CUYAHOGA COUNTY BOARD OF HEALTH

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

Ryan White Part A CQM Committee Meeting
November 15, 2021– Virtual
La'Keisha James– Program Manager – ljames@ccbh.net

Agenda

- **1:00-1:10 Welcome, Introduction**
- *Zach Levar and La'Keisha James-Cleveland TGA*
- **1:10-1:20 Icebreaker**
- **1:20-1:35 Updates, Data, Survey Results**
- **1:35-2:25 QI Project Presentations**
- *Part A Funded Providers*
- **2:25-2:30 Break**
- **2:30-2:40 Trivia**
- **2:40-3:45 QI Project Presentations**
- *Part A Funded Providers*
- **3:45-4:00 Next Steps, Adjourn, Questions**
- *Zach Levar and La'Keisha James-Cleveland TGA*

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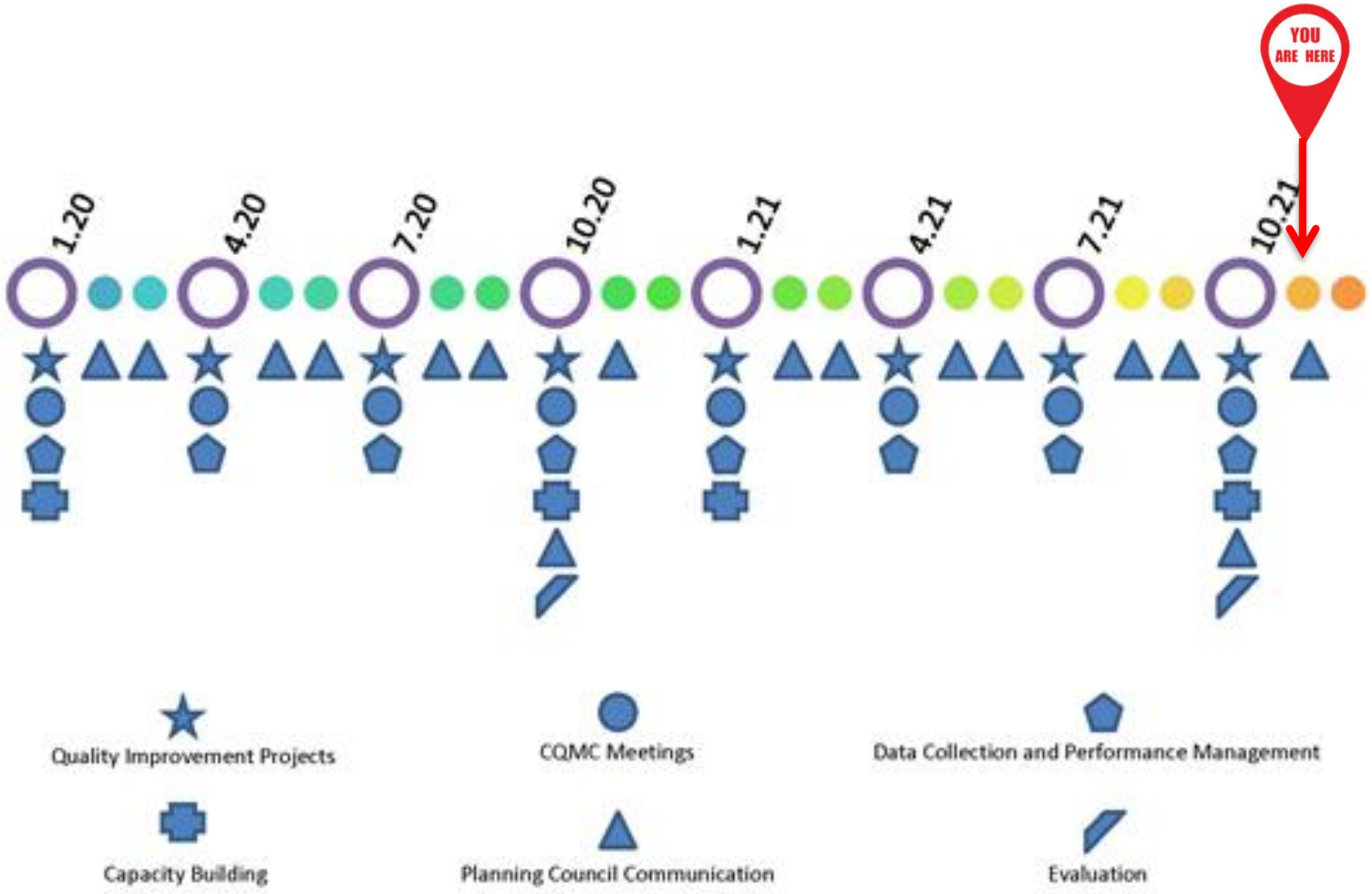
Introductions

Tell us a fun fact about yourself!

CQMC Timeline



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General Updates

- La'Keisha James will be the program lead for CLE Part A CQMC
- The Cleveland TGA had our HRSA site visit in mid-September 2021
  - As a result of some of the recommendations provided to us via HRSA, our CQMC will start to look different beginning in 2022
    - Collaborative Service Category Projects
    - Increased QI learning opportunities
    - More frequent CQMC meetings to update committee

CQMC Needs Assessment Survey

Survey Results

- 58% were either somewhat or not familiar at all with implementing QI tools such as PDSA, DMAIC, Fishbone Diagrams, Flowcharts, etc.

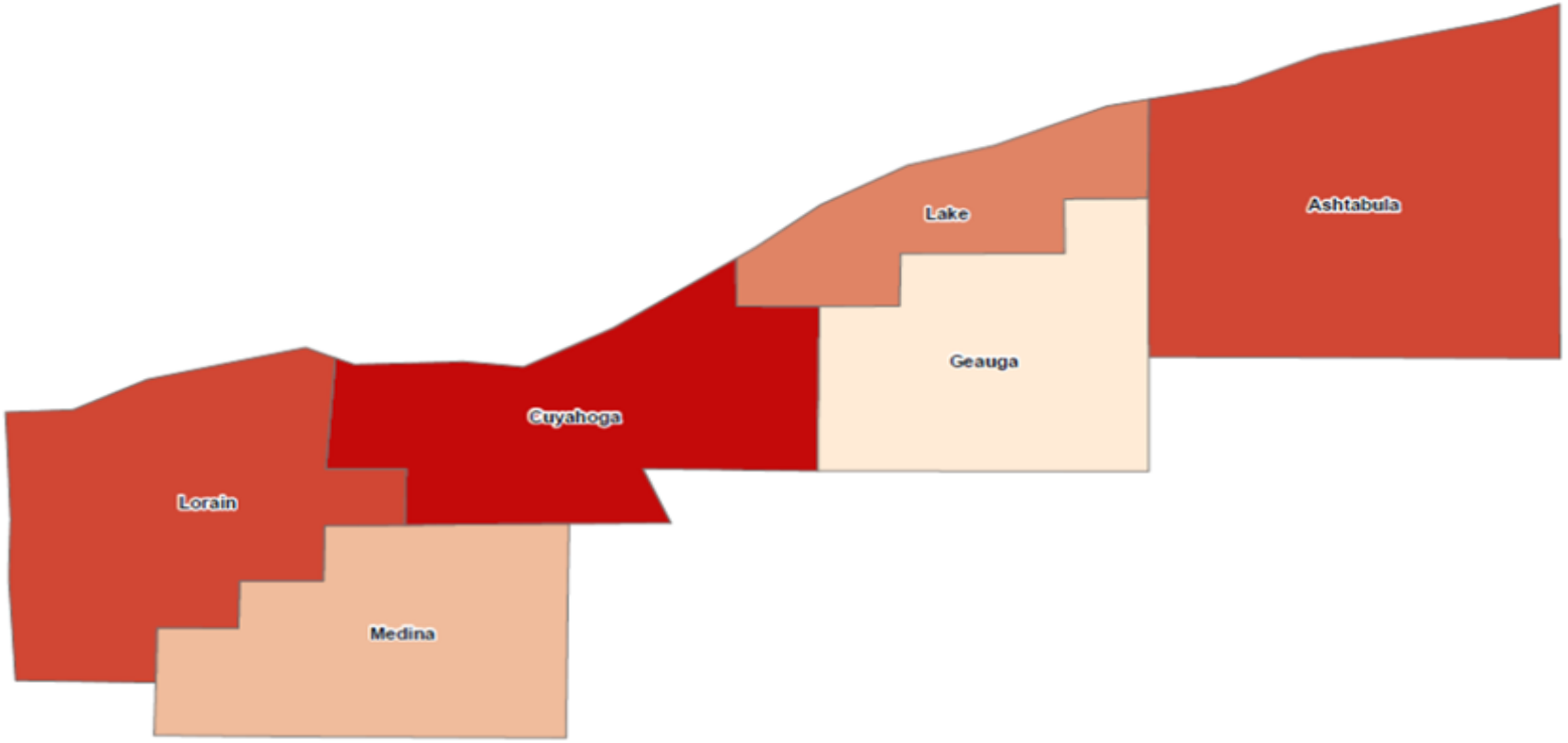
- 58% stated that outside of Ryan White QI projects providers have little to no experience at all completing QIP's.

- 92% were either somewhat or not familiar at all with Policy Clarification Notice (PCN) 15-02.

Survey Results continued

- 56% thought that core service categories would be most beneficial as a regional QIP in 2022 (OAHS, Medical Case Management, Oral Health Care).
  - Psychosocial Support was also mentioned as a support service category to focus CQMC efforts on.
- 45% stated trainings on QI tools, data collection, and trainings on best practices from other jurisdictions would be most beneficial.
- 45% stated that CQMC could help to support your team while implementing QIP's by continuing technical assistance

Cleveland TGA Data



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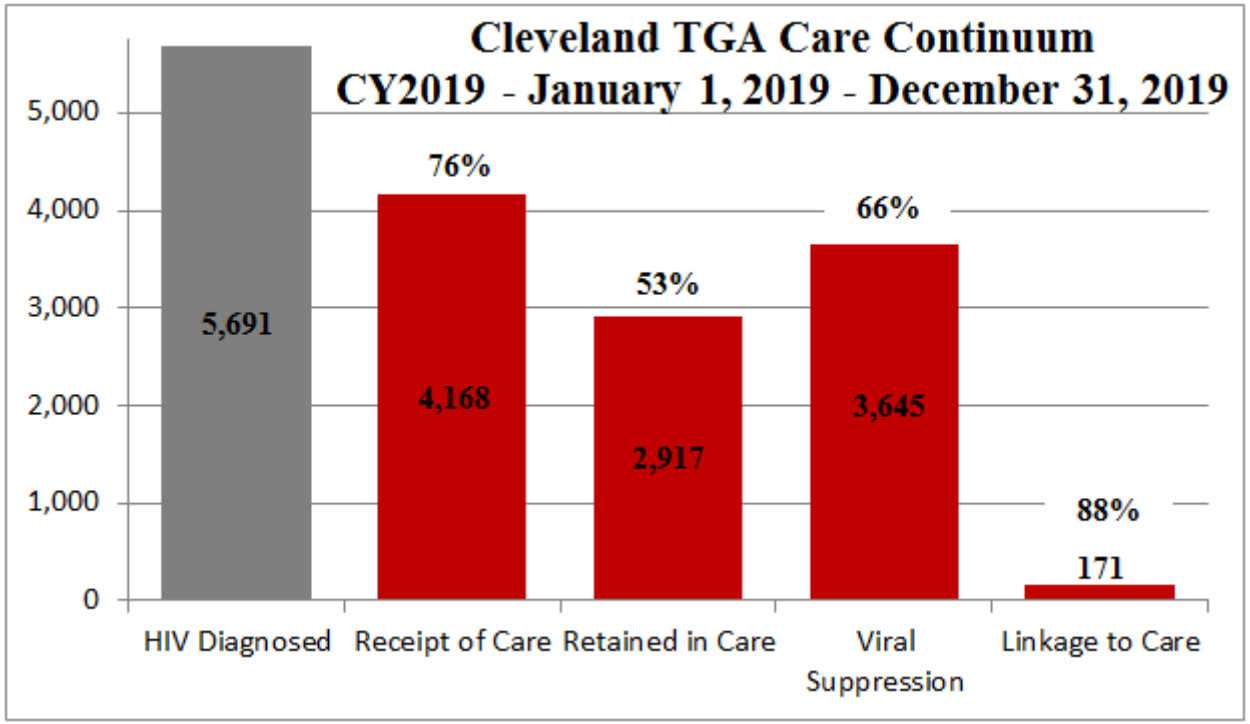
CDC Care Continuum



HIV Diagnosed	Number of persons aged ≥13 years with HIV infection in the jurisdiction at the end of the calendar year.	
Receipt of Care	**Numerator:**	Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load.
	Denominator:	Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.
Retained in Care	**Numerator:**	Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load.
	Denominator:	Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.
Viral Suppression	**Numerator:**	Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed.
	Denominator:	Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.
Linked to Care	**Numerator:**	Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load.
	Denominator:	Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.

