Care:

- 89% Female (90 Clients), 5% Transgender (5 Clients), 6% Youth (6 Clients)

Risk Factors Reported:

- 95% Sexual Contact (96 Clients), 5% Sexual Contact or IV Drug Usage (5 Clients)

Coverage:

- Medicaid 63% (61 Clients), Medicare 28% (28 Clients), Private 5% (5 Clients), Free Care 2% (2 Clients), None 5% (5 Clients)

Race:

- African American 81% (82 Clients), White 18% (18 Clients), Hispanic 2% (2 Clients)

Lallie Kemp Medical Center

HRSA RW PART D Clients Viral Suppression

*HRSA RW Part D Clients	
Project Start Date	4/1/17
Viral Suppression %	83%
GOAL	93%

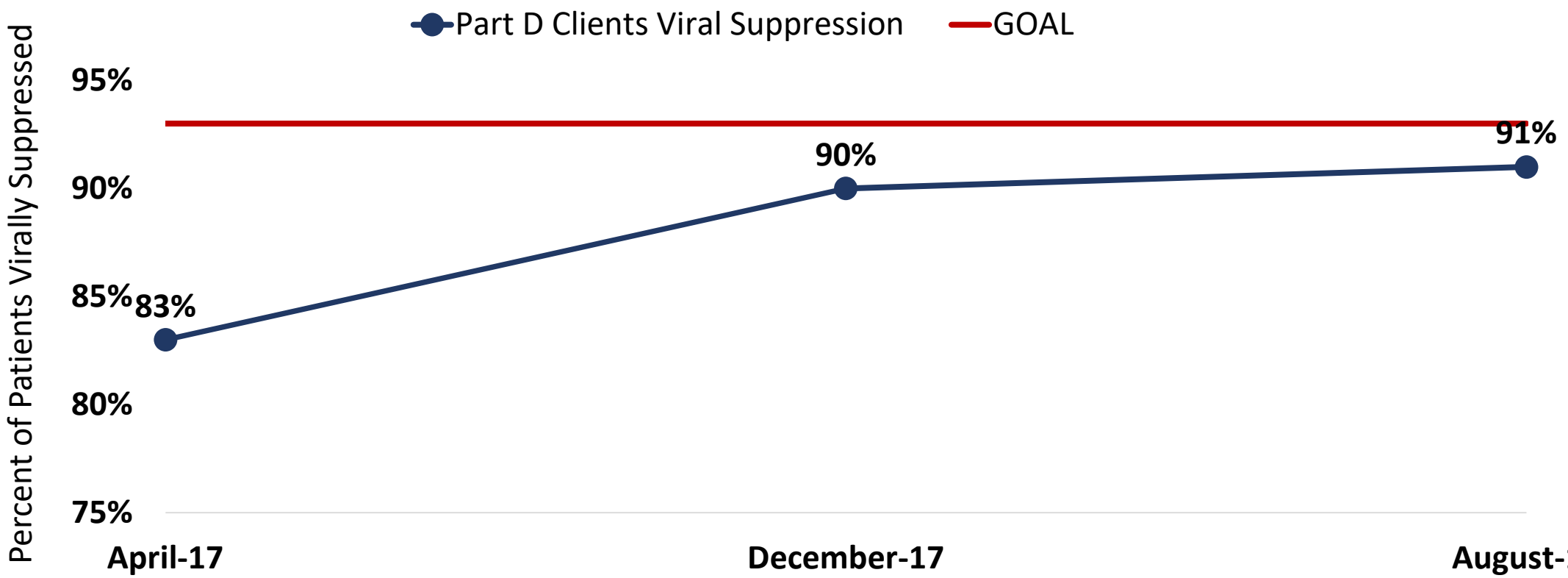
Lallie Kemp Medical Center

HRSA RW Part D Clients

INTERVENTIONS

- Identifying the barrier- Our Patient Educator/Navigator contacts Clients who are not virally suppressed to identify WHY
- Creating a method to overcome individual barriers- now that we know why the Client is not taking their medication, we can work to overcome barrier
- More frequent visits and phone calls- weekly phone calls discussing medication compliance and monthly visits with the Patient Educator/Navigator
- Client involvement with the goal of viral suppression- once Viral Suppression is reached the Client is given a certificate and staff acknowledges their accomplishment

