RETENTION IN CARE

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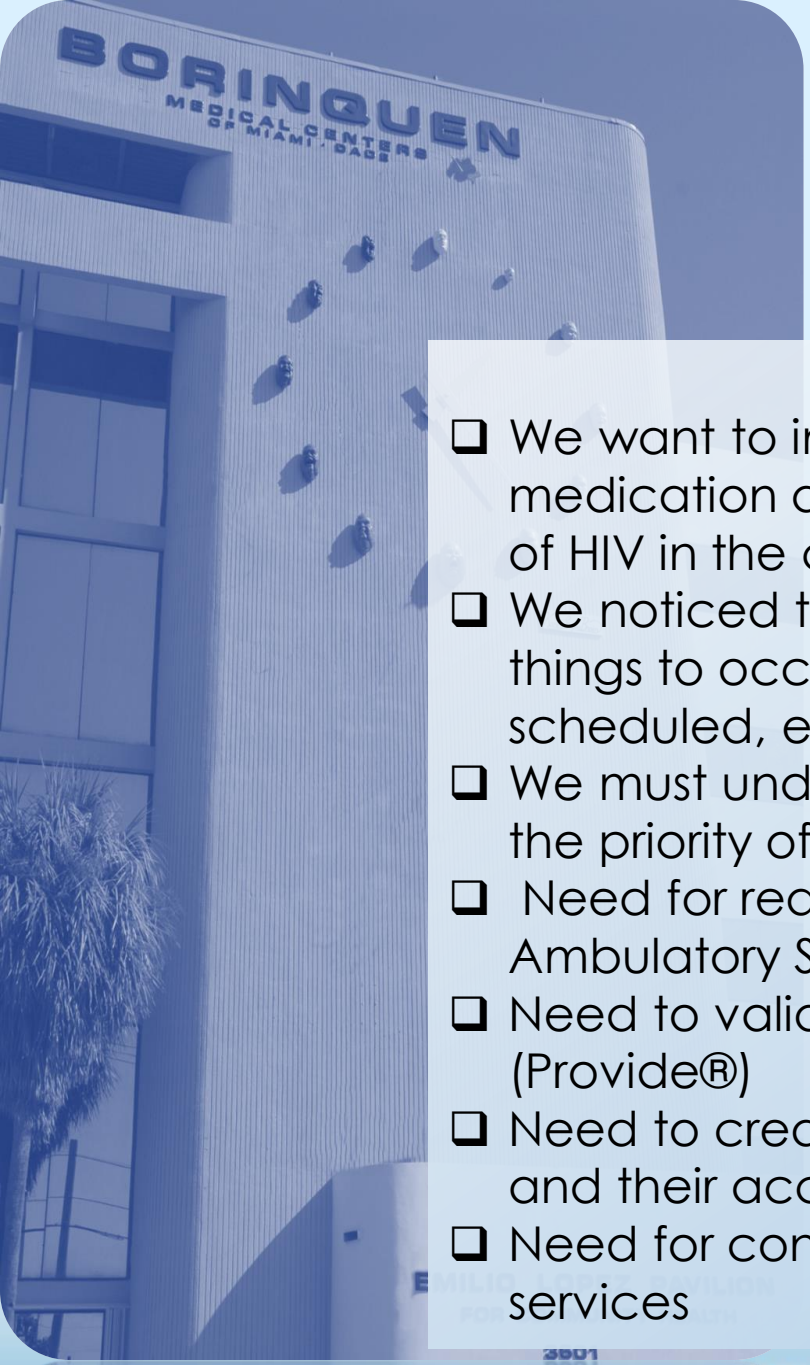
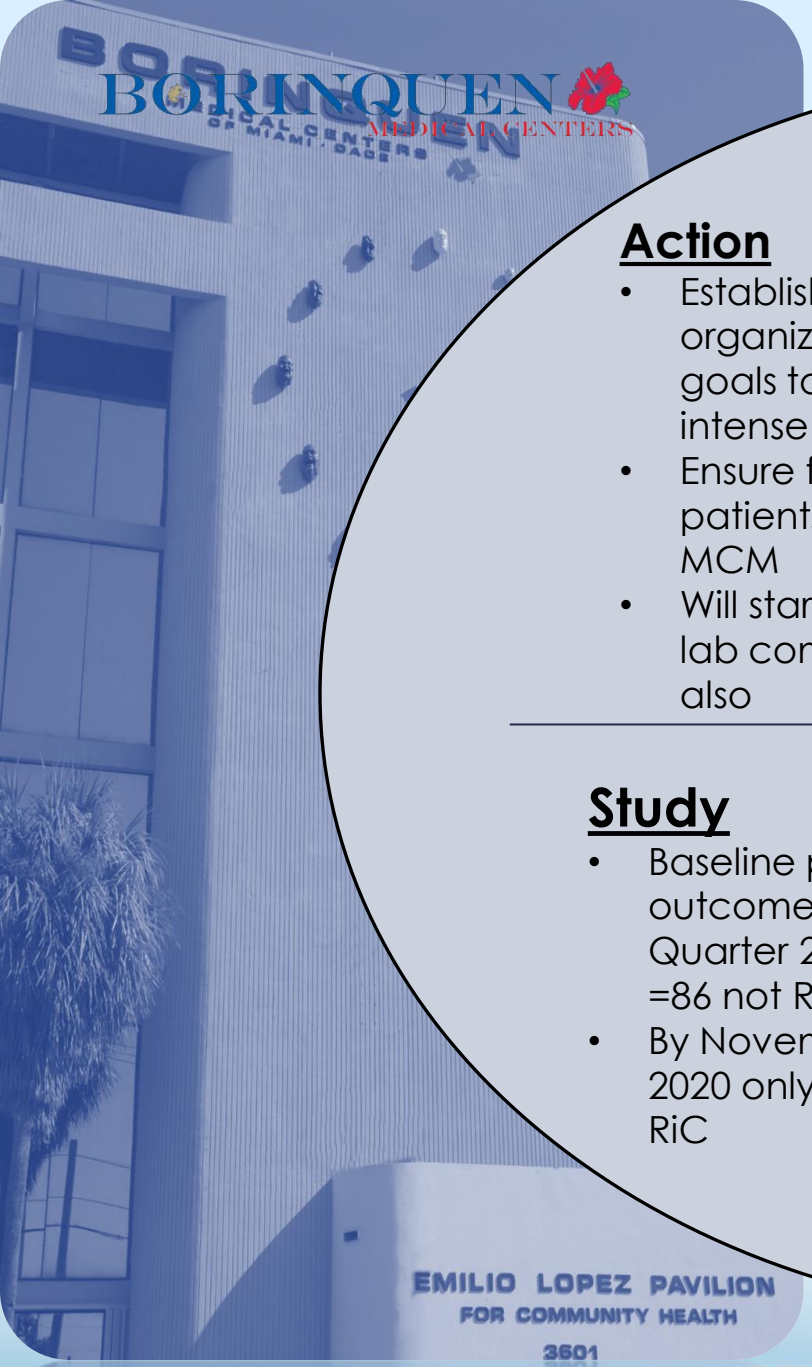