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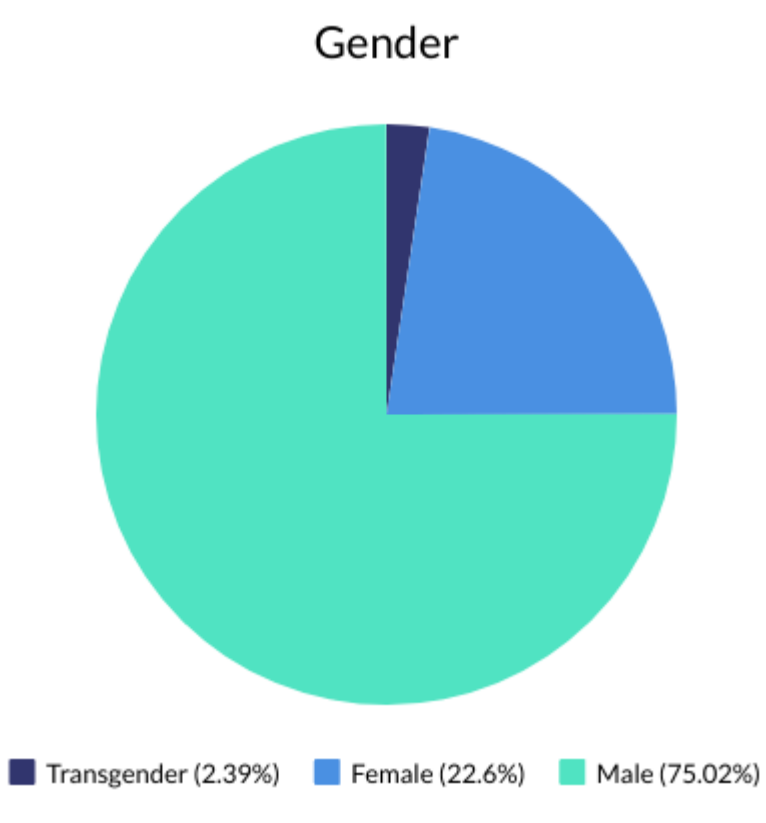
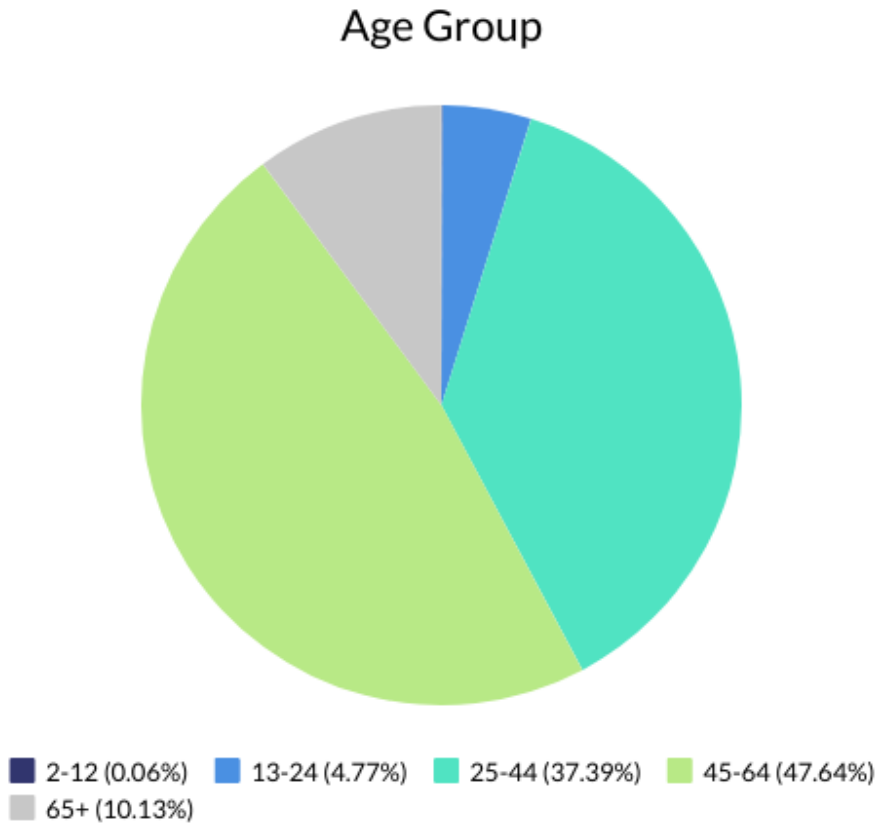
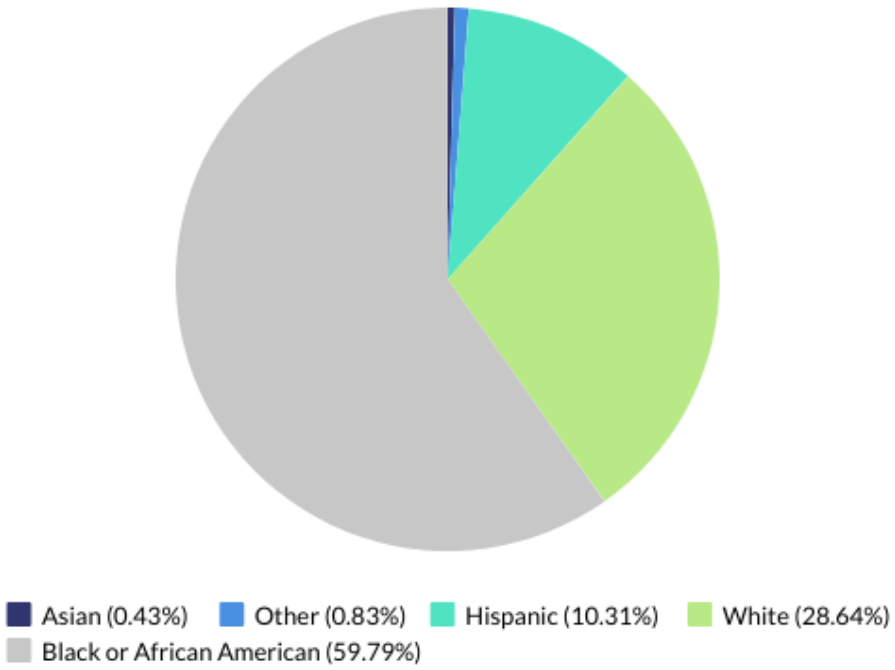
Part A Client Demographics



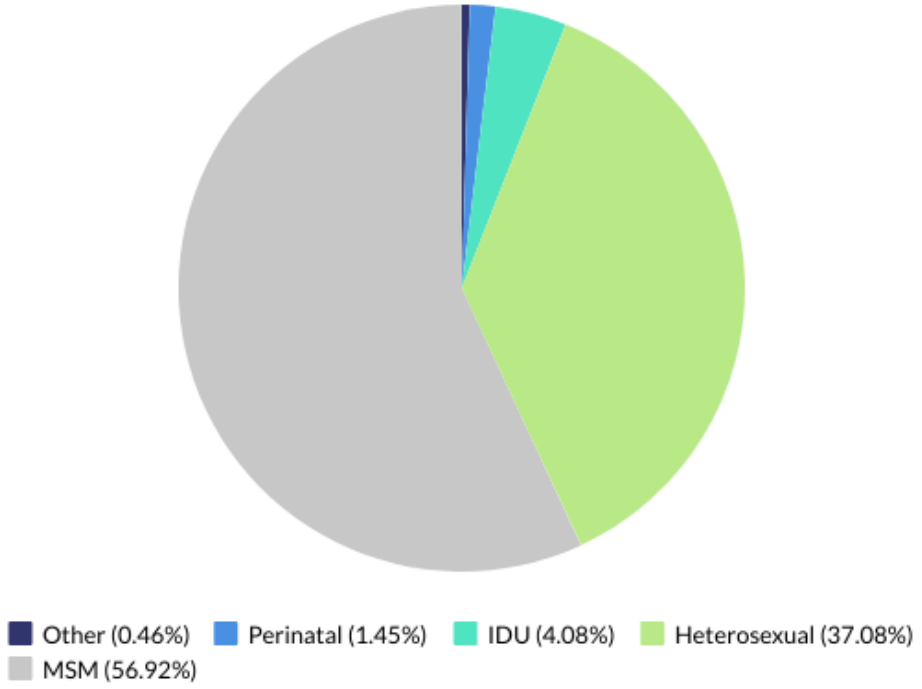


Part A Client Demographics

Race/Ethnicity



HIV Risk



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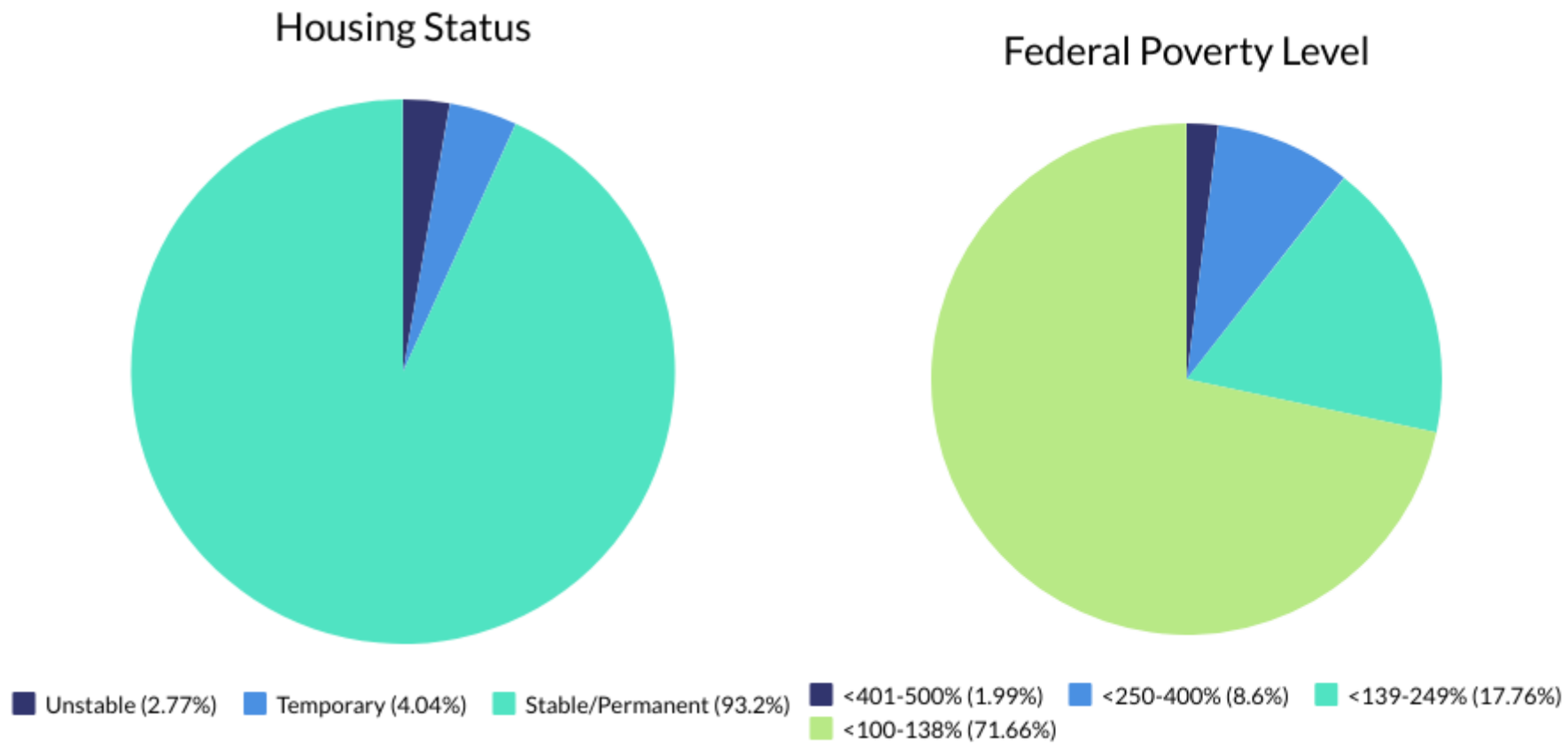
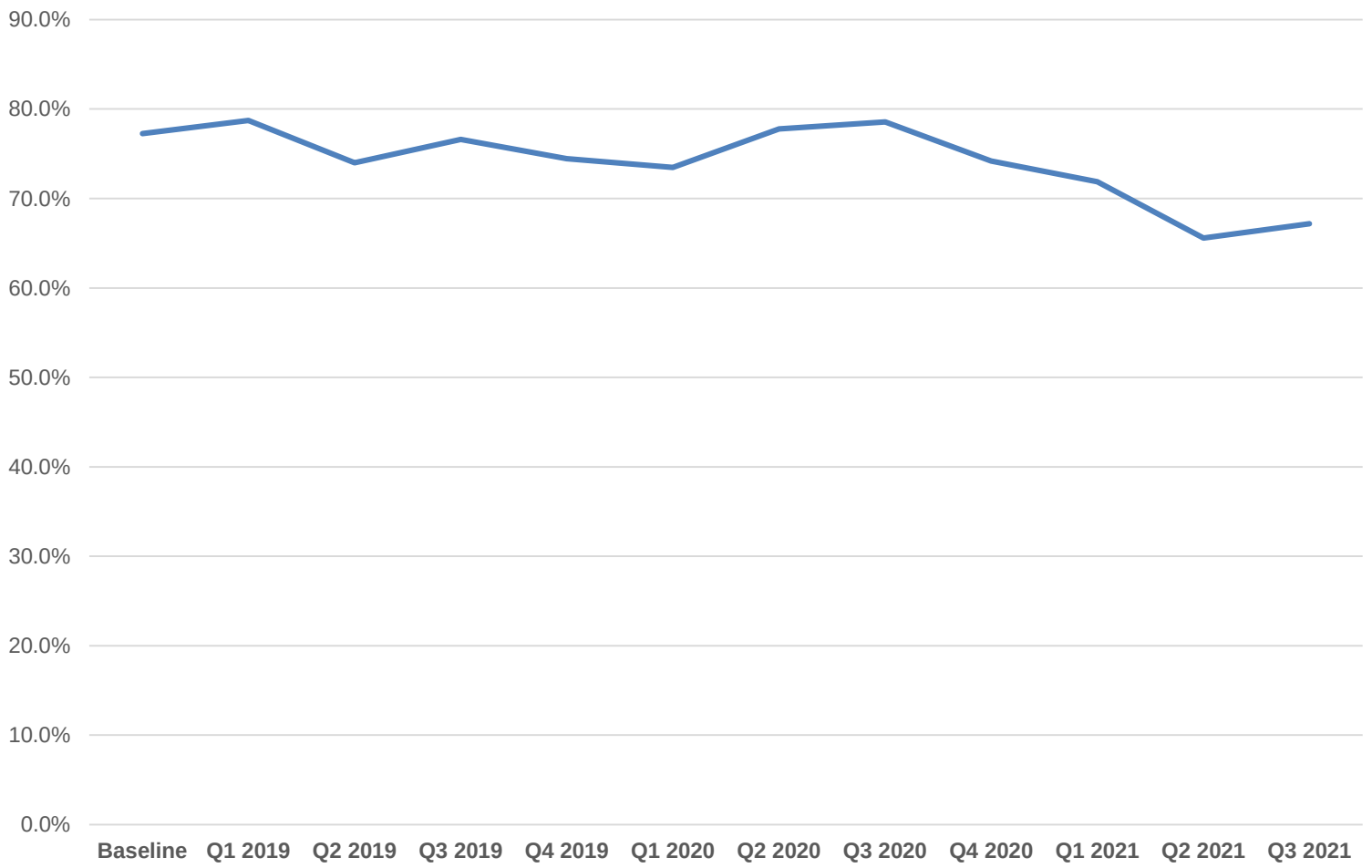
Part A Client Demographics



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%
Q1 2021	71.9%
Q2 2021	65.6%
Q3 2021	67.2%

