CUYAHOGA COUNTY BOARD OF HEALTH

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216-201-2000 www.ccbh.net

Ryan White Part A CQM Committee Meeting
November 16, 2020 – Virtual

Zach Levar – Program Manager – zlevar@ccbh.net

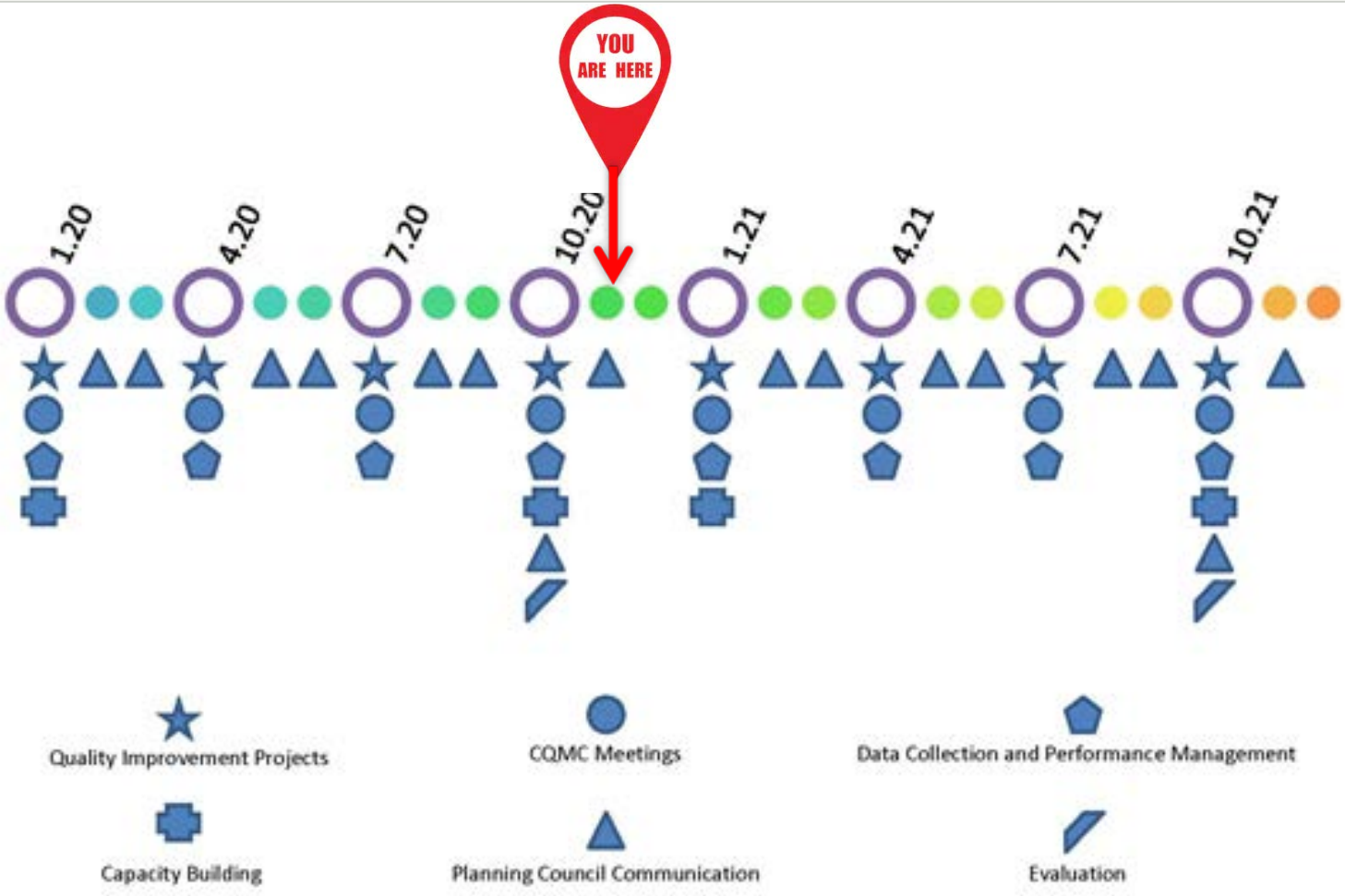
Ryan White Part A
Cleveland TGA

Agenda

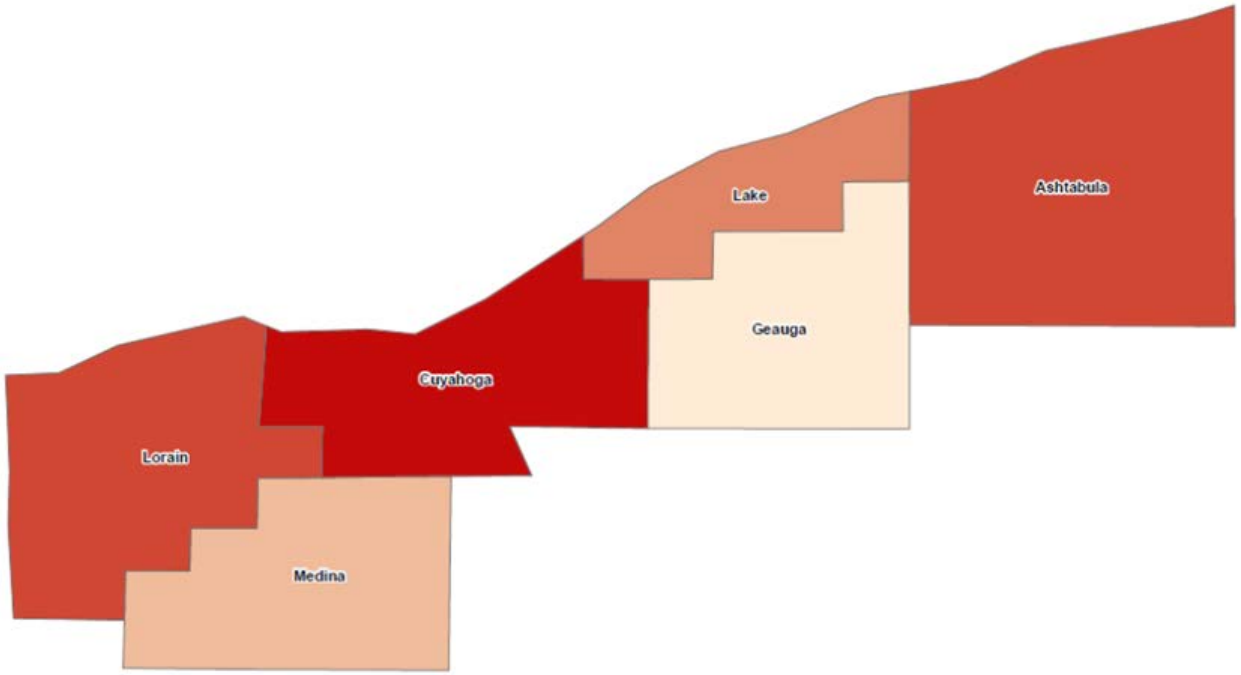
1:00-1:10	**Welcome, Introductions** Melissa Rodrigo and Zach Levar - Cleveland TGA
1:10 - 1:25	**CQMC Updates and Data** Zach Levar – Cleveland TGA
1:25 – 2:30	**CQM QI Project Presentations** Part A Funded Providers
2:30 – 2:35	**Break**
2:35 – 3:25	**CQM QI Project Presentations** Part A Funded Providers
3:25 – 3:30	**Next Steps, Adjourn** Melissa Rodrigo and Zach Levar – Cleveland TGA

Introductions

CQMC Timeline



Cleveland TGA Data



Care Continuum Changes

- The Care Continuum will now report all Part A **eligible** clients
  - Due to eligible scope requirement, which provides data on client labs that are not restricted to Part A funding
- Programmatic changes within CAREWare 6 that limit capability to pull Care Continuum the way it has been in the past
  - Strongly recommended by CAREWare consultant to begin pulling Continuum numbers from Performance Measures rather than Financial Reports as there is no time table for bugs to be fixed

What does this mean?

Linked to Care

- With addition of clients that received labs under other funding sources; hundreds more clients meet this definition
- Linked to Care serves as denominator for VLS/ART/Retained in Care definition(meaning some percentages may have been negatively impacted by change)

TGA/Provider Capabilities

- Using performance measures(PMs), providers can pull agency level continuum numbers at any time
- By using PMs, the TGA and providers will be able to see exactly which clients are not meeting a measure
  - Not a possibility under previous method
  - Focus can be better directed towards clients not meeting these measures

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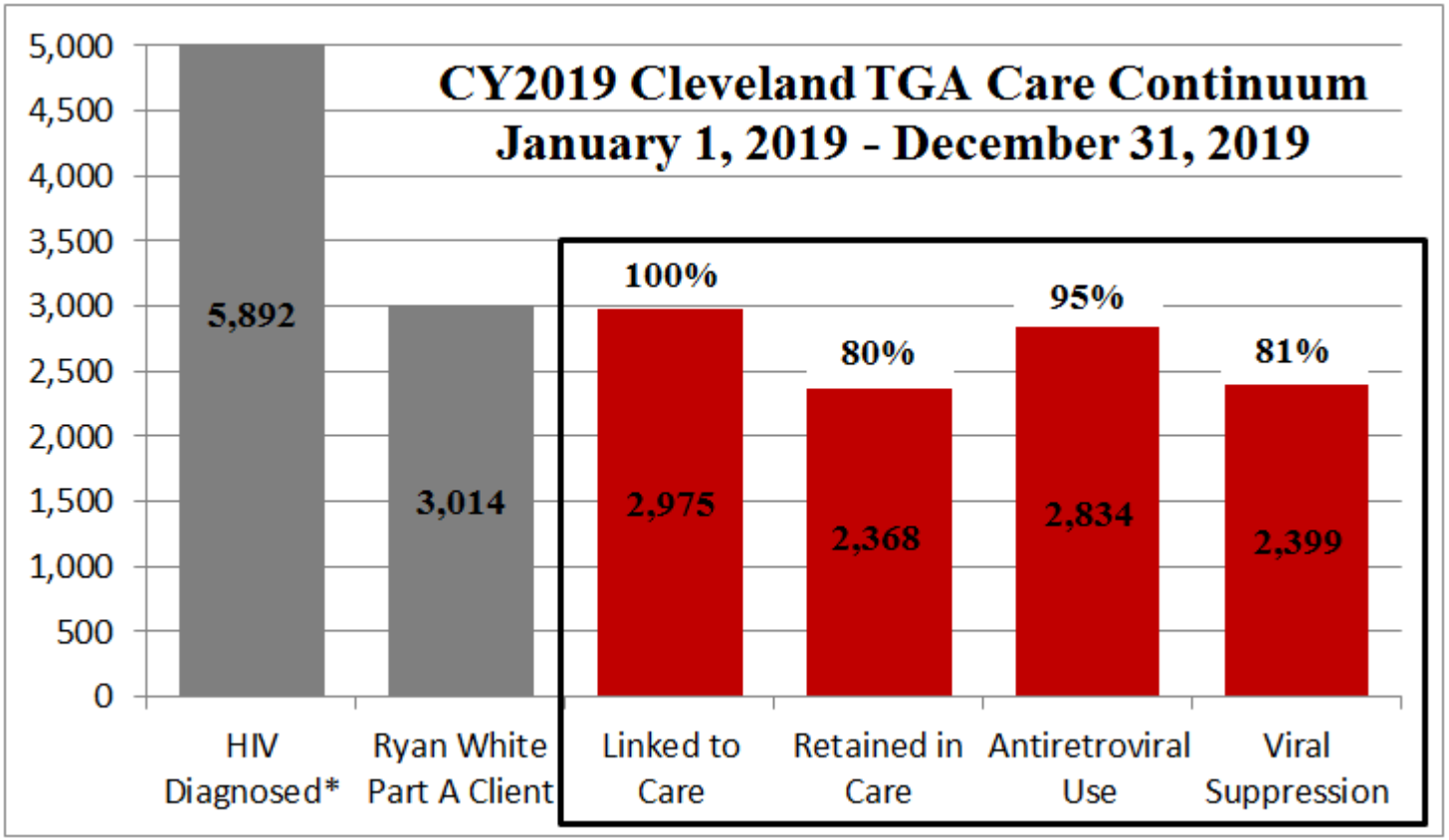


- **HIV-Diagnosed:** Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health. *Please note: The most recent available prevalence data from the Ohio Department of Health is as of December 31, 2019.
- **Ryan White Part A Clients:** Number of diagnosed individuals who received a Ryan White Part A funded service in the measurement year.
- **Linked to Care:** Number of Ryan White Part A eligible clients that had at least one medical visit, viral load test, or CD4 test in the measurement year.
- **Retained in Care:** Number of Ryan White Part A eligible clients who had two or more medical visits, viral load or CD4 tests performed at least three months apart during the measurement year.
- **Antiretroviral Use:** Number of Ryan White Part A eligible clients receiving medical care who have a documented antiretroviral therapy prescription on record in the measurement year.
- **Viral Suppression:** Number of Ryan White Part A eligible clients receiving medical care whose most recent HIV viral load within the measurement year was less than 200 copies/mL.