Viral Load Suppression for Lallie Kemp Medical Center HRSA RW Part D Clients
April 2017 – August 2018



Conclusions

- Statewide Quality Group facilitated quality improvement by providing support and accountability
  - Group provides clinics from across the state a venue to discuss issues
  - Structure of quarterly meetings encourages clinics to complete QI projects on a routine basis
  - Provides technical assistance and prompts projects
  - Reinforces the central role of data in driving improvements

- Results speak for themselves: 64% viral suppression in 2013 when the group was initiated to 81% in 2016 for the state Ryan White recipients

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Establishing Quality Performance Measures in Rhode Island Part B: #QualityISJobOneforRIRyanWhite!

- Marianne Raimondo, Ph.D, MSW, LICSW

  Assistant Professor Rhode Island College

  RI Ryan White Part B Quality Consultant
- Paul G. Loberti, MPH

  Administrator for Medical Services

  RI Medicaid Division, RI Executive Office of Health and Human Services

  Director RI HIV Provision of Care & Special Populations Unit

RI Ryan White Part B Statewide QM

- Statewide RW Part B with collaboration of other RW parts
- Leadership provided by EOHHS Medicaid team
- Participation of all funded agencies
- QI assistance from QM consultant

Quality Goals

- Improving the health and overall well being of PLW/A
- Assuring PLW/A receive the best care possible
- Continuous improvement of care delivery processes to achieve service excellence and optimal clinical outcomes
- Improving the knowledge, skill, and competency of the workforce
- Foster collaboration, cooperation, teamwork among sub-grantees to assure a seamless, continuous system of care in the state

Structure

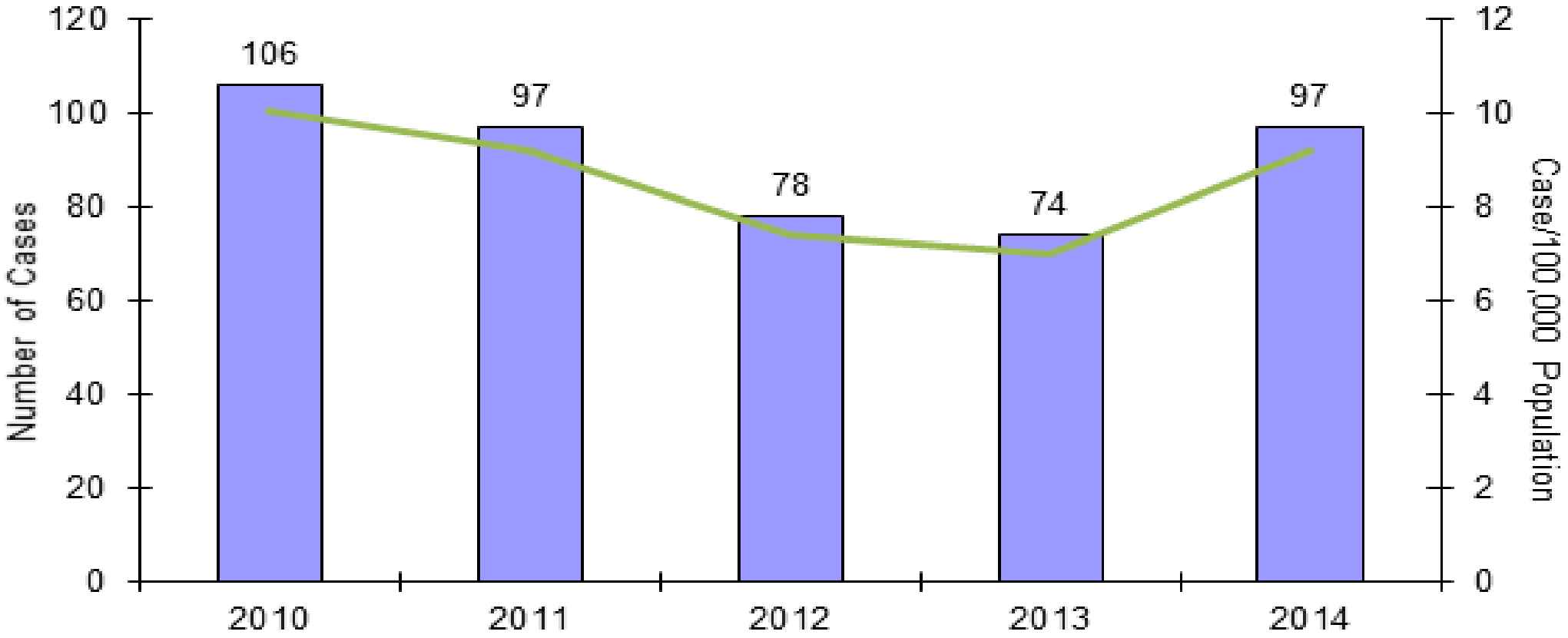
- QM Plan (Statewide, agency)
- QM committee meets monthly with all sub-grantees represented
- Agendas include : review of PM's, identification of opportunities for improvement, updates on QI initiatives, identification of training needs, state wide improvement initiatives
- Additional subgroups, teams as needed
- Quarterly meetings of case managers
- Monthly meetings between medical and non-medical providers
- CAB statewide and agency specific