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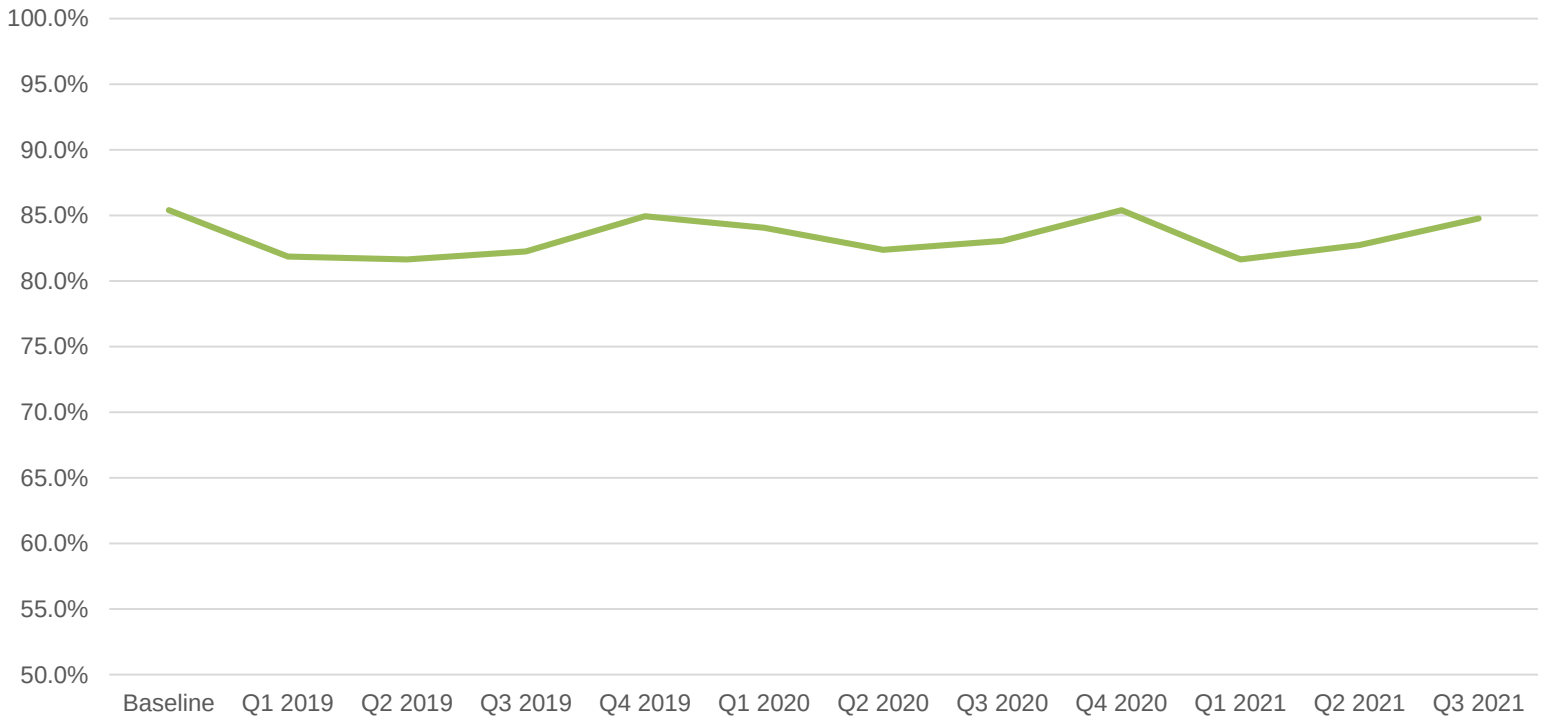
African American/Latina Women



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%
Q4 2020	85.4%
Q12021	81.6%
Q2 2021	82.8%
Q3 2021	84.8%

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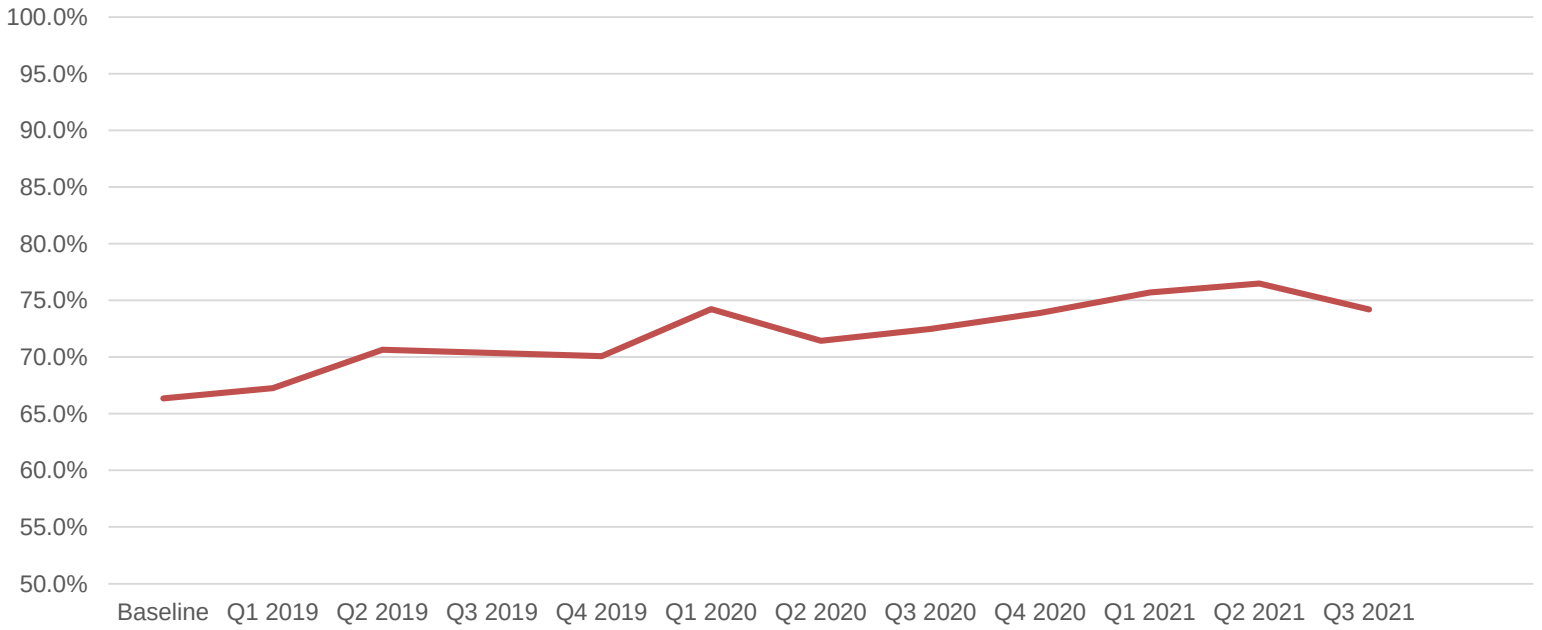
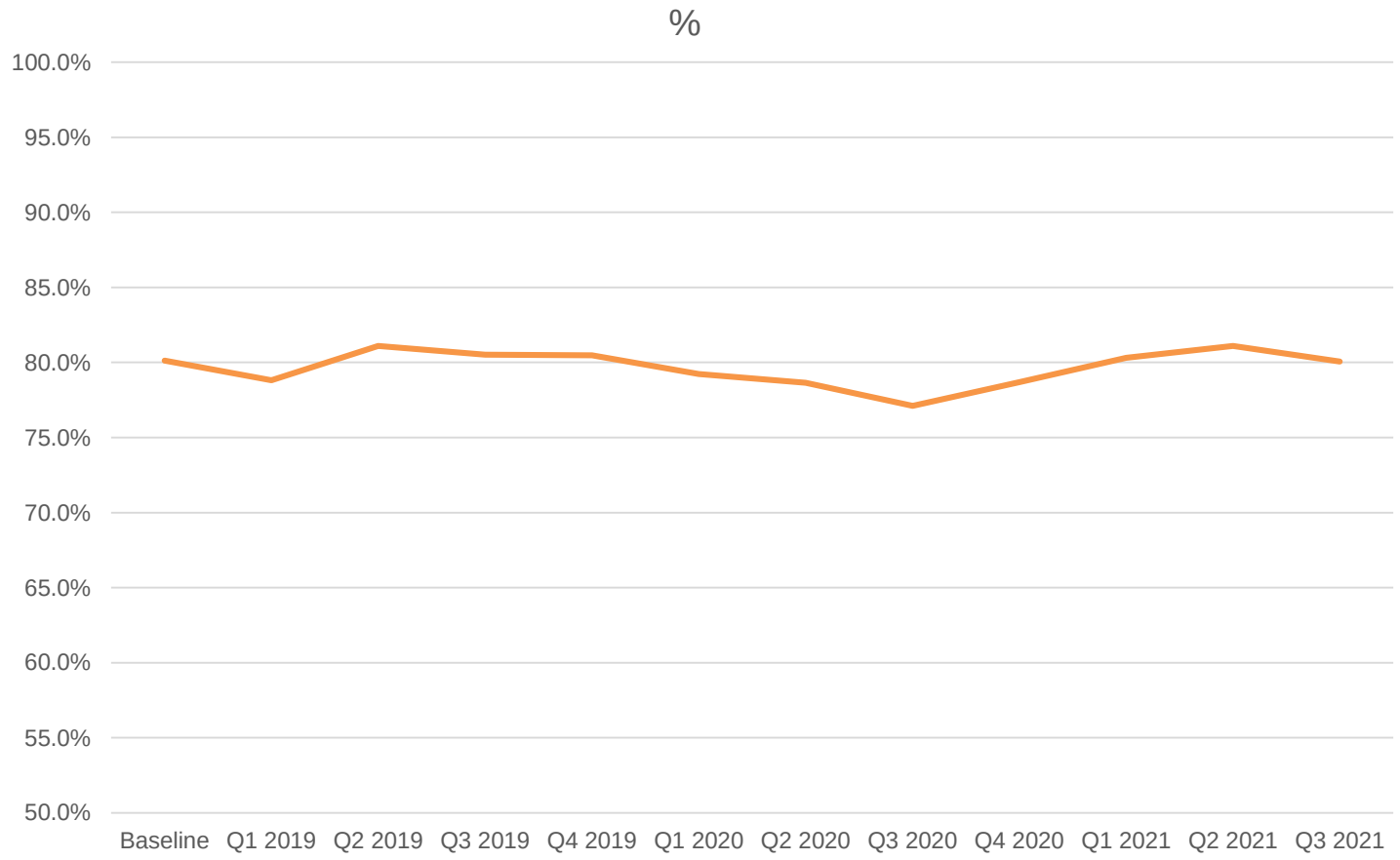
Youth (13-24)



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%
Q4 2020	73.9%
Q1 2021	75.7%
Q2 2021	76.5%
Q3 2021	74.2%

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%
Q4 2020	78.7%
Q1 2021	80.3%
Q2 2021	81.1%
Q3 2021	80.1%

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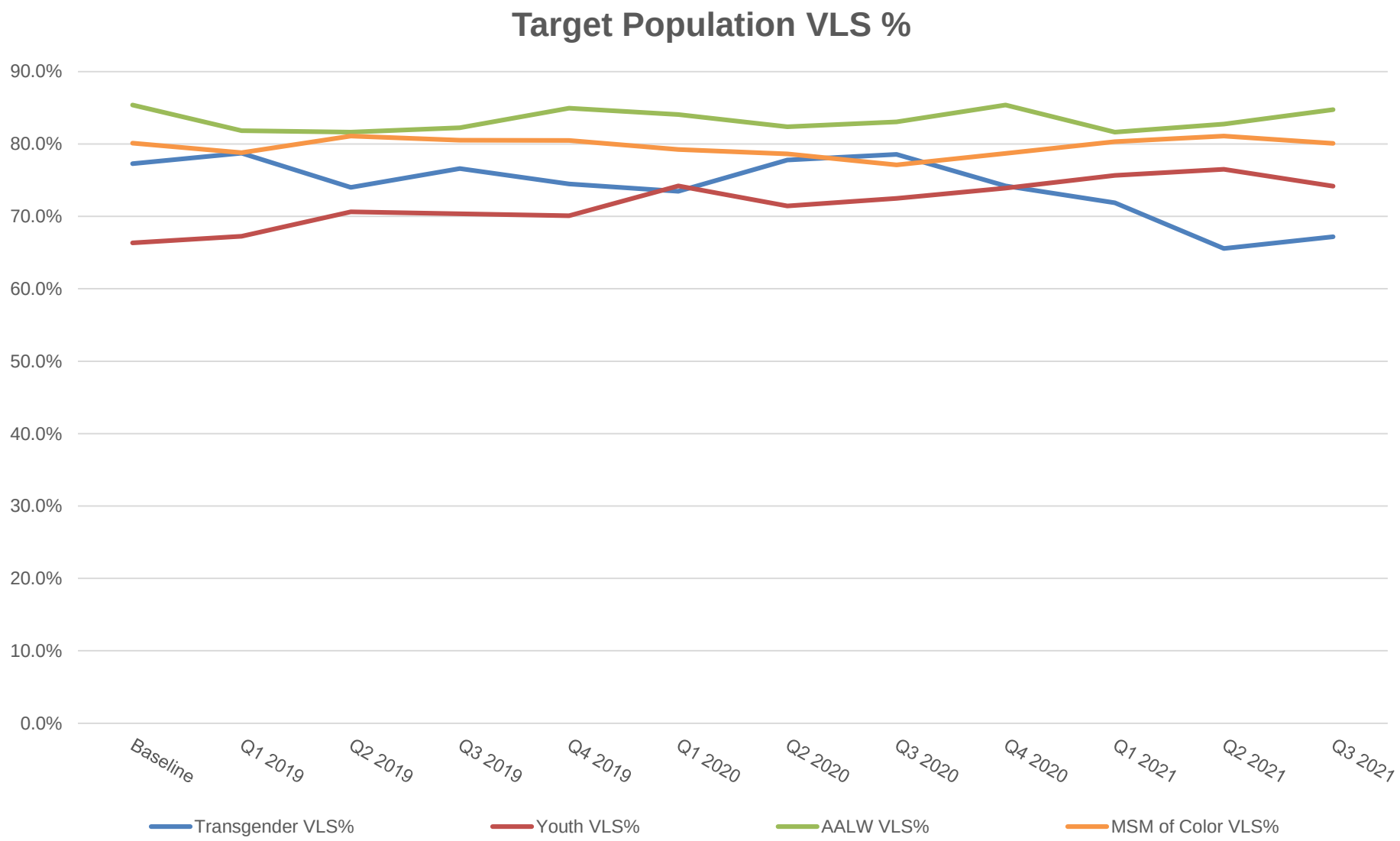
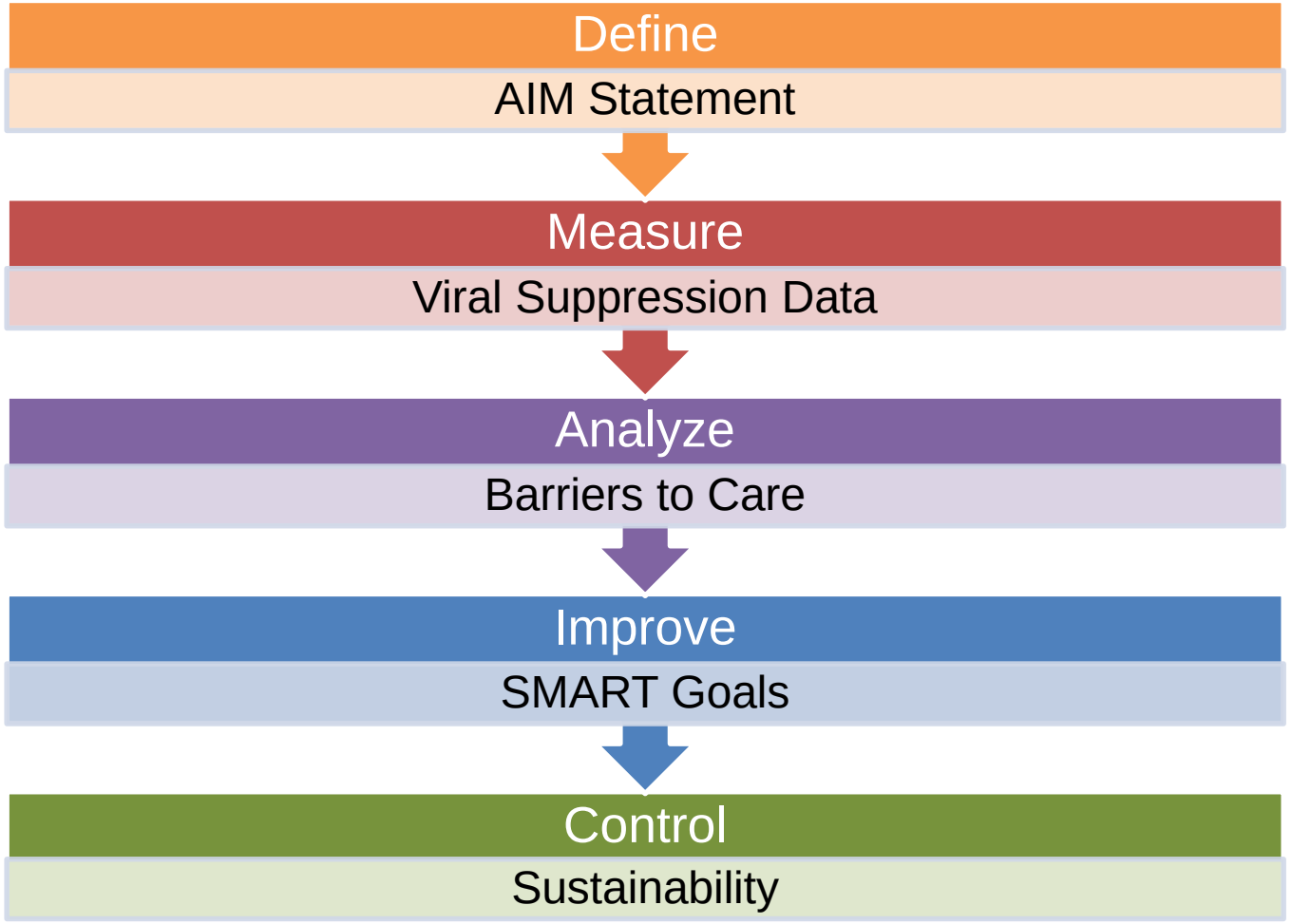
Target Population Overlay