Ryan White 2020 CQMC Efforts

Providers' 2020 Target Populations

Part A Clients

- CCF(MCM clients only)
- Far West Center
- DSAS
- Signature Health
- May Dugan Center
- Family Planning of Lorain

MSM of Color

- AIDS Taskforce
- Circle Health Services
- Nueva Luz URC

Youth

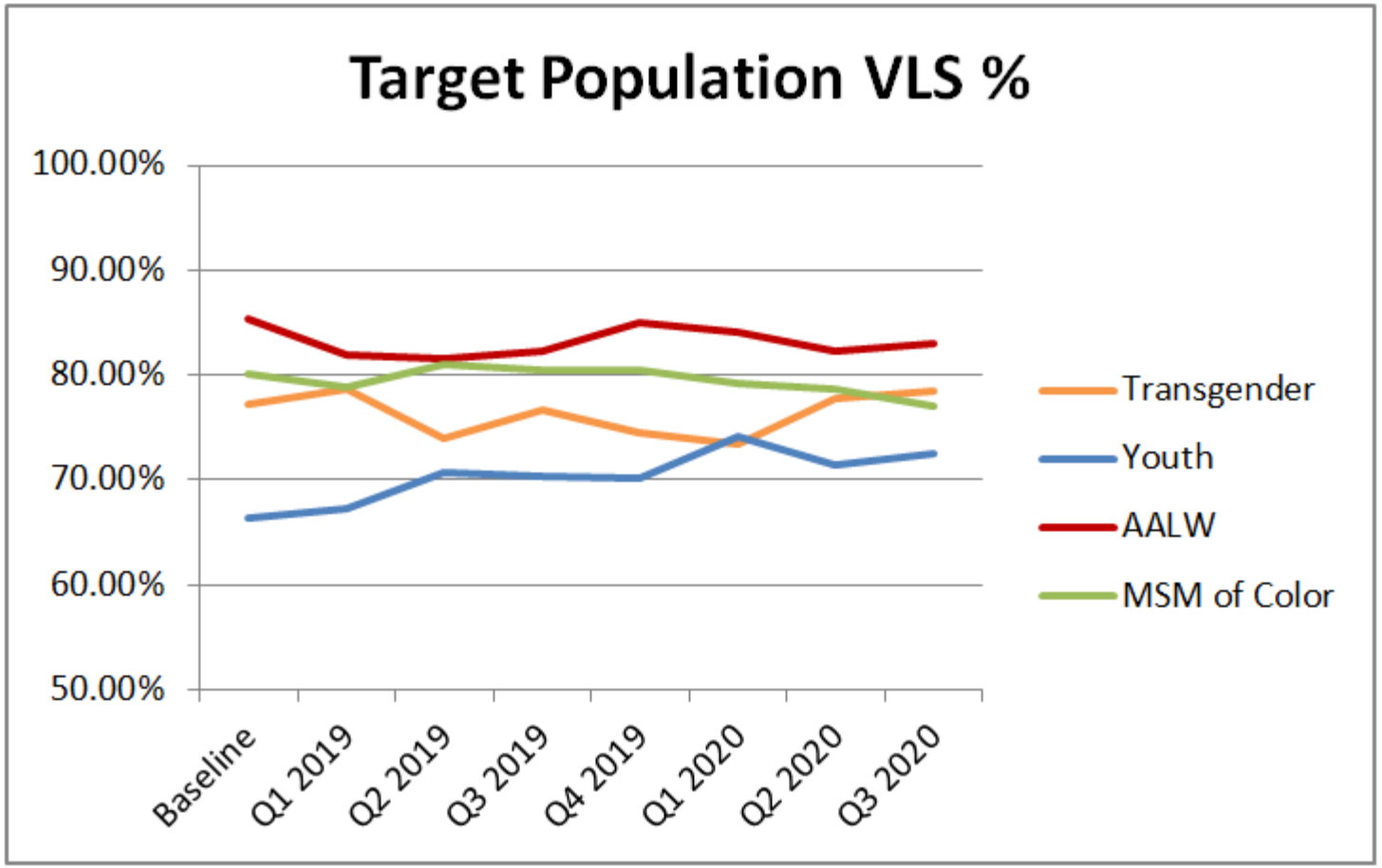
- MetroHealth (13-29)
- University Hospitals

Non-VLS Clients

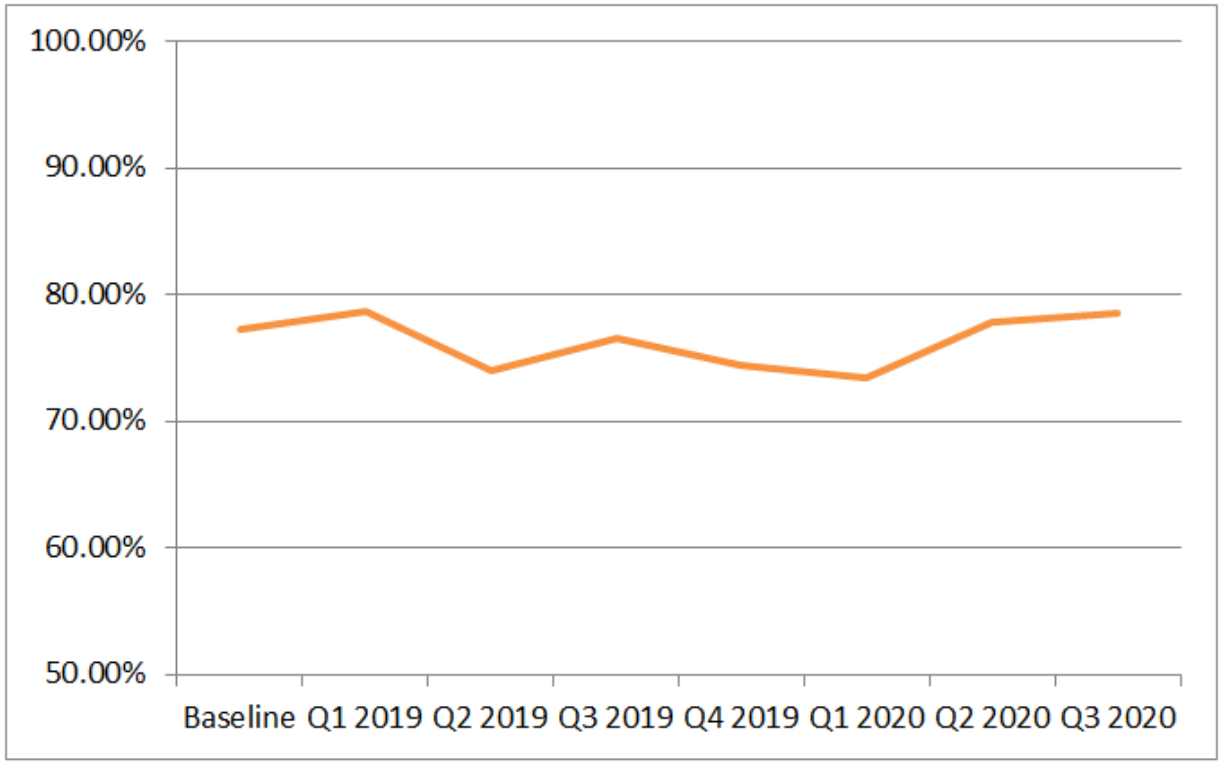
- Mercy Health
- AIDS Healthcare Foundation

CCBH

Target Population Overlay

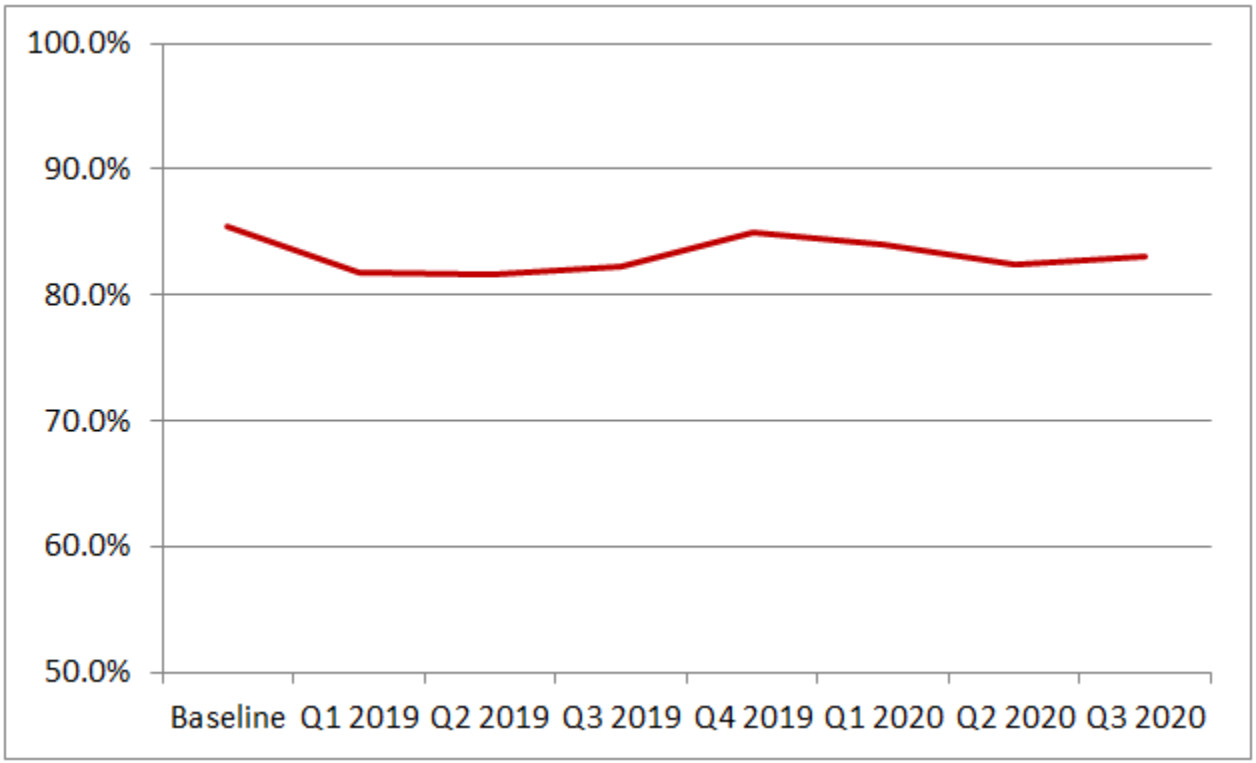


Transgender



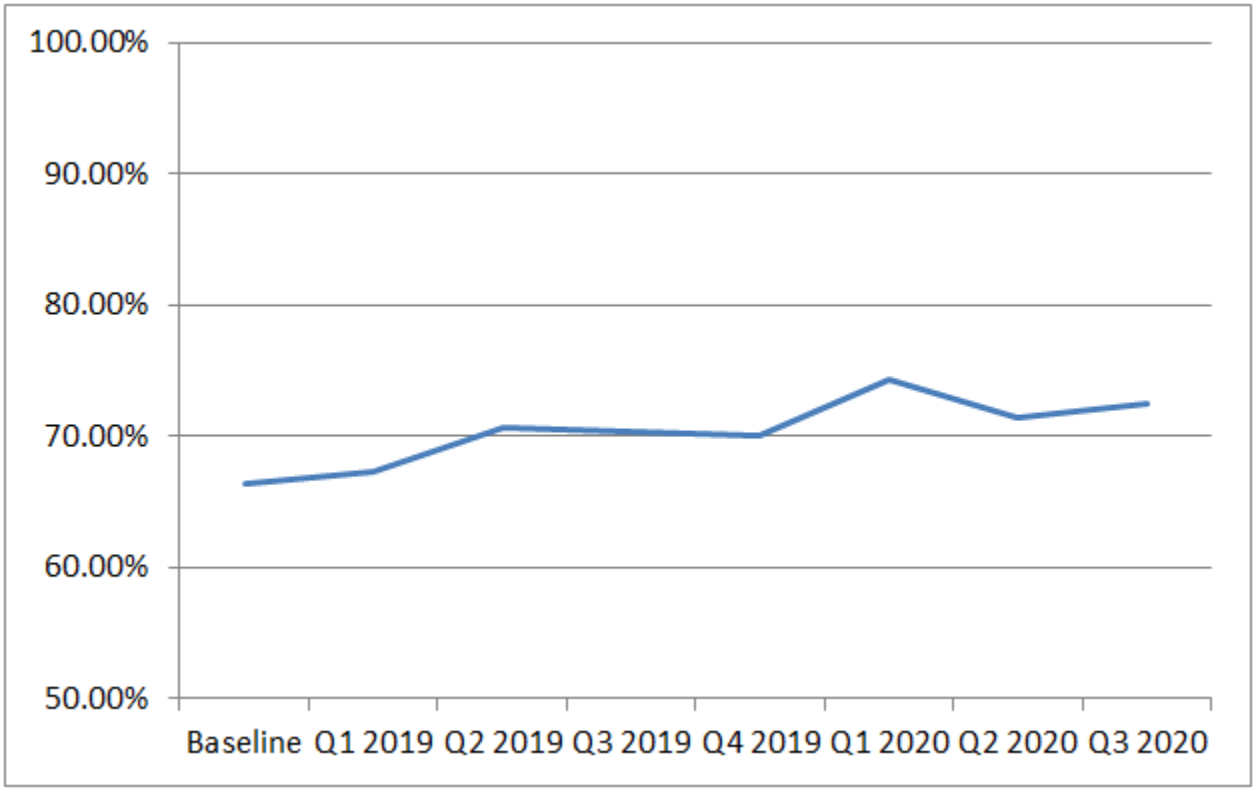
Q	%
Baseline	77.3%
Q1 2019	78.7%
Q2 2019	74.0%
Q3 2019	76.6%
Q4 2019	74.5%
Q1 2020	73.5%
Q2 2020	77.8%
Q3 2020	78.6%

