

Ryan White Part A Quarterly Narrative Report for All Service Categories

BURGDORF CLINIC 2023 - 2024

Quarter (Check One): ☐ Q1 (Mar – May) ☒ Q2 (June – Aug) ☐ Q3 (Sep – Nov) ☐ Q4 (Dec – Feb)

The Ryan White Part A Recipient (formerly referred to as the Grantee) uses quarterly reports to monitor each program's progress on meeting its contracted goals and objectives. Quarterly reporting requirements include the submission of a Quarterly Narrative Report. Quarterly reporting is due by the 15th day of June, September, December, and March (unless instructed otherwise by the Recipient). You must include responses for all service categories for which your agency is currently funded. You are also responsible to complete the Early Identification of Individuals with HIV/HCV survey.

1) Program Successes and Challenges

- a) Discuss at least three program accomplishment and at least three program challenges addressing the [National HIV/AIDS Strategy goals](#), relating to activities implemented based on your 2023 contracted scope of work, Discuss how these challenges were addressed.
1. A big accomplishment has been the ongoing Injectable Medication (Cabreuva) program that we have instituted. We have approximately 45 persons currently on this program. Two patients failed the treatment last quarter. This quarter two dropped out due to side effects. Several of the patients became undetectable after years of struggling to even get near this end point when taking oral medications. They are thrilled and proud.
 2. We have now added an injectable PrEP component to the above program. Currently we have about 5 people on this program. The patients are very satisfied with this program and really love not having to remember to take oral medications on a daily basis. Additionally, injectable PrEP has been found to be more effective then oral PrEP (possibly due to adherence issues).
 3. We are strengthening our follow up of patients with missing visit status. Our new RN is amazing and she is calling all the patients that no-show and encouraging them to come to a new appointment. If they miss a second appt we are referring to EIS (primarily to LCS).

2) Continuum of Care

- a) Explain how the following factors have impacted the HIV care continuum outcomes for people with HIV in your program:
- i. Expanded/reduced resources;

During Covid, services for testing and education were restricted and thus there were less new diagnoses. These services have increased again, becoming more accessible and available, therefore more testing and new diagnoses are occurring. Additionally, during the height of the Covid-19 pandemic people were afraid to come out of their houses to get to appointments. While we did offer telehealth visits I do not believe these were as effective as face to face visits.
 - ii. Unmet need, (the TGA's unmet Black/African Americas, Hispanic and MSM individuals)

In our target population (Black/African American, Hispanic, and MSM individuals) poverty remains an ongoing issue. Additionally, mental health issues, including anxiety, depression, bipolar disorder and schizophrenia have increased in this population. Services are very limited. We had instituted a new

mental health program for Ryan White clients of Burgdorf Clinic during the first quarter of the year but unfortunately the mental health provider left after a couple of months during the 2nd quarter of the year due to personal reasons. We have not been able to replace the 4-6 hours allotted to mental health in our contract, although we continue to search for another provider. This remains one of the biggest needs of the above target population. We are referring to outside agencies but these do not necessarily meet the needs of our clients.

Restrict your response to the populations identified above);

iii. Public health emergencies (e.g., COVID-19, mpox) and/or natural disasters;

Covid-19 has finally begun easing the numbers of newly Covid infected or affected persons. Many of these people were the same people as in our target population – Black, Hispanic, LGBTQ, and elderly. It will continue to take time to return to prior levels of care or even better levels of care. While we had only one person (MSM, HIV positive) diagnosed with monkeypox in the first quarter and none in the second quarter it remains a concern. We are continuing to encourage people to be vaccinated if they are at risk to contract this infection.

iv. Evolving healthcare landscape (e.g., changes in health care coverage options) n/a

b) Report on HCV services conducted in your facility (Medical Provider/Nurses)

# of HCV screenings	# of Clients who Tested HCV Ab or RNA Positive	# of clients educated on HCV	# of Clients who were linked to care	# of clients who reach SVR
All HIV pos pts (approx. 185) are screened annually	No new clients tested positive	All HIV pos pts, esp those using substances, are educated on risks of contracting HCV	None at this time as no new positives or untreated Hep C clients	All of our past clients who were treated for Hep C reached SVR. We had no new untreated Hep C positive clients this year.