Ryan White 2021
CQMC Efforts

DMAIC Process



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Providers' 2021 Target Populations

Part A Clients	• **AIDS Healthcare Foundation** • **CCF (MCM Clients only)** • **DSAS** • **Family Planning of Lorain** • **Far West Center** • **May Dugan** • **Signature Health**
MSM of Color	• AIDS Taskforce of Greater Cleveland • Circle Health • Nueva Luz URC
Youth	• MetroHealth (13-24) • University Hospitals of Cleveland
Non-VLS Clients	• Mercy Health • Neighborhood Family Practice

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CY2021 QI Overall Progress

Baseline	Quarter 1	Quarter 2	Quarter 3
180/379	188/310	214/303	241/343
47.5%	**60.6%**	**70.7%**	**70.2%**

AIDS Healthcare Foundation

AIDS Healthcare Foundation

AIDS Healthcare Foundation

AHF

- **Target Population: All Part A Clients.**

- **AIM Statement: By December 31st, 2021, AHF will improve VLS for all Part A clients from 52% to 65%.**

SMART Objective

AHF

- By March 1st, AHF will conduct analysis on current barriers non-VLS clients.
- By April1st, AHF will develop plans for an intensive outreach workgroup (meeting time, agenda and format).
- By May 1st, AHF will begin an intensive outreach workgroup that consists of staff members from various lines of business such as the Healthcare Center, Pharmacy, Case Management, BHC and come together to address non-VLS clients.
- By October 1st, AHF will conduct a follow-up analysis to see if the bi-weekly meetings had a positive impact on the non-VLS clients.

Intensive Workgroup Meeting

AHF

Agenda

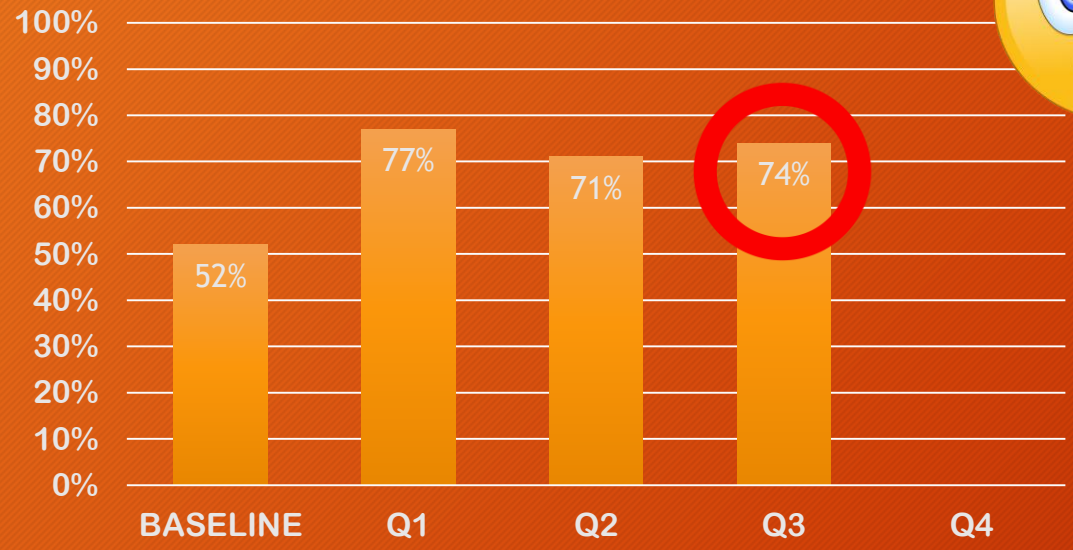
- We conducted bi-weekly intensive outreach meetings with one staff member from the HCC, Pharmacy, BHC and Case Management. Each meeting was 30 mins.
- Each staff member was given the list of non-VLS clients in which we discussed each client in detail.
- We narrowed down the barriers to care for each client.
- Each staff member left the meeting with a task to assist in getting these clients back into care.

Outcome

- Pharmacy was able to give updated phone numbers for 2 of the 9 clients and I was able to reach them and get appointments scheduled.
- Each case manager was sent an email with the list of clients. I asked that if any client listed was their client, to update me with any updated contact information. I was able to get 3 clients scheduled for appointments! ☺

Data Collection

AHF



We were able to surpass our goal of 65% to 74%!

Goal: Increase non-VLS from 52% to 65%

Control

AHF

- 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 with their care. We will continue our efforts of reaching the clients who are still not virally suppressed.

- In 2022, AHF will continue to implement these workgroups on a bi-weekly basis in efforts to continue to raise our VLS rate as well as expand population to all HIV+ clients in AHF care.

Aids Taskforce of Greater Cleveland

Intensive Case Management

Moving Black MSM's to Viral Suppression

Presented by:
Joye E. Toombs, LSW
Director of Services

Mission Statement

To provide linkage and retention to care for Black Same-Gender-Loving males, ages 18-29, who are newly diagnosed or who have fallen out of care and are not virally suppressed.

Purpose

BHC is committed to reducing the viral load to undetectable levels in all participants within 6-9 months of entering the program

Model of Intervention Delivery/Process Flow

Clients Referred to Intensive Case Management	Initial Appointment	Referrals	Barriers to Care Addressed	Ongoing Intensive Case Management
• Clients are referred internally by case management, AHF Clinic, externally by peers, agencies, hospitals and other organizations.	• Initial intake/assessment completed, new patient questionnaire reviewed, ROI's & labs requested	• Pharmacy, AHF Clinic, Housing, Food Pantry, Substance Abuse, Mental Health, Dental, Optical referrals made	• Transportation, Housing, Schedule conflicts, and other barriers to care are addressed and ISP is created	• Case Manager provide minimum weekly contact with client

Intensive Case Management Timeline:

1. Case Manager **makes contact with client within 2 days of referral to schedule initial appointment**
2. Case Manager **completes initial intake and assessment of client**
3. **Referrals made** to substance abuse, mental health, and other services as well as facilitating rapid institution of prophylactic medications, where applicable
4. After initial appointment, **client and Case Manager are scheduled to meet weekly**
5. Case Management continues for until **client reaches undetectable viral load count** to ensure that the client does not fall out of care by keeping all scheduled medical appointment and adhering to all medication schedules as prescribed.

Thank you!

Circle Health

CIRCLE HEALTH SERVICES/ THE CENTERS
RYAN WHITE PART A
VIRAL LOAD SUPPRESSION PROJECT 2021

Adriana T Whelan, DNP, CNP, AAHIVS, Assoicate Director of Primary Care and HIV Programs.
Brittany Hinton, LSW
Naimah O'Neal, MSM, LSW
Fatima Warren, Director of Operations

THE CENTERS
Health. Family. Work. **Hope.**

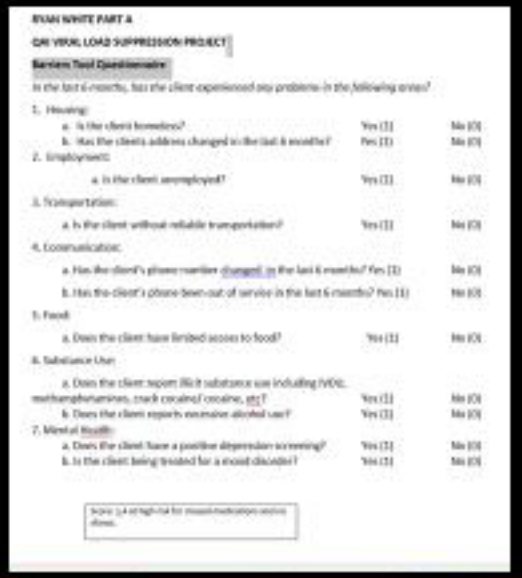
HEADQUARTERS
4500 Euclid Avenue | Cleveland, Ohio 44103
216.432.7200 | thecentersohio.org |

AGENCY OVERVIEW

- The Centers for Families and Children and Circle Health Services, which affiliated in 2017, operate under a shared leadership structure to provide an integrated model of healthcare, coordinating health and wellness services, including Primary Care for children and adults, Behavioral Health, Addiction Services, HIV treatment and Prevention (Syringe Exchange, HIV Testing) , In-house Pharmacy, Dental, Early Childhood Learning, and Workplace Development.

PROJECT OVERVIEW

- Overall Objective:
  - The objective of our project was to focus on all clients who were not virally suppressed (non-VLS) and identify barriers to care that were impacting adherence to treatment recommendations and engagement in care.
- Project Goals
  - By December 31st, 2021, Circle Health Services will improve VLS for non-VLS clients from 0% to 50%.
- Tools and Resources
  - Barrier Tool Questionnaire
    - Housing, Employment, Transportation, Communication, Food, Substance use, Mental Health
  - Intensive Case management
    - Home visits, Weekly check-ins
  - Transportation assistance



RYAN WHITE PART A

CAI: VIRAL LOAD SUPPRESSION PROJECT

Barriers Tool Questionnaire

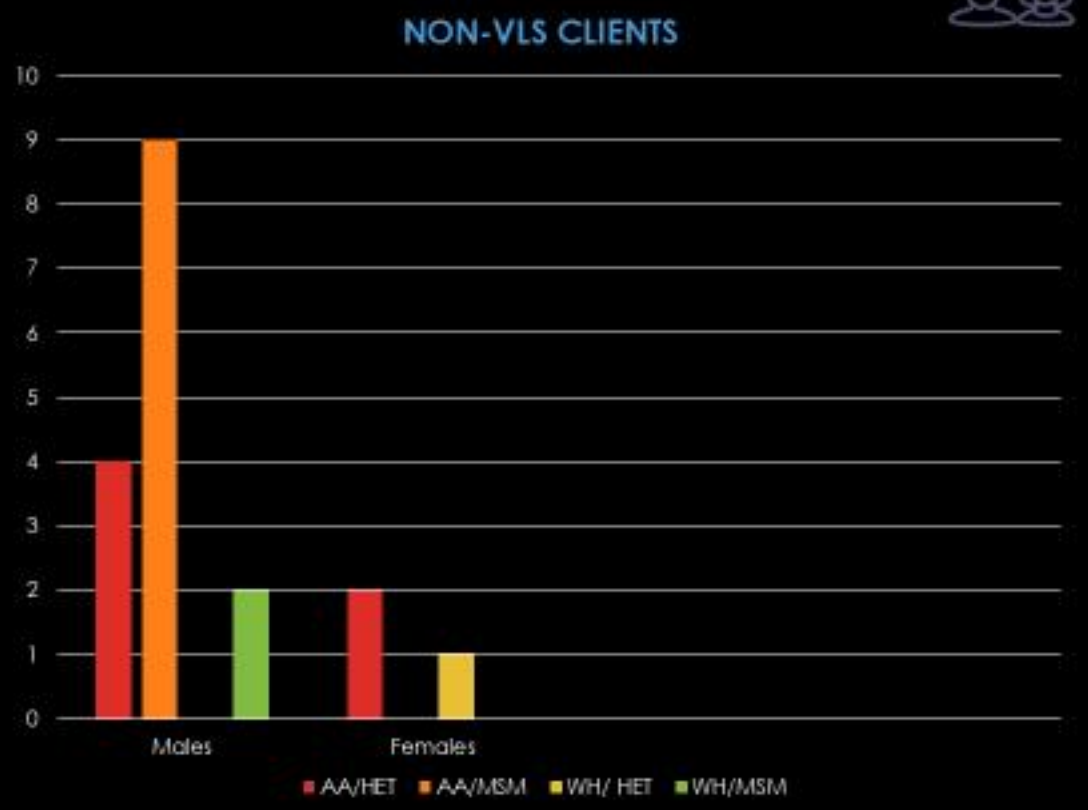
In the last 6 months, has the client experienced any problems in the following areas?

1. Housing:
   a. Is the client homeless? Yes (1) No (0)
   b. Has the client's 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 Health:
   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: 1-4 at high risk for missed medication access/ illness.