African American/Latina Women



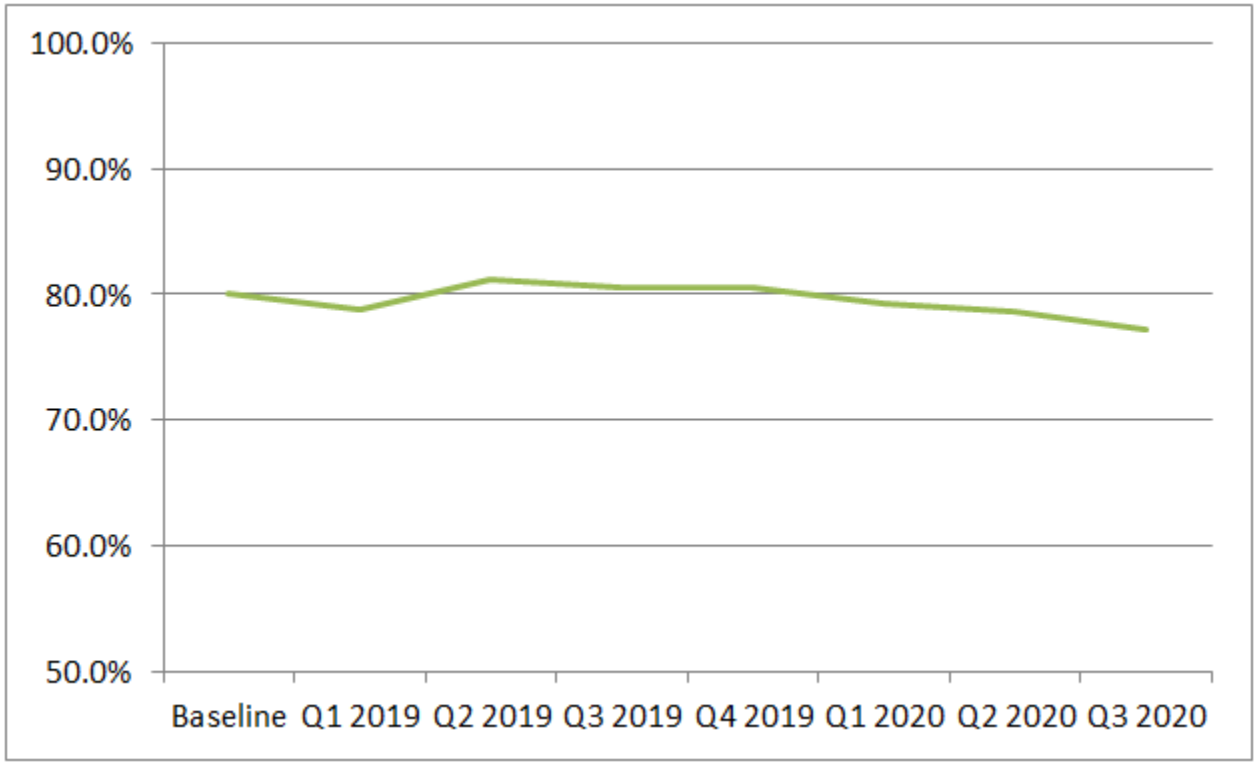
Q	%
Baseline	85.4%
Q1 2019	81.9%
Q2 2019	81.6%
Q3 2019	82.3%
Q4 2019	84.9%
Q1 2020	84.1%
Q2 2020	82.4%
Q3 2020	83.0%

Youth (13-24)



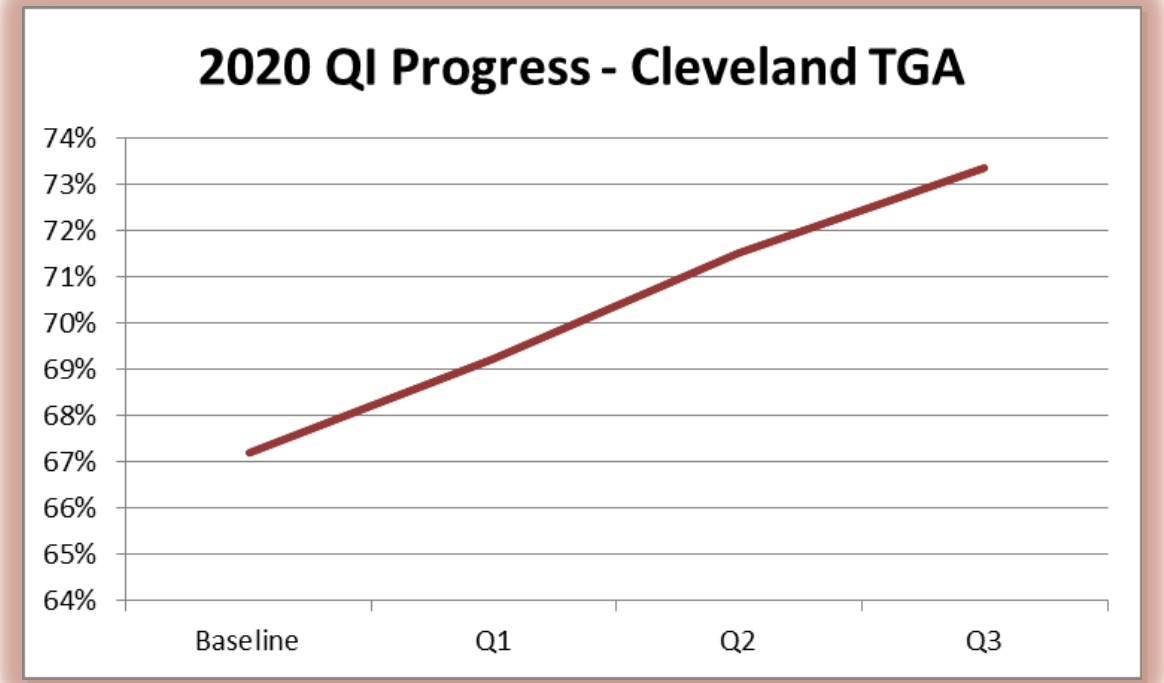
Q	%
Baseline	66.3%
Q1 2019	67.3%
Q2 2019	70.6%
Q3 2019	70.4%
Q4 2019	70.1%
Q1 2020	74.2%
Q2 2020	71.4%
Q3 2020	72.5%

MSM of Color



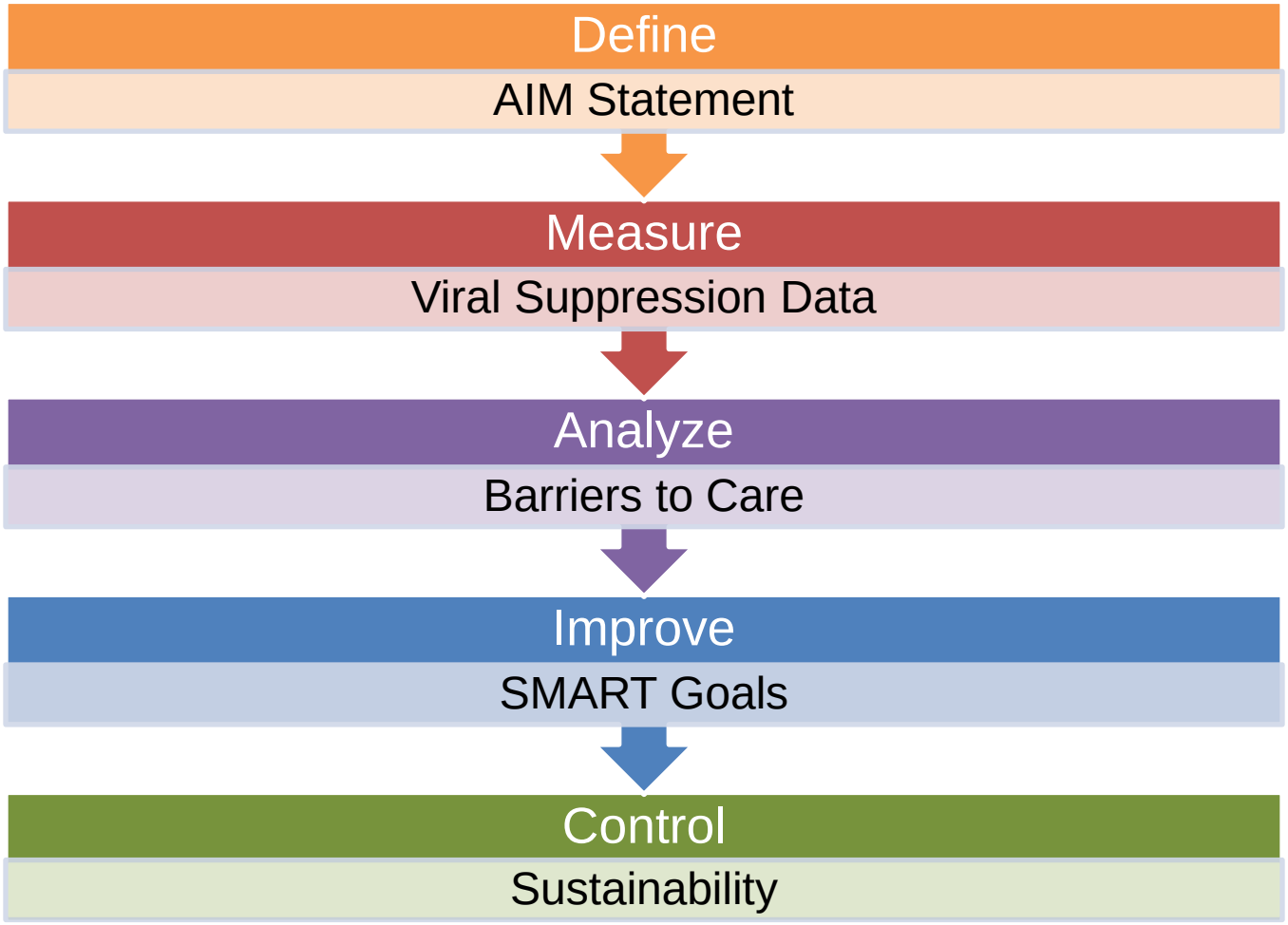
Q	%
Baseline	80.1%
Q1 2019	78.8%
Q2 2019	81.1%
Q3 2019	80.5%
Q4 2019	80.5%
Q1 2020	79.2%
Q2 2020	78.7%
Q3 2020	77.1%

CY2020 QI Overall Progress



Baseline	Quarter 1	Quarter 2	Quarter 3
367/546	385/556	399/558	408/556
67.2%	**69.2%**	**71.5%**	**73.4%**

DMAIC Process



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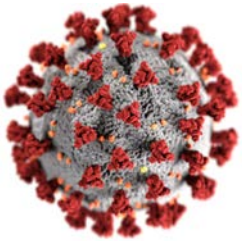
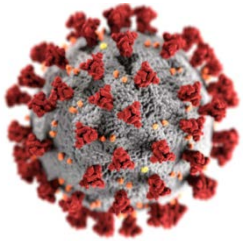


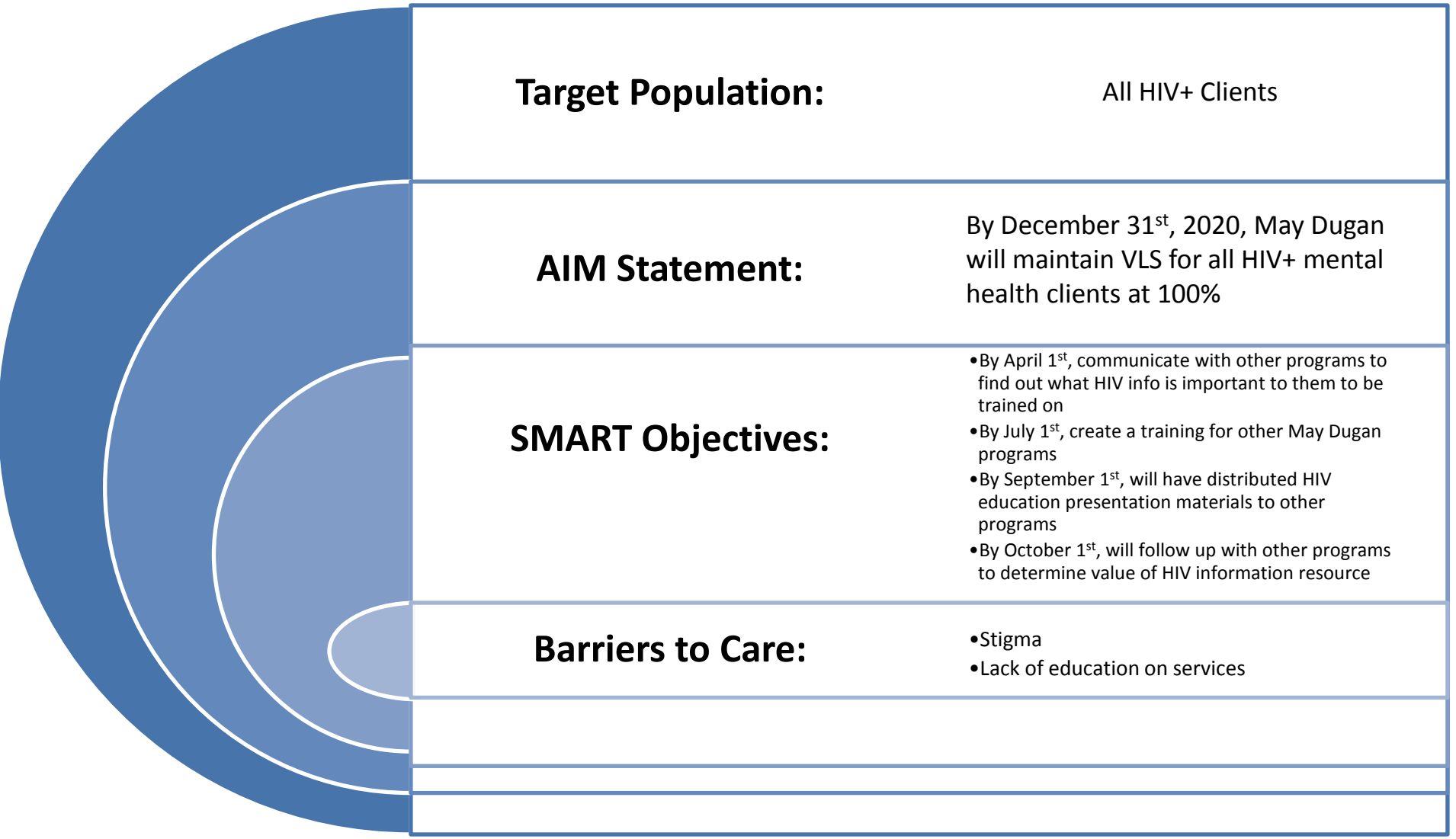
COVID-19 Barriers



- Isolation
  - Less in person visits to meet with clients
  - Increased mental health issues/substance abuse problems
- Viral Suppression
  - Lack of labs being drawn during pandemic
  - Clients not coming in to get medication refills
- Technology
  - Telehealth capabilities for providers and clients
  - Technology posing as distraction for clients when receiving care