(i) Provide an update of your agency's efforts to ensure the rapid entry and engagement of newly identified HIV and HCV positive clients into core medical services within a 48-hour period (**Outpatient**) **The APRN speaks directly with patients who are newly diagnosed and referred for care. We arrange a first visit based on the client needs and availability and the APRN appt availability. This is often the same week and usually within 1-2 weeks. If there is availability we will offer same day appts.**

c. Describe your agency's efforts/activities to retain client(s) in care. Based on the number of clients that were not retained in care for the quarter, indicate how many clients were deemed **lost to care** and the reason (i.e. death, incarceration, relocation, etc.). If client relocated, please indicate what steps were taken to link client to services in the area from which they were relocating to in order to ensure continuity of care. How many people **were referred** to EIS?

We had about 5 clients lost to care this quarter. One was referred to EIS from LCS and was reinstated to care. One is now in a home hospice program. One is in and out of care as he is using substances, despite being in a program. One is incarcerated. One is relocated out of the area.

d. What are some meaningful (e.g., coordinated an HIV care event, participated in an information/educational session, etc.) collaborations your agency has done with faith -based

organizations? Please provide information and a list with contact information of the Faith-Based Organizations you collaborated with during the quarter?

We are considered a faith-based organization. We provide education to medical residents, students, and community members.

- e. How are you implementing a status neutral approach? **(The status neutral approach is a framework that provides care and support to people regardless of their HIV status. It aims to address the social determinants of health that create disparities and affect HIV prevention and treatment. It offers a continuum of care that integrates HIV services with other medical and supportive services in a culturally affirming, inclusive, stigma-free, and responsive way. It works in communities to expand access to interventions and services that meet the needs of all community members, especially those who are disproportionately affected by HIV.)**

What steps and actions have you taken to incorporate this approach in your organization?

This has always been our approach to care. We provide the same care for all of our patients and it is based on their individual needs. We integrate HIV services with primary care providers, consultants, and referrals to community agencies. We allow patients to guide their care plans according to their own cultural needs. We respect the patient's decisions, even if they differ from what we might suggest, as long as they are fully informed of the risks and benefits of any treatment, prevention, care plan, medication, etc. We are fully aware of the intersectional stigmas that effect our patients and consider these when making care plans and offering treatment options for patients.

- f. Have you partnered with other community-based organizations to expanded services to HIV negative persons for engagement in PrEP, mental health and/or substance misuse?

We have offered our availability to several agencies including the City of Hartford Health Department STD Clinic and the Hartford Gay and Lesbian Health Collective for the provision of PrEP. Both agencies refer clients to us for treatment and for PrEP and PeP as well as newly HIV positive individuals. We see these clients as soon as convenient for the client and often the same day.

- g. How many partner/s of HIV infected individuals have you provided **education/referral** to regarding **PrEP**?

We discuss and offer PrEP for partners to all our HIV positive patients. We currently have approx. 6 steady partners of our patients on PrEP. Some of these partners also have other partners. We discuss PrEP for partners with all of our PrEP patients.

- h. How many new clients for this quarter were not virally suppressed? **Four.**

Two were newly diagnoses, one was transferring care from another provider, and one had just fallen out of care from their previous provider.

Please answer these three questions during your 4th quarter report only

- a) How many uninsured clients do you have on your caseload?
- b) How do your clients benefit from ACA?
- c) What are some of the challenges your clients have experienced with ACA?

II. Clinical Quality Management (CQM) and Monitoring:

- a. Describe your agency's internal Quality Improvement Projects (QIPs) relative to both HRSA HAB and local Ryan White performance measures and activities associated with the agency that occurred **during the quarter**, including, but not limited to, internal QM committee meetings, client satisfaction surveys, client focus groups, client file reviews, staff trainings on QI, etc.
- b. Discuss the CQM work plan tasks that have been accomplished this quarter.

i. **First quarter**, please state your PDSA aim, measurable objectives with baseline data and any related activities. Also attach QM meeting minutes and your facility's PDSA.

We have been working on two PDSA QM projects during the first quarter. The first is the Hepatitis B screening and vaccination project. This PDSA was to examine why our percentages of screening and vaccination were so low. We met with Peta Gaye Nemhardt from the Ryan White program, and she connected us with a technical assistant from HRSA, to examine how these items were being documented and evaluated. We were able to identify an issue with dates and time lines and ways of documenting as contributing to the low numbers.

For the second PDSA project we have continued to assess the status of patients not reaching or maintaining undetectable HIV viral load status. We will do this on an ongoing basis. We have already seen a large improvement in our percentages of undetectable HIV viral loads being achieved due to the use of the PDSA program.

ii. **Second quarter**, please give a summary of the PDSA activities completed. State current data as compared with baseline data. Provide your agencies updated PDSA.