Agency Roles

- Attend and Participate in QM meetings
- Submit PM's quarterly basis
- Lead QI projects in their agencies and share progress
- Participate in statewide QM projects, initiatives
- Assure staff receive ongoing training in QI

RI Epi Snips – Small Incidence State

- >2600 People Living with HIV in RI



Rhode Island Quality Management Committee

- RI Quality Management, Ryan White Part B program has been operating for over 18 years.

- The Quality Management Committee was formed about 10 years ago and is composed of non-medical and medical case managers, and has recently been augmented to include new partners from our RI HIV CoEXIST project

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RI QMC Continued

- Membership – Predominately Case Management agencies (both clinical and non-clinical) . For this first time we now have agencies on the QMC that are doing EIS, Housing, Intensive Case Management, Behavioral Health integration, HIV workforce development, public institutions of higher education, mobile clinic outreach, etc.
- Focus on participating in discussions about selecting HRSA Part B Performance Measures, developing standards of practice in the field, sharing stories of clients, barriers to care/treatment, system issues, challenges to case managers and other providers, opportunities, discussing trauma based and crisis management, addressing system and client threats, creating innovative models (e.g., LifeSaver – a list serve for case managers who can post avaible resources like housing slots, residential care, food banks, etc. and to request needs.), etc.

RI QMC Quality Performance Measure Focus

- As a general rule, RI Adheres to the notion that the HAB performance measures (PMs) can be used either at the provider or system level.
- The measures can be rolled up to look at issues from a system perspective, such as with Part A and B Programs. Programs can also work with their subcontractors, vendors or sub-providers to implement the performance measures at the provider level.
- Grantees are encouraged to include a range of performance measures in their quality management plan.
- CQI is a real focus and agencies receive assistance form the RI Executive Office team and QM consultant to think improvement and process so that their efforts are not always on the “prize”

Performance Measures

- Viral Load Suppression
- Medical Visit Frequency
- Gap in Medical Visits
- Complete Assessment
- Complete Reassessment
- Care Plan
- Face-to-Face Contact
- Monthly Case Manager Contact
- Housing Status

RI Quality Management Programmatic Features

- Leadership Training and Development: CEOs, CMs, State staff, consumers
- TA, and Capacity Building for agencies
- QM Monitoring Standards & Reporting (6 month and quarterly reports)
- HRSA Performance Measures
- PM Reporting and Analysis
- Provider review of QM Report Findings
- QM Planning
- QM Training
- Facilitation of QI Teams
- Measurement of Consumer Needs/Expectations