May Dugan Center

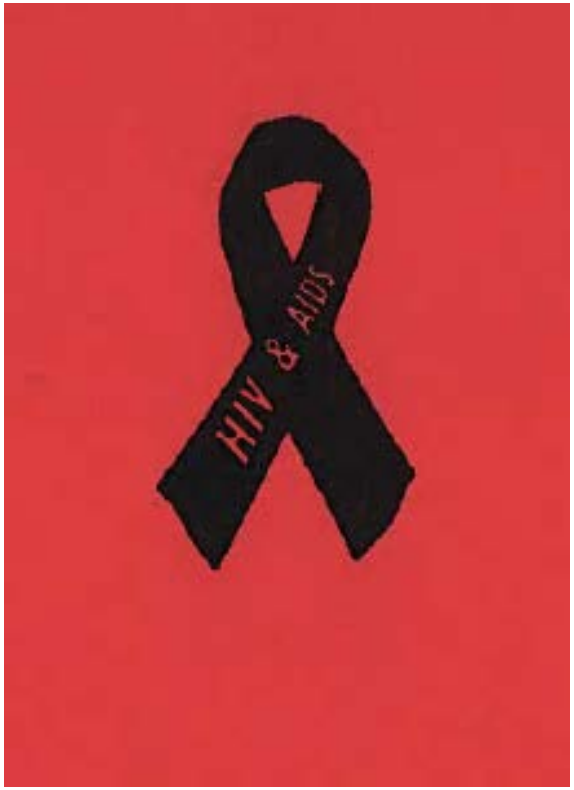
May Dugan Center

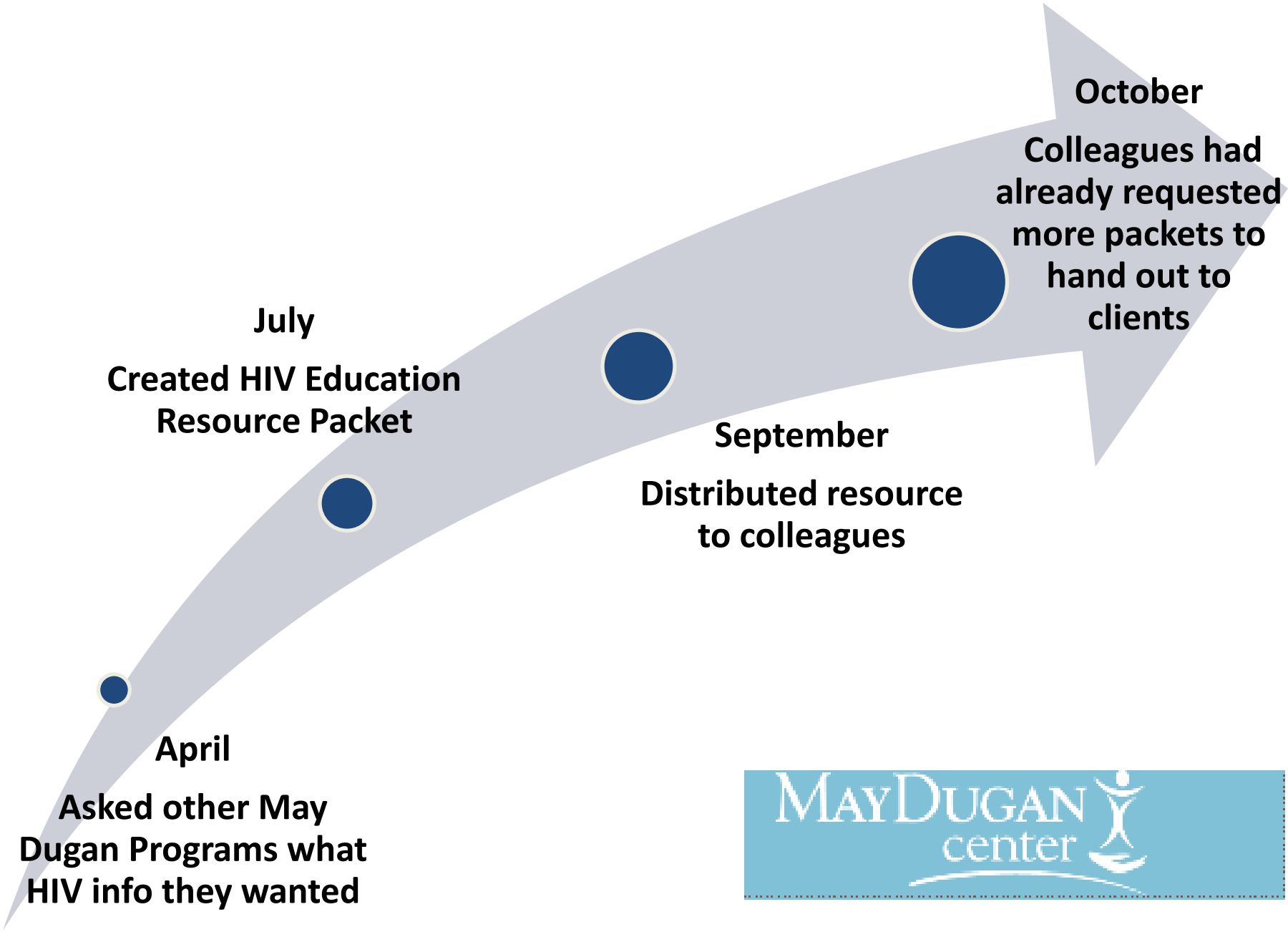


Target Population:	All HIV+ Clients
AIM Statement:	By December 31st, 2020, May Dugan will maintain VLS for all HIV+ mental health clients at 100%
SMART Objectives:	•By April 1st, communicate with other programs to find out what HIV info is important to them to be trained on •By July 1st, create a training for other May Dugan programs •By September 1st, will have distributed HIV education presentation materials to other programs •By October 1st, will follow up with other programs to determine value of HIV information resource
Barriers to Care:	•Stigma •Lack of education on services

Educational resource includes but not limited to:

- History of May Dugan Center's fight against HIV/AIDS
- Ryan White Part A Eligibility Info
- Part A Providers/Services
- #LanguageMatters resource to reduce stigmatizing language
- HIV testing sites
- Transportation resources
- Planning Council Information



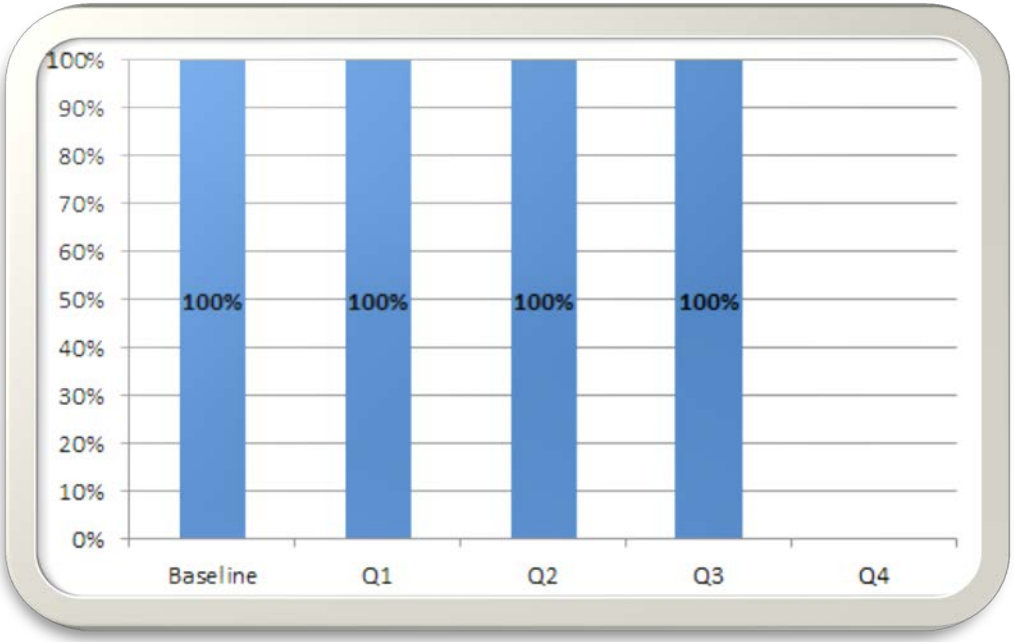


MAY DUGAN center

Control

Will continue to provide HIV education materials to colleagues

Update education resource with new providers/testing sites as needed



Avg. Clients: 10
Goal: 100%

Cleveland Clinic Foundation

Cleveland Clinic Foundation

Target Population:
Part A MCM clients

AIM Statement:
By December 31st 2020, CCF will improve VLS for Part A MCM clients from 71% to 75%

SMART Objectives:

By July 1st, Outreach Coordinator will have taken MS Access training and set list of variables desired for MS Access database

By July 1st, a rough draft of database will be complete

By October 1st, the MS Access database will be finalized and rolled out to staff.

Barriers to Care:

-Transitioning Staff

-New MCM in place as of September

Set up MS Access Database so team members could have reference tool for HIV client information

Cleveland Clinic

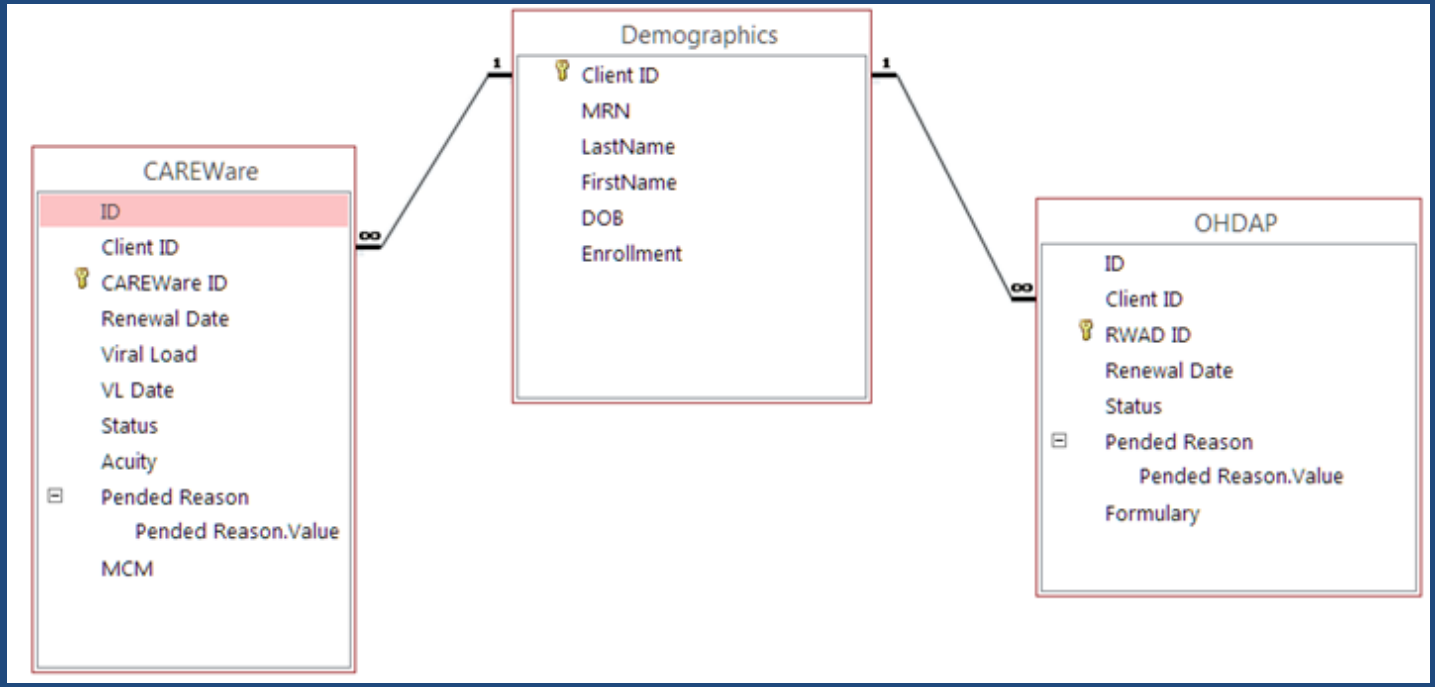


TABLE TOOLS

RWDatabase : Database- C:\Users\GRAMUGM\Documents\RWDat

FILE | HOME | CREATE | EXTERNAL DATA | DATABASE TOOLS | FIELDS | TABLE

View | Paste | Cut | Copy | Format Painter | Filter | Ascending | Descending | Remove Sort | Selection | Advanced | Toggle Filter | Refresh All | New | Save | Delete | Totals | Spelling | More | Find | Replace | Go To | Select | Calibri (Detail) | B I U

Views | Clipboard | Sort & Filter | Records | Find | Text

All Tables

Search...