In this quarter we were able to document the increase in percentage of patient's screened and vaccinated for Hepatitis B due to the issues that were identified and corrected during the last quarter. We now have reached higher percentages than the stated goals. We presented this PDSA on July 27 at the TGA QM presentation. See attached.

We are continuing to track the undetectable viral load status through the PDSA program. It will be an ongoing project for our agency. See attached.

iii. **Third quarter**, please give a summary of the PDSA activities completed. State current data as compared with baseline data. Provide your agencies updated PDSA.

iv. **Fourth quarter**, please provide the outcomes of your PDSA model(s)/methodologies utilized, data tracked, resolutions, and next steps. *(Attach a copy of your updated PDSA, an electronic copy of the most current version of the quality management plan if any changes have been made. Attach any agency internal QM meeting minutes, annual QM Plan evaluations, or other related documentation from this quarter.)*

c. Describe improvements made to client services and/or service delivery this quarter as a result of QIP's, satisfaction surveys, and other activities to enhance the quality of services provided.

The ongoing use of the PDSA QM project to track undetectable vs detectable viral load has made a big difference to successfully encouraging patients to keep appointments, take their medications and achieve undetectable HIV viral load status. We are able to quickly reach out to patients' that have missed appointments, are having trouble being med adherent, or who are potentially lost to care.

Another improvement affecting this delivery of service this quarter is finally being able to find and hire a highly qualified, motivated, RN to assist the APRN in achieving our goals. She has been well received by both staff and patients. She has already demonstrated that she is willing to work with other staff to achieve our goal of high quality, stigma free, successful care for our patients.

d. Describe challenges/barriers that were encountered in implementing these QIPs (including PDSA) and the strategies that were developed and/or action steps undertaken to address these challenges/barriers.

Time and resources are always the main barriers to completing PDSA projects and QIPs. There is very little unaccounted for time to utilize in thinking, planning, and processing projects. We design and manage our PDSA and QIPs to incorporate small bits of time into a whole project.

III. Service Delivery & Program Activities

- a. Report increases or decreases in utilization by service category and provide an explanation of the attributing factors (add more rows if necessary).

Service Category	Contractual Goal	Indicate Under or Over Utilization	Reason for Under Utilization	Action Plan
Ambulatory Care				

- b. Describe any concerns experienced this quarter with access to care and services (e.g. clients denied appointments, barriers to care, processing eligibility, waitlists, etc.) and the resulting planned or implemented strategies intended to resolve these concerns. If a waitlist exists, indicate in what capacity and how many clients are affected?

In this quarter we have reopened our schedule to include newly diagnosed clients, clients transferring from other providers, clients relocating to our area, etc. In the previous quarters we were referring these clients to other providers. Additionally, we previously had a waitlist but now are able to accommodate requests for service within the usual 1- 2 week period.

VI. Program Administration

- a. List any staff changes that occurred during this quarter at your agency.

Name	Title	Start Date	End Date
Viola Odenya, RN	RN for Ryan White Part A Program	Hired May 2023	
Andrea Winston, PharmD	PharmD	2018	Aug 15, 2023

- b. List all vacant Ryan White program funded positions:

Position / Title	RW Funded Stream (Part A or MAI)	% Time Charged to Grant	Date Position Became Vacant

- c. What is the agency's plan for filling the Ryan White program funded positions? **Currently all filled.**
- d. What is the agency doing to fill those responsibilities during the vacancy?
The Ryan White Program RN will take over some of the pharmacist responsibilities until further notice. This includes obtaining prior authorizations, arranging medication deliveries for injectable HIV medications, assisting with CADAP applications if no MCM is avail. She will also participate in the PDSA and QIPs for the program.

VII. Formal Collaborations & Client Grievances

- a. Were there any client grievances for this quarter? If so, how many and how was it addressed/resolved. **One grievance regarding the lab. (Pt was asked out loud if he was waiting for the lab and he became upset. No private information was revealed). Referred to Crystal Miller, RN, nurse manager.**

VIII. Technical Assistance/Training

- a. Describe your organization's technical assistance needs. **Ongoing computer assistance.**

VIII. EIIHAH Plan Survey Link: Please complete at the submission for every 6 months

EIIHAH Plan Survey link: <https://www.surveymonkey.com/r/W9GMSHX> **Due with the second Quarter report only.**

EIIHAH Plan Survey link: <https://www.surveymonkey.com/r/HV69K35> **Due with the fourth Quarter report only.**

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