DESCRIPTION PATIENT POPULATION

- Total number of patients: 18
- African- American/ African
  - Female (Heterosexual, WSW)
    - Heterosexual: 2
  - Male (Heterosexual, MSM)
    - Heterosexual: 4
    - MSM: 9
- Caucasian
  - Female (Heterosexual, WSW)
    - Heterosexual: 1
  - Male (Heterosexual, MSM)
    - MSM: 2



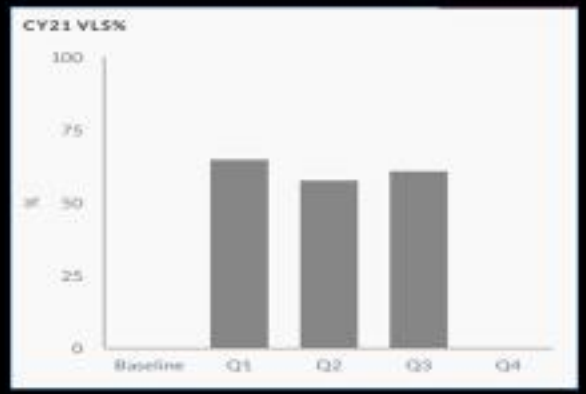
PROJECT OUTCOMES

- ✓VLS is 61%
- ✓Barriers to Care (15/18 completed questionnaire)
  - ✓ Mental Health
  - ✓ Communication (Change in phone numbers)
  - ✓ Transportation
  - ✓ Insurance Coverage
  - ✓ Fear of COVID *
- ✓Impact of Intensive Case Management
- ✓Project sustainability

*Not in questionnaire

VLS (1/1/21 to 8/31/21) among clients who were initially Non-VLS

	VLS Numerator	Non VLS Denominator	VLS %	Total patients
Baseline Agency Totals	0	18*	0	119
MSM of Color	6	9	67%	69
Other	5	9	55%	50



QUESTIONS

Cleveland Clinic Foundation

Cleveland Clinic

CQMP

- 2021
- Cleveland Clinic
- Mary Beth Gramuglia & Kelly VanDerSchaegen

Project

- Increase VLS for Part A MCM clients from 71% to 76%

Analyze

Barriers to Care

- Insufficient lab data record keeping mechanism
- Failure to complete lab orders by client
- Substance abuse
- Mental health concerns

Define

Insufficient lab data record keeping mechanism

Contributing Factors

- Basic Excel spreadsheet
- CareWARE
  - Manually load lab data

Process Improvement

- Enhanced Excel functionality
- Consider EMR/Epic automatic report

Define

Failure to complete lab orders by client

Contributing Factors

- ID lab closed d/t Covid protocols (reopened summer 2021)
- ? Client interpretation from provider
- Internal process precludes lab draws during appointment

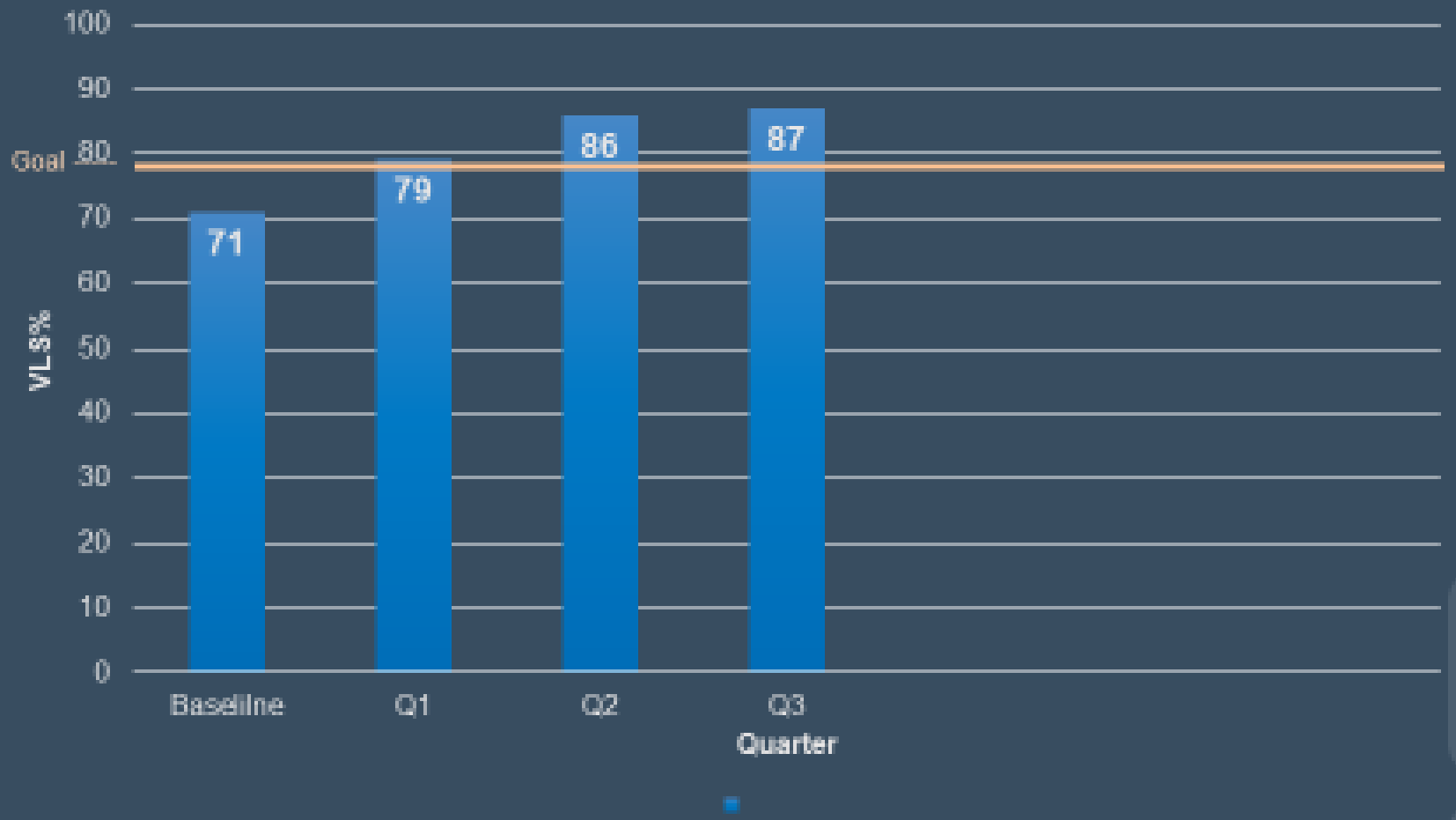
Process Improvement

- Provided navigational maps/assistance to designate labs
- Increased signage
- Client accompaniment to lab
- Constant messaging
- Outreach

Signage


DON'T FORGET!!
Cleveland Clinic
BEFORE YOU GO, PLEASE VISIT THE LAB ON YOUR WAY OUT!

CY21 VLS%


100
90
Goal 80
70
60
50
40
30
20
10
0
VLS%
71
79
86
87
Baseline
Q1
Q2
Q3
Quarter

Key Takeaways

- Enhanced data organization allows for optimal record keeping and early identification of clients due/overdue for lab work.
- Continue w/constant messaging to reinforce lab work is completed same day.
- Continue dialogue w/providers both independently and via monthly Delta meetings.
- Consider utilizing an identification/communication tool in pt's EMR to notify providers that RW labs are due.

Cleveland Clinic

100 YEARS

EST. 1921

THE FUTURE OF HEALTHCARE SINCE 1921

DSAS

HOME CARE SKILLED SERVICES

The Cuyahoga County Division of Senior and Adult Services

Quality Improvement Project 2021

Using CodeRED/ReadyNotify

- The Home Support 2021 Quality Improvement Project focused on notifying Part A recipients on available community resources via robocalls made by the Cuyahoga County CodeRED/ReadNotify Alert System.

- This system is the same system used to communicate emergency information and general information to Cuyahoga County residents, who are in the database.

Increasing Medical Compliance via Barrier/Stress Reduction

- The purpose of this QI project was to reduce stress for PLWHA by notifying them of various resources available in the community. Accessing resources such as food assistance, financial assistance, utilities assistance, etc. may make it easier for the Part A recipients to become medically compliant and actively engage in their medical care if they are not worrying about other matters.
- Stress reduction may lead to increased medical compliance which may lead to increased viral load suppression for the DSAS clients.

QI Project Methodology

- Bi-weekly telephonic messages and email messages were recorded/composed by the DSAS Director of Nursing.
- The recorded/composed messages were informational messages about free resources available on specific dates/locations/times throughout Cuyahoga County. Instructions were provided on how the resource could be acquired.
- These messages were sent to all of DSAS' Part A recipients. The call data was tracked and it was noted that 65%-75% were regularly listening to the message when the call was initiated. The other 25%-35% of calls may have gone to voicemail or went unanswered.

QI Project Methodology Continued

- Anecdotally, the Part A recipients were queried by the nurse/home health aides to determine if the messages were being well received.
- The Part A recipients consistently had positive comments regarding the messages.
- QI Project Goal increase VLS rate from 92% to 96%.

DATA/Outcomes

- 1st Quarter – Viral Load Suppression Data:
- -Total Part A caseload = 26 clients
- -Total clients virally suppressed = 24
- -Viral Load Suppression Rate: 24/26 = 92.3%

- VLS Rate increase by 0.5% overall.
- The goal of 96% was not reached.

BARRIERS to SUCCESS

- - Small caseload with a fluctuation in clients serviced.
- - Limited feedback for the Part A participants.
- - No predictability with community resources available at any given time.
- - COVID rates negatively impacted availability of resources.

PLAN Post QI Project

- Continue providing this notification service on a monthly basis.
- Solicit Part A recipients regarding what types of resources are needed.
- Remind the Part A recipients of the monthly robocall not being spam or fraudulent in purpose.

DATA/Outcomes Continued

- 4th Quarter Data (thus far) – Viral Load Suppression Data:
- -Total Part A caseload = 28 clients
- -Total clients virally suppressed = 26
- -Viral Load Suppression Rate: 26/29 = 92.8%

Family Planning Service of Lorain County

Family Planning Services of Lorain County

QI Project 2021-2022 Early Intervention/Transportation Services

Local resource guide For Lorain County

Process:

- RW Coordinator reviewed referrals she provided to past clients and compiled a list.
- RW Coordinator and FPS volunteer expanded the list and confirmed contact information.
- Shared list with Mercy Hospital and Lorain County Public Health to get feedback – Referrals are not meant to be all inclusive.
- List of referrals developed into a booklet.
- Booklet reviewed and approved by CAB committee on October 12, 2001.

Next Steps:

- Make copies to distribute to other Lorain County RW Part A Service Providers.
- A booklet will be given to each Early Intervention patient.
- Put booklet on Family Planning Services Website.
- Update booklet annually.

Local Resources

Family Planning Services of Lorain County

This resource booklet was made possible with funding from The Ryan White Part A Program

11/2021

Food Pantries

Nueva Luz Urban Resource Center
221 West 21st St, Suite 1, Lorain, OH 44052 (**440)233-1086**
www.nlurc.org

Catholic Charities Family Center
2726 Caroline Ave, Lorain, OH 44055 (**440)242-0056**
www.ccdocle.org/locations/st-elizabeth-center

Lorain Christian Temple
940 W. 5th St, Lorain, OH 44052 **(440)244-5883**
www.loraindisciples.org

The Love Center Food Cupboard
1405 E. 28th St, Lorain, OH 44052 **(440)288-2029**

Faith Ministries Christian Center Food Pantry
1306 Euclid Ave, Lorain, OH 44052 **(440)288-3622**

We Care We Share Ministries
1888 E. 31st St, Lorain, OH 44055 **(440)714-2690**

Commodore Cupboard (for LCCC students only)
1005 Abbe Rd, N. Elyria, OH 44035 440-366-7486
commodorecupboard.edu

Rent/Utility Assistance

Nueva Luz Urban Resource Center
221 W 21st St, Suite 1, Lorain, OH 44052 **(440) 233-1086**

Catholic Charities Family Center
2726 Caroline Ave, Lorain, OH 44055 **(440) 242-0056**

Neighborhood Alliance
424 Earl Ct, Elyria, OH 44035 **(440) 284-9724**

Lorain County Community Action Agency
936 Broadway Ave., Lorain, OH 44052 (440)245-2009
Home Energy Assistance Program
www.lccaa.net

Housing

Nueva Luz Urban Resource Center
(440)233-1086 www.nlurc.org

Lorain Metropolitan Housing Authority (440) 288-1600
www.lmha.org

Faith House (Transitional Living for Women) (440) 277-4430
1561 E. 30th St, Lorain, 44055

Blessing House
(for Children while parent/guardian recovers)
5440 Grove Ave, Lorain, OH 44055 **(440) 240- 1851**

Landlord Leasing
5075 Oberlin Ave, #B, Lorain, OH 44053 **(440) 246-6217**

Neighborhood Alliance Haven Shelter (Emergency Shelter)
1536 E, 30th St, Lorain, OH 44055 **(440) 242-0455**

HIV Labs

Mercy Health- Lorain Infectious Disease
221 W. 21st Street, Suite 1, Lorain, OH 44052 **(440) 233-0138 or**
Mercy Health – Lorain Hospital
3700 Kolbe Rd, Lorain, OH 44053 **(440) 960-4000**

UH Elyria Medical Center
630 E. River St, Elyria, OH 44035 **(440) 329-7500**

Quest Diagnostics
Liberty Point Building, 1268 E. Broad St, Elyria, OH 44035
(440) 366-7500

Fisher-Titus Medical Center
272 Benedict Ave, Norwalk, OH 44857 **(419) 668-8101 or**
24 Hyde St, Wakeman, OH 44889 **(440) 839-2226**
www.fishertitus.org

Cleveland Clinic Elyria Family Health & Surgery Center
Desk C, 303 Chestnut Commons Dr, 2nd Fl, Elyria, OH 44035
440-396-9444

Labcorp at Walgreens
1925 W. Market St, Akron, OH 44313 **(330) 278-0700**

Drug/Alcohol Recovery

The LCADA Way (Inpatient & Outpatient)
2115 W. Park Dr, Lorain, OH 44053 **(440) 989-4900**
www.thelcadaway.org

Primary Purpose (Sober Living Homes)
3222 N. Ridge Rd, Elyria, OH 44035 (**440) 219-4774**
www.primarypurposecenter.com

AppleGate Recovery (Outpatient Treatment)
833 E. Broad St. Unit-1, Elyria, OH 44035 **(440) 472-1924**
www.applegaterecovery.com

Silver Maple Recovery (For Men)
2101 Silver Maple Way, Lorain, OH 44053 **855-762-7531**
www.silvermaplerecovery.com

Alcoholics Anonymous
710 Broadway, Lorain, OH 44052 (**440)246-1800**
www.aalorain.org

Urban Minority Alcoholism and Drug Abuse Outreach Program
(UMADAOP) **(440) 246-4616**
2314 Kelly Pl, Lorain, OH 44052

Narcotics Anonymous
www. Wordpress.naohio.org **1-888-438-4673**

Documents/License/ Birth Certificates

Ohio BMV
4340 N. Leavitt Rd., Lorain, OH 44053 (**440) 244-5445 or**
605 Chestnut Commons Dr., Elyria, OH 44035 (**440) 322-0723**
www.bmv.ohio.gov **(Driver's License, State I.D.)**

Lorain County Public Health
9880 Murray Ridge Rd, Elyria, OH 44035 (**440) 322-6367**
www.loraincountyhealth.com/ **(Birth Certificate)**

American Red Cross
2929 West River Rd. N, Elyria, OH 44035 (**440) 324-2929**
www.redcross.org/local/ohio/northern-ohio.html **(Veteran's Benefits)**

U.S. Social Security Administration
2210 W. 5th Street, Lorain, OH 44052 **1-800-722-1213**
https://www.ssa.gov **(Disability, retirement)**

Transportation

Lorain County Transit Customer Service (440) 329-5525
www.loraincounty.us/commissioners-departments/transit

Provide A Ride 888-288-7050
www.providearide.com

Pegasus Transit LLC (440) 989-2123
www.pegasustransitllc.com

Who we are:

Our Mission:

Family Planning Services of Lorain County strengthens our community by providing accessible reproductive healthcare and education services.