Where We've Been…

Old QA

Continuous Quality Improvement

RI Aspects of Continuous Quality Improvement

- **Focus on Consumer Needs/System Gaps**
- **RI QMC: Assess Jointly, Plan Jointly, Act Jointly**
- **Implement, Evaluate, QI says Let Data Drive Programming (Service Categories)**

Interventions/Improvements

- **Opportunity for improvement:** assessments for mental health and substance use not complete/missing
  - Improvement of assessment process- defined standard for a comprehensive assessment tool and ongoing monitoring of assessment process
- **Opportunity for improvement:** reassessments and revised care plans not being done on a timely basis
  - Established performance measures for ongoing monitoring, established standards for care plans; agencies revised care planning tools; agencies implemented interdisciplinary care planning processes; inclusion of case managers in care planning
  - Developed new Acuity Scale: Focus. “What Matters to You?”, more strength based approach.

Interventions/improvements

- **Opportunity for improvement:** increase retention in care
  - Established standard for monthly contact/outreach and quarterly face to face visits with case manager
- **Opportunity for improvement:** variability among case manager competency/effectiveness as identified by clients and articulated need for training among case managers
  - Developed training/certificate program for case managers now aligned with building of an apprenticeship model
- **Opportunity for improvement:** increase retention in care
  - Improved communication/collaboration between medical and non-medical providers through monthly meetings where individual client challenges are discussed/brainstormed

Interventions/Improvements

- **Opportunity for improvement:** linking clients to mental health/substance use services
  - Improved intake processes which immediately link clients to behavioral health clinicians (colocation of services, interdisciplinary teams in agencies to improve communication among providers)
- **Opportunity for improvement:** improve care for clients, improve client well being
  - *MIRAH* - Allows organizations to collect and analyze patient symptoms to improve outcomes and reduce costs.
  - *Buddy program* - link clients to volunteers at drop in center- create community, meal site, shared activities, added support to clients

RI CoEXIST & Quality: A System Project…

- The RI HIV Provision of Care & Special Populations Unit is in the Medicaid Division under the Executive Office of Health and Human Services: HIV Care and Treatment/Ryan White is in Medicaid – Prevention in DOH
- RI like may states had a difficult time expending rebate funds in a timely and efficient, effective manner
- Our procurement process allowed for delegated authority which allowed for a unique, equitable, efficient and expeditious method of needs based targeting
- The goal was to get the funds out quickly, but to target the right agencies to do the needed tasks to meet needs illustrated in extensive needs assessments, provider capability and capacity assessments and gaps analysis
- Agencies were solicited, reviewed, and selected within three months time
- General motto throughout was to create solutions to address social determinants, broaden the HIV care and treatment provider network in RI (e.g., public institutions of higher education, etc.), synergize partners ability to impact HIV Continuum of Care, create housing, develop and sustain Intensive Case Management with Multi disciplinary team approach (using students!), etc.

CoEXIST Domains Represent the Quality Interface

Sample Domains that indicate Quality to Follow…	**Emphasis upon QI, whereby data collected across qualitative and quantitative outputs is reviewed regularly so change change happen quickly and effectively**
CoEXIST focuses upon system level quality improvements as well as individual agency QM performance measures data	**CoEXIST key areas of effort include behavioral health, substance use, primary care, sexual health, health education, early intervention services, housing, interdisciplinary intensive case management teams, innovative care and treatment, and social media campaigns.**

CoEXIST Domains

Inherent evaluation and quality components are in each agency agreement

HRSA Service Categories

- *Represent Official HRSA Service Categories*
- https://hab.hrsa.gov/sites/default/files/hab/Global/service_category_pcn_16-02_final.pdf

CoEXIST System Categories

- *Represent either:*
  - *HRSA Requirements*
  - *Specific grant related focus areas*
  - ***BOTH** HRSA Requirements and Specific Grant Focus Areas*

