CUYAHOGA COUNTY BOARD OF HEALTH

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Ryan White Part A CQM Committee Meeting
November 18, 2019 – CCBH

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Tahir Arif – Grant Coordinator – tarif@ccbh.net

Ryan White Part A
Cleveland TGA

Agenda

1:00-1:15	**Welcome, Introductions** Melissa Rodrigo and Zach Levar - Cleveland TGA
1:15 - 1:35	**CQMC Updates and Data** Zach Levar and Tahir Arif – Cleveland TGA
1:35 – 2:30	**CQM QI Project Presentations** Part A Funded Providers
2:30 – 2:40	**Break**
2:40 – 3:45	**CQM QI Project Presentations** Part A Funded Providers
3:45 – 4:00	**Next Steps, Adjourn** Melissa Rodrigo and Zach Levar – Cleveland TGA

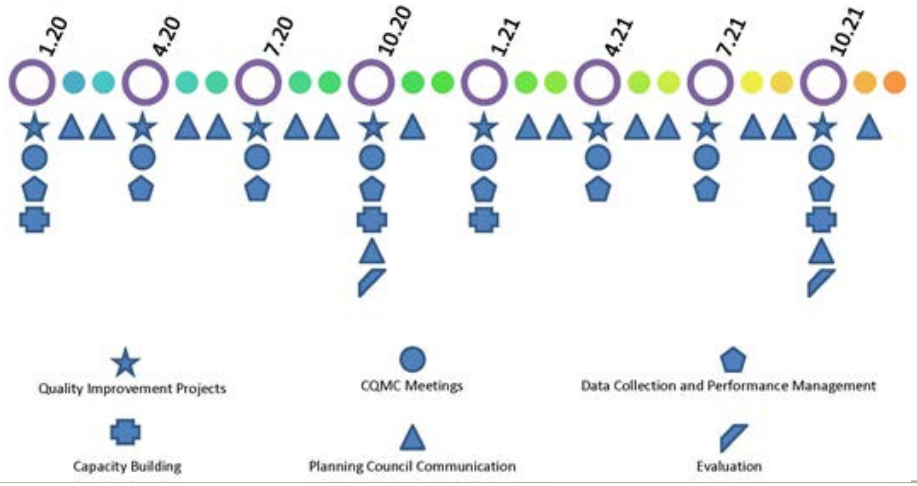
CQM Plan Updates

- Updated National Comparison and Goal for Viral Suppression Rate

Performance Measure	Reporting Provider	*National Benchmark	TGA Goal
Viral Suppression: Percentage of HIV patients with a viral load less than 200 copies/ml.	All fundedmedical and support service providers	85%	90%

* Ryan White Services Report, 2017

- Updated Timeline to reflect 2 year plan rather than 1 year



Organizational Assessment

- Are there any sub-populations outside of the 4 that we currently target in CQM projects (MSM of Color, Youth, African American/Latina Women, and Transgender) that you would like to see trended data for? This can include demographic variables, service category usage, etc.
- Are there new/emerging priorities to address through our committee?
- Are there any specific QI tools that you are interested in and would like to learn more about?
- Are the goals of the committee still appropriate, or do they need revision?
- Please use this space to provide any general feedback/requests/changes that are not addressed in the above questions:

OA Highlights:

- Are there any sub-populations outside of the 4 that we currently target in CQM projects (MSM of Color, Youth, African American/Latina Women, and Transgender) that you would like to see trended data for? This can include demographic variables, service category usage, etc.

Priority:

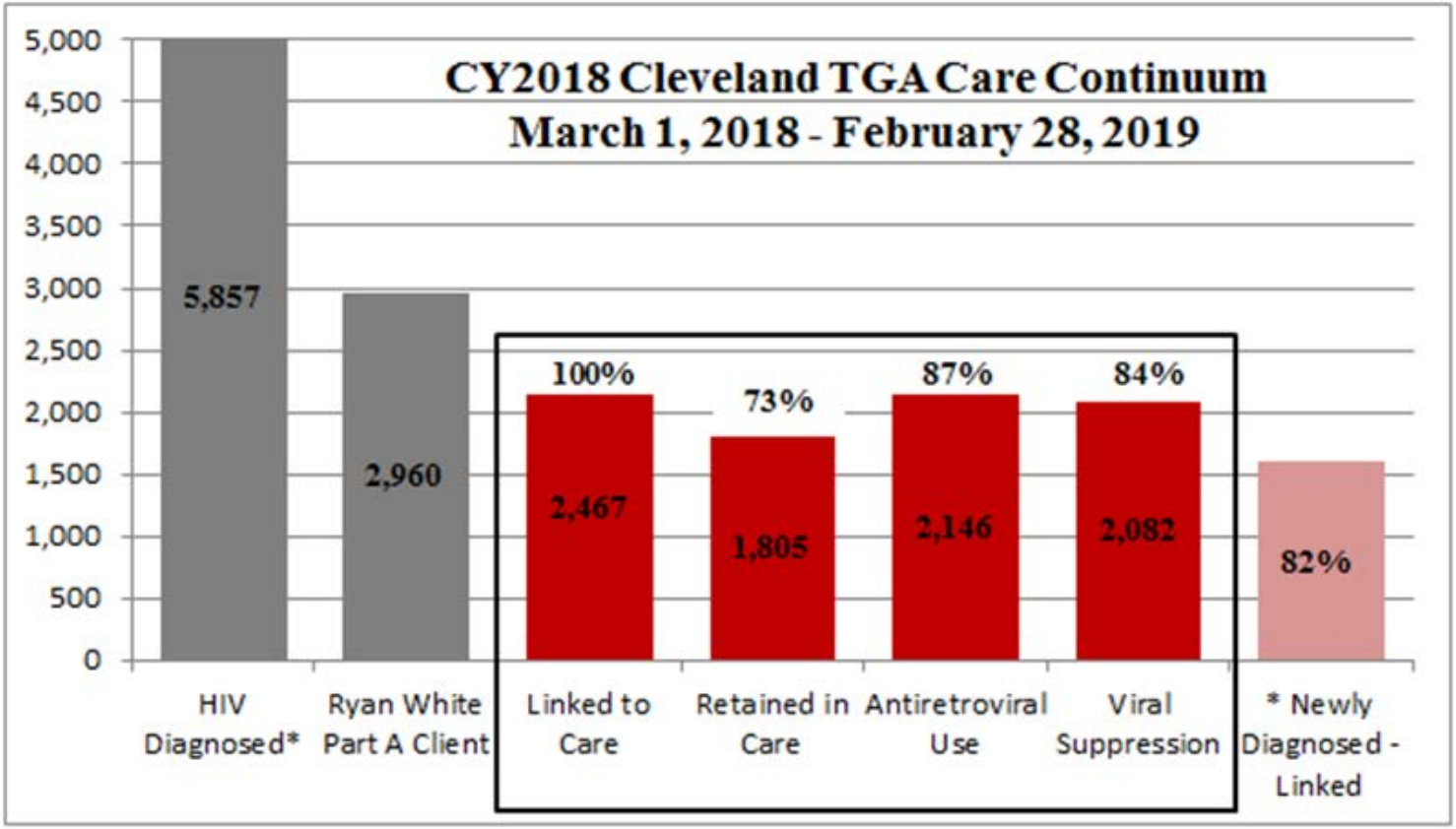
- IV Drug User VLS Data
- Mental Health VLS Data
- Housing status crossed by VLS

Future Possibilities:

- Employment Data
- Historic lab data for those diagnosed between 1980-1996 along with co-morbidities (ODH may have this)
- Substance Abuse data (no longer a funded Part A service)

- Are there new/emerging priorities to address through our committee?
  - How mental health and/or substance abuse affects viral load suppression
  - Trauma-sensitive care

- General feedback/requests:
  - Literacy training for staff/consumers on history of disease, important milestones, agents of change
  - Presentation on HIV Molecular Surveillance/Cluster – perhaps from State



- **HIV-Diagnosed:** Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health. *Please note: The most recent available prevalence data from the Ohio Department of Health is as of December 31, 2018.
- **Ryan White Part A Clients:** Number of diagnosed individuals who received a Ryan White Part A funded service in the measurement year.
- **Linked to Care:** Number of HIV positive individuals that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test in the measurement year.
- **Retained in Care:** Number of HIV positive individuals who had two or more Ryan White Part A funded medical visits, viral load or CD4 tests performed at least three months apart during the measurement year.
- **Antiretroviral Use:** Number of HIV positive individuals receiving Ryan White Part A funded medical care who have a documented antiretroviral therapy prescription on record in the measurement year.
- **Viral Suppression:** Number of HIV positive individuals receiving Ryan White Part A funded medical care whose most recent HIV viral load within the measurement year was less than 200 copies/mL.
- ***Newly Diagnosed - Linked:** Number of HIV positive individuals receiving a diagnosis of HIV in the measurement year that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test within ninety days of diagnosis. *Please note the denominator for Newly Diagnosed - Linked is different from the denominators used to calculate other steps in the continuum.

Numbers to Date

Date:	3/1/18 - 2/28/19	%	10/1/18 - 9/30/19	%
Ryan White Clients	2960	-	3001	-
Linked to Care	2467	-	2514	-
Retained in Care	1805	73%	1804	72%
ART Prescription	2146	87%	2185	87%
Viral Suppression	2082	84%	2188	87%

Cleveland TGA Treatment Cascade by Service Category

March 1, 2018 - February 28, 2019

Treatment Cascade Totals	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
	2,960	2,467	100%	1,805	73%	2,146	87%	**2,082**	**84%**	84	82%

Core Service Category	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed		Newly Diagnosed Linked	
Outpatient Ambulatory Health Services (OAHS)	2,064	2,034	99%	1,594	78%	1,826	90%	**1,744**	**86%**	68	93%
Medical Case Management	1,101	903	82%	694	77%	826	91%	**755**	**84%**	24	71%
Early Intervention Services (EIS)	197	183	93%	103	56%	120	66%	**119**	**65%**	29	91%
Oral Health Care	320	281	88%	237	84%	257	91%	**261**	**93%**	2	100%
Mental Health Services	247	238	96%	187	79%	204	86%	**199**	**84%**	6	100%
Substance Abuse Outpatient Care	2	1	50%	1	100%	1	100%	**1**	**100%**	-	0%
Medical Nutrition Therapy	228	222	97%	194	87%	217	98%	**211**	**95%**	3	75%
Health Insurance Premium Cost Sharing Assistance (HIP	108	92	85%	73	79%	80	87%	**85**	**92%**	0	0%
Home/Community Based Health	35	23	66%	21	91%	23	100%	**23**	**100%**	-	0%
Home Health Care Services	37	24	65%	22	92%	24	100%	**24**	**100%**	-	0%
Support Service Category	**Part A**	**Linked to Care**		**Retained in Care**		**Prescribed ART**		**Virally Suppressed**		**Newly Diagnosed Linked**	
Medical Transportation Services	1,422	1,189	84%	908	76%	1,022	86%	**1,018**	**86%**	43	81%
Emergency Financial Assistance (EFA)	48	46	96%	30	65%	30	65%	**33**	**72%**	3	100%
Food Bank / Home Delivered Meals	388	290	75%	224	77%	250	86%	**227**	**78%**	3	75%
Non-Medical Case Management Services	1,584	1,386	88%	1,027	74%	1,119	81%	**1,125**	**81%**	50	88%
Outreach Services	400	284	71%	156	55%	246	87%	**194**	**68%**	10	56%
Other Professional Services	231	172	74%	142	83%	153	89%	**140**	**81%**	2	67%
Psychosocial Support	132	120	91%	97	81%	103	86%	**97**	**81%**	3	75%
Substance Abuse Services - Residential	1	0	0%	0	0%	0	0%	**0**	**0%**	-	0%

Where can we focus VLS discussion?

- Below are service categories that displayed more than a 5% variance between ART prescription and VLS rates for FY2018:

FY2018	ART %	VLS%
Medical Case Management	91%	84%
Food Bank/ Home Delivered Meals	86%	78%
Outreach Services	87%	68%
Other Professional Services	89%	81%
Psychosocial Support	86%	81%

Cleveland TGA Treatment Cascade by Demographics

March 1, 2018 - February 28, 2019

FY2018 Treatment Cascade Totals	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
	2,960	2,467	83%	1,805	73%	2,146	87%	2,082	84%

Race	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Black Non-Hispanic	1,758	1,434	82%	1,003	70%	1,205	84%	1,159	81%
Hispanic	330	296	90%	210	71%	231	78%	242	82%
White Non-Hispanic	832	705	85%	540	77%	627	89%	617	88%
More Than One Race/Other	39	33	85%	22	67%	25	76%	27	82%

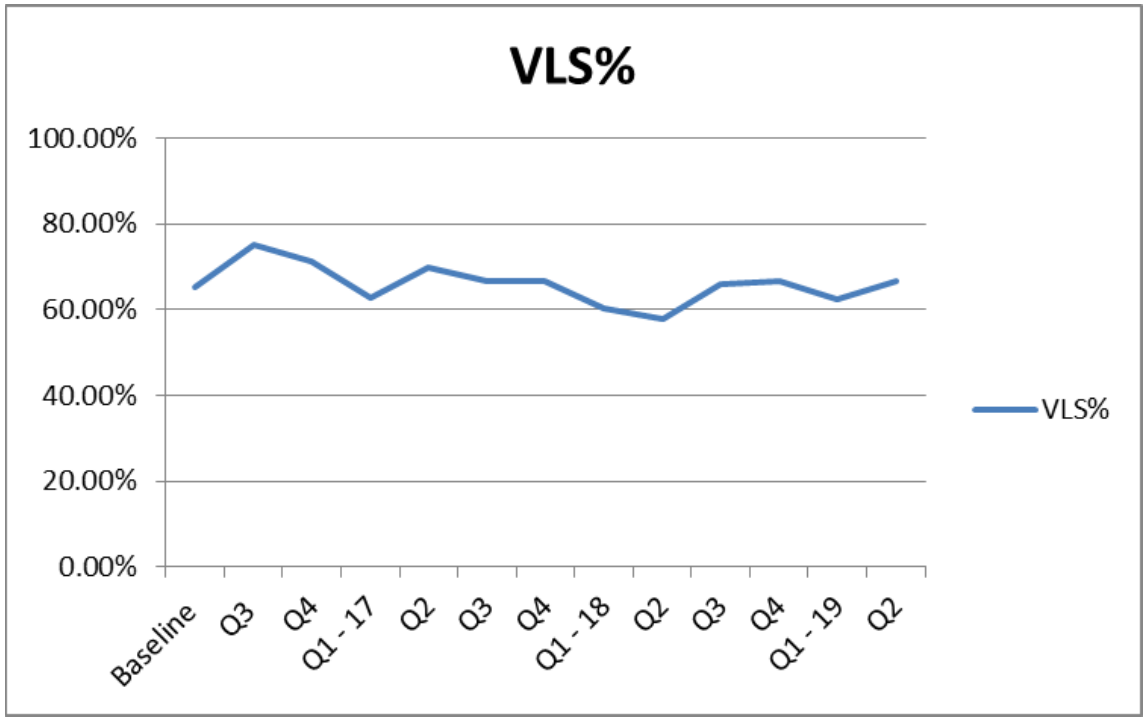
Age	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
2-12	5	5	100%	3	60%	2	40%	3	60%
13-24	127	108	85%	56	52%	70	65%	67	62%
25-44	1,083	901	83%	555	62%	699	78%	689	76%
45-64	1,525	1,268	83%	1,001	79%	1,140	90%	1,111	88%
65+	219	186	85%	160	86%	177	95%	175	94%

