HIV Care and Treatment Program: CAREAssist and HIV Community Services

2023 Performance Measures, HIV Care Continuum, and Quality Improvement Projects

Performance Measures

Performance measure data are collected and analyzed for health disparities across target populations on a quarterly basis by the HIV Care and Treatment program. HIV Community Services sub recipient Agency providers analyze this data and provide a semi-annual performance measure narrative plan for meeting unmet goals.

All Service Categories, regardless of funding:

HIV Care and Treatment clients (CAREAssist and HIV Community Services) who received a service in the Calendar Year (CY), regardless of funding source:

1. **Viral Suppression**: 90%[1] clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.
2. **In Care/Retained in Care**[2]: 90%[3] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

Program: CAREAssist

1. **Application Determination**: 95% of CA applications[4] approved/denied for new CA enrollment within 14 days of CA receiving complete application in the year.
2. **Eligibility Recertification:** 95% of CA enrollees reviewed for continued CA eligibility two or more times a year.

Program: HIV Community Services

1. **MCM Care Plan:** 90% of medical case management (MCM) clients will have a MCM care plan developed and/or updated 2 or more times a year
2. **Stable Housing:** 90% of clients will have stable housing.

[1] Oregon HIV/STD/TB Program Strategic Plan goal
[2] In Care is part of HIVCaT Care Continuum and uses the same definition as CDC's HIV Care Continuum "Receipt of Care"
[3] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal
[4] New applications of clients received complete in CY who were never enrolled before

Performance measure by HRSA Service Categories[5]

Program: CAREAssist

Service Category: **ADAP**

1. Clients enrolled in CAREAssist (CA) at any point in the calendar year

   1.1. **Viral Suppression**[6]: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   1.2 **In Care/Retained in Care**: 90%[7] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

2. Insured CAREAssist (CA) clients who had one Pharmacy dispensing payment for medication.
   2.1. **Viral Suppression:** 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

3. Uninsured CAREAssist (CA) clients who had <u>one full</u> cost payment for CA-funded medication
   3.1. **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

Program: HIV Community Services

1. Service Category: **Case Management (non-medical)**[8]
   1.1 **Viral Suppression**: 90%[9] clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   1.2 **Stable Housing:** 90% of clients will have stable housing.

2. Service Category: **Medical Case Management**
   2.1. **MCM Care Plan**: 90% of medical case management (MCM) clients will have a MCM care plan developed and/or updated 2 or more times a year

   2.2. **In Care/Retained in Care**: 90%[10] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

3. Service Category: **Emergency Financial Assistance**

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[5] PM's align with HRSA/HAB FFY22 PTR Implementation Plan
[6] Part B funding source in addition to all funding sources
[7] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal
[8] Part B funding source in addition to all funding sources
[9] Oregon HIV/STD/TB Program Strategic Plan goal
[10] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal

3.1. **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

4. Service Category: **Food Banks/Home Delivered Meals**

   4.1 **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   4.2 **In Care/Retained in Care:** 90% of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

5. Service Category: **Housing Services**

   5.1 **Stable Housing**: 90% of clients will have stable housing.

6. Service Category: **Medical Transportation**

   6.1 **In Care/Retained in Care**: 90% of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

HIV Care Continuum

HIV Care and Treatment: CAREAssist and HIV Community Services HIV care continuum

1. **Enrolled:** clients who received a service in CY.
2. **In Care:** Clients who received at least one service and had at least one CD4 or VL lab reported in CAREWare (CW) in CY. Goal=90%[11]
3. **Suppressed**: Clients who had HIV viral load less than 200 copies/mL at last HIV viral load test in CY. Goal=90%

State of Oregon HIV care continuum:

1. **Infected:** Total HIV-infected in Oregon, diagnosed and not diagnosed
2. **Diagnosed:** Confirmed HIV cases living in Oregon
3. **In Care:** One or more CD4 or viral load result reported in CY
4. **On Treatment**[12]: Medical Monitoring Project estimate of 97% of in-care patients on ARVs
5. **Suppressed:** Percent of resident HIV cases whose last viral load in CY was < 200 copies/mL

[11] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal remains the same for 2023
[12] Medical Monitoring Project estimate of 97% of in-care patients on ARVs

New HIV diagnosed clients only:
Linked to Care: New HIV diagnosed clients will attend a routine medical visit within 30 days of HIV diagnosis, as measured by VL or CD4 (lab test). Goal=85%[13]

2023 Quality Improvement Projects

Program: CAREAssist

CAREAssist 2023 Quality Improvement (QI) Project 2023: Client Outreach

Purpose of this project: Historically, CAREAssist clients who were not virally suppressed and not in case management were often impacted by social determinants of health and racial inequities that create additional barriers to obtaining and maintaining HIV health care and access to ART medications. For this reason, initially the focus of this project was to address potential racial inequities for clients of color, but we only identified nine clients of color who were not virally suppressed and not in HIV case management. We also recognize that all clients in this virally unsuppressed subgroup may need services, so we chose to expand the project to include all CAREAssist clients who are virally unsuppressed (or do not have a viral load lab) and not in case management, as this will provide CAREAssist an opportunity to help all of these clients while also comparing how these clients' experiences might be the same or different across groups.

