Together We Achieved: Reflections on the Impact Now Collaborative

The Florida Department of Health in Orange County's Sunshine Care Center was 1 of 30 Ryan White HIV/AIDS Program (RWHAP) recipients selected by HRSA's RWHAP Center for Quality Improvement & Innovation (CQII) to participate in their most recent learning collaborative. The Impact Now Collaborative was a national quality improvement initiative to maximize the viral suppression rates by targeting those RWHAP recipients that had the highest potential for measurable national impact. The 18-month collaborative aimed to raise the viral suppression rates of each RWHAP recipient to the national viral suppression mean and beyond. In doing so, the Impact Now Collaborative would account for 1 in 3 newly suppressed RWHAP clients.

As a team the Sunshine Care Center worked to increase the viral suppression among Black/African American clients from 86.81% to 89.91%, thus surpassing the goal of the project and the national viral suppression rate; the clinic-wide viral suppression also increased from 88.64% to 91.69%. Strategies implemented to achieve such success included coordination of door-to-door transportation, referrals to psychosocial support, and the co-location of mental/behavioral health services.

The Sunshine Care Center's work within the Impact Now Collaborative was also recently recognized at the local level. On December 6, 2024, the Sunshine Care Center was 1 of 3 honorees for the 2024 Orlando Service Area Quality Care Award. The Quality Care Award recognizes three Ryan White HIV/AIDS Program Part A or Part B subrecipients that achieved impressive measurable improvements over time through the development, implementation, and integration of a formal quality improvement project. The Sunshine Care Centered was honored with the award of, 'Most Innovative Quality Improvement Project'.

To learn more about the Sunshine Care Center's work readers are encouraged to explore the program's storyboard as shared within this publication, or as posted within the Sunshine Care Center's clinic.

By Kelly Bastien

Leading Innovation, Lasting Impact
2004 - 2024

impact now collaborative

Learning Session 6
June 6 - 7, 2024

Florida Department of Health in Orange County

Increasing Viral Suppression:
A Dance of Changing Improvement Cycles

QI Team Overview
- Located in Orlando, FL; Funded by Part A, B, C, D, F
- Collaborative efforts were focused on the Sunshine Care Center
- Total # of virally suppressed patients/patients in caseload:
  - March 2023: 1483/1673 (88.64%)
  - March 2024: 1478/1612 (91.69%)
- Key population: Black/African American clients (~845 clients)

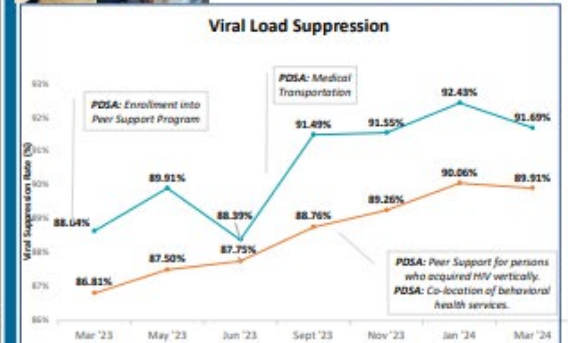
Collaborative Activities
- QI Coaching Group: Julia, Melissa, and Rose
- Participation in monthly coaching call and office hours:
  - QI Tools (aim statement, fishbone diagram, priority matrix)
  - Power of 1 when testing changes
  - Meaningful involvement of people with lived experience
  - Performance measurement; Looking beyond viral suppression.
  - Data visualization; Run charts and visualization software
- Participation Collaborative affinity groups:
  - Data affinity – drilling down data, performance measurement, navigating EMRs.
  - Patient Liaison – engaging youth; sharing information back to QMC
  - Leadership – benchmark reports, leadership checklist
- Learning Session highlights:
  - PDSA Speed Dating
  - Learning how to elevator pitch PDSA cycle
  - Strategies for meaningful involvement of people with lived experience
  - Strategies for appointment adherence among patients; 2/2 Contact Method

Problem Statement & Root Causes
- Initial site level performance data indicated that Black/African American patients had a lower viral suppression rate than other subpopulations
- Root causes:
  - Missing scheduled visits
  - Needing varied appointment reminders
  - Need for learning how to take an active role in self-management
  - Cost and accessibility to reliable transportation
  - Reliable access to behavioral health services
  - Referrals to community partners; no in-house behavioral health services

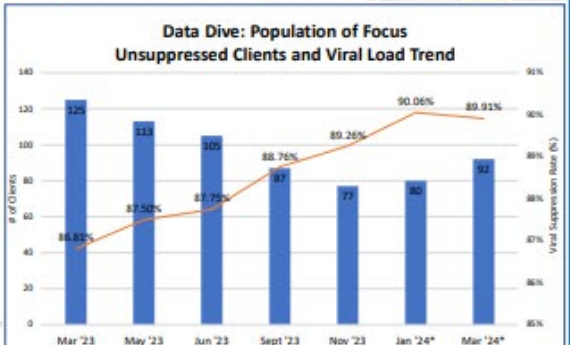
"Continuing to integrate services at our site is a necessary step in reducing health disparities and increasing engagement into care." - Nila Desai, MD, Senior Physician

Aim Statement
- At least 90% of Black/African American clients with unsuppressed viral loads, regardless of age, will increase their viral suppression rate to at least the national mean of 89.4% by June 2024.
  - Goal 1: Decrease/eliminate barriers related to SDOH among Black/African American clients enrolled in care by June 2024
  - Goal 2: Increase the VS rate among Black/African American clients by removing transportation barriers
  - Goal 3: Provide peer support services for non-virally suppressed Black/African American clients who acquired HIV vertically. Ensure that Peer being referred also acquired HIV vertically.
  - Goal 4: Increase accessibility to behavioral health services for non-virally suppressed Black/African American clients.