Gender	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Male	2,188	1,806	83%	1,288	71%	1,522	84%	1,494	83%
Female	708	613	87%	452	74%	527	86%	512	84%
Transgender	63	49	78%	35	71%	39	80%	39	80%

HIV Risk Factor	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
MSM	1,625	1,335	82%	947	71%	1,118	84%	1,102	83%
IDU	143	112	78%	81	72%	95	85%	98	88%
MSM and IDU	25	23	92%	13	57%	21	91%	21	91%
Heterosexual	1,252	1,060	85%	765	72%	897	85%	873	82%

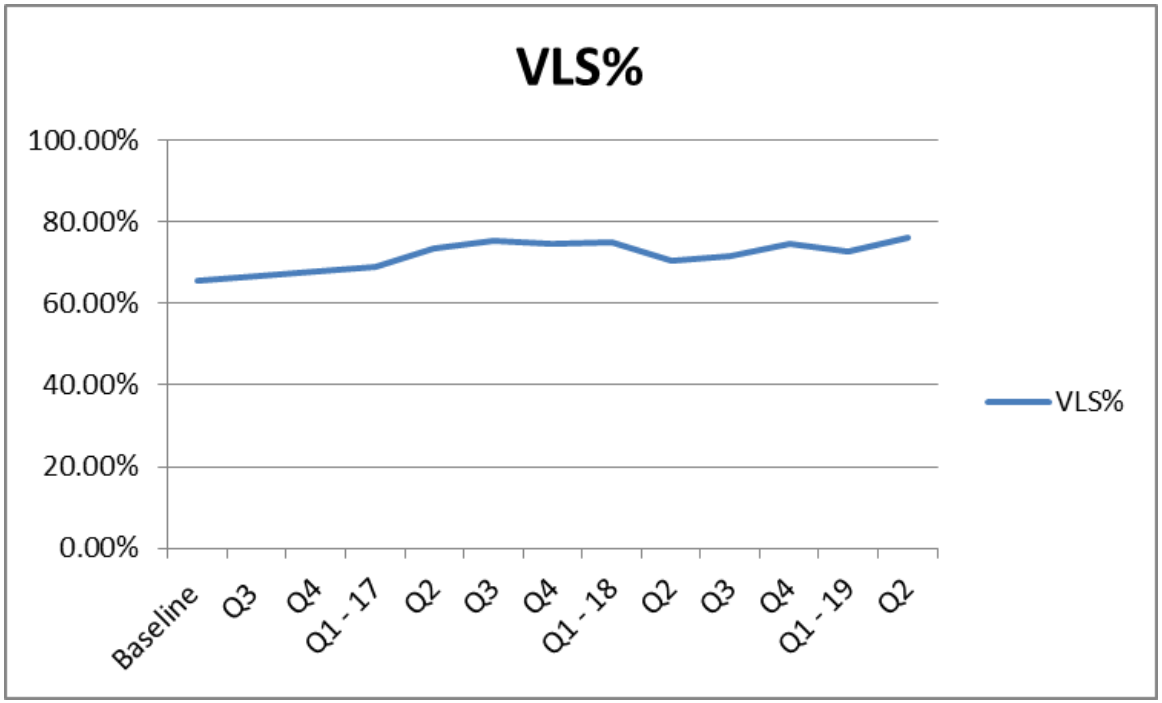
CQMC Target Population Data

Transgender



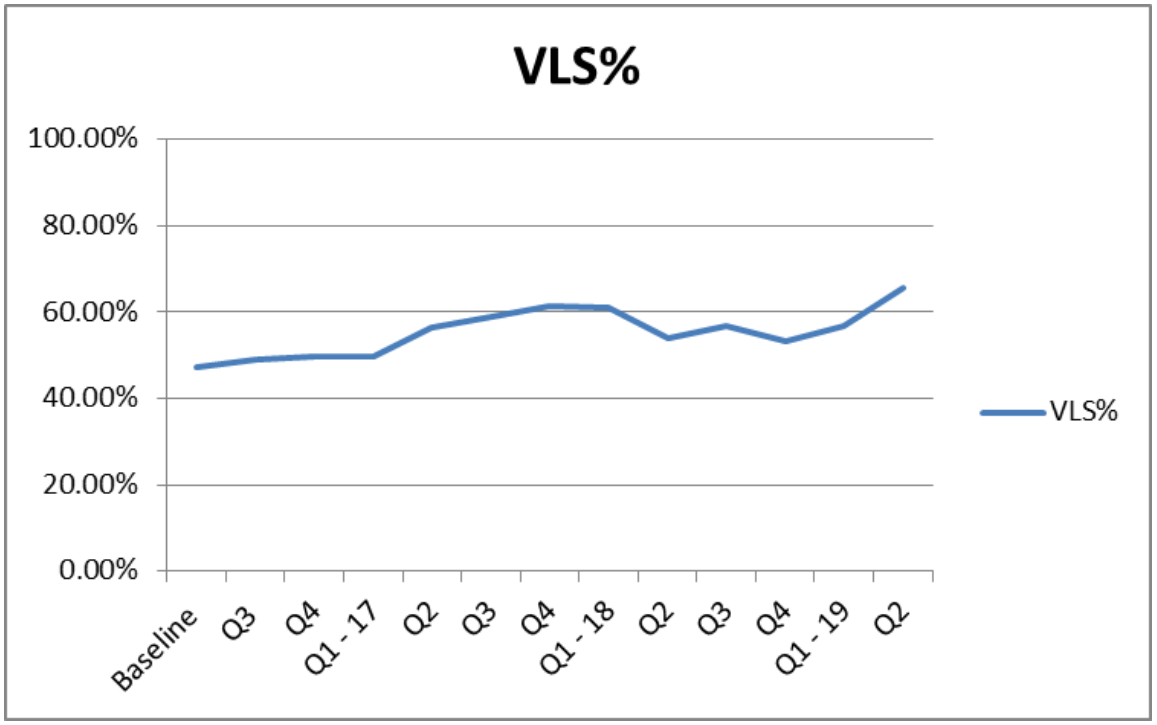
Q	N	D	%
Baseline	28	43	**65.1%**
Q3	30	40	**75.0%**
Q4	30	42	**71.4%**
Q1 - 2017	32	51	**62.7%**
Q2	37	53	**69.8%**
Q3	40	60	**66.7%**
Q4	42	63	**66.7%**
Q1 - 2018	38	63	**60.3%**
Q2	37	64	**57.8%**
Q3	41	62	**66.1%**
Q4	42	63	**66.7%**
Q1 - 2019	40	64	**62.5%**
Q2	42	63	**66.7%**

African American/Latina Women



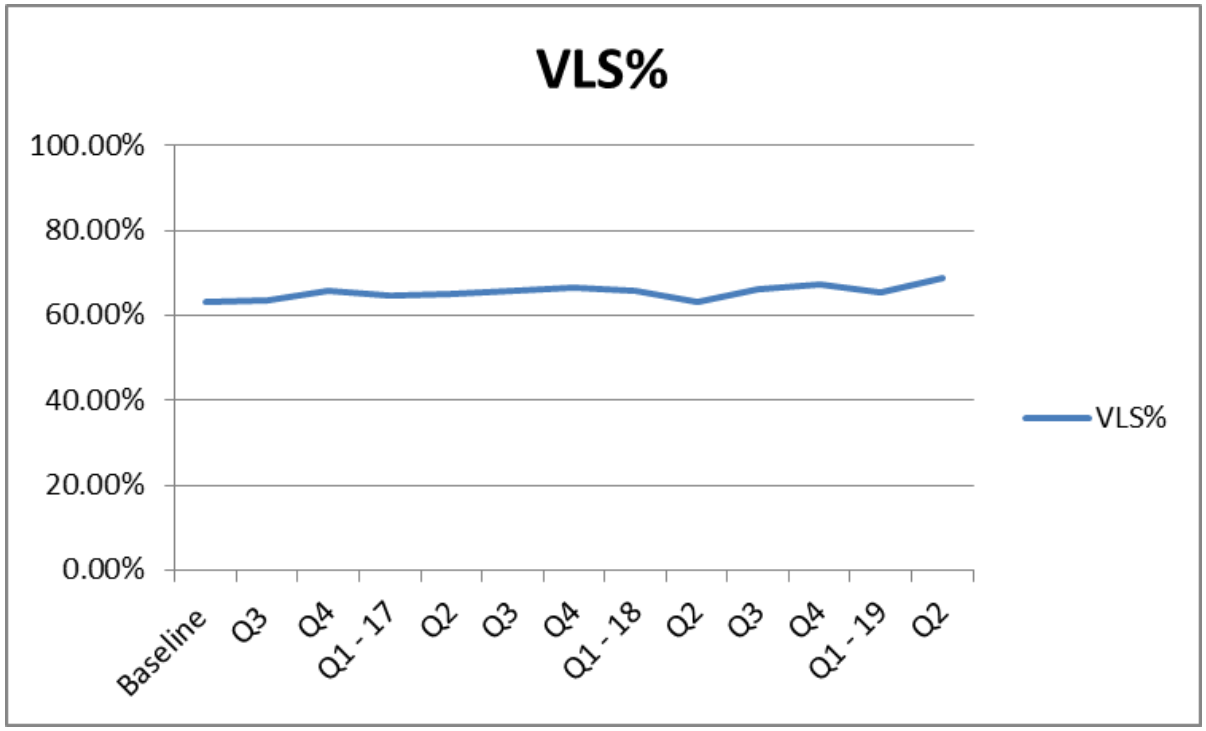
Q	N	D	%
Baseline	364	554	**65.7%**
Q3	366	549	**66.7%**
Q4	374	551	**67.9%**
Q1 - 2017	396	574	**69.0%**
Q2	422	575	**73.4%**
Q3	435	578	**75.3%**
Q4	435	582	**74.7%**
Q1 - 2018	438	585	**74.9%**
Q2	416	590	**70.5%**
Q3	423	592	**71.5%**
Q4	427	572	**74.7%**
Q1 - 2019	421	579	**72.7%**
Q2	445	585	**76.1%**

Youth (13-24)



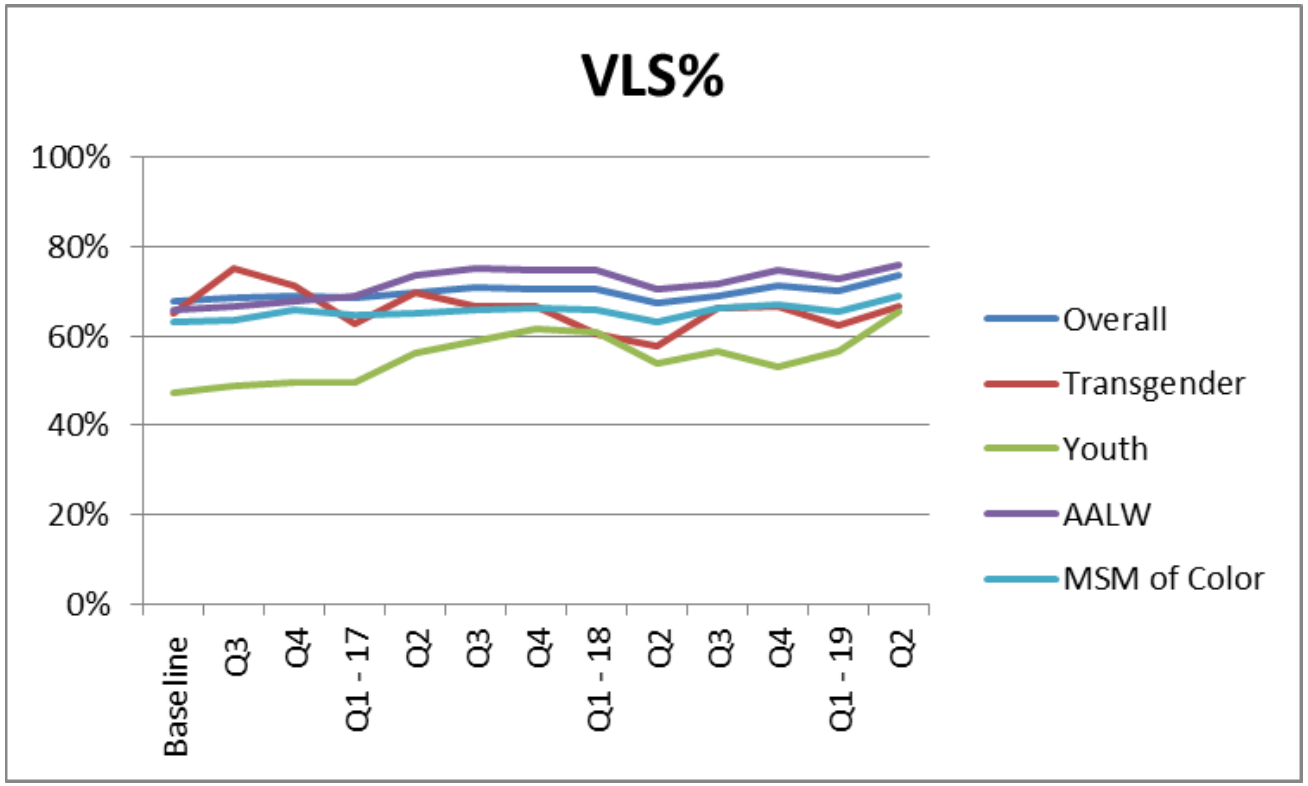
Q	N	D	%
Baseline	81	171	**47.4%**
Q3	85	174	**48.9%**
Q4	86	173	**49.7%**
Q1 - 2017	83	167	**49.7%**
Q2	93	165	**56.4%**
Q3	95	161	**59.0%**
Q4	94	153	**61.4%**
Q1 - 2018	87	143	**60.8%**
Q2	70	130	**53.8%**
Q3	72	127	**56.7%**
Q4	66	124	**53.2%**
Q1 - 2019	72	127	**56.7%**
Q2	84	128	**65.6%**

MSM of Color



Q	N	D	%
Baseline	615	975	**63.1%**
Q3	628	987	**63.6%**
Q4	644	979	**65.8%**
Q1 - 2017	657	1016	**64.7%**
Q2	691	1061	**65.1%**
Q3	732	1111	**65.9%**
Q4	732	1103	**66.4%**
Q1 - 2018	729	1108	**65.8%**
Q2	695	1104	**63.0%**
Q3	700	1059	**66.1%**
Q4	686	1022	**67.1%**
Q1 - 2019	683	1044	**65.4%**
Q2	724	1052	**68.8%**

TGA Overall



Q	N	D	%
Baseline	1915	2832	**67.6%**
Q3	1951	2851	**68.4%**
Q4	1953	2832	**69.0%**
Q1 - 2017	2015	2945	**68.4%**
Q2	2107	3019	**69.8%**
Q3	2205	3118	**70.7%**
Q4	2181	3093	**70.5%**
Q1 - 2018	2188	3112	**70.3%**
Q2	2092	3100	**67.5%**
Q3	2075	3009	**69.0%**
Q4	2072	2911	**71.2%**
Q1 - 2019	2083	2968	**70.2%**
Q2	2206	3001	**73.5%**

Ryan White FY19 QI Project

- Viral Load Suppression
- DMAIC framework
  - Define
  - Measure
  - Analyze
  - Improve
  - Control
- Data driven
  - Baseline
  - Three reporting periods