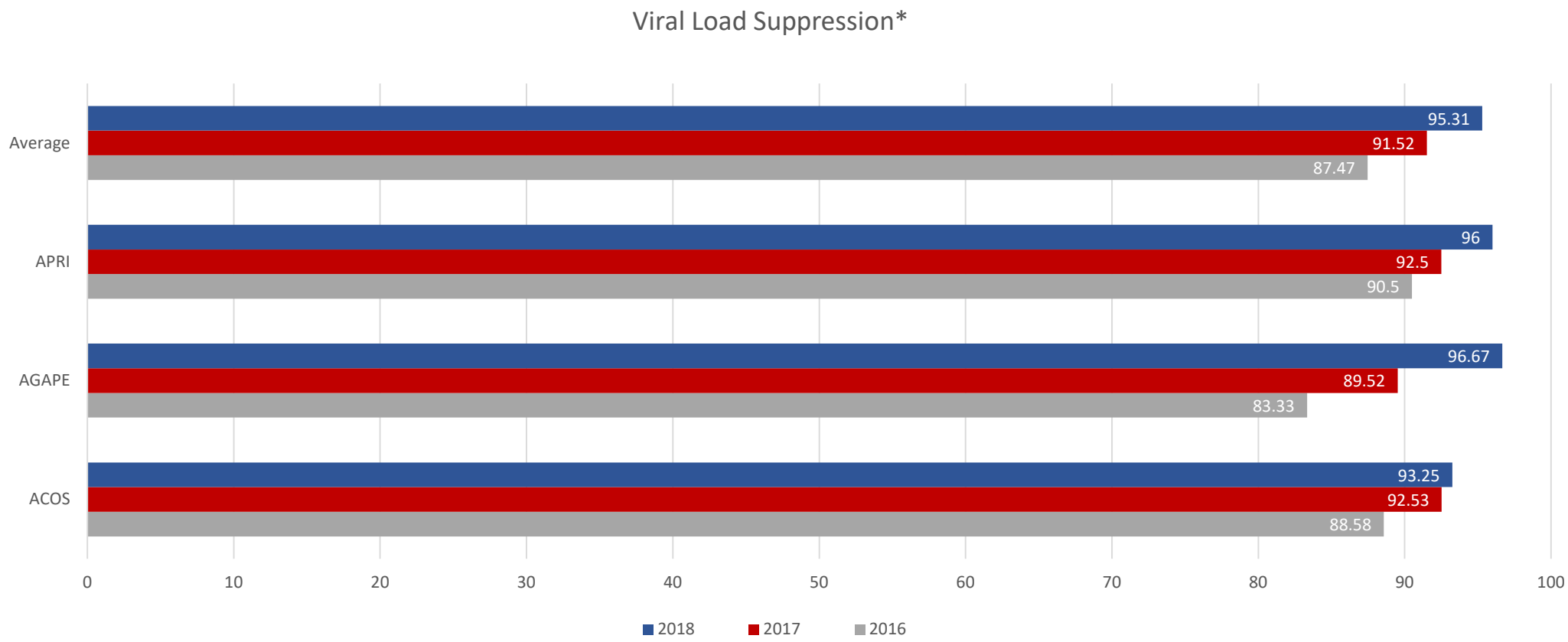
An Example: Rhode Island College: CoEXIST Performance Measures

- Client Satisfaction
- ICM Team Contacts with Clients
- Evaluation of Training/Conferences
- Pre/Post-Test of Students Attitudes toward HIV/AIDS
- Peer Education (number of events held)
- Agency Satisfaction with Student Support

Early Feedback CoEXIST

- “Students bring a fresher platform, it’s a mutual relationship, so thy get that information from us and they can help us spice things up”
- “We help empower them for their future and helping empower them we can give them information that they don’t know for our community.”
- “Its good for them to know how to treat patients and how to deal with the community and how to treat people and to know that sometimes doctors don’t know how to treat you”