Demographics

Demographics : Table

Demographics

OHDAP

OHDAP : Table

CAREWare

CAREWare : Table

CAREWare | Demographics | OHDAP

ID	Client ID	CAREWare ID	Renewal Date	Viral Load	VL Date	Status
* (New)	0					

Active
Pended
Closed

Record: 1 of 1 | No Filter | Search

Datasheet View

CONTROL

2020 served as a preparation/trial period of Microsoft Access database. With staffing in place, Cleveland Clinic plans to rollout database for use in 2021.

Signature Health

Target Population:
All Part A clients

AIM Statement:
By December 31st 2020, Signature Health will improve VLS for all Part A clients from 93% to 95%

SMART Objectives:

- By April 1st, will have formulated a needs assessment and plan for distribution
- By June 30th, will have distributed needs assessments to clients
- By December 1st, will have held a virtual support group based on feedback from needs assessment

Barriers to Care:
Mental Health - Stigma
Transportation - Substance Abuse

Signature Health

Signature™ HEALTH

Needs Assessment

Delivered via phone to plan support group structure; information collected includes:

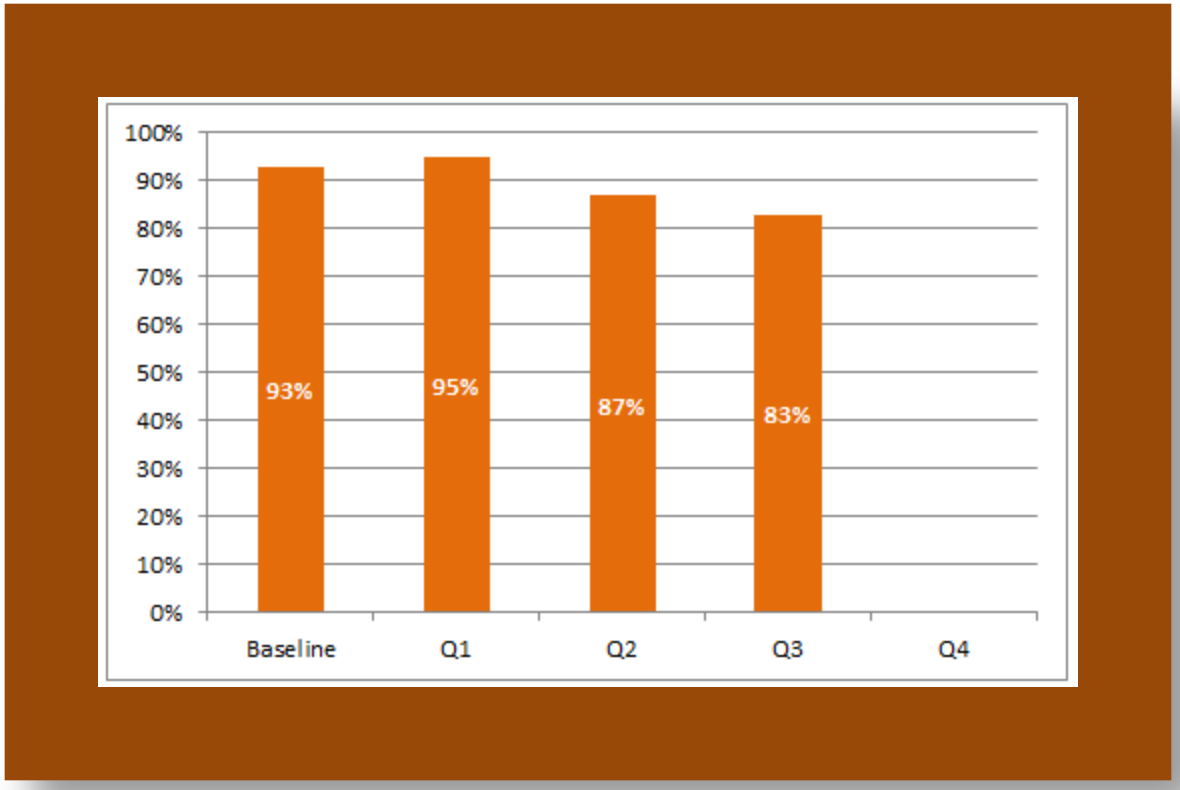
- County of Residence
- Best Day of the Week
- Best Time of Day
- Barriers to Attendance
- Virtual/In Person preference
- Expectations of Group
- Topic Suggestions

Outcomes

-59 Completed Needs Assessments
-33 Interested in attending group(56%)

Among 33 Interested clients:
-60% reported barrier to attending
-48% interested in attending virtual group
-48% cited connecting to people/building a sense of community as main goal

1st Virtual Positive Living Group Scheduled for Nov 17th



Signature Health continues to expand as an OAHS provider, leading to 35% more clients since January 2020.

Baseline – 43 clients

Q3 – 66 clients

Goal – 95%

CONTROL

Found needs assessment helpful in gauging client interest and expectations of a support group.

Plan to implement future bi-annual needs assessments to keep up to date on clients changing needs.

Signature™ HEALTH

Department of Senior and Adult Services

Department of Senior and Adult Services

Target Population: All Part A clients

AIM Statement: By December 31st 2020, DSAS will improve VLS for all Part A Clients from 91% to 95%

SMART Objectives:

- By February 14th, will finalize a one-page educational handout for RNs to give to clients that prepares client for medical appointment
- By March 1st, RN will begin distributing handout to clients and educating them on how to utilize it to improve their medical care
- By August 1st, develop standardized questions for RNs to follow-up at home visits to determine impact of handout

Barriers to Care:

- Lack of education
- Medication and treatment plan noncompliance

Cuyahoga County
Senior and Adult Services

Evidence based practice has shown that medical clients often do not have all of their needs met at medical appointments:

-Unanswered questions

-Concerns about changes in their medical status

-Confusion regarding treatment plan

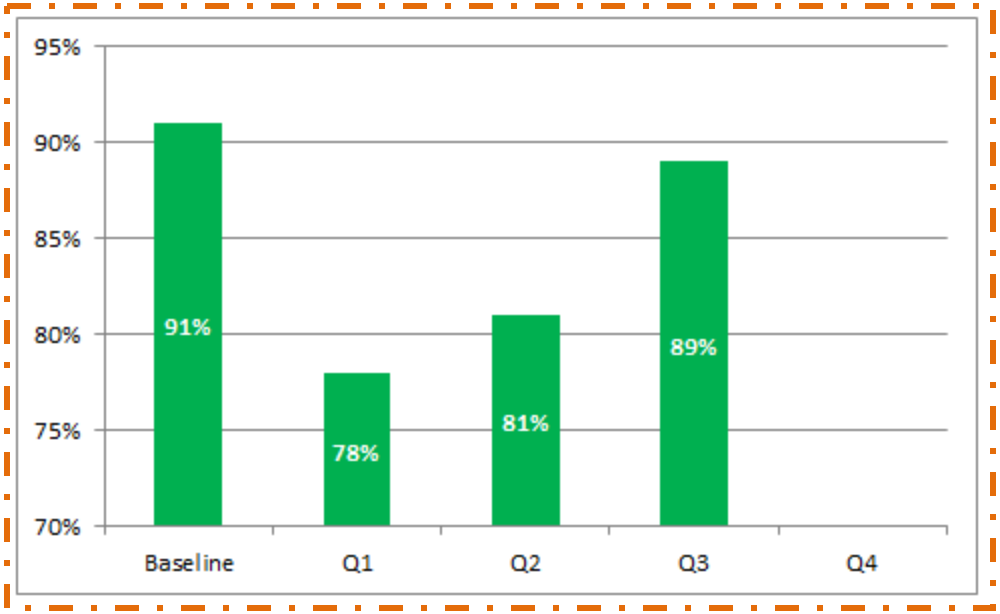
Created Educational Handout for clients to take to medical appointments for note taking

RNs provided training to clients on how to prepare for medical appointments, and followed up after medical appointments to answer any medical related questions a client may have

Handout included space for clients to take down questions regarding:
Client's condition
Tests or procedures
Medicines
Other Treatments

Cuyahoga County
Senior and Adult Services

Avg Clients: 32
Goal: 95%



CONTROL

Due to switch from in-person medical appointments to telehealth during pandemic, DSAS has noticed some clients are too distracted with the change to focus on this handout.

However, DSAS has received positive feedback from clients about the form, and plans to fully implement post-pandemic.

Far West Center

Far West Center

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

- **AIM Statement:** By December 31st 2020, Far West Center will improve VLS for all Part A clients from 80% to 100%.

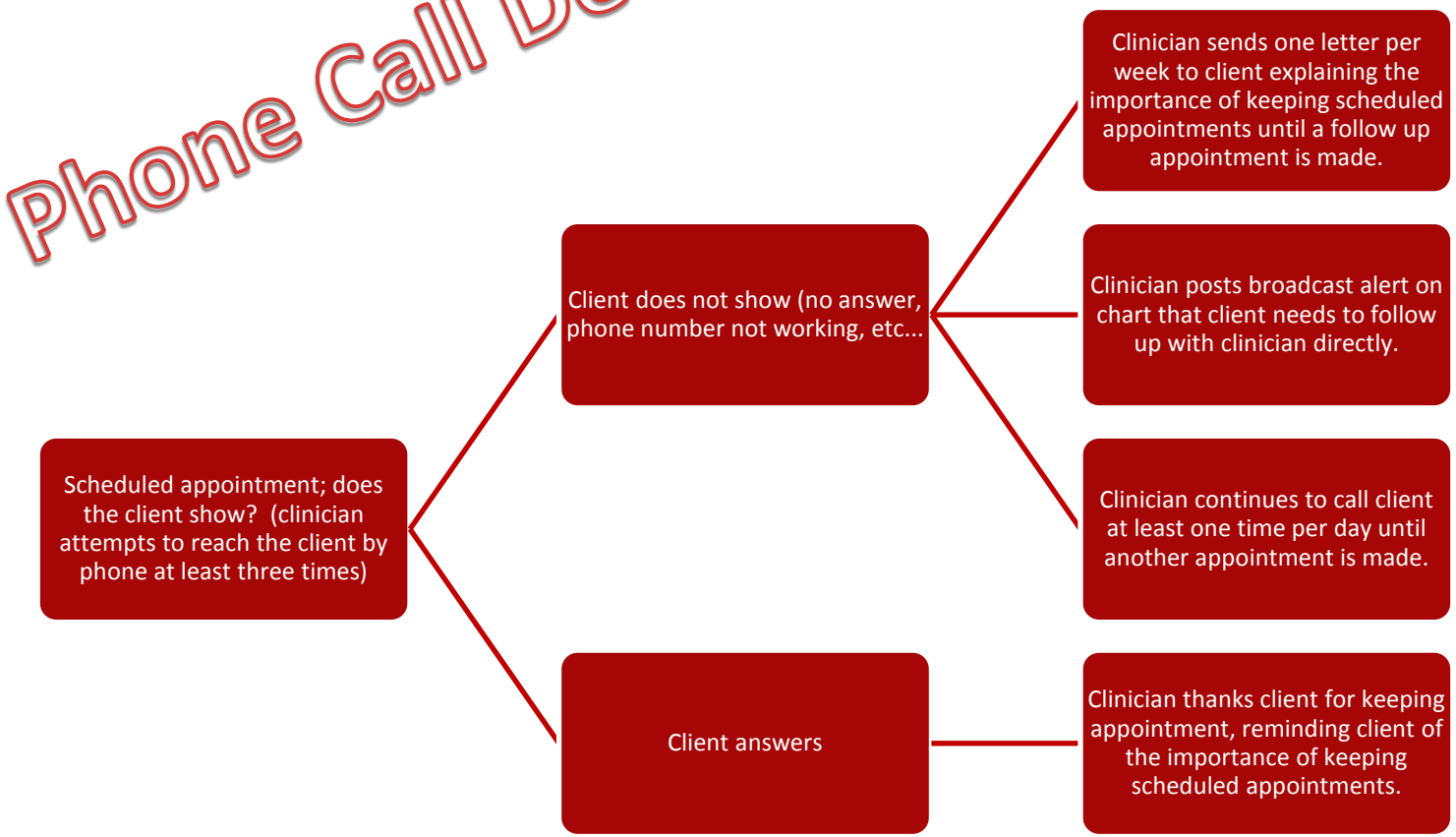
SMART Objectives:

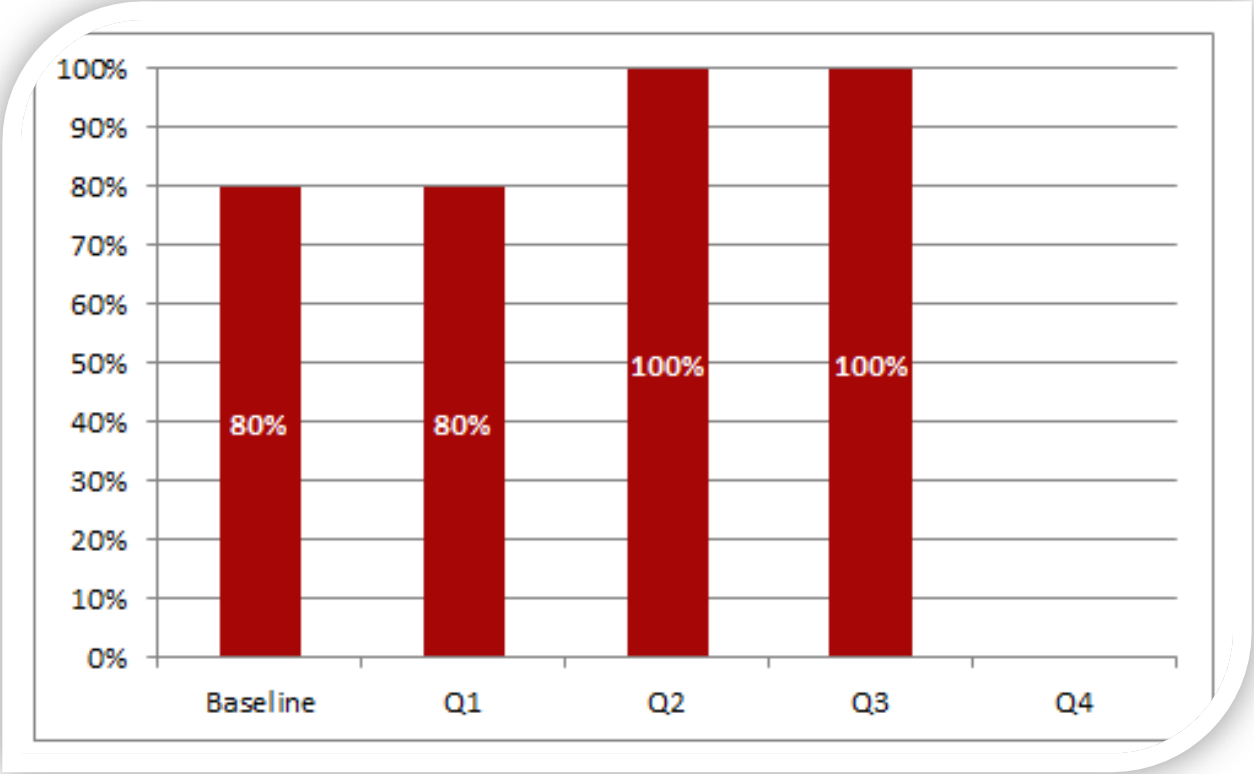
- By February 1st, will begin pre-appointment calls (appointment reminder, assess barriers to care, help to access care)
- By March 1st, create intensive follow up procedure to reach out to clients who miss appointments
- By December 31st, decrease number of no shows/short notice cancels by 50%(11 no shows/short notice cancels in 2019)

Barriers to Care:

- No shows/missed appointments
- Transportation
- Language barriers

Phone Call Decision Tree





Avg Clients: 5
Goal: 100%

CONTROL

Project proved to be successful in lowering no-show rates in 2020, plan to expand pre-appointment calls to all clients in 2021.

4 no shows as of Q3, down over 50% from last year

AIDS Healthcare Foundation

AIDS Healthcare Foundation

Target Population: All Part A clients

AIM Statement: By December 31st 2020, AIDS Healthcare Foundation will improve VLS for all Part A clients from 57 to 70%.

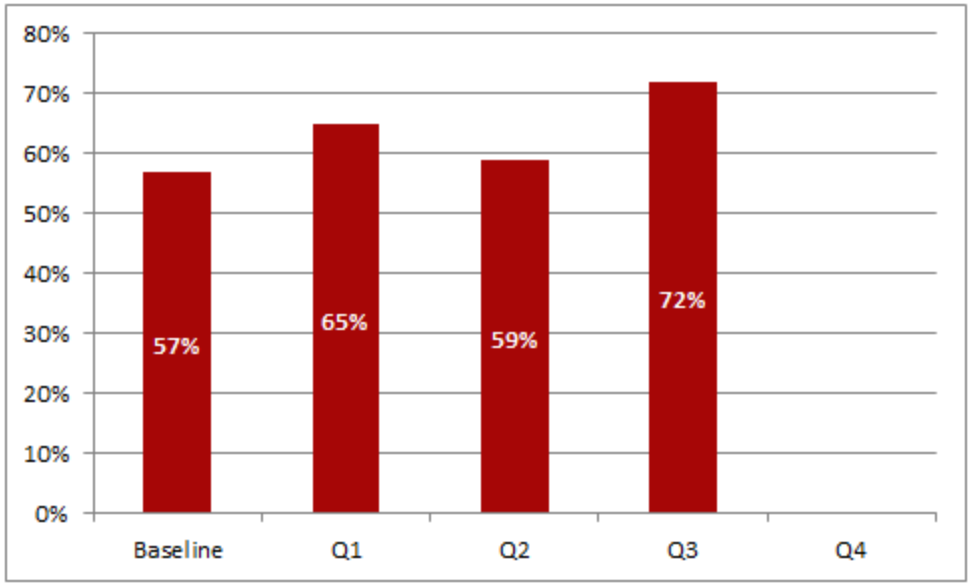
SMART Objectives:

- By July 1st, will have analyzed Part A clients who are non-VLS and create summary of barriers to care/compare to VLS clients
- By August 1st, will have implemented action plan to address non-VLS clients' barriers to care
- By October 1st, follow up analysis to see if intervention had impact on non-VLS clients

Barriers to Care:

- No show rate
- Communication with clients(disconnected phones, etc.)
- Staffing shortage

AIDS Healthcare Foundation



Avg. Clients: 25
Goal: 70%

Findings

Of 9 clients who were originally non-VLS:
-2 newly diagnosed
-2 clients transferred care
-3 clients now VLS
-3 clients now Retained in Care

Methods

AHF met frequently with Pharmacy team and ATF Case Managers to learn more about non-VLS patients(i.e. updated contact information, if they were coming in, etc.)

C O N T R O L

Overall, this project did help to shine light on the VLS rate. We were able to retain a few of the clients and get them back on track. The clients that are still not virally suppressed have been communicated to CM's, pharmacy, Doctor and Nurse. Also, having access to the performance report is another useful resource to help with RW patient retention.

In 2021, AHF plans to continue to meet frequently with pharmacy and medical case management teams to discuss non-VLS clients as well as expand population to all HIV+ clients in AHF care.


Take
A
Break

MetroHealth Medical Center

MetroHealth Medical Center

Target Population: Non-VLS Youth Ages 13-29

AIM Statement: By December 31, 2020, MetroHealth will improve VLS for non-VLS youth(age 13-29) from 0% to 30%.

SMART Objectives:

- By February 1st, will have developed an internal non-VLS Youth Workgroup that will meet monthly
- By April 1st, will have begun process of intensive outreach to non-VLS youth along with chart reviews to determine barriers to care
- By June 1st, will have compiled list of barriers and prioritized order in which they will be addressed
- By September 1st, will have created strategies to assess prioritized barriers for non-VLS youth

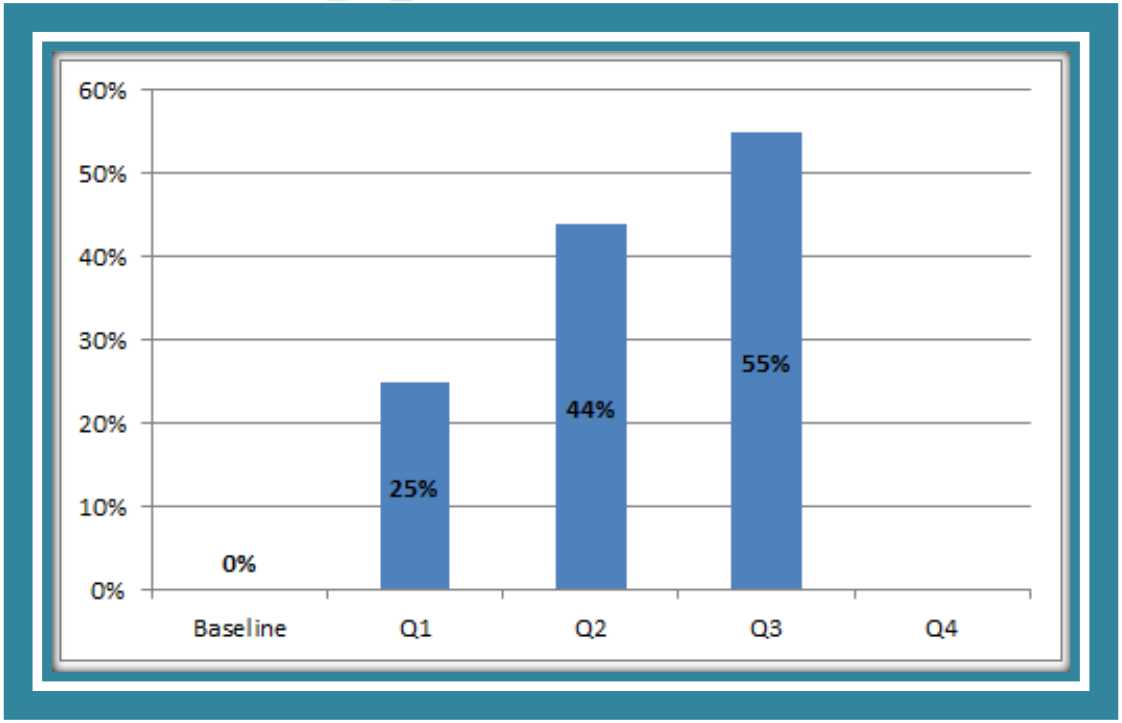
Barriers to Care:

- Population easily falls out of care
- Newly diagnosed youth/Perinatal infections
- Lack of understanding about treatment plans/follow ups

Documenting a Client's Care Journey

March 2020	April 2020	May 2020	June 2020	July 2020
Appt set for 4/4. Emailed RN to enter labs. Called patient and reminded about appt and to get labs this month.	Patient no showed to appt. Did not get labs. Called patient and rescheduled appt for 5/5. Patient to get labs.	Patient attended appt 5/5. Patient did not get labs. Pharmacy note reports patient filled prescription. Called patient and reminded patient to get labs. Patient agrees.	Still did not have labs drawn. Called patient. Patient reports transportation issues. Arranged LYFT for patient to get labs on 6/6.	VL ND!!! Called patient to discuss results. Scheduled next appt with doctor for 10/10. Patient to have labs in Sept.

MetroHealth



55 Client Cohort
Current: 55%
Goal: 30%

Current Successful Strategies:

- Reminder Calls
- Compass, Facebook, Youth Support Group – youth outreach volunteers
- Lyft
- Outreach Services

Ideas for Future Exploration:

- Contact through Social Media
- Integration of EIS team in non-VLS Youth Workgroup
- Use of MyChart during MCM appointments


CONTROL
MetroHealth has found substantial success in developing a monthly Non-VLS Youth Workgroup, and intends to continue workgroup into the future to engage youth clients in the TGA.

University Hospitals

University Hospitals of Cleveland

SMART Objectives:

~~By January 1st, begin case conferencing with Social worker, Nurse Care Coordinator, and Quality Improvement Manager.

~~By January 1st, begin intensified case management with nurse coordination for non-virally suppressed youth.

~~By June 1st, develop criteria and regulations for Lyft usage and implement program.

Target Population:

Youth 13-24

Barriers to Care:

Transportation

Retention in Care

AIM Statement:

By December 31st 2020, University Hospitals will improve VLS for Youth 13-24 from 81 to 85%.

University Hospitals

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

Effects of MT on Youth VLS

University Hospitals is currently conducting a study to research the effects that providing alternative medical transportation methods(Lyft) has on Youth viral suppression.