This 2022 QI project was modified from 2021 to include all CAREAssist clients not in HIV case management and not virally suppressed or have no current viral load lab.
Goal: increase client participation in the project to improve client viral suppression.
Plan:
The Plan-Do-Study-Act (PDSA) model of improvement was utilized. Project/call protocol and the project tool from 2021 was revised with CAREAssist leadership and caseworker's input, removing one COVID-related question for a total of 20 tool client questions. Also revised the "Support Networks and Client Resources" referral sheet (includes crisis, culturally specific services, LGBTQ agencies, and case management resources).

Do:
Attempted outreach to 45 clients who had either missing or outdated viral load/cd4 labs and were not in Part A or Part B Ryan White Case Management. 50% of the outreach clients live in Ryan White Part A Multnomah County. Outreach occurred over 3 PDSA cycles, covering 7/5/22-8/31/22.

Study:
Analyzed the final PDSA Cycle 3 data, compiled a summary and outcomes, and presented the closing project outcomes to the following: CAREAssist team, HIV Care and Treatment Quality Management Committee, Ryan White Grant federal Project Officer, CAREAssist Advisory Group.

[13] Oregon 2017-2021 Integrated HIV Prevention and Care Plan goal remains the same for 2023

Outcomes: 12 participated in the project: 14 clients were successfully reached and 2 chose not to participate; 29 clients were unable to be reached; 2 clients became disenrolled and were therefore not contacted; and 3 out of the 12 clients who did participate wanted to engage with RW case management. There was a 25% increase in issues around accessing health appointments over prior year. Analyzed the data to determine if outreach and offering referrals was an effective intervention leading to improved linkage to care and viral load labs. Results: 3- and 6-months post project data collection to determine if the twelve clients who engaged in the project became enrolled in HIV case management, obtained a viral load lab, and/or became virally suppressed.

The six-month post project data review indicates the project was a success, due to the twelve clients who participated in the outreach project showing the following improvements: 25% (n=3) did enroll in HIV case management; 50% (n=6) had a current viral load lab; 100% (n=6) of those who had a current viral load were virally suppressed.

Act:
The 2023 QI Project will build on this 2022 project. The project protocol, tool and referral sheet will be revised further to address the difficulty in reaching clients during the project, based on the lessons learned from the 2021 and 2022 projects. Next year in 2023, we plan to set a goal for each of the following: increase in client participation from the previous year; select the percentage of clients who will enroll post-project in HIV Case Management; and select the percentage of clients who will obtain viral suppression at six months post-project. The ultimate objective of this project is for case workers, because of this outreach, will build a relationship with their clients in the project. We belief a strong case worker-client relationship will aid in identifying individual client barriers that CAREAssist can help the client address, such as access to health insurance to obtain medical care and ultimately viral suppression through access to ARV medications and overall improved health outcomes.

Program: HIV Community Services

Food Security Improvement Project

Plan:
In 2021, a VISTA volunteer coordinated efforts to address food insecurity among PLWH and presented the findings, in addition to a presentation on food insecurity screening and intervention, at our Part B Case Management Task Force. In small groups, the value of adding the Hunger Vital Sign Questions to forms as another way to address food insecurity (to align with our integrated plan activities) was proposed.
Do:
The following changes were made in 2022:

- Added the Hunger Vital Sign questions related to SNAP to annual client Psychosocial Triage and Psychosocial Screening forms.
- Added a new CAREWare Food Security Status subservice. A comment box and the following check boxes were included: SNAP ineligible, SNAP Application submitted and SNAP Benefits currently active. This subservice is used by case managers to document food security services with clients and select the associated checkboxes.
- Included food security in CAREWare case note templates

- Increased recommended annual client Food Banks/Home Delivered Meals service category cap
- Provided data to providers to assist in identifying clients most likely in need of food assistance.

2023 plans: add food security questions to Biannual reporting with additional data points and narrative for providers to identify barriers and challenges.

Study/Act:
2023/2024: analyze the data and determine if there are increased SNAP enrollments, reduced food insecurity Triage responses, as well as an indication the neediest clients are being supported.