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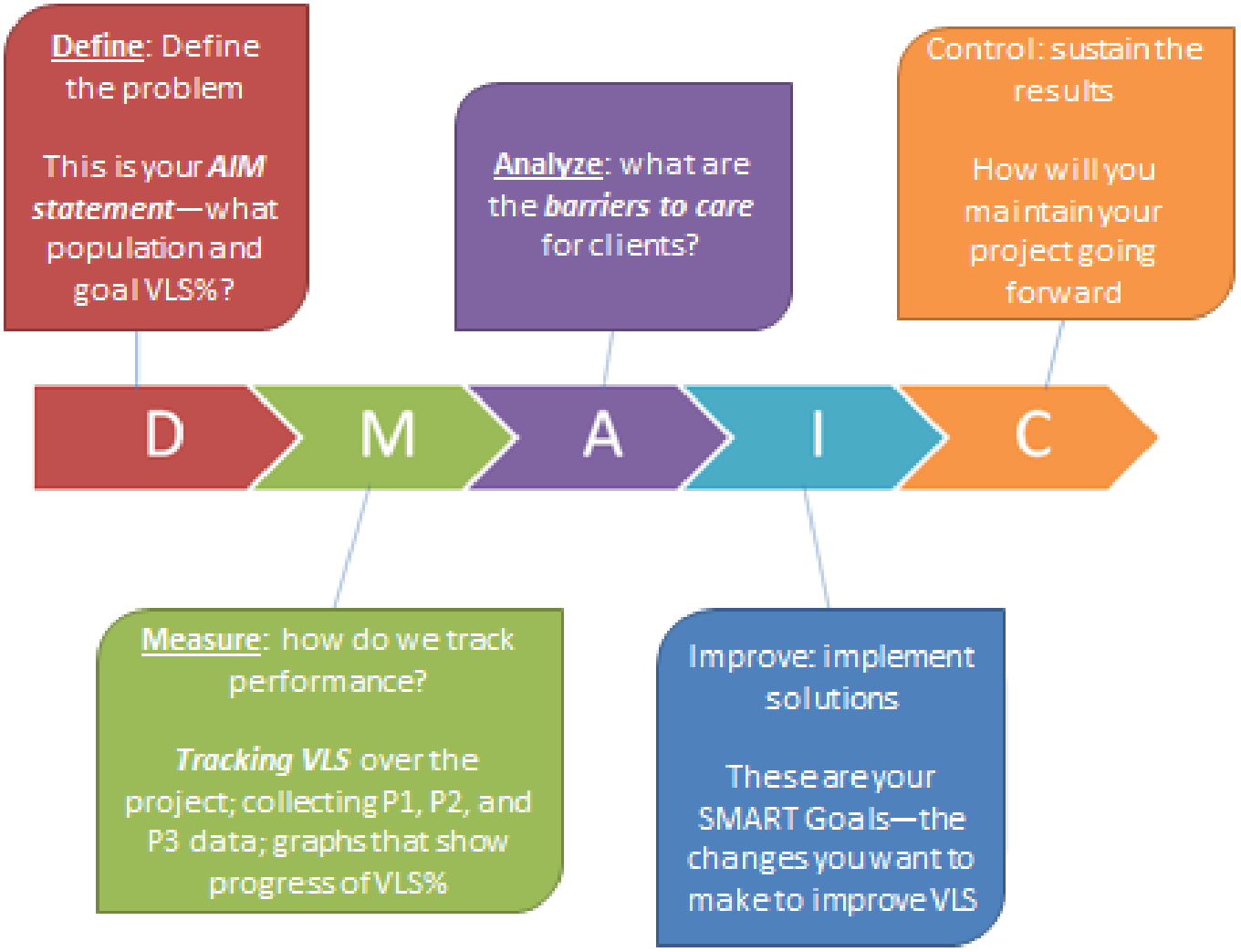
Define: Define the problem
This is your AIM statement—what population and goal VLS%?
Analyze: what are the barriers to care for clients?
Control: sustain the results
How will you maintain your project going forward
D
M
A
I
C
Measure: how do we track performance?
Tracking VLS over the project; collecting P1, P2, and P3 data; graphs that show progress of VLS%
Improve: implement solutions
These are your SMART Goals—the changes you want to make to improve VLS

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Cleveland TGA QI VLS 2019

All projects overall:

Max	100%
Min	61%
Average	83.69%

Providers' Target Populations

Part A clients	CCF (MCM clients only)	Far West	DSAS	Signature Health
HIV+	AHF	FPS	May Dugan	
MSM of color	ATF	Circle Health	Mercy Health	Nueva Luz URC
Youth	MetroHealth	UH		

AIDS Healthcare Foundation

AIDS Healthcare Foundation

Target Population: All HIV+ clients

AIM Statement: By November 1, 2019 AIDS Healthcare Foundation will improve VLS for all HIV+ clients from 66 to 71%.

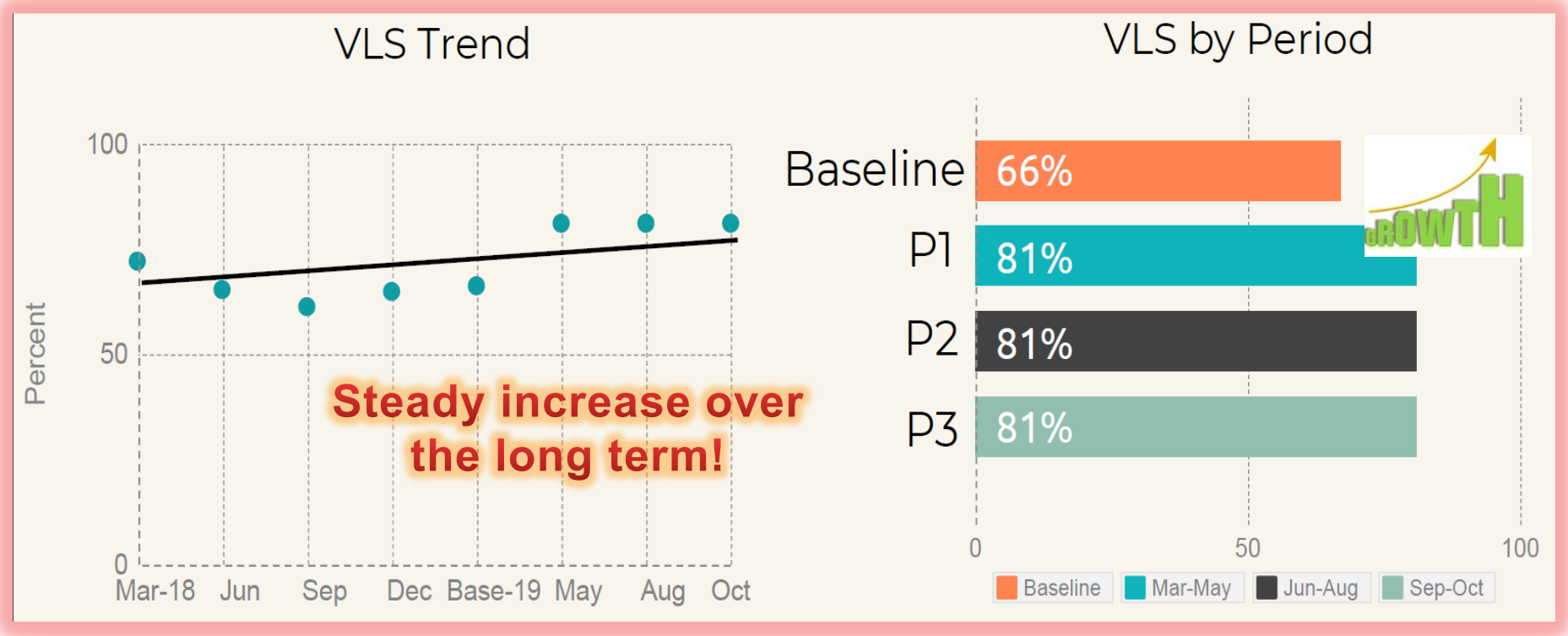
SMART Objectives:

- By March 31st, will have conducted at least 1 evening clinic
- By April 30th, will have developed and implemented a questionnaire regarding clinic accessibility

Barriers to Care:

- Loss of physician; nurse practitioner is only available one day a week for clients
- Patients not showing up to appointments regardless of incentives/transportation

AIDS Healthcare Foundation



Evening clinic was a huge success! Moving forward, AHF hopes to expand to multiple times a week for the clinic.

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CONTROL

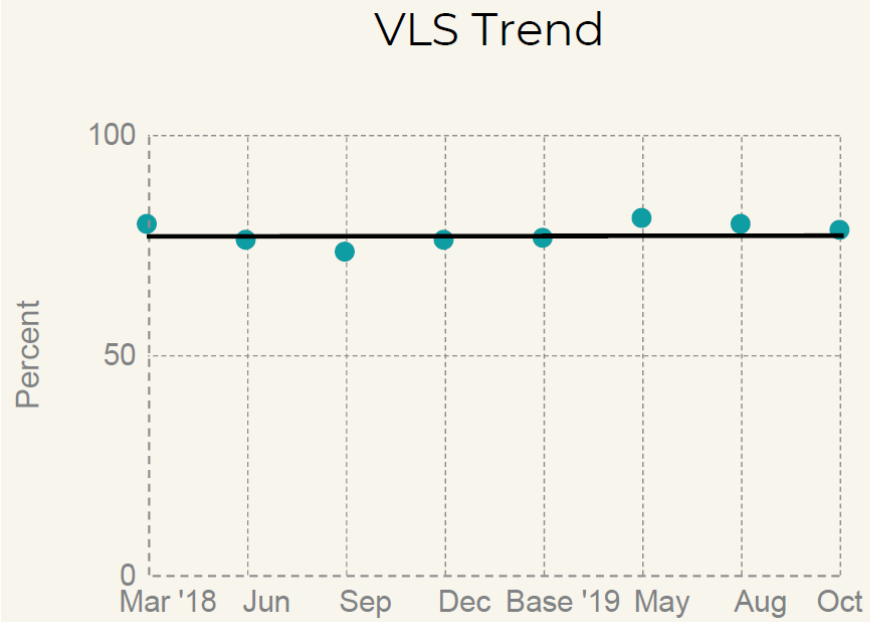
Nationally, AHF has decided to utilize evening clinic hours, so when a provider is hired, evening clinic will be fully implemented at Cleveland AHF

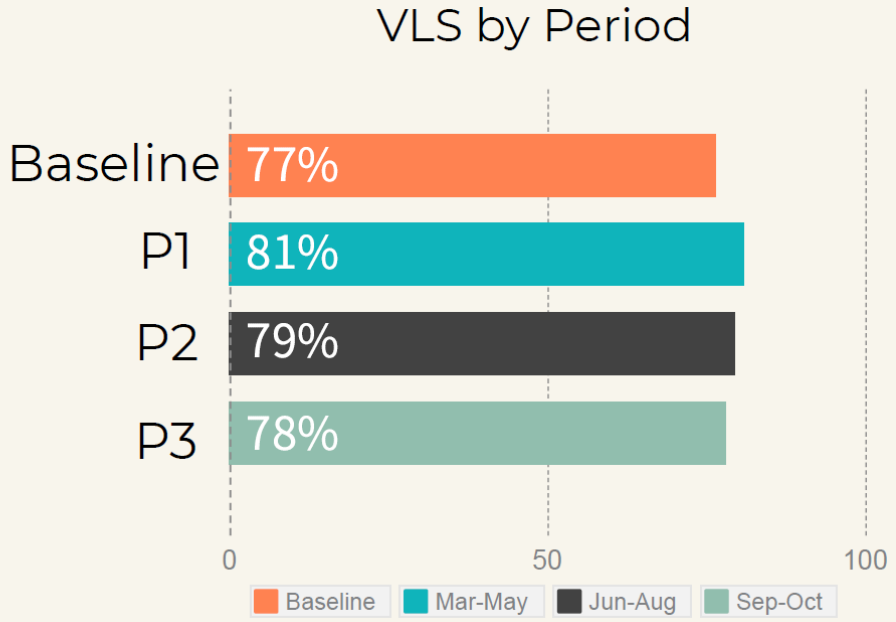
Questionnaire will not be used in the future, as AHF decided there is another survey already in place that covers clinic accessibility

AIDS Taskforce of Greater Cleveland

Target Population: MSM of Color

AIM Statement: By November 1, 2019, AIDS Taskforce will improve VLS for MSM of color from 77 to 80%.





SMART Objectives:

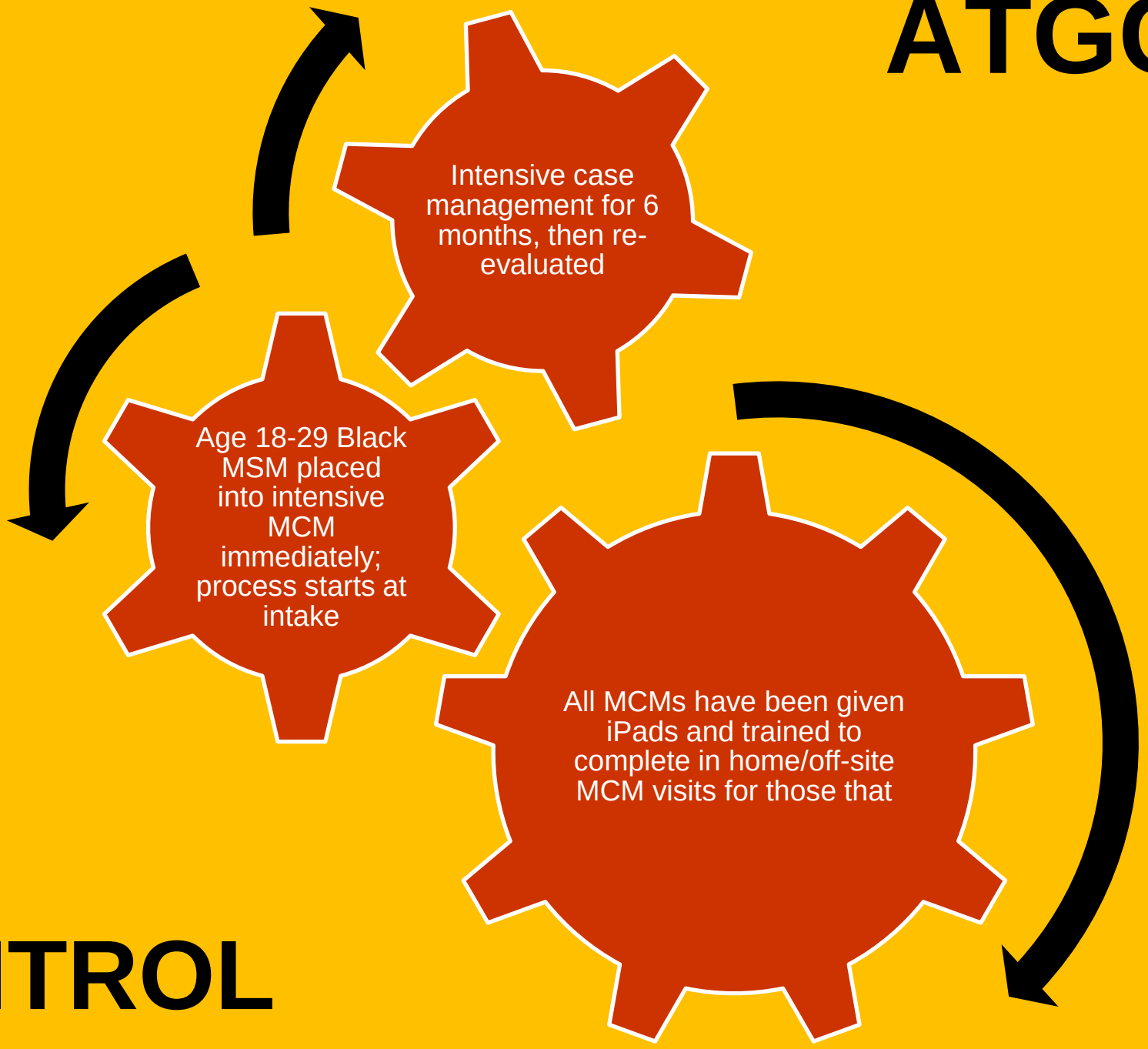
- By March 31st, ATF will identify participants requiring intensive case management and begin documenting discussions of medication adherence in case notes to promote VLS
- By May 31st, ATF will have a process in place to determine which clients require offsite case manager visits and begin implementation of process

Barriers to Care:

- Homelessness/unstable living environments
- Transportation
- Mental health

Recently hired a behavioral health specialist to decrease the mental health barrier. Great idea!