Background

- We want to increase viral load suppression, increase medication adherence, decrease the rate of transmission of HIV in the county
- We noticed that Viral Load Suppression requires multiple things to occur like attend MCM, PCP, Specialist, Lab scheduled, etc….(i.e. retention in care)
- We must understand Social Determinants of Health (What is the priority of the patient) and try to mitigate them
- Need for real time integration of MCM services and Ambulatory Services at BHCC
- Need to validate data from E.H.R. vs MCM software (Provide®)
- Need to create a seamless process of RW part A patients and their access to care
- Need for continuity and coordination of care across all services

What to do next?

- Implementation of a QI project to address Retention in Care-County score card and low hanging fruit…
- Create a PDSA
- Collaborate with BSR to pilot and implement the project
- Closing the loop of the PDSA
- Full implementation of the PDSA and Project



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Action

- Established organizational goals to increase intense MCM.
- Ensure follow up of patients at entry to MCM
- Will start tracking lab compliance also

Plan

To increase the % of MCM who are retained in Care from 83% to 89% by Nov, 30,2020

Study

- Baseline pilot outcome: RiC 4th Quarter 2019-2020 =86 not RiC
- By November 2020 only 31 not RiC

Do

- Detailed reporting of MCM clients w/o OAHS quarterly
- No show report
- Sharing report to MCM to call
- Outreach team tasked with 2 No-shows

1st step of PDSA –Describe the problem

Retention in Care is low (83%):

- Buy in from Clinical and MCM team to understand the problem
- Tracking of RW OAHS scheduled appointments
- No-Show rate of MCM scheduled appointments vs non MCM
- Tracking of Lab appointments vs fulfilled appointments
- Data entry/transfer validation on E.H.R.
- Real time integration and accountability of MCM and Clinical Team

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PLAN-Have an AIM Statement

The AIM statement supports and focuses:

- What we want to accomplish
- How will we know improvement happens
- What change can we make to make it happen

AIM STATEMENT

- By the End of FY30 Q3 (Sep,1, 2020-Nov30, 2020) the % of MCM clients who are retained in care will increase from 83%-89%

DO-After areas for improvement identified =>STRATEGY DEFINED

Data Needed monthly @ least:

- E.H.R. report of OAHS patients w/o a visit from Rx Provider in the last 3 months and next appointment
  - Sent to MCM
  - Patient case noted in E.H.R. by MCM
  - Tickler appointment to remind and f/up before appointment with client
- No-show report bi-weekly of scheduled appointments
  - Assigned to MCM and Clinical Manager

Data Analysis and Buy In

- Review reports and analyze with team
- Share information at HIVQual committee and describe trends and ask feedback

STUDY-Evaluate if strategy is answering your question-RiC improved?

Baseline data and actions taken improved small data set?:

- Data from 4th quarter 2019-2020 86 patients were not RiC
- Pilot testing of our initiative with same population showed by November 2020 only 31 were not RiC

Opportunities for Improvement:

- MCM had multiple tracking mechanisms not properly used or implemented, as well Clinical team needed to understand why!!
- Buy in from Clinical Team to understand what RiC means and how it is measured is a MUST
- Validation of reports and tracking them is critical to use the tools
- HIVQual Committee drives outcomes

ACT-Review plan and its outcomes!

What did we learn:

- Organizational goals must meet programmatic goal (i.e. RFI)
- Coordination of care is complex with much of our community- We need to ensure it's done from all levels and perspectives
- Social determinants of health can hinder but not define outcomes if we try to address them
- It has been standardized across the organization

ACT-Review plan and its outcomes!

What did we learn:

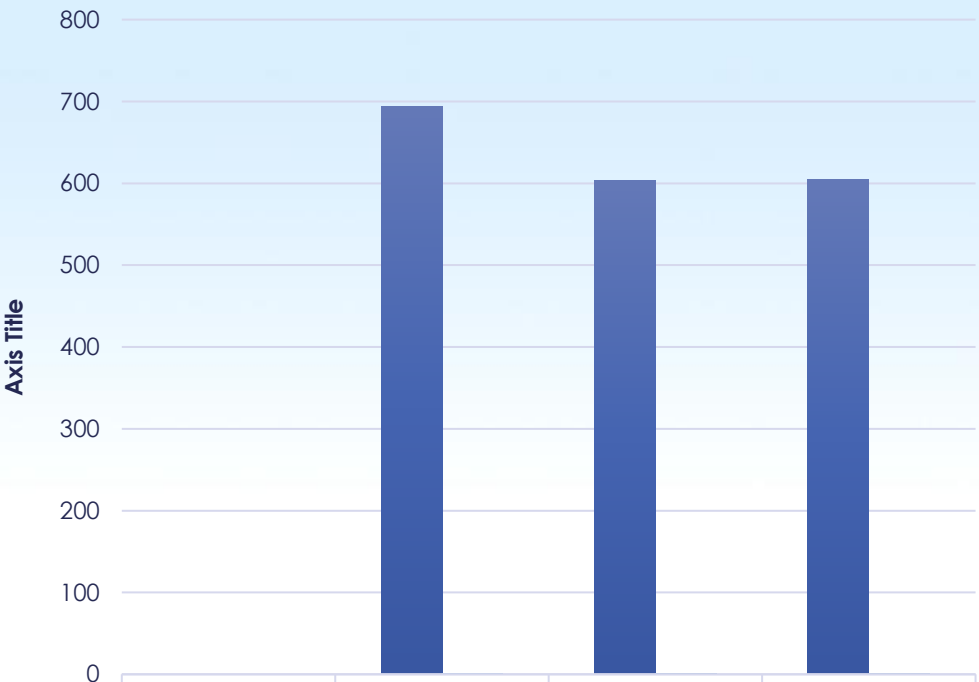
- **Return on Investment (ROI)?:**
  - Streamlining the processes and protocols to accomplish goals as an organization is valuable
  - We have increased OAHS services and expanded access to multiple sites and providers to ensure appointments are made and patients attend closer to their home or work (social determinants of health)

Additional Challenges found:

- Human Error is feasible
- ROOM FOR IMPROVEMEMT

Where we are now!

2020 RiC as of 12/31/2020



	Program	Total RWP A	Total RWP A VLS	RWP A - RIC - (seen by PCP within 90 days)
Series1	0	694	603	604
Series2	0	100%	87%	87%


Question
Time!