We Are Confidential:

No records will be discussed or sent out without your permission except if required by law- reporting some sexually transmitted infections, sexual or physical abuse of minors, and homicidal or suicidal intent.

We Are Affordable:

Our fees are based on a sliding scale, based on your household income and the number of people who depend on you for support. If you have little or no income, you may be able to receive services at no cost through our Title X or Ryan White grant. We accept many major insurances as well as Medicaid. No one will be turned away for an inability to pay.

Contact Us:

We are located off Lorain Blvd, on the corner of Midway Blvd. and Leona Street.

Family Planning Services of Lorain County
602 Leona Street
Elyria, OH 44035
Phone: (440) 322-7526
Website: familyplanningservices.org

Family Planning Services Of Lorain County

Far West

Far West Center

QI Project 2021

The Project and Components

- Continue the 100% VLS rate
- Target October 1st
- Process: A simple questionnaire in which clients could identity on a scale how much the pandemic affected their lives to better understand thoughts, values, and beliefs that might lead one to decline the vaccine.

What was measured?

- 1. Quality of Life
- 2. Ability to Manage Symptoms
- 3. Feelings of Empowerment, and
- *1) Have you received the Covid-19 vaccine?*
- *2) If no, do you plan to receive it?*
- *3) If not, why?*

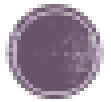
The analyzed data

- Of 10 clients
  - 5 participated in the survey
  - 4 declined
  - 1 could not be reached

Quality of Live average 2.8
Symptoms Management 2.6
Empowerment 2.8

4 out of 5 clients were already vaccinated

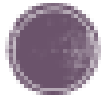
Narrative data: Powerlessness, Hopelessness, Helplessness, *Fear*



Strengths and Weaknesses

- Weaknesses:
  - 50% participation rate – Why? Fear?
  - small population
- Strengths:
  - insights into how strongly this pandemic affected our clients living with HIV/Aids
    - strong impact on respondents' well-being and challenges to their resiliency
    - news coverage and other media affected the respondents in influencing their views and reactions to the pandemic

100% VLS continues



Moving Forward

- The study could be applied to our entire population so that we may better understand the pandemic's impact on their quality of life, ability to manage their symptoms, and feelings of empowerment.

Break (5 minutes)

Cleveland Themed Trivia Game!

Question #1:

What system is unofficially called “The Emerald Necklace?”

Question #2:

What is the name of the oldest African-American theatre in the US?

Question #3:

What famed superhero was created by a pair of pals from Cleveland's East Side?

May Dugan

May Dugan Center Ryan White QI Project

Dylan Dickinson MSSA LSW

Anne M. Spelic LISW-S

Project Description

By December 31st, 2021, May Dugan will maintain VLS for HIV+ mental health clients at 100%

How?

Relationship Development & Engagement flow chart

Measures

Viral Load Suppression

Client consistency

Erratic attendance

Analyzed Data

- Q3 and complete CY2021 data, received on 11/2, states 100% VLS and data collection

Strengths/ Growth Opportunity

Operationalized unique rapport building ability, new perspective and connections of new practitioner, adaptability of engagement methods

Learning curve of new practitioner, COVID anxiety, isolation, client attrition

Future

- Operationalized engagement plan helps ensure consistency and transparency of process
- Adjust as necessary for clients
- Expand community partnerships
- Close service gap of Cleveland's far westside, western Cuyahoga County and eastern Lorain County

Mercy Health


MERCY
HEALTH
LORAIN
QI PROJECT
2021

PROJECT GOAL

To give our patients, the tools and support they need, to overcome the barriers, that are keeping them from proper care and viral suppression.

We chose to focus on this issue, because we have a smaller patient population, therefore allowing us to give more individualized attention to each patient's specific needs.

OVERCOMING BARRIERS TO CARE, FOR VIRAL SUPPRESSION

MEASURABLE COMPONENTS

VIRAL LOAD

CURRENT VL

PREVIOUS VL

DATES EACH PATIENT'S LABS ARE DRAWN & RESULTED

DATES EACH PATIENT'S LABS ARE DUE TO BE DRAWN BY

ENCOUNTERS

ANY AND ALL CONTACT WE HAVE WITH EACH PATIENT

APPOINTMENTS

REMINDER CALLS

MEDICATION REFILLS

FOLLOW UP CALLS

BI-WEEKLY CHECK INS WITH EACH INDIVIDUAL PATIENT

ECT.

BARRIERS

WE WORK ONE ON ONE, WITH EACH PATIENT TO TRY AND DETERMINE WHAT "BARRIERS" ARE KEEPING THEM FROM CARE, THUS KEEPING THEM FROM BEING VIRALLY SUPPRESSED

A FEW EXAMPLES OF BARRIERS OUR PATIENTS ARE FACING:

- HOUSING - MEDICATION COST
- LACK OF SUPPORT - ADDICTION
- MENTAL HEALTH - STIGMA
- LACK OF TRANSPORTATION
- ... AND THE LIST GOES ON

RESOLUTION/PLAN

ONCE WE IDENTIFY THE BARRIER(S), OUR PATIENTS ARE FACING, WE CREATE A PLAN, THAT WILL ADDRESS EACH BARRIER, THAT IS AGREEABLE FOR THE PATIENT, DOCTOR, AND US, AS THE PATIENT'S CARE TEAM.

ONCE THE BARRIER IS RESOLVED, WE WORK CLOSELY WITH THE PATIENT, TO HELP THEM STAY IN CARE AND MAINTAIN VIRAL SUPPRESSION.

IF THE INITIAL PLAN IS UNSUCCESSFUL, WE USE WHAT RESOURCES WE HAVE AVAILBLE TO ASSIST US GOING FORWARD.

HOW WE DO THIS

GRID STYLE FLOW SHEETS

This is how we keep track of all the information. Viral loads, all encounters we have with the patients, barriers to care, the resolutions and/or plans, and basic demographic information.

We document each encounter; with the ***reason*** and the ***date the patient was last contacted***

Our grid sheets, are also where we track the ***progress of our patients***, throughout the project

We found that the use of the updated flowsheets, is an easier way to keep all our patients' information ***readily accessible***, and ***all in one place***!

We started out with a VERY basic flowsheet, and minimal information. We then found that we needed a LOT more space, and more detailed information

RESOURCES

NLURC (housing, utilities, legal, etc.)
DIS (assists in patient demographics)
Support Groups (currently held monthly; guest speakers, discussions)
ODAP (medication costs, through co-pay cards and coverages)
Transportation service (allows patients with no transport options, to attend healthcare appointments, and more*)

We are very thankful,
to have access
to so many wonderful
resources

15 Out Of 16

Patients are now

UNDETECTABLE

MOVING FORWARD

What we CAN control

Throughout our project, we've done our absolute BEST to make sure our patients have everything they need to be successful; but the only thing we have control over... is **OUR OWN EFFORTS**, in giving our patients, the best care we can! Check-in calls, reminders, transport options..... etc.

We feel that our flow sheets are working very well, and will continue to use them as part of our daily routine

We have reached out to DIS, to assist us in contacting patients that we are unable to locate, in hopes of getting them back into care.

MetroHealth

MetroHealth

Concerned Client Committee

Jason McMinn and Xiomara Merced

Concerned Client Committee

Goal

By December 31st, 2021, MetroHealth will improve VLS for non-VLS concerned clients from 0% to 30%. The cohort consisted of 55 concern clients meeting our criteria.

Criteria

1) No ID clinic visit ***OR*** No labs in >10 months
2) Last Viral load >200

The intention of the list is to have a centralized place to keep track of folks who need re-engaged in care.

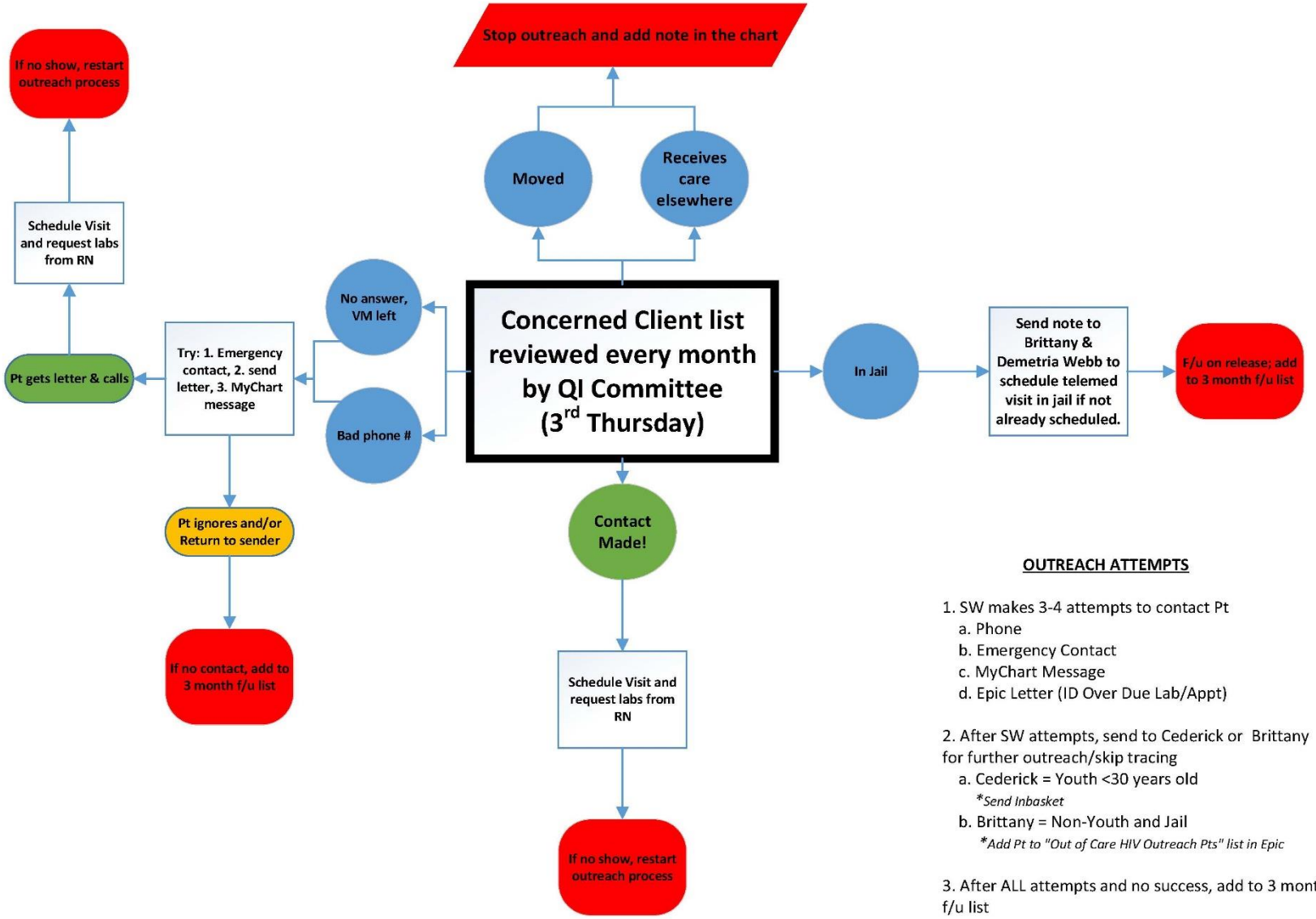
Once someone has a viral load test result within the last 6 months that is **undetectable**, they are either removed from the list if they no longer require oversight or will remain on the list and the committee will continue to monitor (patients who are frequently out of care.)

Documenting a person's monthly journey

March 2021	April 2021	May 2021	June 2021	July 2021
During team meeting, patient's chart is reviewed. No labs, no appts. Team calls patient and requests return phone call.	During team meeting, reviewed chart. pt has returned phone call & scheduled appt for May 2021. No labs entered – **message RN to enter labs**. **Call pt and encourage labs before appt.**	During team meeting, reviewed chart. Patient did not attend appt. Called patient and assisted pt with rescheduling appt. Patient will come for labs.	During team meeting, reviewed chart. Patient came to appt. Labs drawn, viral load 2100. MCM met with patient and patient was forgetting doses.	During team meeting, chart reviewed. Call to patient to assess adherence since last appt. Patient reports adherence much better. Next appt in Oct. Next call to patient in September. Patient to have VL drawn before appt

Outreach Workflow

We updated out Outreach workflow this year and will continue to update as needed.



OUTREACH ATTEMPTS

1. SW makes 3-4 attempts to contact Pt
   a. Phone
   b. Emergency Contact
   c. MyChart Message
   d. Epic Letter (ID Over Due Lab/Appt)

2. After SW attempts, send to Cederick or Brittany for further outreach/skip tracing
   a. Cederick = Youth <30 years old
      **Send Inbasket*
   b. Brittany = Non-Youth and Jail
      **Add Pt to "Out of Care HIV Outreach Pts" list in Epic*

3. After ALL attempts and no success, add to 3 month f/u list

4. If no contact at 3 months, follow up in 6 months.

Viral Load Suppression Data

Baseline

VLS% = 0%

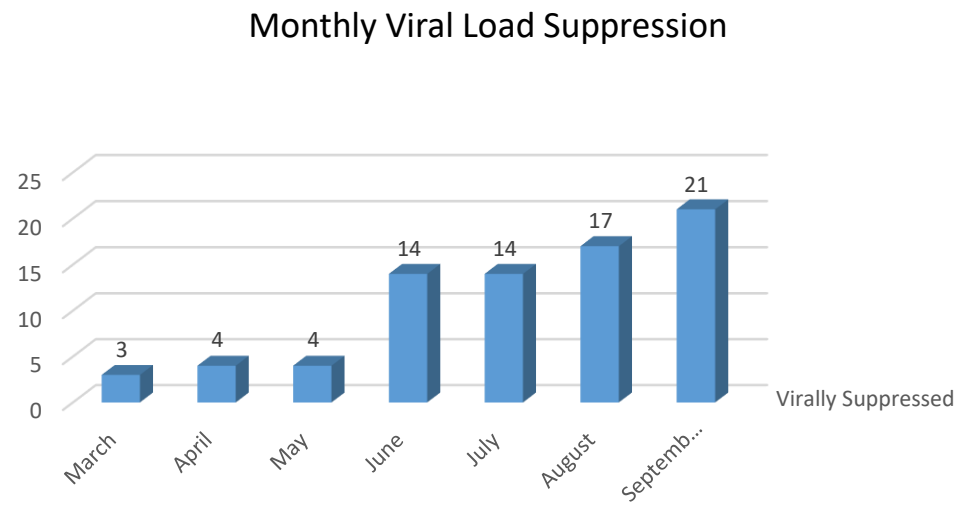
Clients = 55

As of 9/30/21

VLS% = 38%

Clients = 21

GOAL: VLS% = 30%



October, November and December months are not accounted for in the graph

Strengths

- Monthly chart reviews is an effective way to monitor progress.
- Creates better connection with patient.
- Increases health literacy and understanding of treatment plan.
- Team approach.