ATGC



CONTROL

Circle Health Services

Circle Health Services

Target Population: MSM of Color

AIM Statement: By November 1, 2019, Circle Health Services will improve VLS for MSM of color from 77 to 82%.

SMART Objectives:

- **By May 30th, conduct an analysis on non-virally suppressed clients to see how often insurance lapses and develop an intensive MCM follow-up process**
- **By October 31st, decrease time between diagnosis of depression and initial counseling visit**

Barriers to Care:

- **Retention in care**
- **Medication issues due to lapse of insurance**
- **Transportation**

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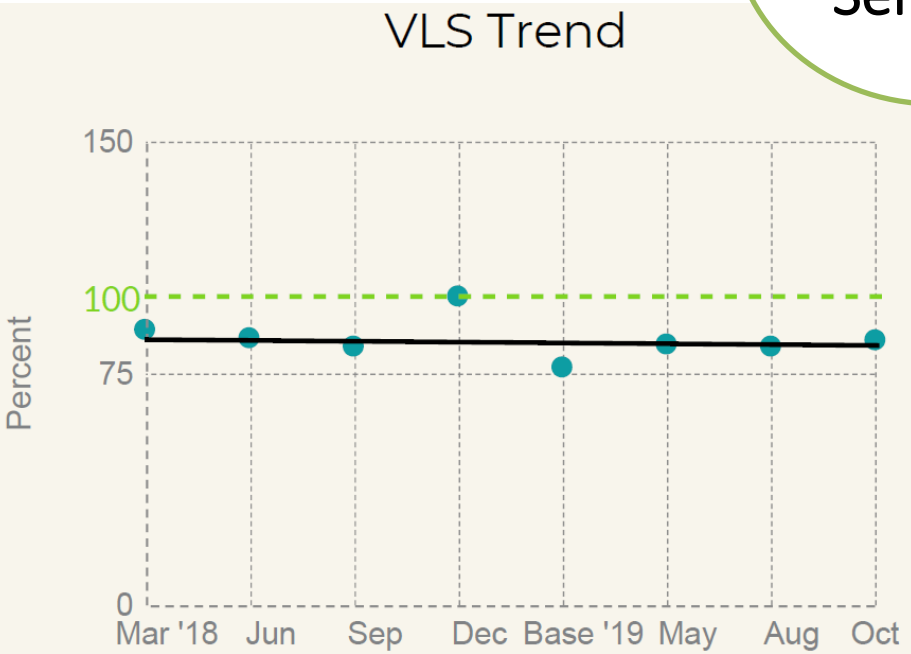
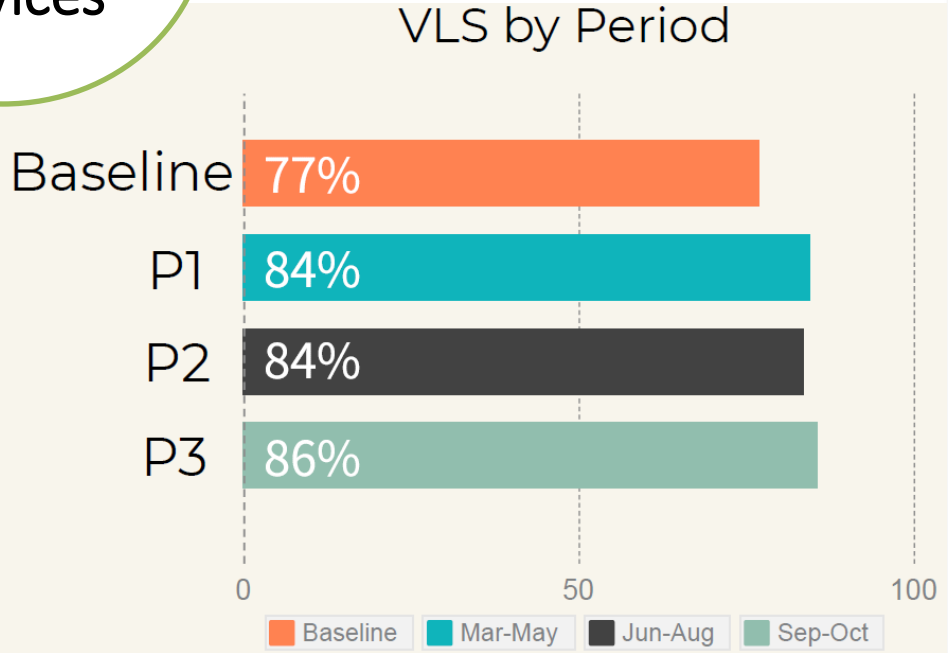
Circle Health Services





Medical Case Managers now have work cell phones (ahhh, what convenience!)

CCBH

		VLS	Total Patients	%	Comments
Baseline (3/2019)	All patients	97	119	81%	
	MSM of Color	44	57	77%	
Quarterly Summary (11/2019)	All patients	95	112	85%	
	MSM of Color	48	56	86%	
	Other	47	56	84%	
	+ Depression Screening MSM of Color	6	6	100%	
	Lapsed insurance		4		4 patients with lapsed insurance affecting ability to obtain medication and VL.

Of the patients that currently screened positive for Depression, the following interventions were implemented:

- 3 patients are in counseling.
- 1 patient declined counseling
- 2 patient erratically in and out of care.

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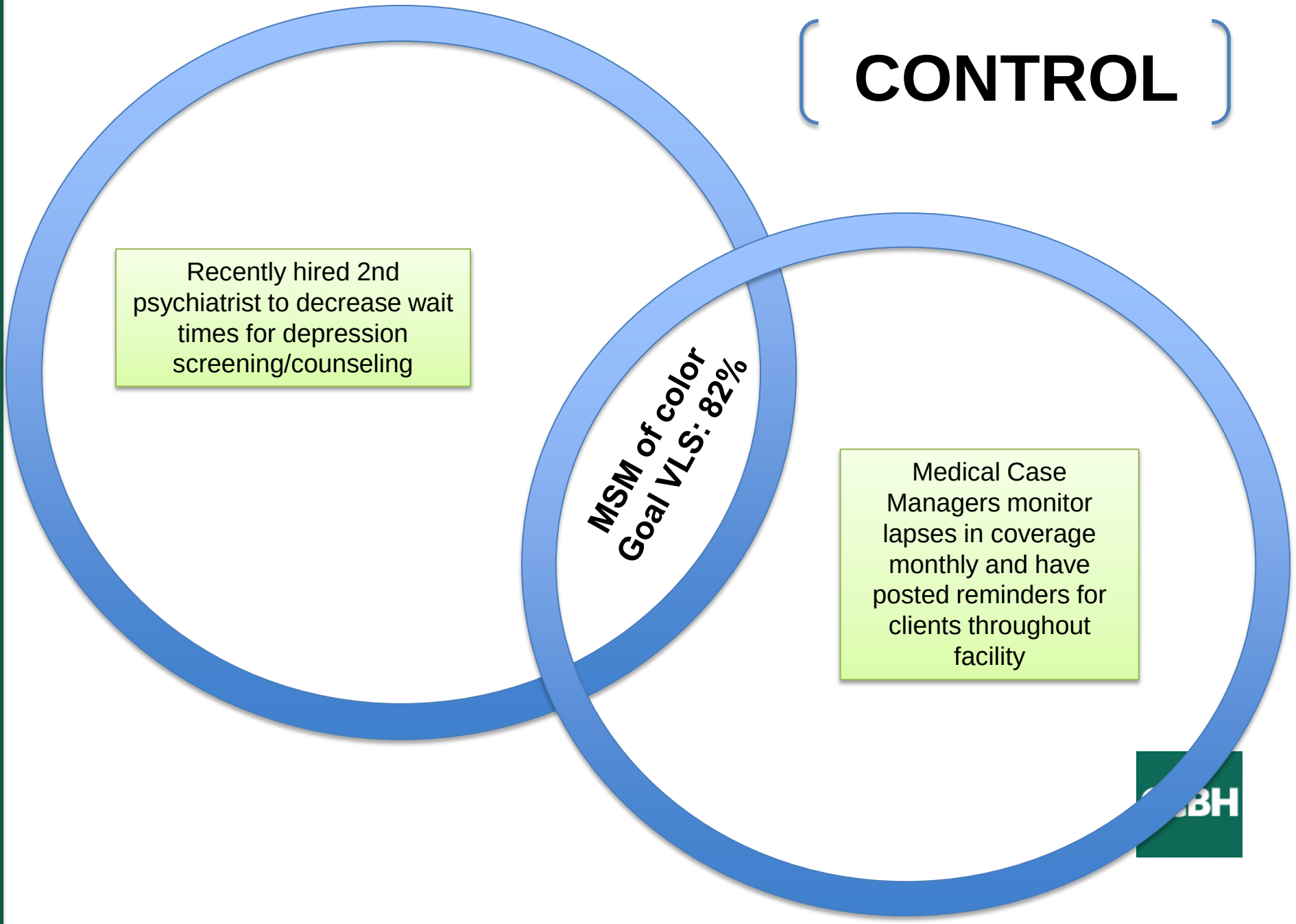
CONTROL


Recently hired 2nd psychiatrist to decrease wait times for depression screening/counseling
MSM of color Goal VLS: 82%
Medical Case Managers monitor lapses in coverage monthly and have posted reminders for clients throughout facility

Cleveland Clinic Foundation

CCBH

Cleveland Clinic Foundation

Target Population: Part A MCM clients

AIM Statement: By November 1, 2019, CCF will improve VLS for all Part A MCM clients from 75 to 85%.

SMART Objectives:

By May 1st, will begin running RWAD reports at the beginning of each month to check for upcoming OHDAP renewals

By May 1st, outreach worker will start contacting all clients with upcoming coverage lapses by the 15th of every month

By June 1st, medical case manager will start including Medicaid discussion with all clients at appointments, documented in the case notes

Barriers to Care:

--Medication Adherence

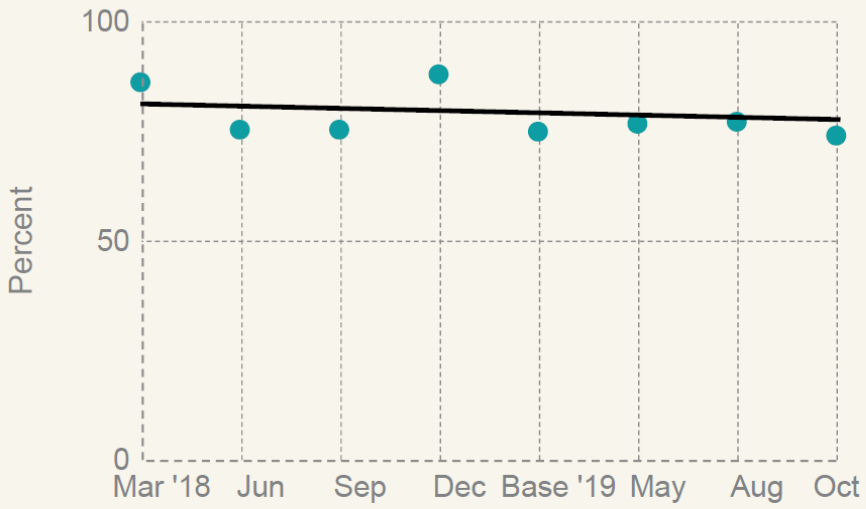
--Clients forgetting to complete labs while at CCF

New MCM started at end of June and will join the project

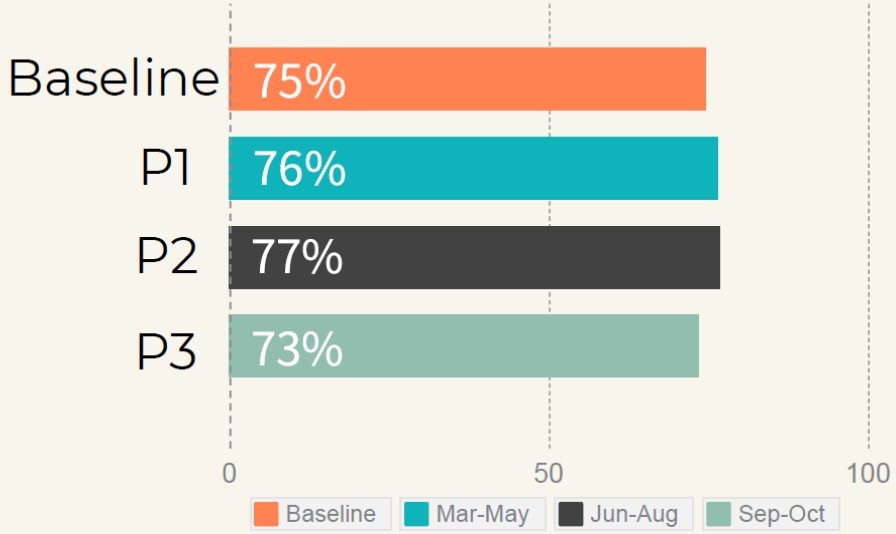
Cleveland Clinic

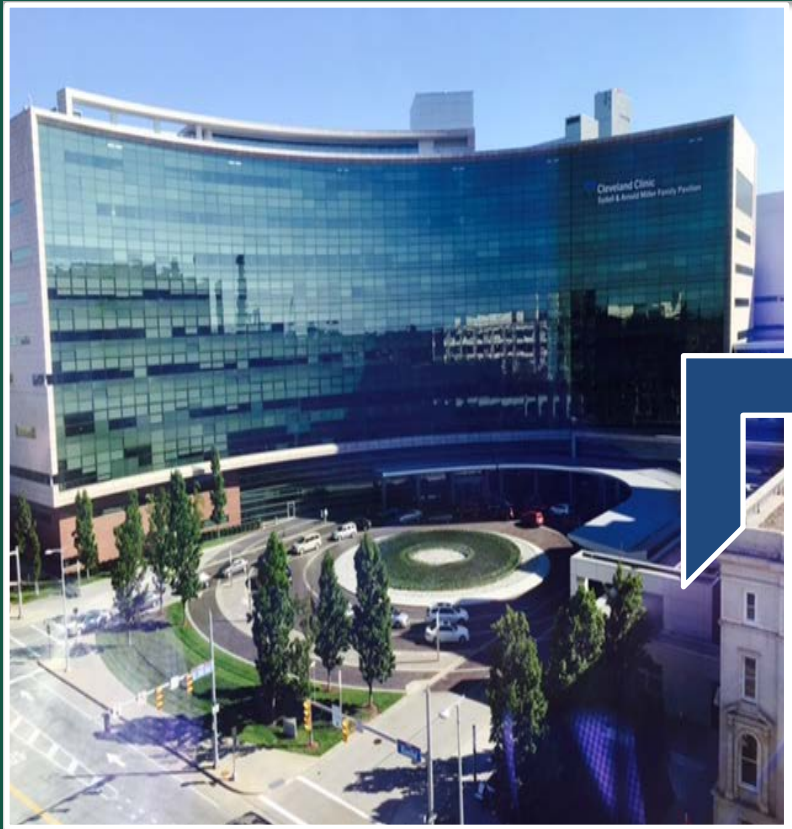
Project allows CCF to scan lists on non-virally suppressed clients more often and keep them at the forefront at monthly Delta meetings

VLS Trend



VLS by Period





CONTROL

1. Working on project to incorporate a standardized database that will include information such as

OHDAP renewal dates, coverage lapse dates, etc. for more efficient tracking

2. Incorporating Medicaid discussion/smart phrase into Psychosocial Assessment

Department of Senior and Adult Services

Department of Senior and Adult Services

Target Population: All Part A clients

AIM Statement: By November 1, 2019, DSAS will improve VLS for all Part A clients from 92 to 95%.