Funding:

-Program Income

Eligible Youth Clients:

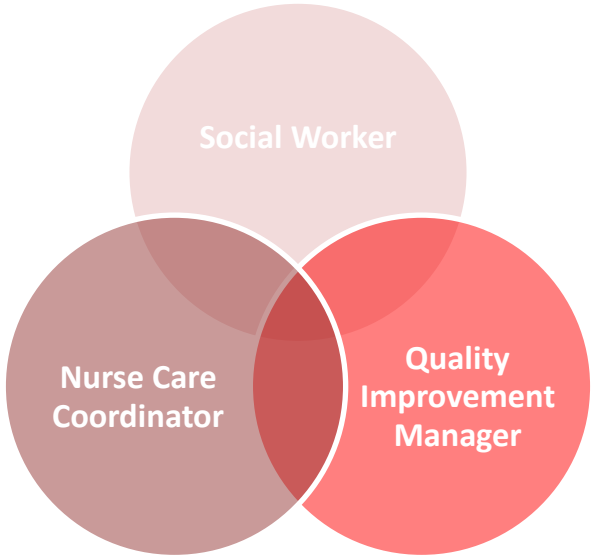
-Those that are not virally suppressed(<200 copies/mL)

-Newly diagnosed

-Those that are erratically in care and only recently virally suppressed

Case Conferencing

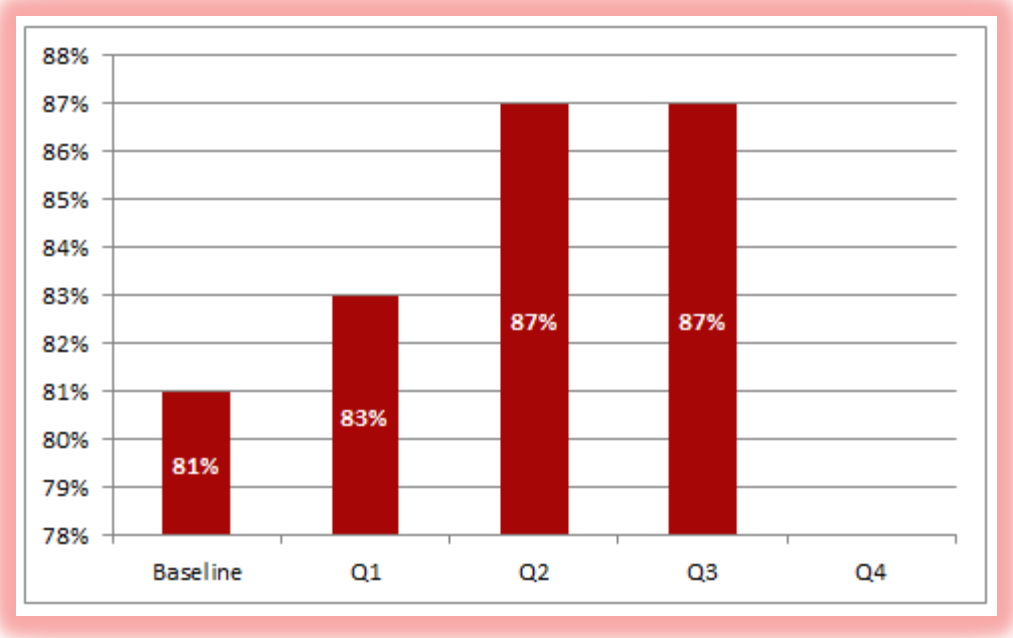
UH has also developed and implemented a case conferencing team for youth clients that utilizes a three-pronged approach to ensure clients are receiving optimal care and becoming virally suppressed.



University Hospitals

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

52 Client Cohort
Goal: 85%



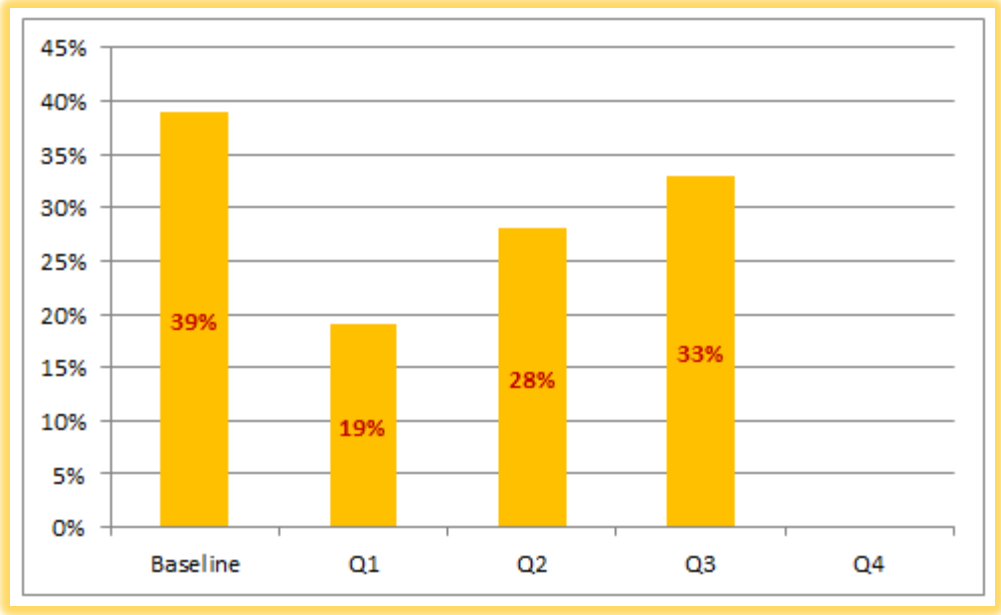
CONTROL

-Case Conferencing teams will continue into 2021 to provide a multi-pronged approach to youth care.
-Lyft usage data low due to COVID-19 pandemic, will look to continue study in future.

AIDS Taskforce of Greater Cleveland

Target Population: MSM of Color(Brother's Health Connection Program)

AIM Statement: By December 31st 2020, ATF will improve VLS for MSM of Color in the Brother's Health Connection Program from 39% to 44%.



Average Client Count: 32

In 2020, AIDS Taskforce of GC focused on Phase 2 of the Brother's Health Connection, the transition to normal day to day case management.

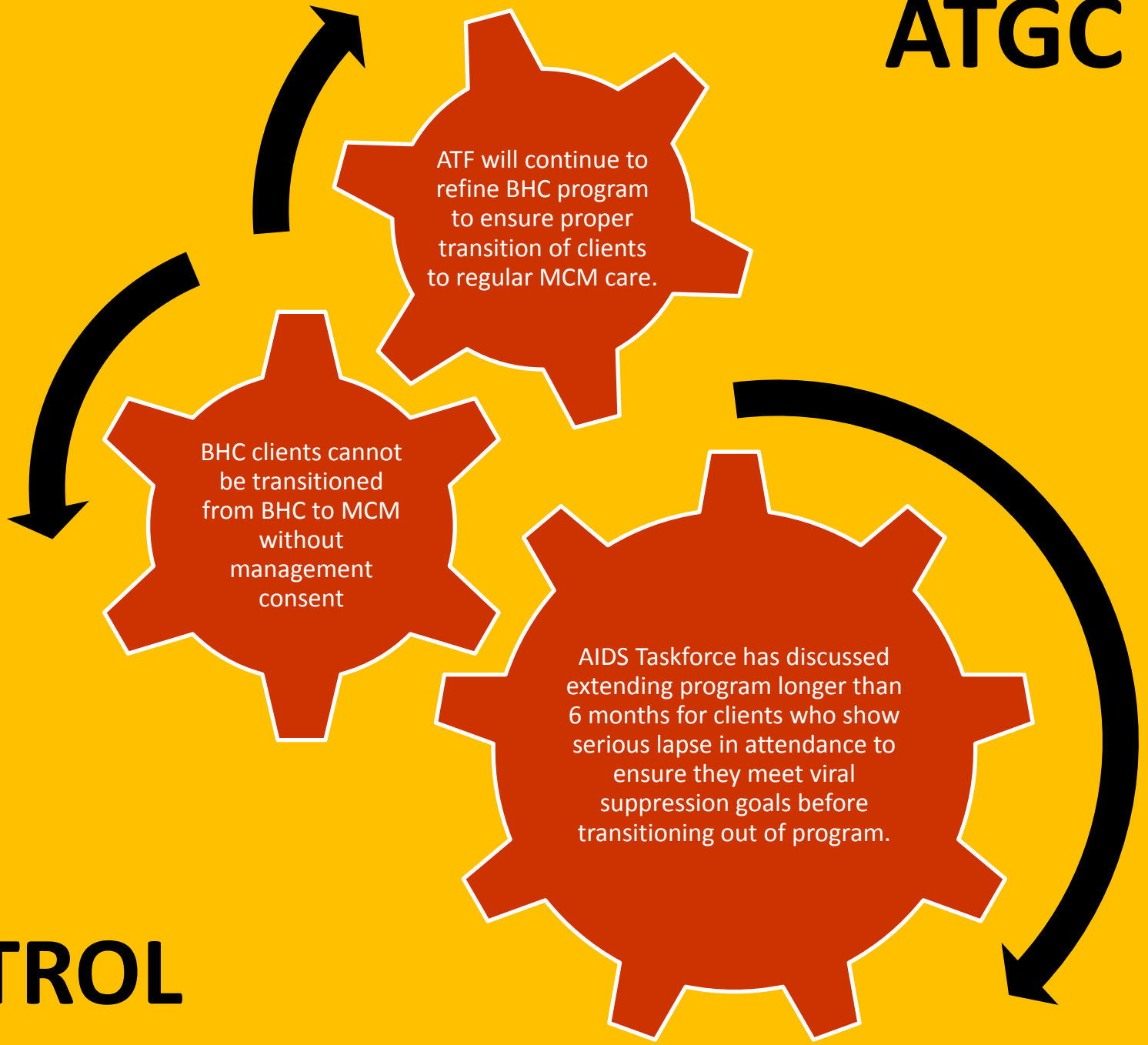
SMART Objectives:

- By April 1st, develop the process to transition clients from intensive case management through Brother's Health Connection program to regular medical case management
- By June 1st, will develop a process to address clients that do not transition from intensive MCM to regular MCM well, to ensure they are not lost to care

Barriers to Care:

- Homelessness/Housing
- Client Engagement
- Communication with Clients

ATGC



CONTROL

Circle Health Services

Circle Health Services

Target Population: MSM of Color

AIM Statement: By December 31st 2020, Circle Health Services will improve VLS for MSM of color from 83 to 88%.

SMART Objectives:

- **By April 1st, create a comprehensive tool that determines patients barriers to coming to appointments and taking medication**
- **By April 1st, deliver comprehensive tool to at least 75% of MSM of Color target population**
- **By June 1st, utilize intensive case management to address barriers discovered through use of comprehensive tool**
- **By October 1st, complete feasibility assessment of offsite case management for erratic clients**

Barriers to Care:

Retention in care

Insurance Lapses

Transportation

Medication Adherence

Mental Health

Developed Barriers Tool Questionnaire that addresses:

- Housing
- Employment
- Transportation
- Communication
- Food
- Substance Use
- Mental Health

If client scores 4 or above

Enroll in EIS for intensive outreach

If client scores 3 or lower

Enter/Remain in MCM

RYAN WHITE PART A

QAI VIRAL LOAD SUPPRESSION PROJECT

Barriers Tool Questionnaire

In the last 6 months, has the client experienced any problems in the following areas?

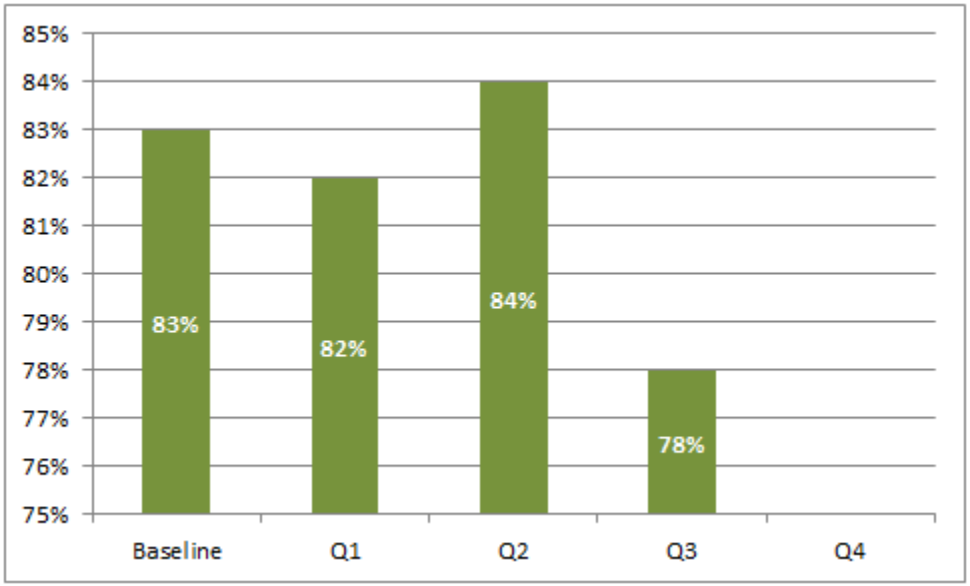
1. Housing:
   a. Is the client homeless? Yes (1) No (0)
   b. Has the clients address changed in the last 6 months? Yes (1) No (0)
2. Employment:
   a. Is the client unemployed? Yes (1) No (0)
3. Transportation:
   a. Is the client without reliable transportation? Yes (1) No (0)
4. Communication:
   a. Has the client's phone number changed in the last 6 months? Yes (1) No (0)
   b. Has the client's phone been out of service in the last 6 months? Yes (1) No (0)
5. Food:
   a. Does the client have limited access to food? Yes (1) No (0)
6. Substance Use:
   a. Does the client report illicit substance use including IVDU, methamphetamines, crack cocaine/ cocaine, etc? Yes (1) No (0)
   b. Does the client reports excessive alcohol use? Yes (1) No (0)
7. Mental Heatlh:
   a. Does the client have a positive depression screening? Yes (1) No (0)
   b. Is the client being treated for a mood disorder? Yes (1) No (0)

Score: ≥ 4 at high risk for missed medications and no shows.

TOGETHER. FOR ALL.

Circle Health Services

Avg Clients: 63
Goal: 88%



Questionnaire Outcomes

-55 total assessments given thus far: 85% of target population(MSM of Color)

-10 clients scored 4 or above and enrolled in EIS for intensive outreach

CONTROL

Circle Health Services saw the following benefits in using the Barriers Tool Questionnaire:

Quick assessment of client needs/barriers

Assess best plan of care for clients on individual basis (EIS or MCM)

Useful for erratic clients that don't come in often

Can be delivered anywhere(offsite/East and West clinics/phone)

Circle Health plans to continue utilizing questionnaire in the future to assess client needs and barriers.

Nueva Luz Urban Resource Center

NLURC
Nueva Luz Urban Resource Center

SMART Objectives:

* By April 1st, develop list of questions regarding medical care that all staff will ask non-VLS clients, and train staff on questions/process.