Viral Load Suppression



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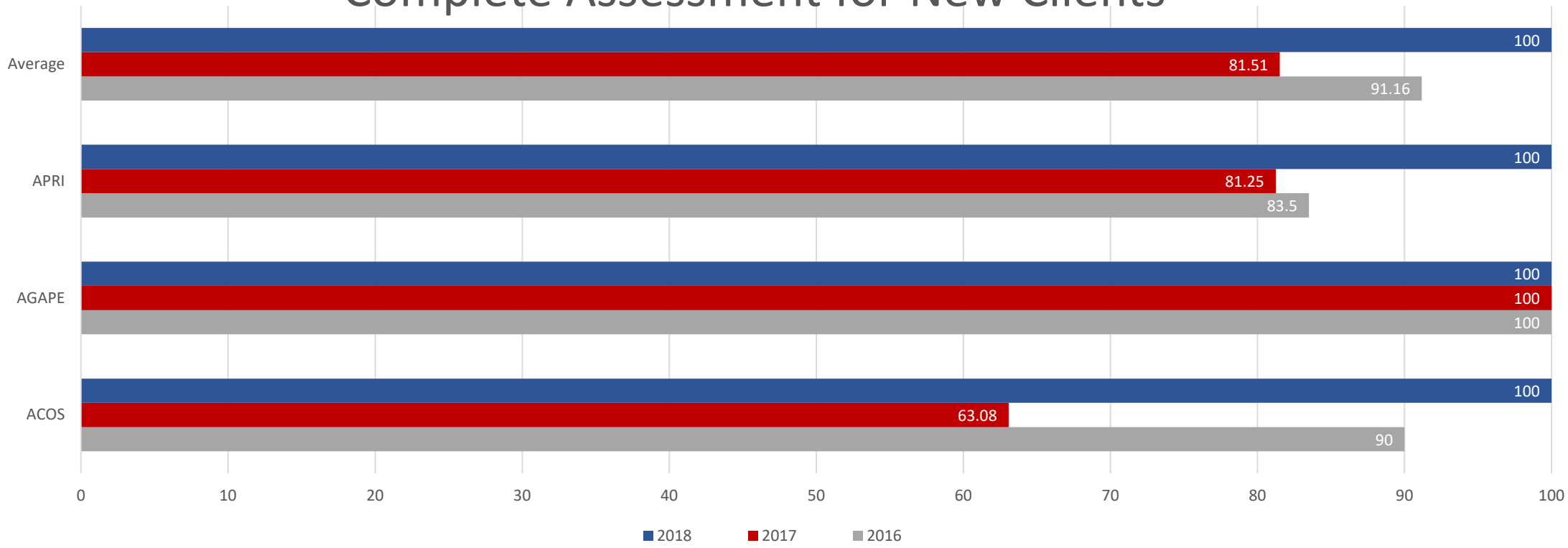
Viral Suppression Slide Footnotes

- The number of clients with a HIV Viral Load less than 200 copies/mL at the last HIV viral load test within the last 12 months.
- Numerator is defined as, the number of clients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test within the last 12 months.
- Denominator is defined as, all Ryan White Part B non-medical case management clients, regardless of age, with a diagnosis of HIV.