Cuyahoga County
Senior and Adult Services

SMART Objectives:

- By March 1st, will develop a questionnaire for home health aides to ask clients about viral suppression
- By March 1st, will develop a structured follow-up process for issues identified at home visit
- By March 31st, will have trained home health aides on the questionnaire process

Barriers to Care:

- Communication with clients
- Training for staff

Cuyahoga County
Senior and Adult Services

DSAS developed a form that requires all Home Support staff to understand and acknowledge their role in the Home Support QI Project

Home Support serves 25 Ryan White clients

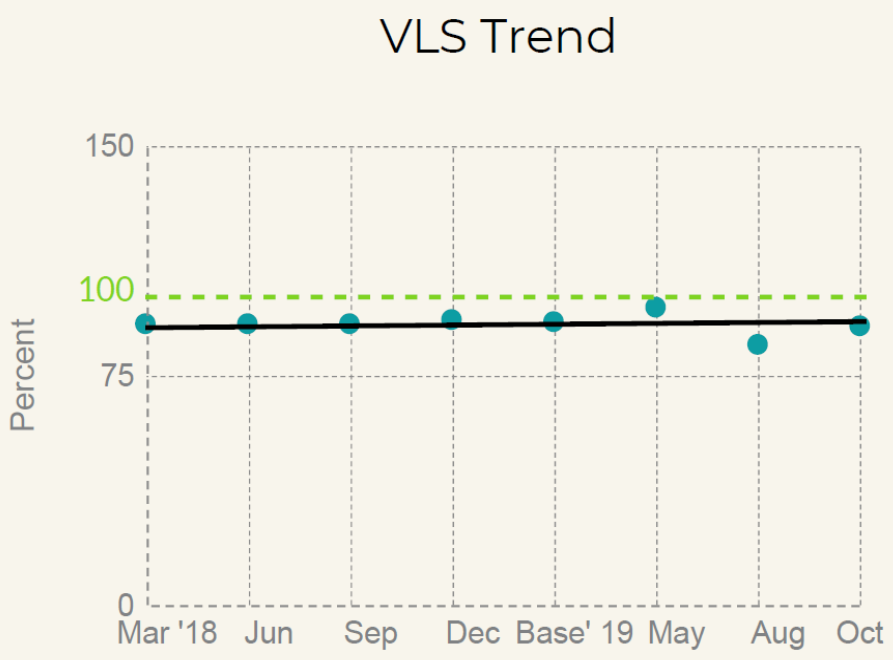
For 2019, their goal was to reach 96% viral suppression for these clients

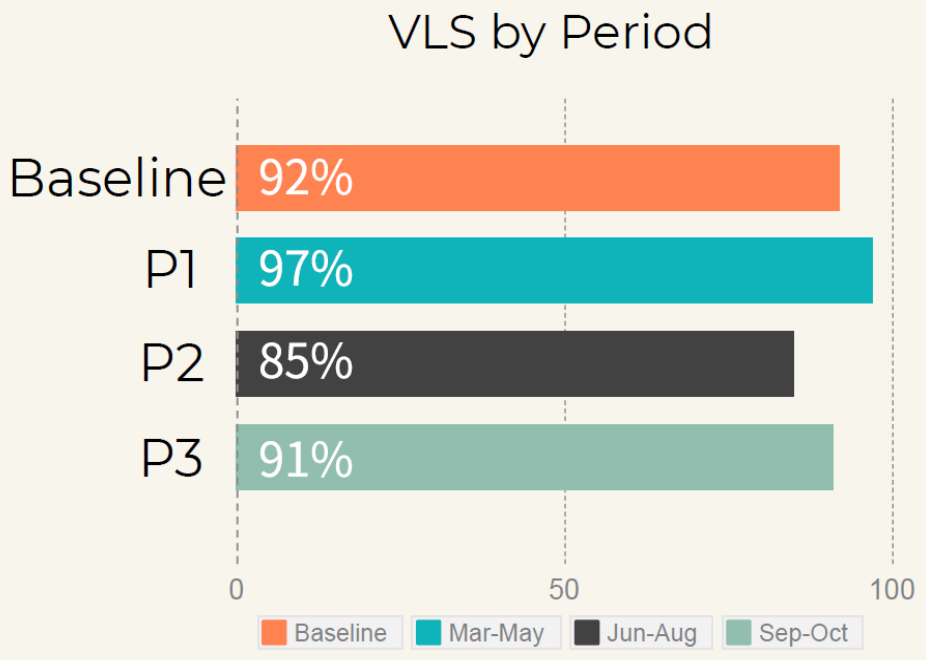
To achieve this all Home Support staff must ask the client about their medication regimen (taking it on time? When is the next dose? Enough meds for at least a week?)

Some issues DSAS ran into:

- One client with VA benefits not taking meds consistently, medication management assumed by VA pharmacist.
- Another client who has only consistently taken meds for the last six months and is known to be immunocompromised.
- Fluctuations in small client caseload with case openings/closings.
- Temporary reassignment of staff due to maternity leave of caseload RN.

Cuyahoga County
Senior and Adult Services





CONTROL

1. On 10/28 & 10/29, the home health aides reviewed and refreshed the process for follow-up
2. Q1 2020 they will have an additional training on QI and QI projects to prepare for next year's QI project

CCBH

Family Planning Services of Lorain

Family Planning Services of Lorain County

Target Population: All HIV+ clients

AIM Statement: By November 1, 2019, FPL will maintain VLS for all HIV+ clients at 60% or greater.

SMART Objectives:

- By May 31st, will create a Part A provider resource packet for new clients
- By August 31st, will create an expansive list of Lorain County resources available (food banks, homeless shelters, mental health clinics, etc.)

Barriers to Care:

- Connecting clients to available resources
- Reaching clients who are not in care

CCBH

FPS created the Lorain County Resource List to help clients link to services! (more in list than shown here)

STI testing & birth control:
Family Planning Services
of Lorain County
(440) 322-7526

Hotlines for suicide prevention:
24/7 Emergency/Crisis Line
1-800-888-6161

Trevor Lifeline
1-866-488-7386

Primary Care:

Lorain County Health &
Dentistry
Lorain, Elyria, & Oberlin
440-240-1655

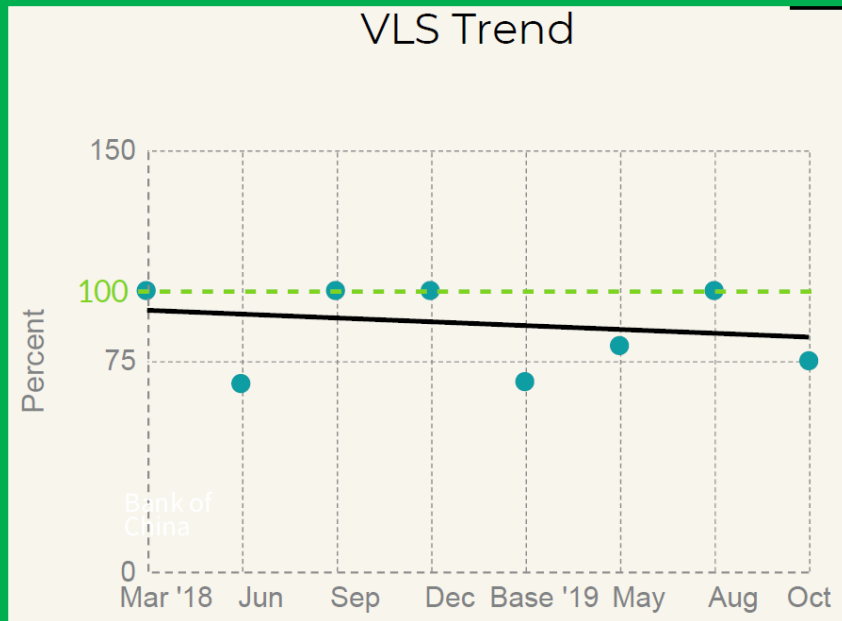
Lorain Free Clinic
5040 Oberlin Ave. Lorain, OH
440-277-6641

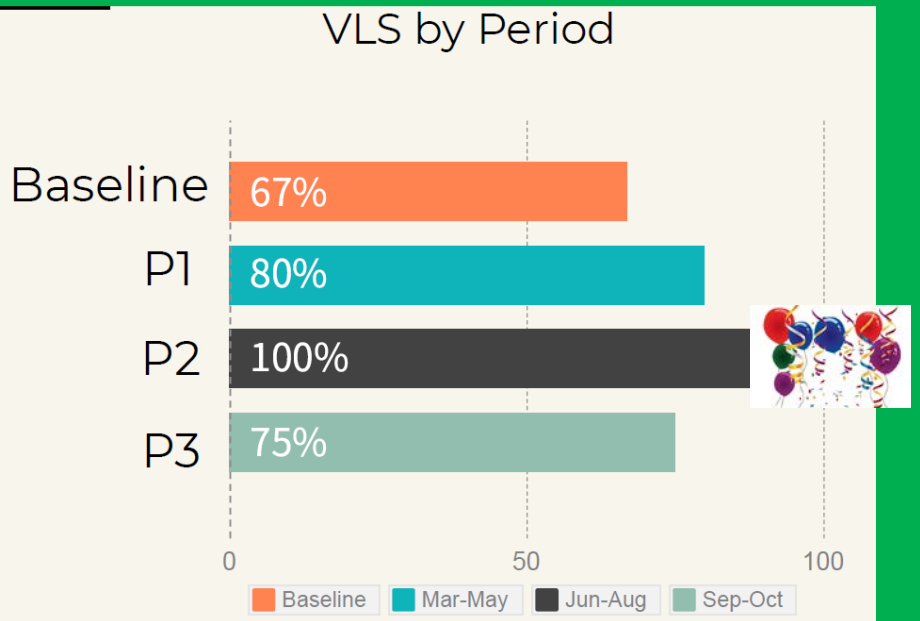
Drug/Alcohol Recovery Services:

The LCADA Way
2115 W. Park Drive.
Lorain, OH
440-989-4900

Primary Purpose
3222 N Ridge Rd, Elyria, OH
44035
440-219-4774

CCBH





CONTROL

Will provide all new clients with Part A provider resource packet, as well as providing any HIV+ clients applicable list of Lorain County Resources

CCBH

Far West Center

far WEST Center

SHINING with a NEW light

- **Target Population:** All Part A clients

- **AIM Statement:** By November 1, 2019, Far West Center will maintain VLS for all Part A clients at 100%.

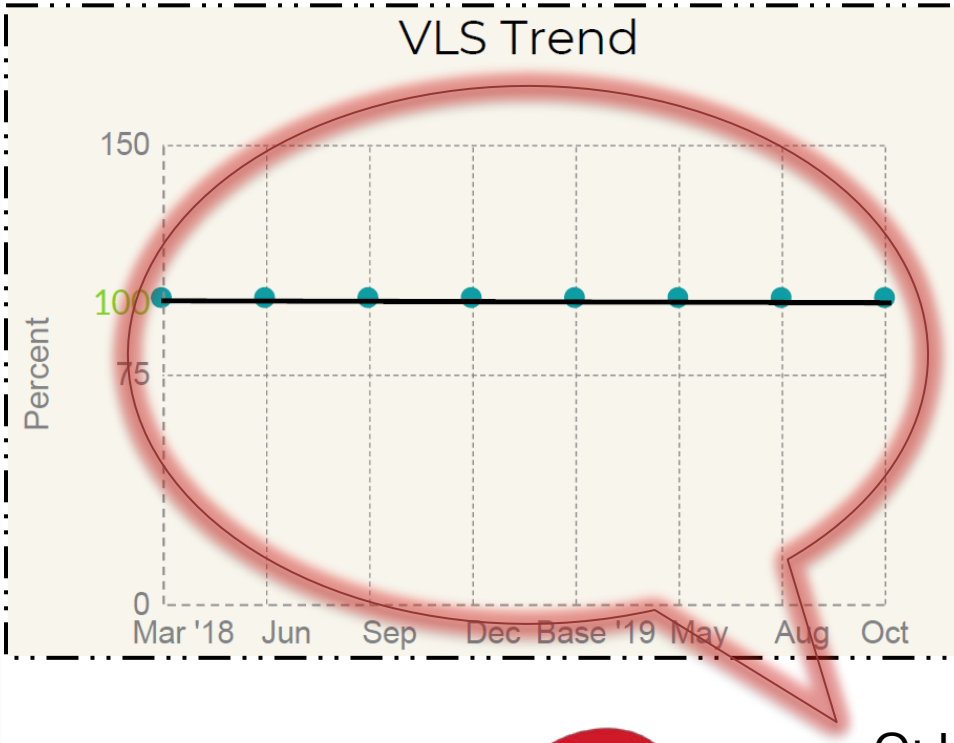
SMART Objectives:

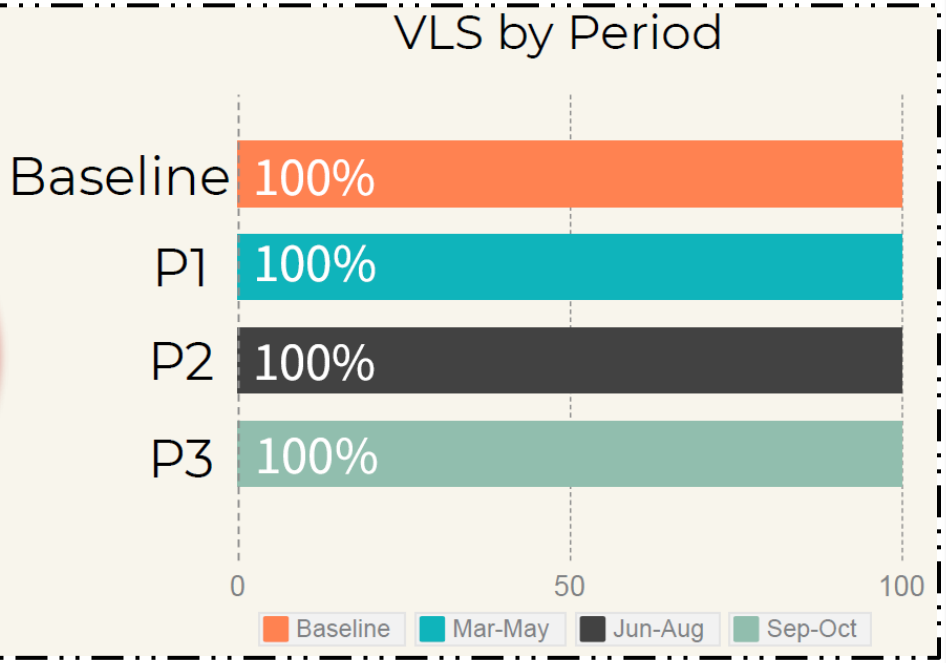
- By March 31st, will provide HIV 101 training to staff
- By May 31st, will research U=U and gain approval to disseminate information in clinic
- By July 31st, will book a medical expert to speak to staff on HIV related topics (medication adherence, medication effects on clients, etc.)