* By June 1st, develop a flowchart to depict process that will occur if a red flag comes up when asking client questions regarding medical care.

* By October 1st, create a spreadsheet to see how many non-VLS clients have been positively impacted by use of this process.

AIM Statement: By December 31st 2020, NLURC will improve VLS for MSM of Color from 77% to 85%

Target Population:
MSM of color

Barriers to Care:

Housing instability or homelessness

Substance Abuse

Mental Health

Nueva Luz trained staff in all service areas to start utilizing the medication adherence card below when meeting with clients

- MCM/NMCM(Housing)
- Outreach
- Legal
- Nutrition
- Recovery

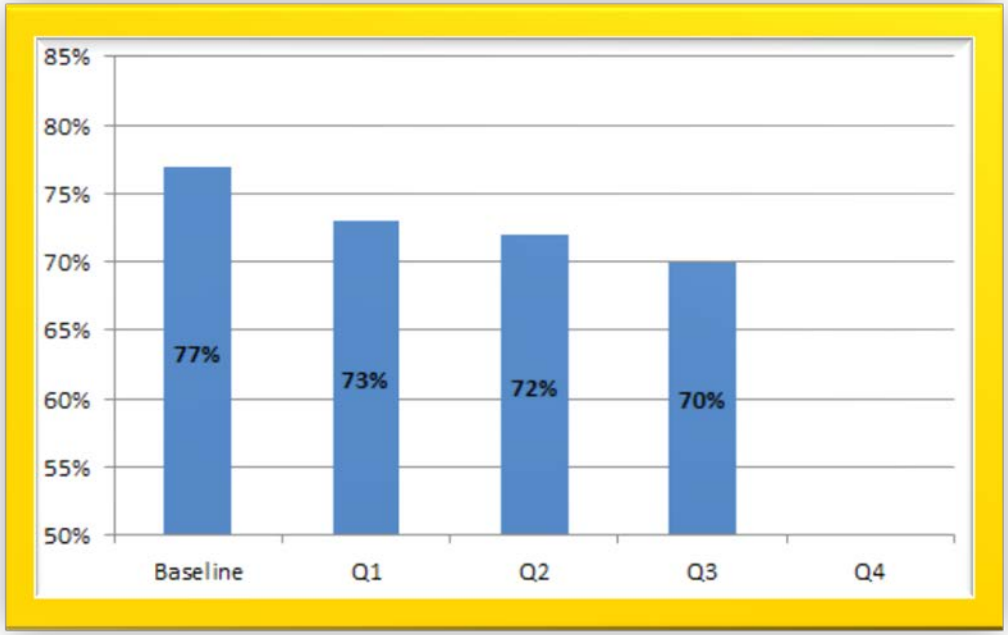
Medication adherence reference card

- How is everything going with your medications?
  - If Good – verify if client takes medication as prescribed.
    - If they are adherent, MCM –offer words of affirmation and encourage adherence, maintain follow up.
    - If they are adherent, Non-medical staff – offer words of affirmation and verify if CT has a case manager. If yes, encourage follow up with MCM.
    - If client does not have a MCM – refer client to NLURC MCM. If MCM is at different agency, obtain release and follow up, or refer to lead MCM to follow up.
  - If Not So Good – MCM follow up with client and address concerns.
    - Non-medical staff – verify if client's MCM is aware of concerns.
      - If YES – follow up with MCM to verify the client's concerns.
      - If NO – refer client to MCM
- Goal: To encourage HIV treatment adherence and to promote viral suppression.

- MCM = Medical Case Manager (including NMCMs)
- Non-Medical Staff = Housing, Legal, Nutrition, Recovery, Outreach staff.
- Viral suppression, according to RW Part-A <200
- Treatment adherence = taking medications as prescribed, attending ID appointments, complying with ID doctor's treatment recommendations.

NLURC
Nueva Luz Urban Resource Center

Avg Clients: 166
Goal: 85%



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

NLURC
Nueva Luz Urban Resource Center

Tracking Table (example)

Client Name	Follow up Date	Staff name
John Doe	10/7/2020 10/10/2020 10/20/2020	Jean Luc. Alison Keyana

Control

COVID-19 impacted ability to fully rollout project during 2020 due to interpersonal conversation approach. Plan to fully implement intervention in 2021 to test impact.

Family Planning Services of Lorain

Family Planning Services of Lorain County

Target Population:
All HIV+ clients

AIM Statement: By December 31, 2020, FPL will improve VLS for all HIV+ clients from 75% to 80%

SMART Objectives:

- Communication with clients out of care
- Connecting clients to services/resources

Barriers to Care:

- By April 1st, explore need/feasibility of acquiring work cell phone for client communication
- By June 1st, create standardized consent form for client contact permission
- By Oct. 1st, create standardized language for text messages

While cell phone acquisition delayed due to COVID-19, FPL utilized this time to develop forms for seamless integration of cell phone into day to day operations.

Consent Form allows EIS worker ability to send:

- **Doctor Appt. reminders**
- **Lab Draw reminders**
- **Check-in messages**
- **Missed Appt. notifications**
- **Assess barriers to care**
- **Provide knowledge of community resources**

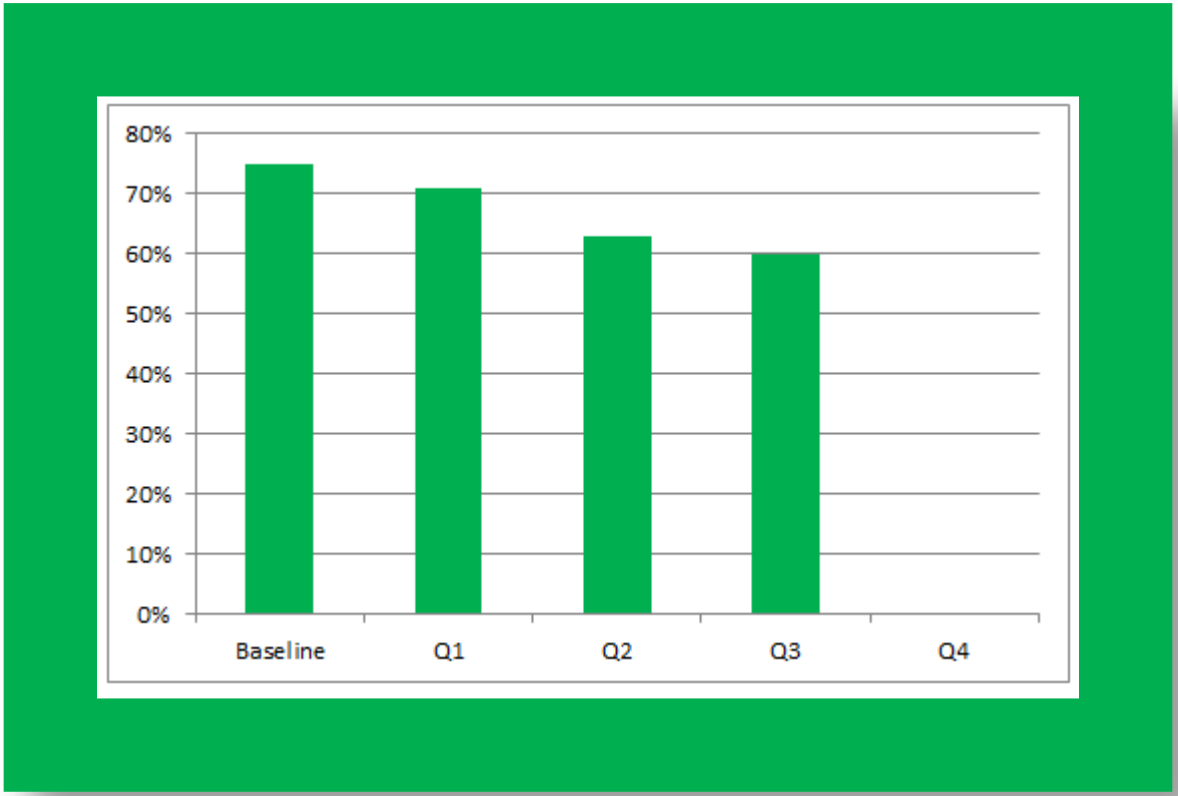
Support Group Example:

Hello, this is Family Planning Services of Lorain County with a reminder of a support group at X time at X location. Please call Summer at X number if you have any questions.

Community Resources Example:

Hello, this is Family Planning Services of Lorain County, X community resource is available. Please call or text this number for more information.

Avg. Clients: 6
Current: 60%
Goal: 80%



CONTROL

Project focused on devising plan for use of company cell phone for outreach to clients, will implement in 2021 when phone can be acquired.

Mercy Health

Target Population: Non-VLS Clients

AIM Statement: By December 31st 2020, Mercy Health will improve VLS for non-VLS clients from 0% to 50%.

MERCY HEALTH

SMART Objectives:

- By March 30th, develop a document to determine barriers to care that non-VLS clients are facing
- By March 30th, meet with regional EIS partner and share document
- By September 30th, record and address all of the barriers noted by clients

Barriers to Care:

- Communication with clients
- Transportation
- Staffing Shortage
- Medication Adherence

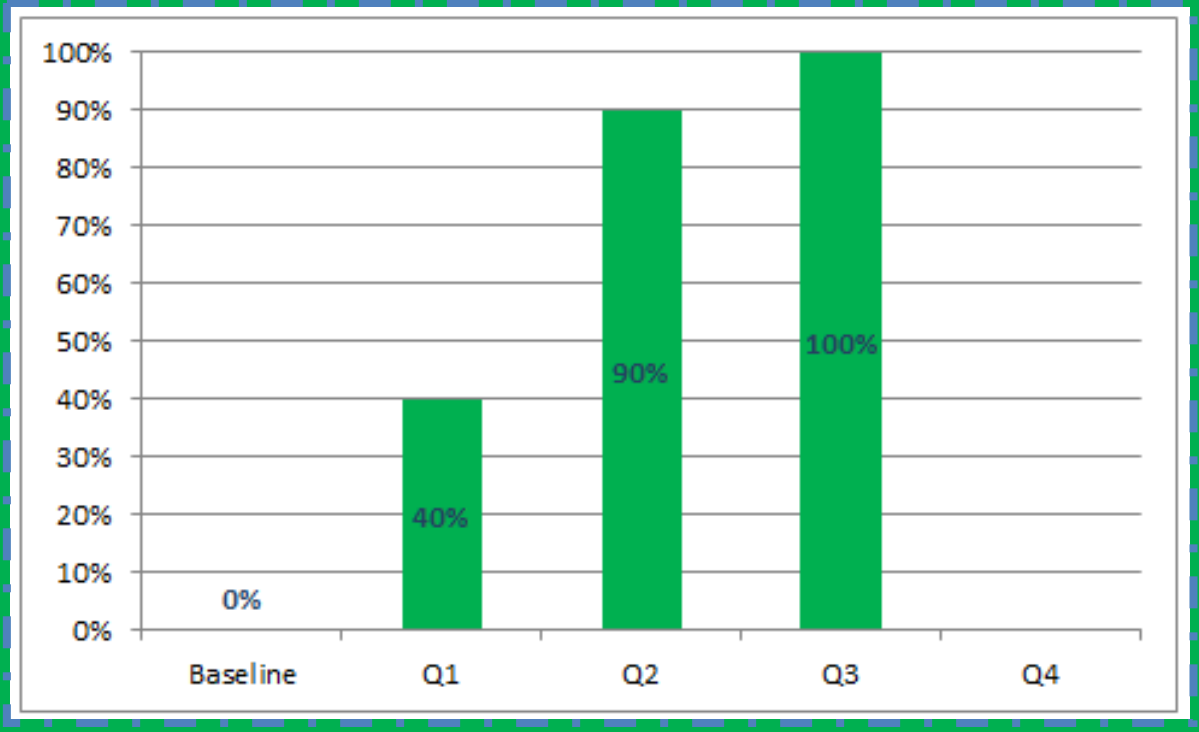
Key Activities:

-Created list to track non-VLS clients/latest labs

-Collaborated with regional EIS partner to find clients and address barriers

-Tracked non-VLS clients throughout year to help them become medically adherent and virally suppressed

Avg Clients: 10 Goal: 50%



Control

After testing out the non-VLS tracking list, Mercy Health decided that it did not factor into a patient becoming medically adherent, and will not continue to utilize it in the future.

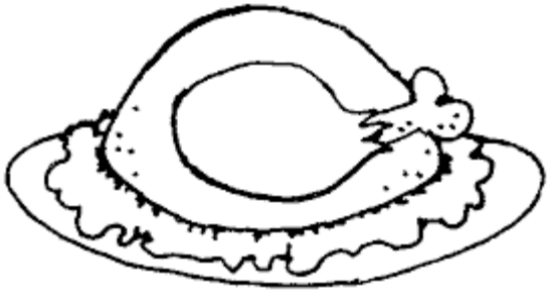
Through this process, Mercy Health found that communicating with clients via text message helped to address some barriers to care, so that method will continue to be used for clients who may be erratically in care.

MERCY HEALTH

Next Steps

- Data collection for Q4 of 2020 projects
  - Submission due early January to Part A office
- Start thinking of CY2021 Project Ideas
  - Look out for email to set up January meeting dates for project set up
- Slide Deck/Minutes will be emailed to CQMC soon
  - Also can be found at https://www.ccbh.net/ryan-white-provider-resources/

Happy Thanksgiving!



6 Feet

CCBH

Ryan White Part A Cleveland TGA

Ryan White Part A
Cleveland TGA

CUYAHOGA COUNTY

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