Weaknesses

- Difficult to identify barriers to care for patients we can not locate.
- Time consuming.
- Unable to locate patients who don't want to be found.

Sustainability

- ❖ This project is sustainable and has become a part of our day-to-day activities.
- ❖ We have created a patient EPIC list to continue the work.
- ❖ We are in the process of creating a centralized location within the EPIC system to connect all touch points within a client's chart.

MetroHealth

Nueva Luz URC

NLURC QI PROJECT 2021

Focus on improving VLS for MSM of color

Focus Group

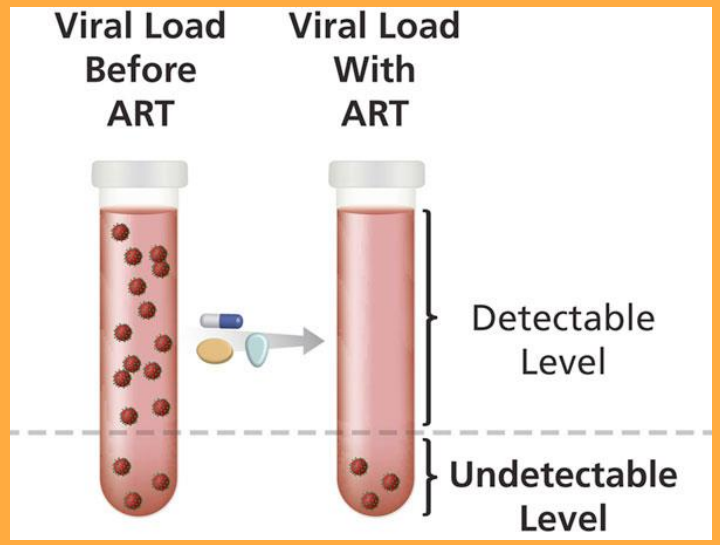
- Minority Men who have Sex with Men (MSM) who are not virally suppressed.
- Enrolled in Medical and Housing Case Management.
- Not virally suppressed (200+ copies)
- 12 high acuity MCM of color who are non-VLS selected.

- History of unstable housing.
- Currently homeless, living in shelters, living with family members or friends, living in transitional housing.
- Currently housed with high risk of losing housing.

AIM STATEMENT

Define

By December 31st 2021, Nueva Luz Urban Resource Center will improve VLS for non-VLS MSM of color (12 clients) from 0% to 50%.



Analyze

Barriers to care patient care

- Substance Abuse
- Mental Health
- Fear of COVID
- Homelessness

SMART GOALS

Improve

- By April 1st 2021, create non-VLS MSM of color list and variables to be tracked for project period.
- By May 1st, begin holding regular internal meetings to address non-VLS list and develop action steps to remove barriers to care.

Continued…

- By October 1st, create summary of addressed barriers to assess the impact on MSM of color client VLS.

CONTROL

Sustain

- Project will be sustained going forward. Weekly MCM meetings to address barriers, primarily homeless, will continue to be held.

VLS DATA

Baseline/ QI DATA

Number of focus clients who achieve VLS = 0

Number of focus clients who obtained/maintained stable housing = 1

Overall VLS for all MSM of color = 77.33%

Measure (VLS) = 0%

Q2 DATA

Number of focus clients who achieve VLS = 3

Number of focus clients who obtained/maintained stable housing = 4

Overall VLS for all MSM of color = 62.82%

Measure (VLS) = 25%

VLS DATA continued...

Q3 DATA

Number of focus clients who achieve VLS = 5

Number of focus clients who obtained/maintained stable housing = 5

Overall VLS for all MSM of color = 77.38%

Measure (VLS) = 42%

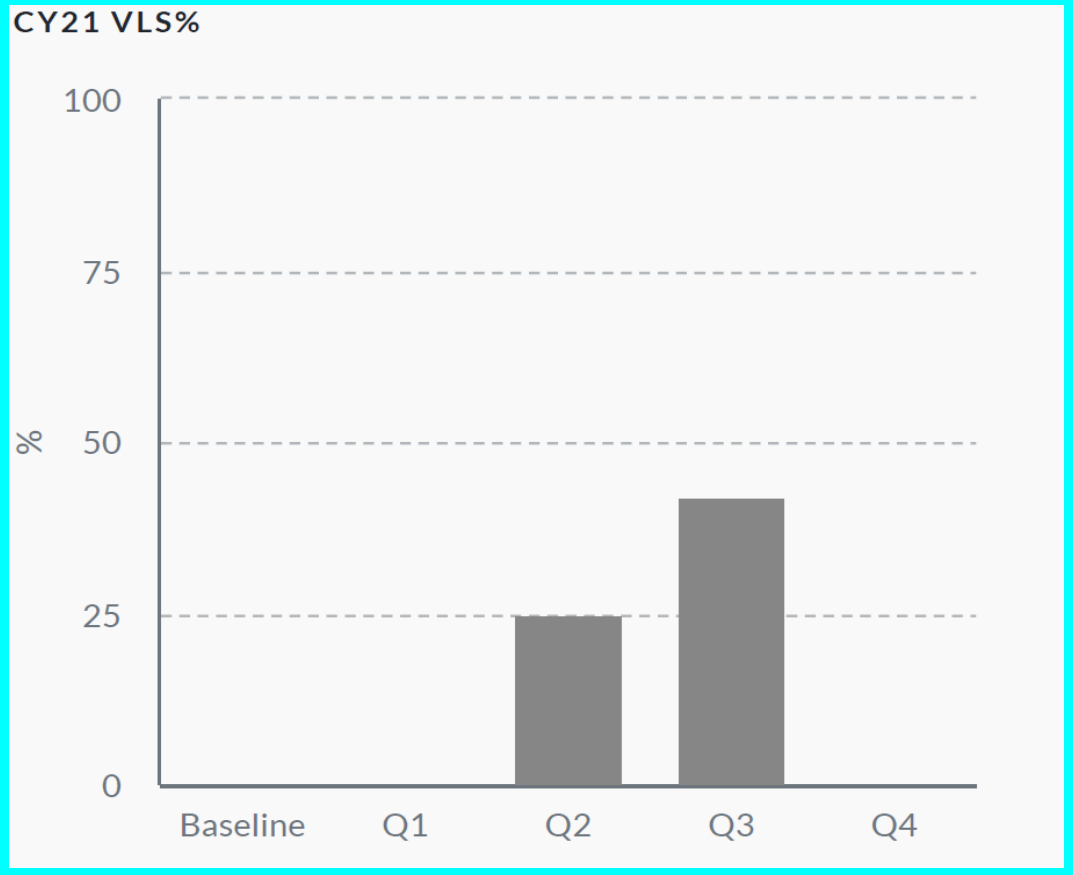
Q4 DATA

Final quarter objectives

- Re-engage 3 clients from focus group in MCM and HCM services.
- Continue to collaborate with HCMs to assist clients with housing needs.
- MCMs will address additional barriers to care/treatment adherence for clients who are currently housed.
- HCMs will follow up with clients who are currently housed to ensure that they remain housed!
- Final data to be calculated at the end of Q4.

Data Summary

Q4 data TBD



Questions/comments??

*Thank you Zach & La'Keisha for your assistance/support with this project!!

Signature Health

Signature Health

CQMC Project 2021

Focusing on Behavioral Health

Target Population:

Part A clients with a documented DSM 5 Substance Use and/or Mental Health Disorder.
Signature Health chose to focus on this population because behavioral health concerns can be a barrier to maintaining medical care. Linking clients to appropriate care may lead to better health outcomes and achievement of viral load suppression.

AIMS Statement:

By December 31, 2021, Signature Health will improve VLS for Behavioral Health participants from 93% to 100%.

SMART Objectives

SMART Objectives:

1. By February 1st, MCM will begin delivering PHQ-9 to clients receiving external medical care and reviewing PHQ-9 assessments that are delivered during internal medical visits.

2. By May 1st, will have a referral system in place for MCM to set up behavioral and mental health appointments with internal/external providers during MCM visit.

3. By June 1st, will develop a tracking system for external behavioral and mental health visits to ensure client attended first appointment

Limitations

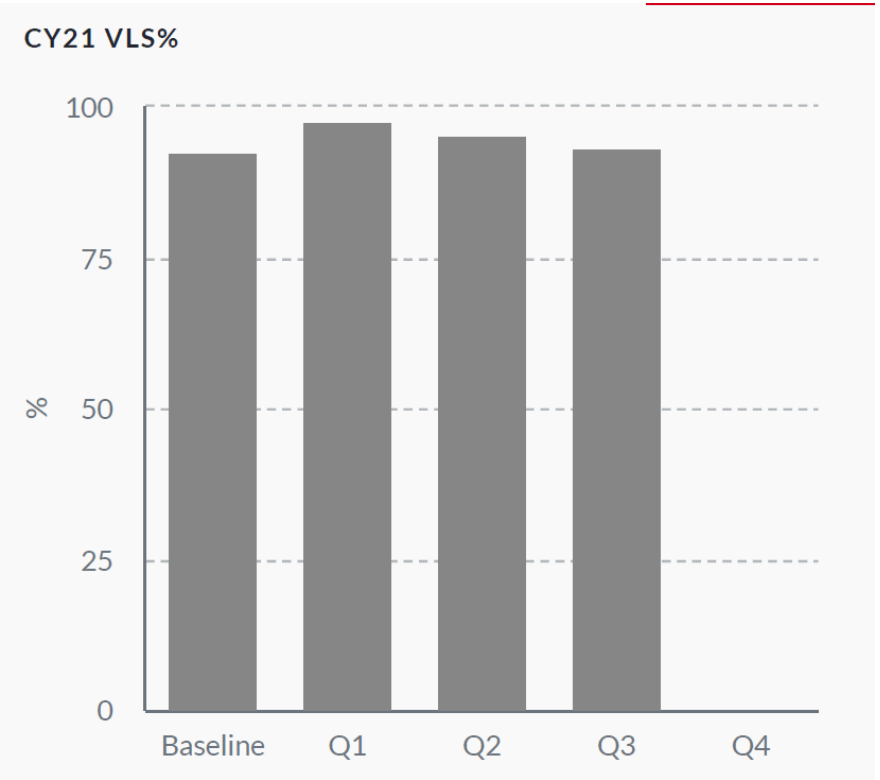
- Serious mental health symptoms and substance use issues create natural barriers for engaging with clients.
- During 2021, Signature Health changed electronic medical record systems, creating barriers to tracking referrals as staff were trained to learn the new system and find tools and reports that were helpful and meaningful.
- Some clients continued to decline linkage to behavioral health services and relied on medical case manager for support.

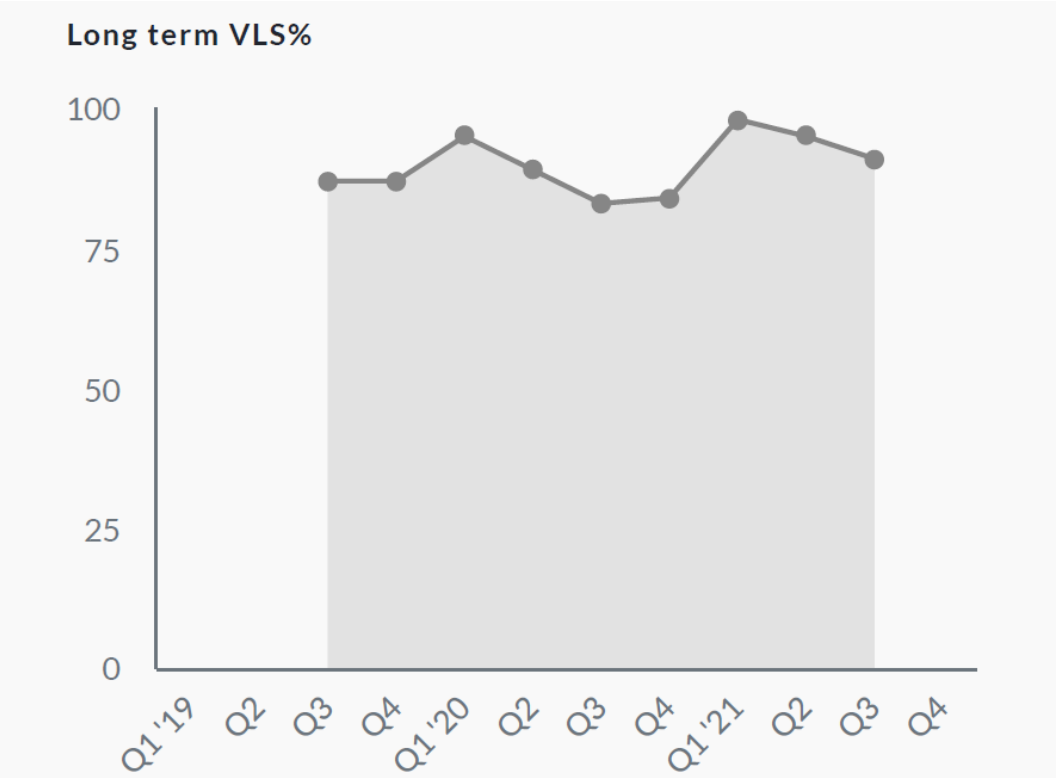
Successes

- Signature Health staff learned how to track internal referrals using electronic medical record.
- Of 43 active clients in the project, 40 were virally suppressed.
- 27 clients were referred and linked to a psychiatrist, counselor, or both.
- 13 clients were referred but had not yet connected to care (lack of follow through on client's part, waiting lists, etc.)
- Significant changes in viral load were observed: One client linked to intensive BH case management improved viral load from 16,300 to 323; Another made improvement from 8110 to <20; Another made improvement from 720,000 to <20 over the course of this project.

Successes

Baseline: 93% VLS; Q1: 97% VLS; Q2: 95% VLS; Q3: 93% VLS; Q4: Ends 12/31/21





Lessons Learned

- PHQ-9 was not the best measure of client progress in this project, as the numbers tended to change sporadically.
- Frequent and intensive support is effective in helping clients achieve and maintain viral suppression.
- Behavioral health issues contribute to gaps in care or gaps in connecting with supports – because of this, viral load did fluctuate over the course of this project for some clients.

University Hospitals of Cleveland

UNIVERSITY HOSPITALS CLEVELAND

JOHN T CAREY SPECIAL IMMUNOLOGY UNIT (SIU)

CLINICAL QUALITY IMPROVEMENT PROJECT HIGHLIGHT

2021 Rapid Start Project

Project Overview:

Designated SIU staff will work with newly diagnosed individuals to make sure that they are seen by our multidisciplinary care team within seven days of diagnosis and that they are prescribed Antiretroviral Therapy (ART) at their first visit at the SIU.