Complete Assessment for New Clients



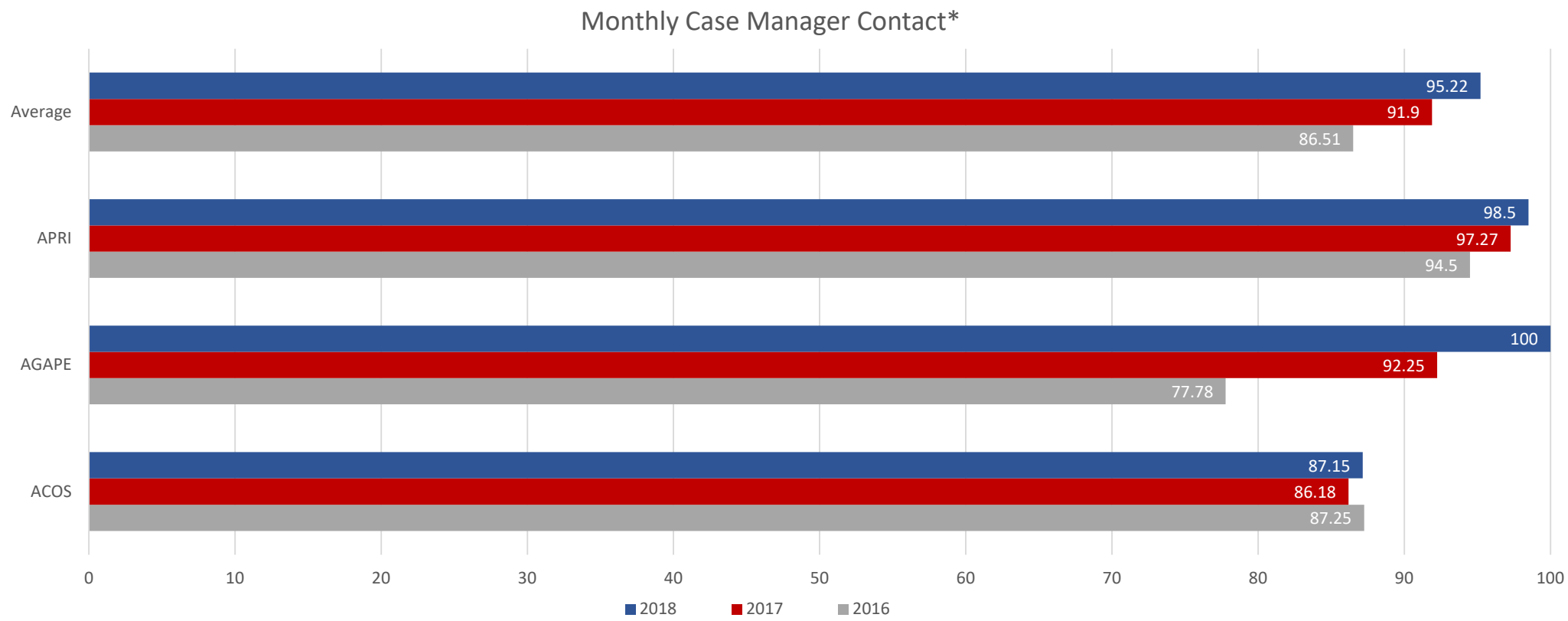
Complete Assessment for New Clients Footnotes

Percentage of new non-medical case management clients, regardless of age, with a diagnosis of HIV that have a complete assessment on file during the reporting period at the onset of case management services. All new non-medical case management clients will be given a full assessment within 15 business days on their onset as a case management client.

Numerator is defined as the number of new clients, receiving non-medical case management services at your agency within the reporting period, that have a complete assessment on file, within 15 business days of their onset as a case management client.

Denominator is defined as the number of new clients that began receiving non-medical case management services at your agency within the reporting period.