Barriers to Care:

- Client's understanding of increased mental health risk associated with HIV diagnosis
- Keeping staff up to date with HIV/AIDS breakthroughs

CCBH





Q: How is the Far West Center performing?

A: Spectacularly!

CONTROL

Q: How are they going to keep it up?

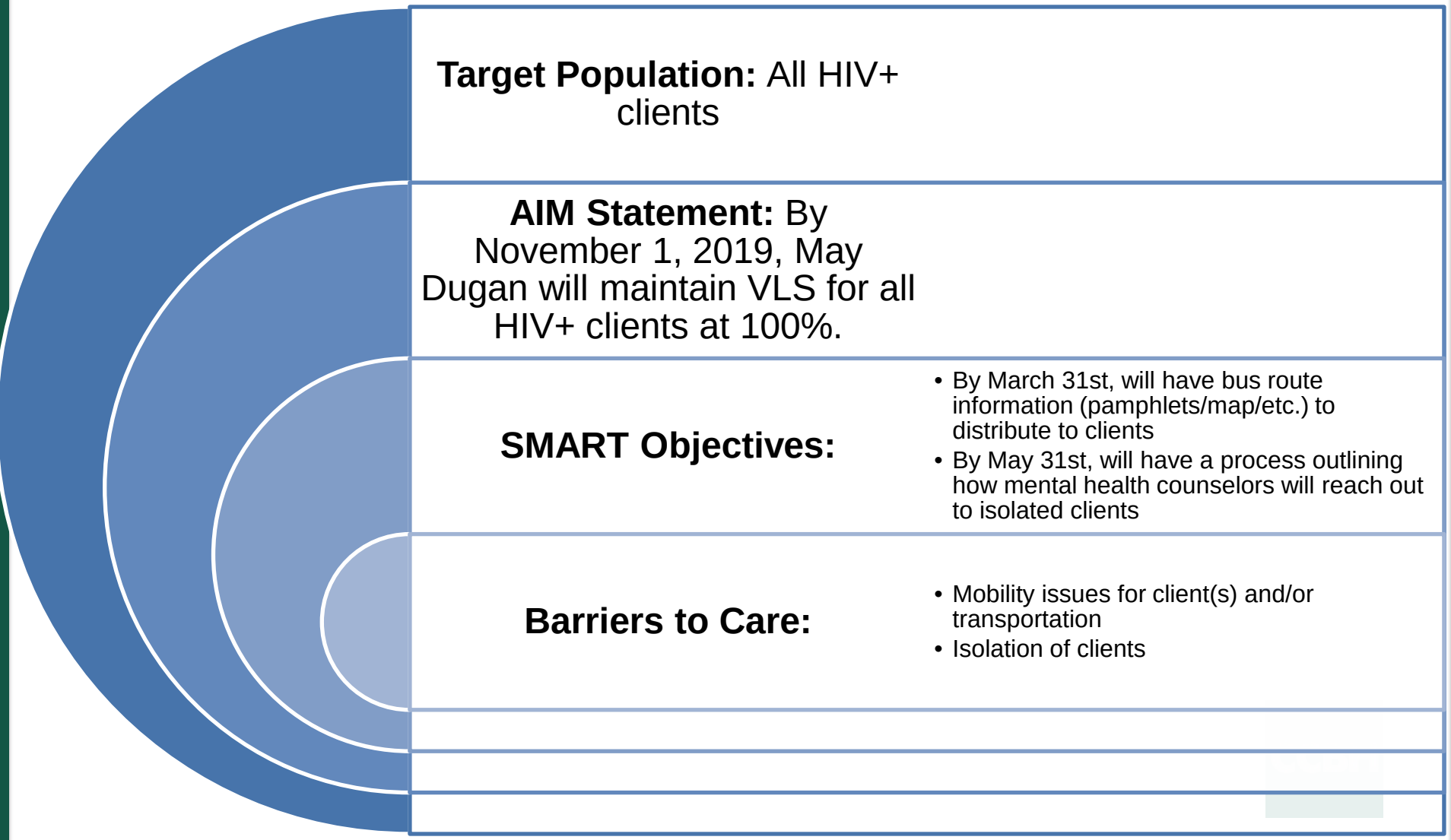
A: Continue annual staff trainings on "HIV 101" and attempt to book an HIV expert annually to speak about HIV topics

CCBH


Take
A
Break

May Dugan Center

May Dugan


Target Population: All HIV+ clients
AIM Statement: By November 1, 2019, May Dugan will maintain VLS for all HIV+ clients at 100%.
SMART Objectives:
• By March 31st, will have bus route information (pamphlets/map/etc.) to distribute to clients
• By May 31st, will have a process outlining how mental health counselors will reach out to isolated clients
Barriers to Care:
• Mobility issues for client(s) and/or transportation
• Isolation of clients

RTA

Visit www.riderta.com for information on the following:

- Plan a trip
- Access Bus, Rail, and Trolley arrival/ departure times and routes.
- Fare pricing
- Handicapped accessible locations (including escalator and elevator access).
- And more.

The Veterans Administration provides transportation to VA medical facilities for injured and ill veterans.

Louis Stokes Cleveland VAMC
10701 East Blvd. Cleveland, Ohio 44106
(216) 791-3800
Transportation # (216) 698-2600

Parma CBOC
8787 Brookpark Rd. Parma, Ohio 44129
(216) 739-7000
Transportation # (216) 698-2600

TRANSPORTATION ASSISTANCE IS AVAILABLE* FOR THOSE WHO ARE HIV+.

***Ask receptionist or your case manager for details.**

May Dugan Center

4115 Bridge Avenue
Cleveland, Ohio 44113

Phone: 216-631-5800
Fax: 216-631-4595
www.maydugancenter.org

The mission of the May Dugan Center is "to help people enrich and advance their lives and communities."

In Need of Transportation?

Transportation Options for Seniors

Senior Transportation Connection

Seniors who are age 60 and older and reside within the service boundary are eligible for transportation.

For more information, to enroll, or schedule a ride call 216-265-1489.

RTA Senior Rate

Any person 65 or older qualifies to pay a discounted Senior rate to ride RTA buses and trains.

Present either a RTA Senior ID card, State-issued photo ID, or Medicare card with photo ID with your discounted ticket.

Medicaid Recipients

As a Medicaid recipient you are eligible for 30 free one way (equivalent to 15 roundtrip) rides per year.

Trips can be used for doctor visits, clinics, hospital, trips to the pharmacy after a medical visit, provider office, therapy or behavioral health, and WIC or Medicaid appointments.

To schedule a ride please contact your assigned insurance provider.

CareSource- (800) 488-0134

Molina- (866) 642-9279

Buckeye- (866) 246-4358

United Healthcare- (844) 443-4078

***Please note, you must give 24 hour notice for a cancelation or the ride may be deducted from the yearly total.**

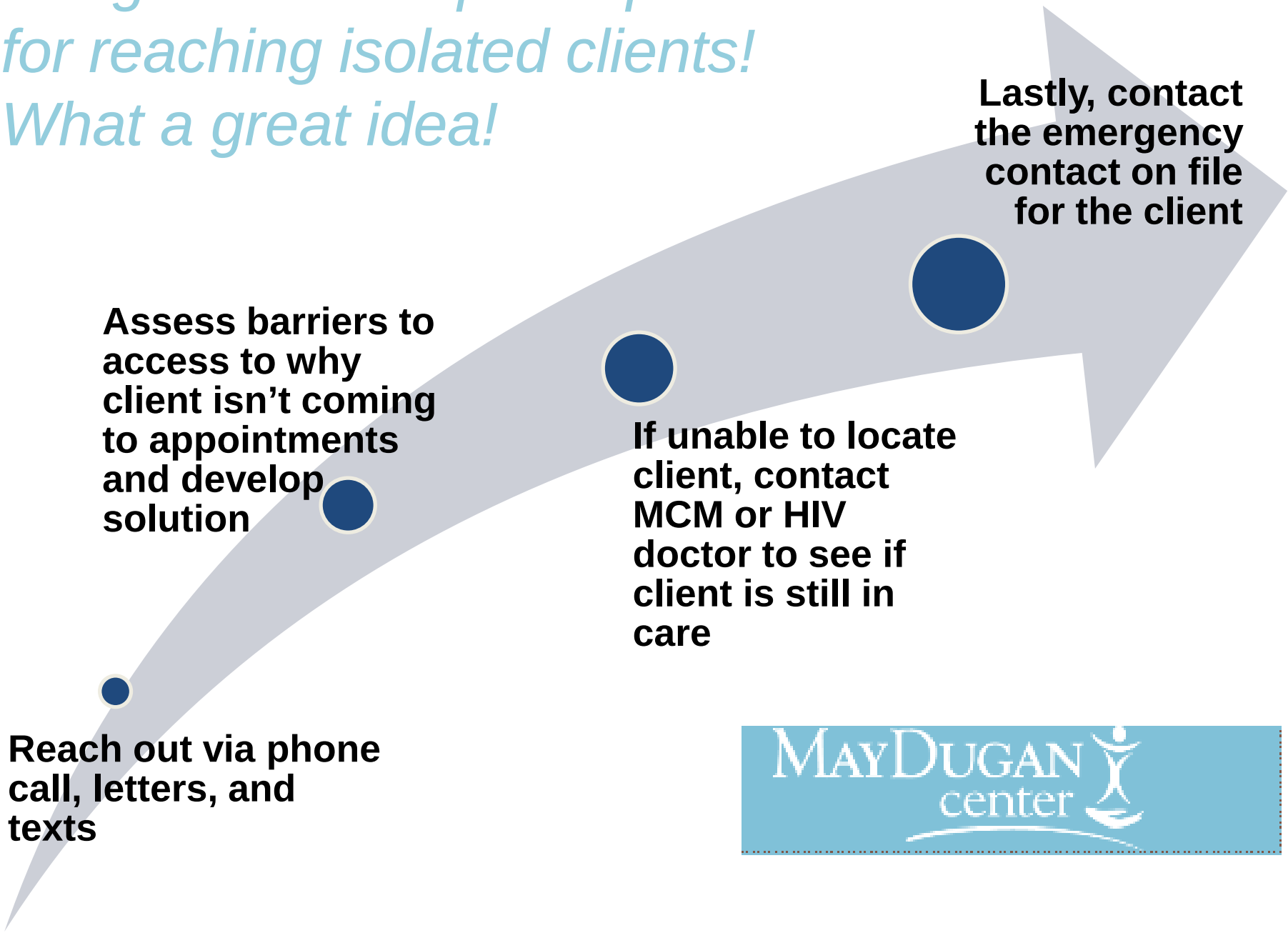
Handicapped Options

Paratransit service through the Greater Cleveland RTA is provided to persons who, because of their disabilities, are unable to independently travel on the public transit system.

The paratransit offers a "door-to-door" travel from your home to a destination within a five-mile radius.

Qualifying persons may obtain an application at http://www.riderta.com/paratransit or call 216-566-5124, 8 a.m.-4:30 p.m. Monday-Friday.

Doug has developed a process for reaching isolated clients! What a great idea!

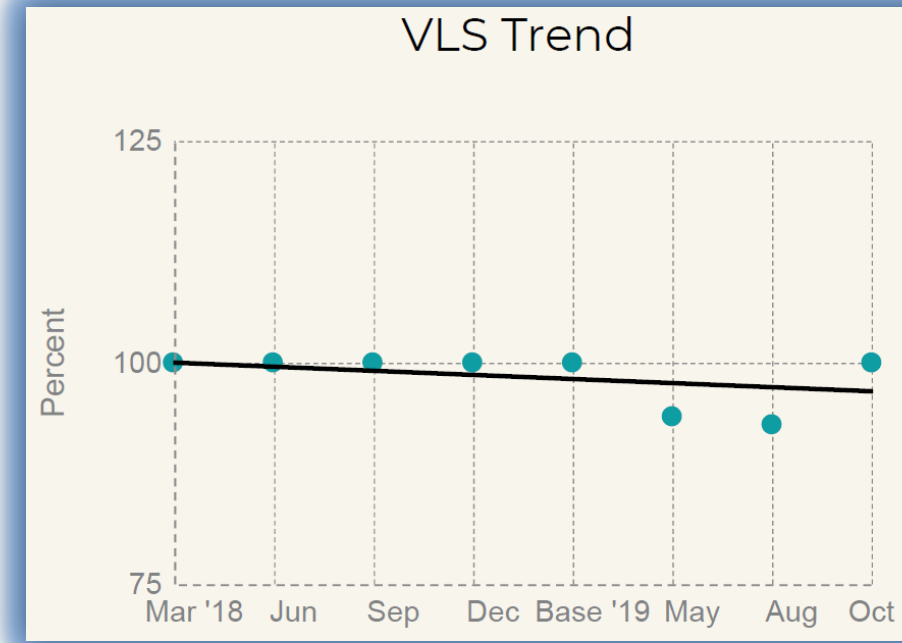


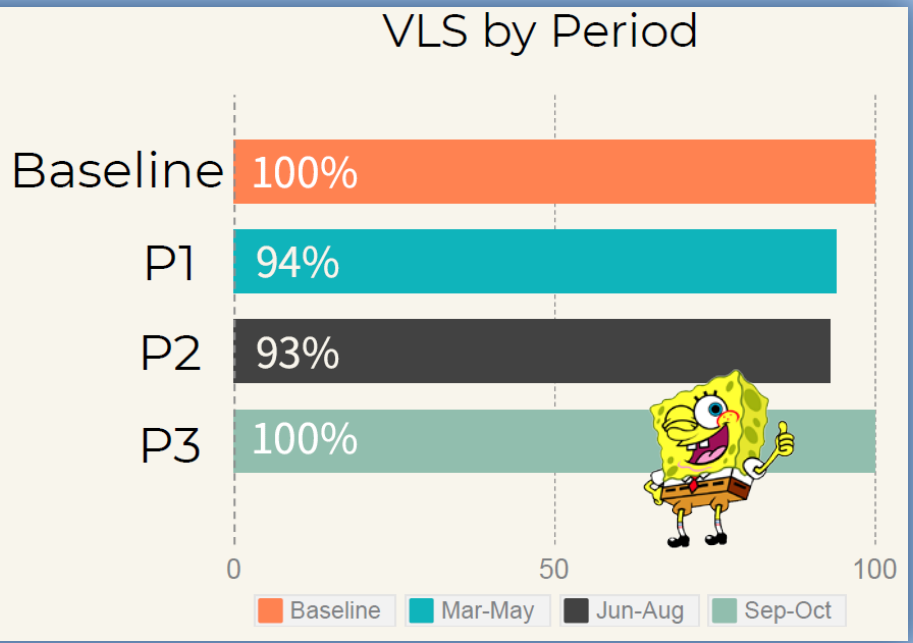
MAY DUGAN center

May Dugan completed both SMART objectives by the end of May

The transportation resource brochure has been used by one of May Dugan's clients

May Dugan is reaching out to isolated clients—call, text, letters





MAY DUGAN center

Control

May Dugan will continuously update transportation brochure as necessary

Transportation brochures will be available to all people at May Dugan; they will be left at the front desk for all to access

CCBH

Mercy Health

Target Population: MSM of color

AIM Statement: By November 1, 2019, Mercy Health will improve VLS for MSM of color from 80 to 85%.