Viral Load Suppression

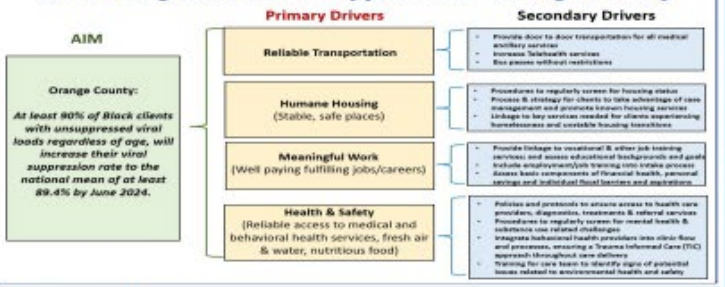


Data Dive: Population of Focus
Unsuppressed Clients and Viral Load Trend

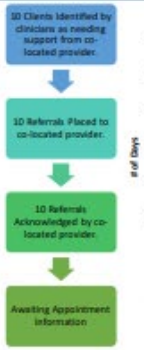


Selection of Interventions
- Reviewed social determinants of health experienced by clients
- Identified cross-functional team members from key departments
- Communication and feedback from CAB
- Monthly updates to quality management committee (QMC)
- Promoted and implemented door-to-door transportation, referral for Peer Support, and co-location of a behavioral/mental health provider
- Driver diagram: Better understand what will influence the project aim and helps the QI team plan accordingly; assisted with QIP selection
- Priority matrix: Helped QI team build consensus on QIP direction and which interventions could have the most impact with population of focus

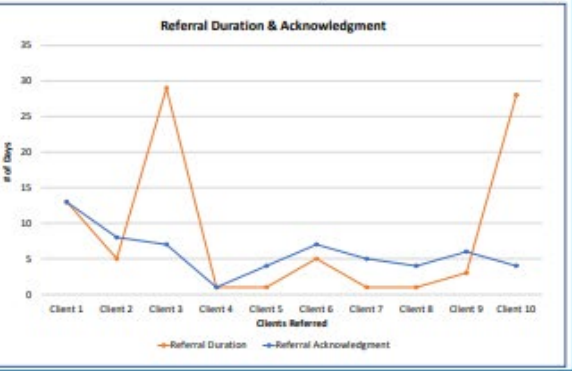
Driver Diagram for HIV Suppression –Orange County



Intervention Implementation
- Peer Support
  - Enrollment into Peer Support and referral for clients who Acquired HIV vertically
- Medical transportation (unrestricted door-to-door transportation)
  - Unlike original prediction, arranging transportation did not change appointment adherence; need to incorporate appointment reminders and consistent communication
- Co-location of behavioral health provider
  - Close monitoring of activities revealed need for multiple trainings with the co-located provider
  - Realization that an internal process regarding specialty referrals could benefit from a separate quality improvement project
- Updates provided monthly at QMC meetings to include:
  - Status of interventions (successes, challenges, modifications necessary, etc.)
  - In-depth review of clients who remain unsuppressed
  - Update to CAB for feedback on intervention activity



Referral Duration & Acknowledgment



Florida HEALTH Orange County

Process and Outcome Measures

Process Measures	Outcome Measures
• Arranged transportation • Peer Support Referral for people with HIV who acquired HIV vertically • Mental health referrals generated in Provide • Same day warm handoff to co-located mental health counselor	• Enrolled into Peer Support Program • Provision of adherence support • Kept clinical appointments • Kept mental health appointments

Spread & Sustainability
- Co-location of behavioral health provider will be adapted into the broader system; this change will be reviewed on an ongoing basis at QMC meetings
- The aim statement was met and the viral suppression for the entire clinic, not just the priority population, increased during the collaborative
- Awarded by Local Part A Office as '2023 – 2024 OAHS Agency with the Highest Viral Suppression Rate'

Engagement of Staff & People with HIV (PWH)
- Monthly face-to-face progress updates with all staff during all staff meetings, QMC during QMC meetings, and CAB during CAB meetings
- PWH are represented and involved at every level of programmatic services and stipends are provided for involvement in QMC
- Engaged with patients via 1:1 conversations to assess barriers, CAB engagement, and client satisfaction surveys that are reviewed quarterly
- Integrate clients into culture of quality and ensure bi-directional information flow between QMC and CAB

Lessons Learned
- Actively involve a representative sample of PWH being served to ensure that the needs of PWH are being addressed
- Ensure that data is accurate and consistently analyzed in a timely manner
- Continually assess SDOH to understand barriers clients face
- Develop a system to regularly analyze VS rates so that unsuppressed client information is readily available – remember that data is more than numbers, it's people
- Ensure that the QIP has structure and dedicated staffing resources
- Be flexible and ready to try new interventions
- You don't have to achieve your aim or meet every goal to have a successful project; find value in what was accomplished
- Don't forget to celebrate small victories!

Team Members and Acknowledgment

Alvina Chu, MHS – Director, Division of Infectious Diseases
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Asim Jani, MD – Executive Medical Director Infectious Disease Division
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