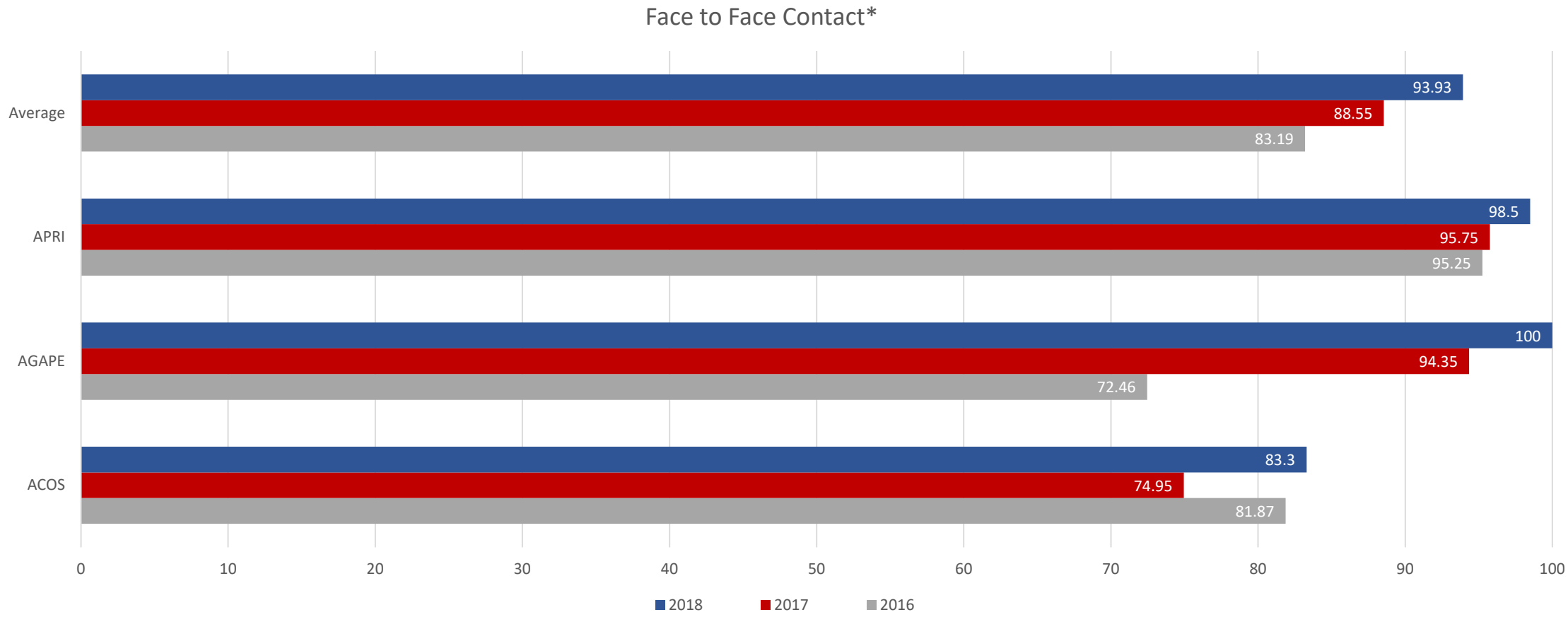
Monthly Case Manager Contact



Monthly Case Manager Contact Footnotes

- Percentage of non-medical case management clients regardless of age, with a diagnosis of HIV who had contact with their case manager during the reporting period (whether face to face, over the phone, text message, email, etc.)
- Numerator is defined as the number of clients receiving non-medical case management services at your agency within the recording period who had some contact with their case manager at least once during the reporting period.
- Denominator is defined as the number of new or established clients, regardless of age, receiving non-medical case management services at your agency.

Face to Face Contact



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Face to Face Contact Footnotes

- Percentage of non-medical case management clients, regardless of age with a diagnosis of HIV who have had at least one face to face contact with their case manager during the reporting period. Note: All clients MUST have a face to face contact with their case manager at least every 3 months.
- Numerator is defined as the number of clients, new or established, that have had at least one face to face contact with their case manager during the reporting period.
- Denominator is defined as the number of clients, new or established, regardless of age, receiving non-medical case management services at your agency.

Why is Viral Suppression at 97% with RI RW Part B Providers???

- We're a small state that's manageable, compact geographically
- The QMC is involved, dedicated and committed to the HIV Continuum of Care Plus Model
- A Village Approach Towards Victory: Includes, Public Higher Education, RI Public Health Institute, State Agency Partners (BHDDH, DOH, DOC), ACOs, SIMs, mHealth app, etc
- Clear and effective capacity building that allows one on one approach
- We believe in a two way street whereby we all can learn from each other
- Agency integration of services whereby RW Service Category co-location is inherent

RI Strengths, Barriers, Opportunities, Challenges

- Barrier: Compensation of Staff, lack of upward mobility
- Strength: Working to change above via Apprenticeship Plus program
- Strength and Barrier: Provision of ongoing training and professional development. While built into contracts CMs struggle to keep up
- Barrier/Challenge: A fragmented health/behavioral health care system
- Barrier/Challenge: Overwhelming Workload at agencies challenging to QI and training efforts
- Strength: Collective mentality, sharing and caring group
- Strength: A dedicated process and committed people that make Quality performance measures and integral part of client and patient care

Panel & Audience Discussion

- What interventions have aided in viral suppression in your clinic or case management agency?
- Do you have a statewide quality initiative?
  - If so, what are the key features, successes, and lessons learned?
- How is data used in your clinic or case management agency to drive quality improvement?
- How do you keep your clinic/case management agency focused on quality improvement as opposed to other competing interests?

Thank You!

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

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