

Santa Cruz County RW Part C

PDSA 10-2-18

Topic: Determine how we will look at who is retained in care and who is not retained in care, and what our action steps will be to address identified gaps.

Timeline: 10/2/18-1/2/19

PLAN:

1-Define for the purposes of our PDSA retained in care and not retained in care.

2- Tentative definitions pending consult with CQI clinician:

State Office of AIDS definition of retained in care: At least one outpatient ambulatory health service visit with primary HIV provider and 1 viral load test during the last calendar year.

State Office of AIDS definition of not retained in care: Did not have at least one outpatient health service visit with primary HIV provider and 1 viral load test during the last calendar year.

3- Current clinic measures for continuity visits and vl testing is every 6 months. Do we want to use the same measures or for the purposes of establishing retention to care criteria and who needs to be outreached, or is every 12 months enough? May not be standards of care, but would our proposed definition indicate that a patient is being retained in care?

4- Possible way to determine which information is most useful would be to run a report on who has and has not had a continuity visit with

primary HIV provider and vl in the past 6 mo and the past 12 mo, then identify where there are gaps.

5-Once we establish those patients who are and are not retained in care, based on the reports and review of reports, we will need to determine our action.

DO:

1-A report was run by IT looking at who had a viral load in the past 6 mo and past 12 months, and who was seen by an HIV provider in the past 6 months and 12 months.

2-List was routed to case managers for input on clients where gaps were identified.

3-Patients who were identified as no longer receiving care at the clinic were changed to non SC PCP status in EPIC, so that they won't be counted in future reports.

4-CQI RN also looked at EPIC patients where gaps were identified for more information. Based on the EPIC review, additional comments were added (ex last vl, last visit, homeless status, whether out of care, whether the patient was seen since the report was run, etc). Case management status and follow up appointment status columns were also added to the list. (In the future, we will add another column to identify whether the patient is being seen at WHC or SC.)

5-Results were tabulated on patients before and after EPIC SC PCP status was filtered in EPIC, and case management status results was tabulated.

STUDY:

- 1- Before patients were filtered in EPIC to non SC PCP, there was a total of 168 patients. Out of that, 140 had a viral load test in the last 6 months (=83%), 165 had a viral load test in the last 12 months (=98 %), 136 saw an HIV provider in the last 6 months (=81%), and 164 saw an HIV provider in the last 12 months(=98%).
- 2- After patients were filtered in EPIC to non SC PCP, there was a total of 153 patients. Out of that, 137 had a viral load test in the last 6 months (=90%), 151 had a viral load test in the last 12 months (=98%), 133 saw an HIV provider in the last 6 months (=87%), and 150 saw an HIV provider in the last 12 months (=98%).
- 3- Once patients were filtered, there was a 7 % difference in patients not meeting viral load test criteria in the last 6 months (from 17% to 10%); there was a 1% difference in patients not meeting viral load test criteria in the last 12 months (2% to 1%); there was a 6 % difference in not meeting HIV provider visit in the last 6 months (19% to 13%); there was no percentage difference in patients not meeting HIV provider difference in the last 12 months (stayed at 2 %).
- 4- Once we filtered out patients who were no longer being seen at the clinic, and patients who were seen since the original report was run, we looked at the case management status of the remaining individuals. There were 5 on call patients, 5 patients who were being case managed on the GCM program, 2 patients who were d/c'd from the CARE Team, and 1 who was not a CARE Team patient.
- 5- Sub committee met to review the results. There were a few patients, who HIV provider noted met the criteria, but she believed were no longer being seen at the clinic.

ACT:

- 1- CQI Nurse forwarded the list to other HIV Providers and requested that they review to see if there are any possible discrepancies. Providers will be requested to do a manual audit of patients if they question any of the data. Any corrections will be forwarded to the lead CQI staff person to correct the list.
- 2- We acknowledge the State Office of AIDS definition of Retained in Care as at least 1 outpatient ambulatory health visit with primary HIV provider and 1 viral load test during the last calendar year. However, for the purpose of our outreach efforts, we will use the standard of care as continuity visits with an HIV provider and viral load testing every 6 months.
- 3- We will run this report every 6 months and route it to all HIV providers and the CARE Team case managers.
- 4- Our outreach efforts will prioritize:
 - a- Individuals who have been out of care for greater than 12 months
 - b- Individuals with low CD4 counts or who are not virally suppressed
 - c- Individuals with psychosocial and risk barriers such including homelessness, risky use of substances, h/o of STD's/risky sexual behavior, untreated mental health disorder, cultural/linguistic barriers, other
- 5- If individual is case managed, the case manager is to outreach the client, and document efforts in EPIC, then route an interim note to the provider. Case managers must attempt to contact client no less than once a month. If the client cannot be located after at least 3 documented attempts over a period of 3 consecutive months, there will be further discussion and collaboration regarding course of action, which will be documented.

- 6- If the individual is an on-call CARE Team client, the CARE Team supervisor will assign a case manager to outreach the client. Documentation is to take place as stated in # 5. If the client cannot be located after at least 3 attempts over a 1- month period, there will be further discussion and collaboration, which will be documented. If client is unable to be contacted, attempts must be made to outreach community agencies, providers, or other entities that the client has been known to engage with, that are allowed for in the Release of Information. There should be at least 1 entry into EPIC documenting these efforts.
- 7- If the individual is not a CARE Team client, the provider is to either delegate or perform the outreach.