MERCY HEALTH

SMART Objectives:

- By March 31st, will include education on STIs at each client visit and document it in client file
- By March 31st, will create a standardized intake process
- By June 30th, will create a policy to determine criteria for receiving gas cards

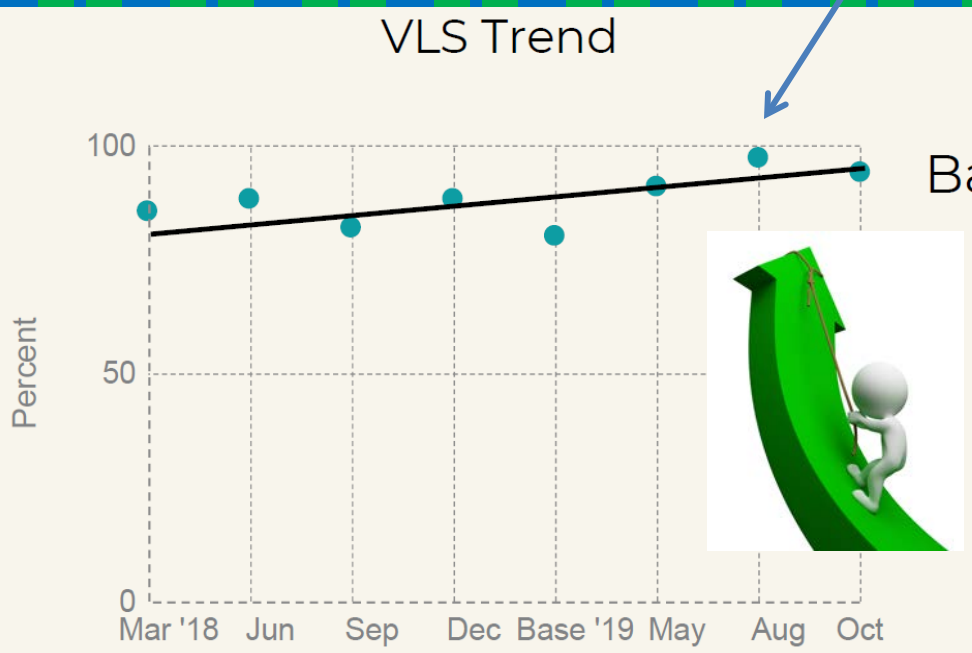
Barriers to Care:

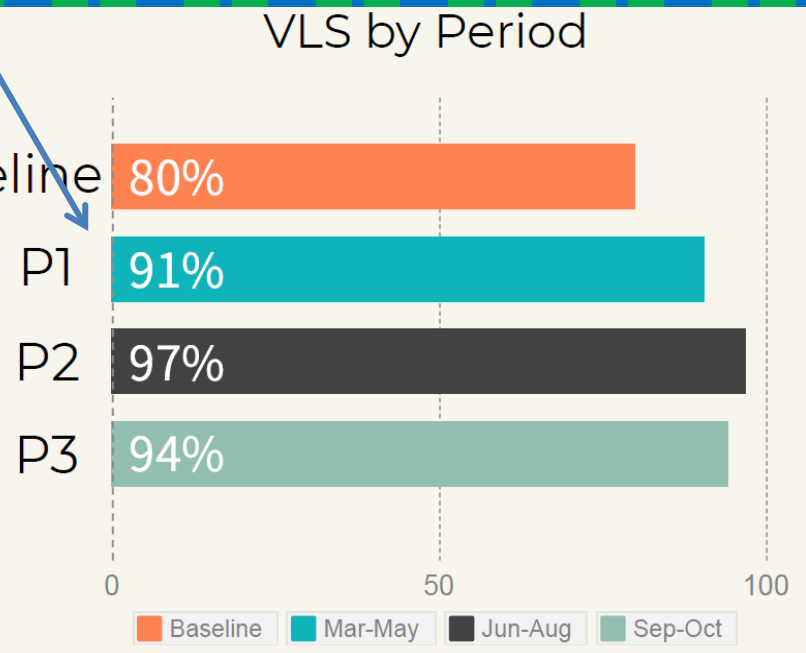
- No show rates
- Intake/front desk process
- Client education of STIs

CCBH

Mercy Health has been on a steady increase since March ’18

Big increase after start of FY19 QI project!





Mercy Health created a new intake process and gas card voucher forms

Intake Process

- --EIS/HD/DR referral or patient call
- --Nurse with patient same-day
- --Psychosocial, mental health, and substance abused assessments completed
- --During intake
  - Medical history
  - RW eligibility
  - Needs assessment
- --Lab orders place, Dr. appt. scheduled

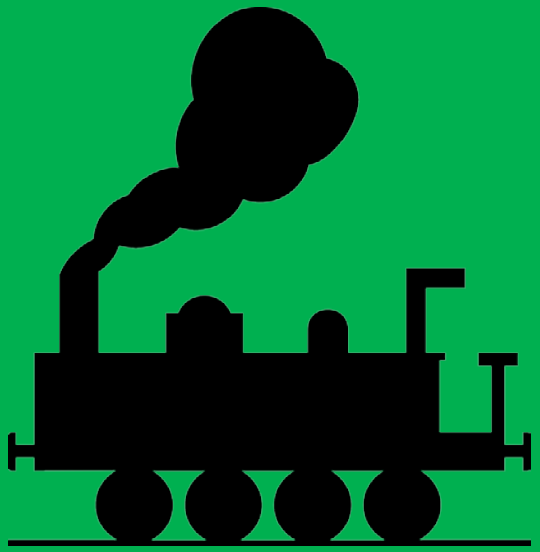
- Voucher policy
  - --Must be RW eligible
  - --Follow-up and labs at least every 6 months
  - --RW eligible patients can receive 1 food and 1 gas card voucher

MERCY HEALTH

How will Mercy Health “steam ahead” with their QI project?

CONTROL

- Will continue STI education – every patient, at least once in the year
- Will continue using the new standardized intake process going forward



MetroHealth Medical Center

MetroHealth Medical Center

Target Population: Youth

AIM Statement: By November 1, 2019, MetroHealth will improve VLS for youth from 67 to 80%.

SMART Objectives:

- By April 1st, will have established a procedure for tracking client-level Lyft usage
- By May 1st, will have developed a policy for Lyft no-shows
- By June 1st, will determine criteria for when Lyft should be utilized
- By July 31st, will have completed training with internal staff on how to use the Lyft service
- By August 31st, will roll out the Lyft service to the youth cohort as an alternative option for medical transportation to and from appointments

Barriers to Care:

- No show rates
  - Stigma
- Transportation

MetroHealth's Lyft Policy

Procedure for tracking client-level Lyft usage

HIV appt. scheduled by client	*RW eligibility confirmed*

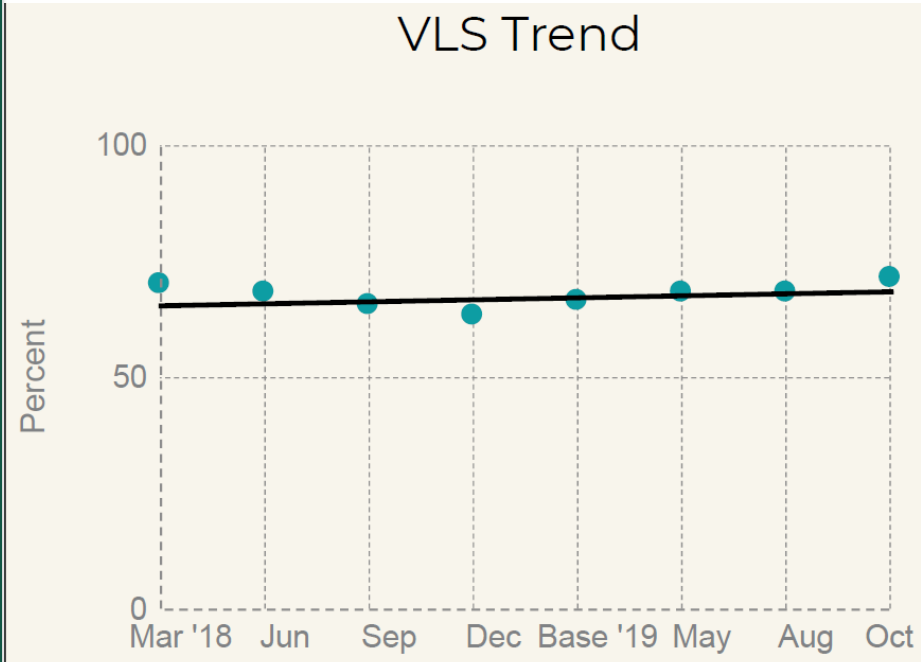
Scheduling the Lyft ride

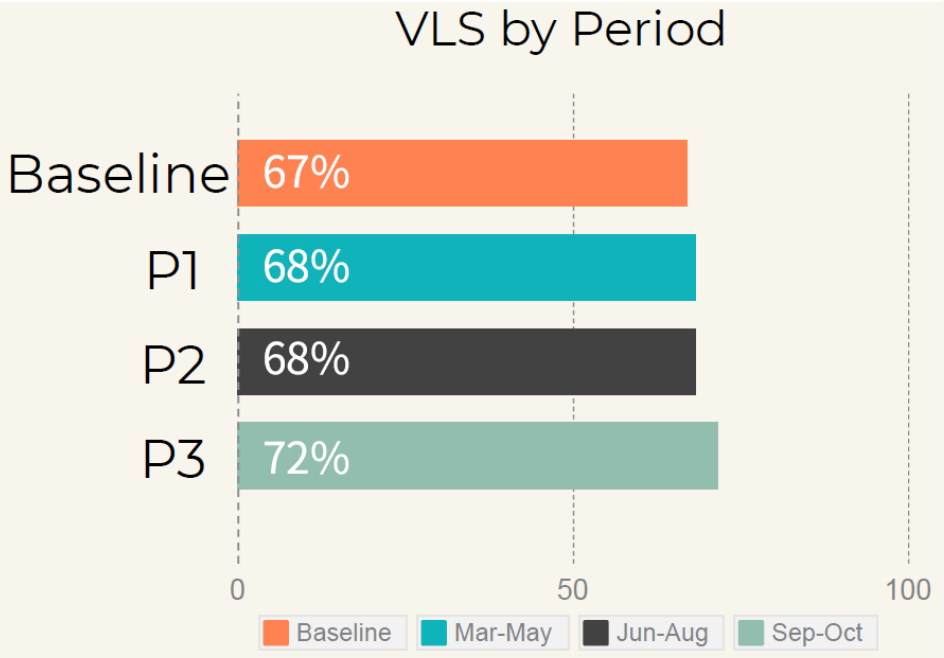
MH staff use Lyft Concierge Dispatch tool to schedule rides	*Ride options: On-demand, pre-scheduled, flex*

Getting the Lyft ride

Patient told to expect a text from Lyft driver	*Patient must be ready on time for pick-up (+5 min)*

MetroHealth





- **No-shows:** MH staff will evaluate reason for no-show and evaluate other transportation options
- **When should Lyft be used:** RWA eligible, HIV related appt., barriers with other transport, non-virally suppressed

Priority criteria for Lyft utilization: History of chronic no-shows, youth, non-virally suppressed

CCBH

1. Will continue rolling out Lyft service, have been using 1-2 times a week since September
2. Will determine if it is a viable option under Part A funding

Nueva Luz Urban Resource Center

NLURC
Nueva Luz Urban Resource Center

SMART Objectives:

* By March 31st, intake will begin receiving confirmation from housing referral source that client is receiving medical case management elsewhere

* By June 30th, will have held staff training on PrEP, medication adherence and resistance, and other HIV related topics

* By September 30th, will have completed 3 face-to-face meetings with other agencies in the TGA; to explain Nueva Luz URC services and create stronger partnerships with other agencies

AIM Statement: By November 1, 2019, Nueva Luz will improve VLS for MSM of color from 69 to 74%.

Target Population:
MSM of color

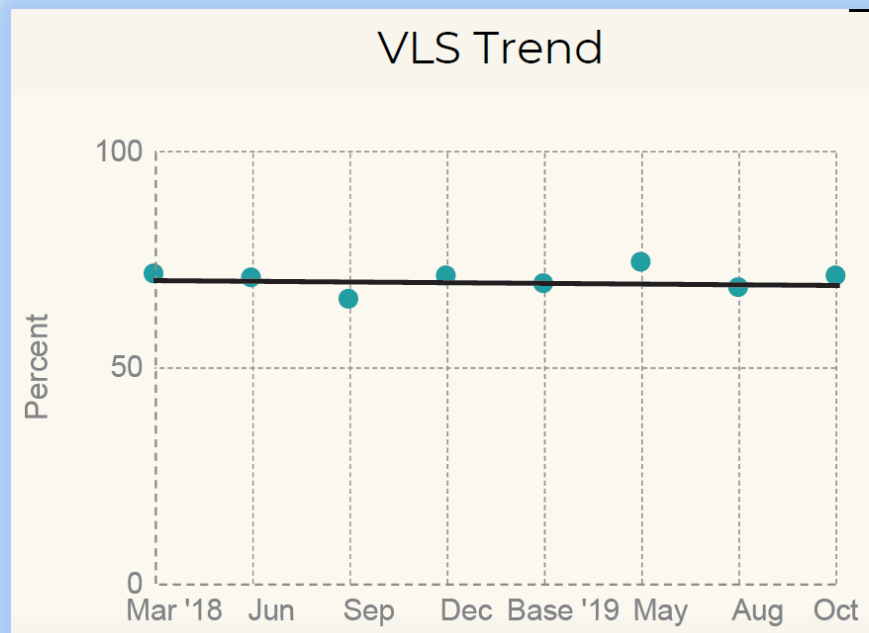
Barriers to Care:

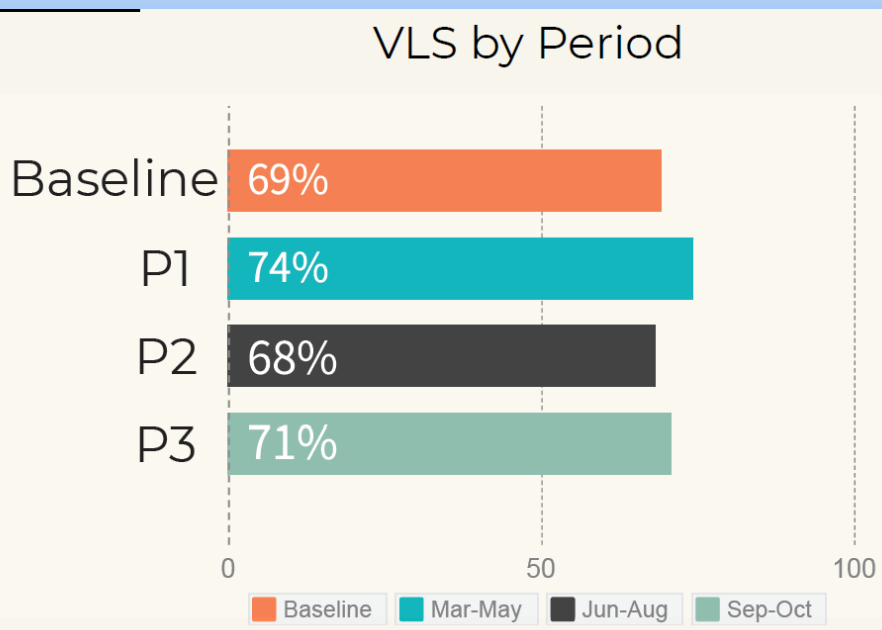
Housing instability or homelessness

Substance Abuse

Mental Health

NLURC
Nueva Luz Urban Resource Center





NLURC has been running their staff trainings since project start – 11 so far covering:

- HIV and mental illness
- Medication adherence & resistance
- PrEP
- Cultural competence
- Futures without violence

Intake procedure in place to ask for referral source, inquire if client has MCM elsewhere

NLURC is also offering group and individual counseling sessions in collaboration with The Center for Evidence Based Treatment

NLURC
Nueva Luz Urban Resource Center

Control

HIV staff trainings will continue on an annual basis

Face to face meetings have created a partnership with UH for housing

Signature Health

Target Population:
All Part A clients

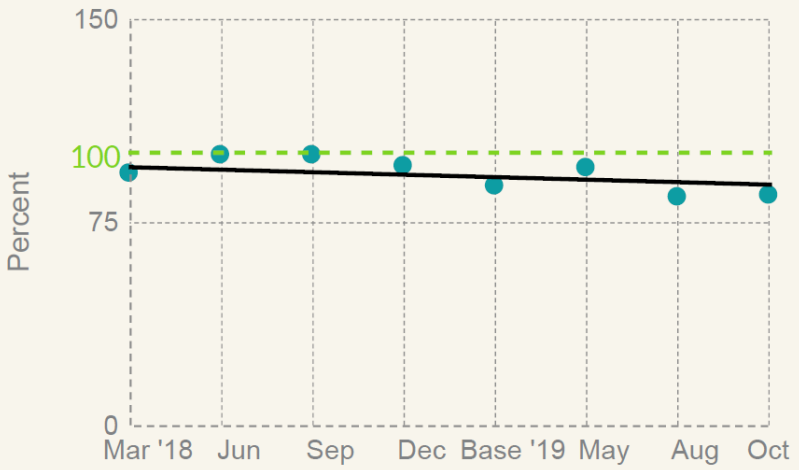
AIM Statement:
By November 1, 2019, Signature Health will improve VLS for all Part A clients from 88 to 93%.

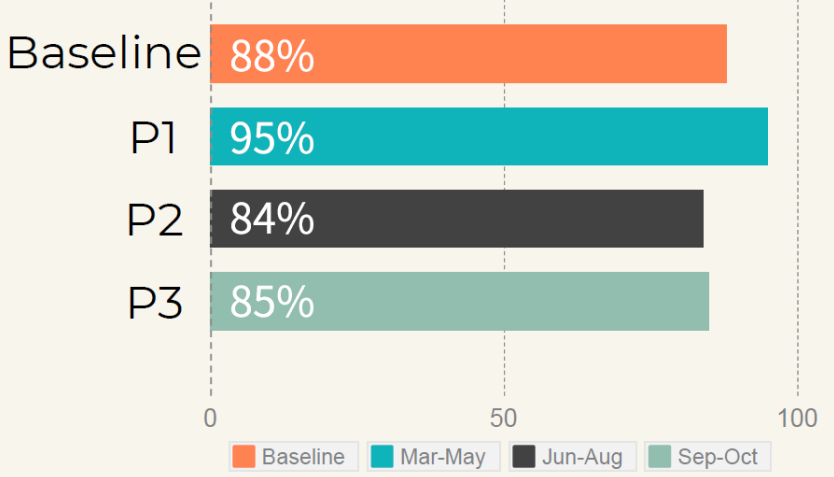
SMART Objectives:
++By April 30th, will have created a How-To card for clients on utilizing Lyft services
++By April 30th, will have created a How-To guide for other providers on Lyft services
++By May 30th, will have created a process for Part A team members to track day-to-day Part A Lyft usage
++By August 30th, will have met with providers to explain Lyft system and exchanged contact information

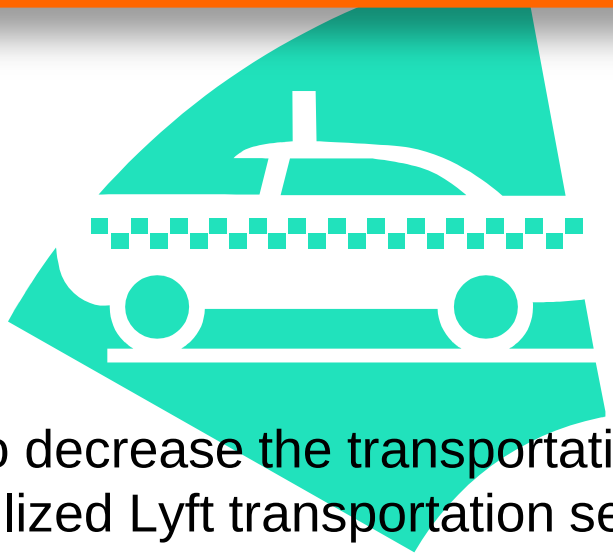
Barriers to Care:
Transportation
Communication with providers

CCBH

Signature Health







Signature™ HEALTH

CCBH

To decrease the transportation barrier, Signature Health has utilized Lyft transportation services via Circulation

Signature Health Transportation via Circulation

Your Signature Health Medical Case Manager has scheduled a ride for you to your medical appointment through Circulation. Here's what you need to know:

1. *A driver will be sent to pick you up at your home or another location determined by you and your Signature Health Case Manager.*
2. *You will receive a text message on your cell phone when the car is on the way to pick you up. The message will tell you the make, model, color and license plate of the car picking you up to take you to your appt.*
3. *A car will arrive to pick you up shortly after your receive the text message. The driver will transport you to your appointment.*
4. *If you are being transported home from your appointment you will have been texted a link with a code to initiate your ride home. You will need to reply to the message with the code provided to you to initiate that ride home.*
5. *If you experience any difficulties during the process please contact your Signature Health Medical Case Manager Kristin Ziegler-Alban at 440-785-5736, Robin Orlowski at 440-855-0271 or the SH Transportation Dept. at 440-578-8200 for assistance.*

CONTROL

Continue the Lyft/Circulation program and continue to troubleshoot issues (i.e. lack of drivers in certain locations)

Signature™ HEALTH

University Hospitals

University Hospitals of Cleveland

SMART Objectives:

~~By March 1, 2019 the youth nurse and social worker will be provided with the list of youth that were not virally suppressed as of December 31, 2018

~~By March 1, 2019 intensified case management and nurse care coordination services will be provided to all youth that are not virally suppressed. All outreach activities will be noted by the case manager and nurse

~~By March 31, 2019, monthly youth team meetings will be set up to discuss successes and barriers with focused youth outreach activities. Case studies will be presented and meeting notes will be documented by the SIU quality manager and made available for review by the patient's care teams

Target Population:

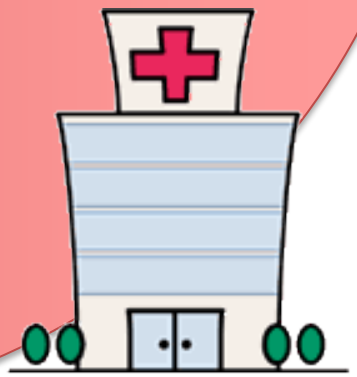
Youth

Barriers to Care:

Appointment adherence
Medication adherence
Socioeconomic factors

AIM Statement:

By November 1, 2019 University Hospitals will improve VLS for youth from 84 to 87%.



CCBH

University Hospitals

The Science of Health. *The Art of Compassion.*

Cohort Study:

At Baseline the SIU had nine non suppressed youth under the age of 25.

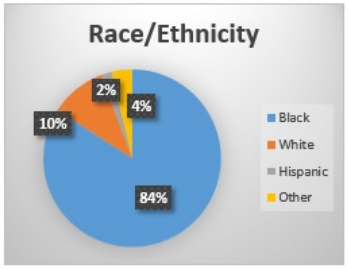
One of the original nine is now suppressed bringing the cohort suppression rate from 84% to 86%.

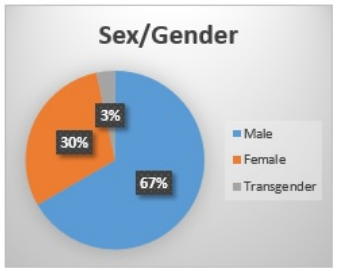
Documented patient level factors for not reaching our 87% goal included:

- 2 patients were lost to care over the nine month study
- 2 patients were erratically in care with multiple documented missed appointments
- 3 patients had documented med adherence issues

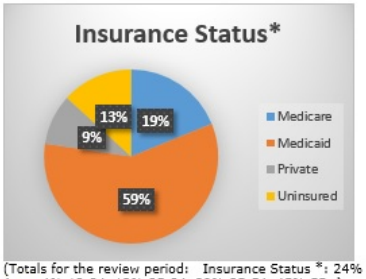
Clinic Wide Non-Suppressed Study:

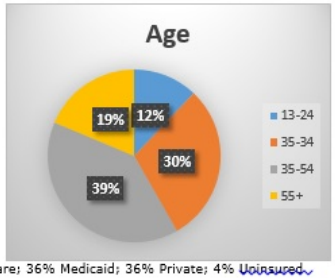
So Who Were our Non-Suppressed as of June 30, 2019?





(Totals for the review period: 60% Black, 33% White, 3% Hispanic - 76% Male, 23% Female, 1% Transgender)





(Totals for the review period: Insurance Status *: 24% Medicare; 36% Medicaid; 36% Private; 4% Uninsured. Age: 4% 13-24, 12% 25-34, 39% 35-54, 45% 55+)

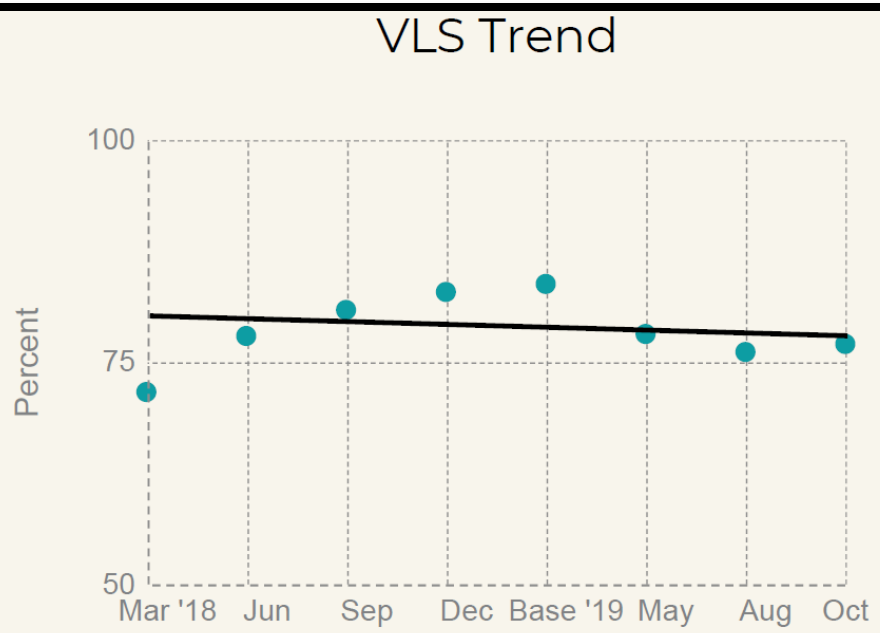
- 92% reported having stable housing * (vs 97%)
- 39% reported that they have been diagnosed with a mental health condition * (vs 29%)
- 58% reported extremely high health literacy. 11% reported having no health literacy skills at all * (vs 75% and 3%)
- 28% reported drug use – of those, 27% reported using more than just Marijuana. * (vs 27% - and of those 13%)
- Most popular communities where non-suppressed patients reported living/staying in: *
  - 44108/Glenville neighborhood (11 individuals)
  - 44102/Detroit Shoreway neighborhood (7 individuals)
  - 44105/Garfield Heights area (7 individuals)
  - 44137/Maple Heights are (6 individuals)
  - 44118/East Cleveland area (6 individuals)

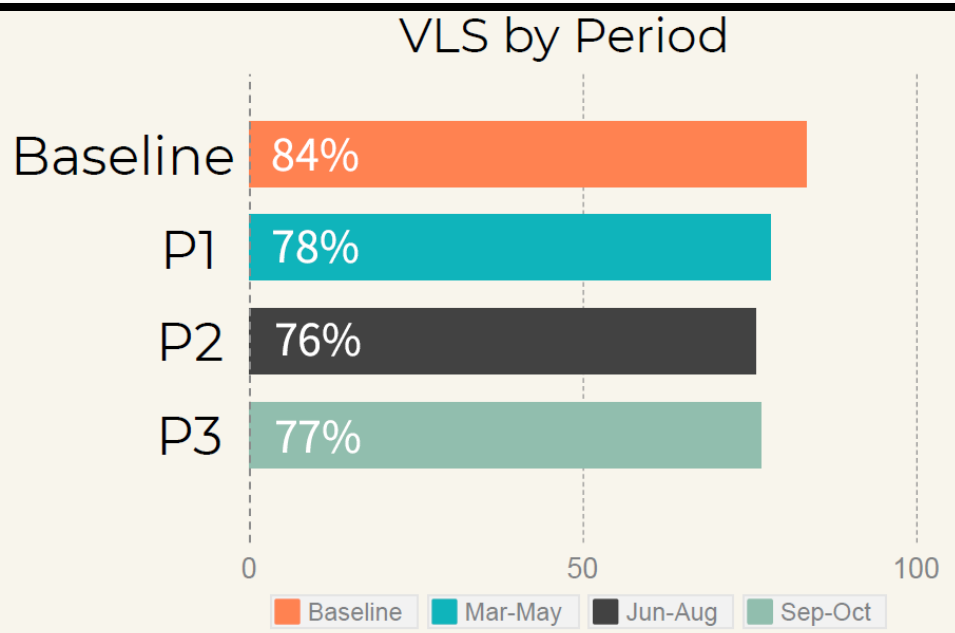
  (vs five most popular zips served: 44120 (Buckeye/Shaker), 44102, 44108, 44118 and 44103 (St. Clair/Superior)

*Indicates data collected from Annual Patient Questionnaire with varying Ns

University Hospitals

The Science of Health. *The Art of Compassion.*





CONTROL

Monthly youth team meetings will continue into next year, with future addition of social worker to complete nurse/social worker care coordination services

CCBH

Thank you all for your time and efforts. We at the Ryan White Part A office appreciate the hard work that you do. You rock!

Ryan White Part A
Cleveland TGA

CCBH

Next Steps

- Look out for email including:
  - Finalized CQM Plan
  - Doodle Poll to set up January QI site visit meeting
- Slide Deck being uploaded to the website at this moment
  - Find at https://www.ccbh.net/ryan-white-provider-resources/

Ryan White Part A Cleveland TGA

Ryan White Part A
Cleveland TGA

CUYAHOGA COUNTY
BOARD OF HEALTH
YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

5550 Venture Drive Parma, Ohio 44130
216-201-2000 www.ccbh.net