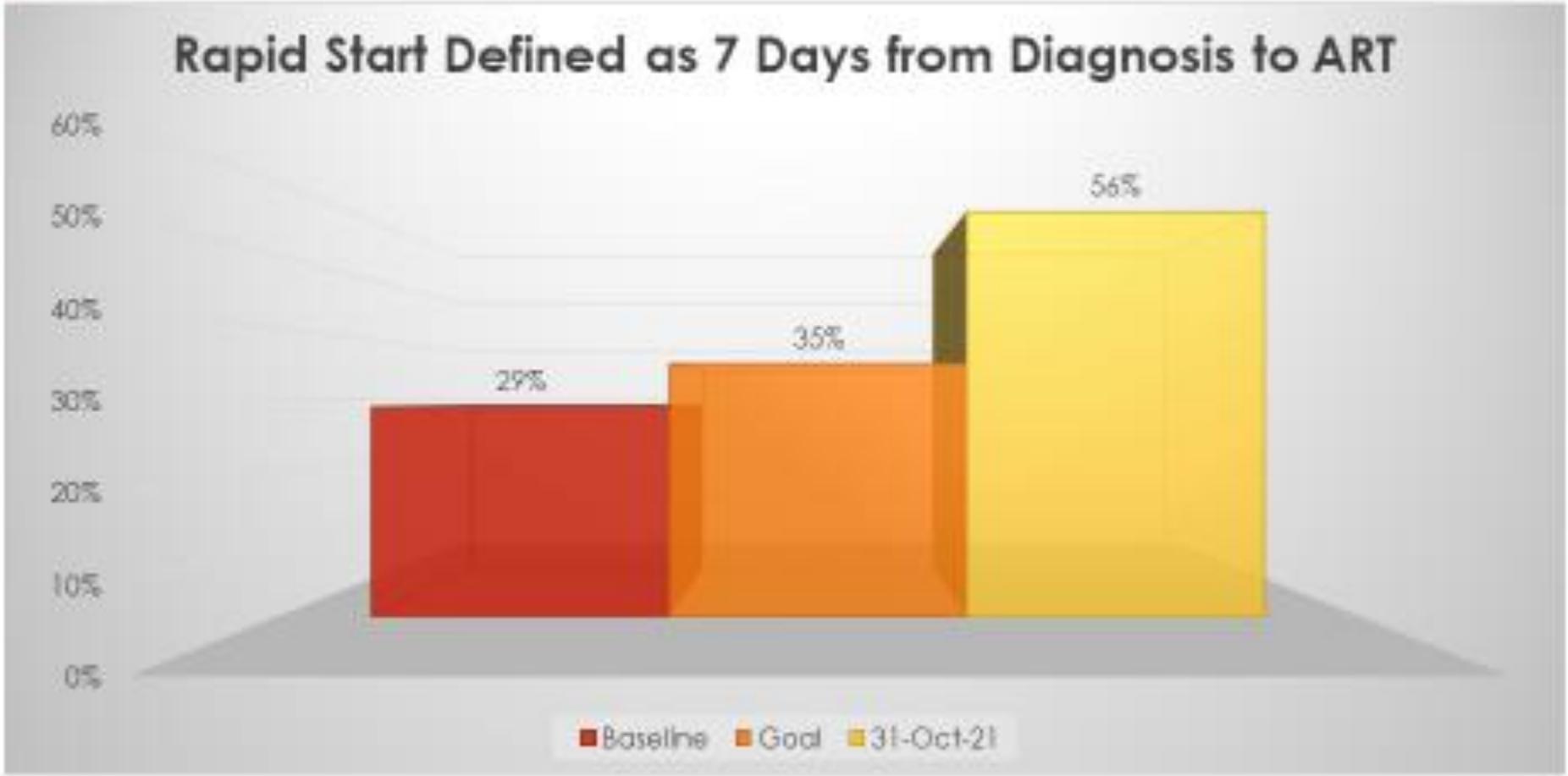
Goals:

- Increase the number of newly diagnosed individuals receiving rapid start services from 29% to 35% by December 31, 2021.
- Increase the number of newly diagnosed individuals receiving at least three medical visits in the first year from 90% to 92% by December 31, 2021.
- Increase the number of Rapid Linkage patients that are virally suppressed by the six month marker from 88% to 92% by December 31, 2021.

WHY RAPID START?

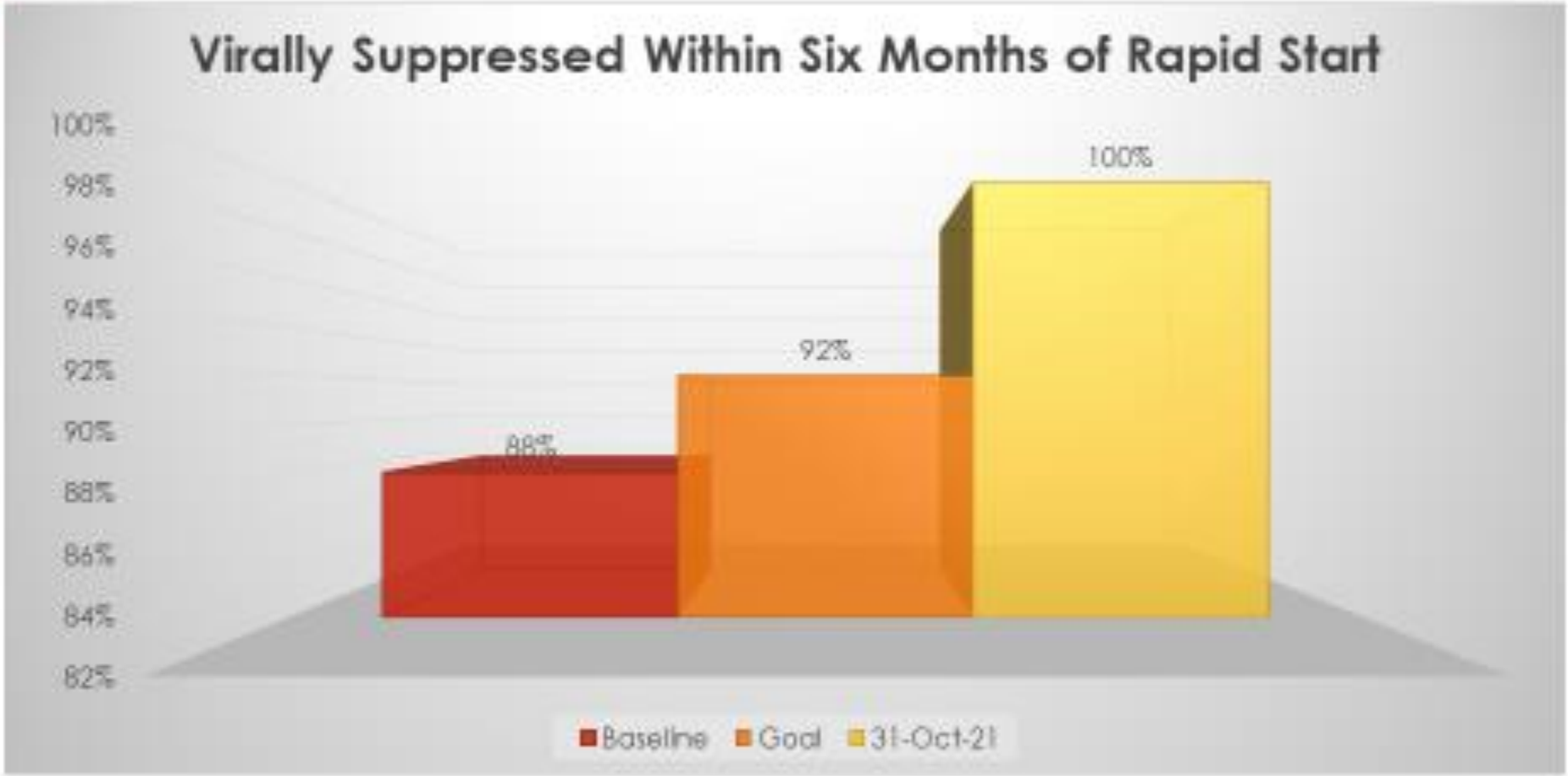
- Clinical pilots in New York City and San Francisco showed that patients achieve viral load suppression more quickly than those started on a "standard treatment" timeline and at the end of one year, patients in the rapid initiation group were more likely to remain engaged in care.
- US Department of Health and Human Services (DHHS), World Health Organization, and the International Antiviral Society-USA (IAS-USA) all advise prompt ART initiation regardless of CD4+ T cell count.
- Data from clinics in New York and San Francisco show that over 75% of patients accepted the option of expedited treatment. Participants also reported that same day treatment eliminates a potentially stressful waiting period and reduces barrier to initiation of HIV care.

Key Component mapping from SPNS Building Capacity to Implement Rapid Start to Improve Care Engagement in RWHAP Settings

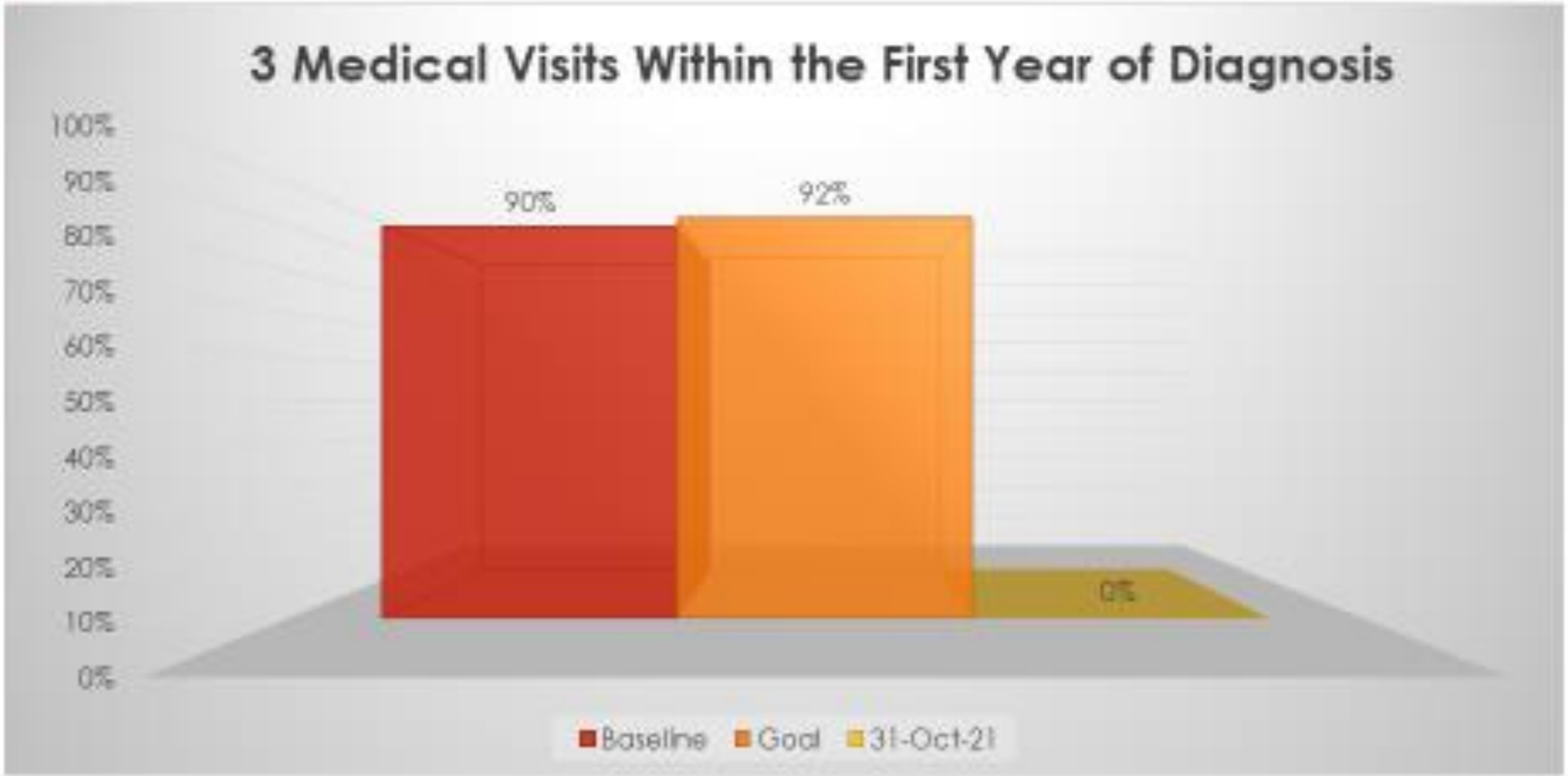


56% (10/18) ART within 7 days of diagnosis

89% (16/18) started meds the same day that they saw an SIU provider.



100% (12/12) were virally suppressed within six months of diagnosis and Rapid Start initiation.



Too early to calculate outcome but of those diagnosed within the past six months:

- **42% (5/12) have had three or more visits in 6 months**
- **83% (10/12) have had two or more visits in 6 months**

Successes:

Improved Communication with Emergency Department

Improved System Flow Within SIU

Challenges:

Provider Schedules VS Patient Schedules

Time required for Rapid Start Appointments

Thank You.

Kate Burnett-Bruckman
Quality Improvement Manager
University Hospitals Cleveland
Special Immunology Unit
Catherine.Burnett-Bruckman@UHHospitals.org

University Hospitals

Neighborhood Family Practice

Neighborhood Family Practice QI Project 2021

Dr. Lisa Navracruz

Dr. Prakash Ganesh

Lichelle Jennings, Nurse Care Coordinater

Daytona Harris, Medical Case Manager

DEFINE

By December 31st, 2021, Neighborhood Family Practice will improve VLS for non-VLS clients from 0% to 30%

AIM STATEMENT

By April 1st we were able to develop a rough draft of variables for non-VLS patients.

- **This included Client information that would assist in keeping contact with hard-to-reach clients:**
  - Additional Phone Numbers
  - Additional contacts
  - Work locations
  - Places frequented by the patient

By June 1st, we were able to finalize this list and begin using it with our patients.

Data was retrieved during office visits and initial Psychosocial Assessments

Patient Name	Home Address	Primary Contact	Secondary Contact	E-mail	Emergency Contact	Other Contact	Location #1	Location #2	VL	In Care?
Baseline 2020										
Q1 Jan-March										
Q2 April - June										
Q3 July - Sept.										
Q4 Oct. - Dec.										

Red – Patients lost to Care
Yellow – Non VLS
Green – Non VLS carried over to next Quarter
Purple – Non RW patients

Our patients

	Q1	Q2	Q3
Overall Viral suppression	**96.3%**	**96.5%**	**94.3%**
Patients with VL > 200	3	3	5

- 87 patients enrolled by the end of Q3
- 9 non-suppressed patients targeted YTD
- Two patients in Q3 were also not virally suppressed in Q2, all others were suppressed at subsequent lab check

- VL suppression rate as targeted in our AIM improved from 0%-> 50%

Data Analyzed

Non-VLS clients remained hard to reach, and the follow up analysis did not yield the anticipated correlation

Our non-suppressed patients each had unique barriers

Bottom Line – The QI intervention did not contribute to improving viral load suppression in our few target patients.

What did the project improve?

Our understanding as to why patients were non-VLS.

Reasons found?

Resistance Issues	Missed medications	Out of care, but now back in care

Next Steps

- Data collection for Q4 of 2021 projects
  Submission due early January to Part A office

- Look out for email to set up 1st quarter meeting to discuss 2022 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/

Questions?


with warm
appreciation
we wish you a
Happy Thanksgiving!

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