Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Thursday, March 23, 2017
3:00 p.m.

A G E N D A

CALL TO ORDER ..... Kendall Guthrie
Moment of Silence

NHAS GOALS ..... Member
- Goal 1: To reduce new HIV infections
- Goal 2: To increase access to care and improve health outcomes for people living with HIV
- Goal 3: To reduce HIV-related disparities and health inequities
- Goal 4: To achieve a more coordinated national response to the HIV epidemic

ROLL CALL ..... Nathaniel Hendley

APPROVAL OF FEBRUARY 23, 2017 MINUTES ..... Kendall Guthrie

ADMINISTRATIVE AGENCY – PART A REPORT ..... Sandy Arts

LEAD AGENCY – PART B REPORT ..... Max Wilson

COMMITTEE REPORTS:

Executive .....Page 7 ..... Nathaniel Hendley

Membership .....Page 11..... Nathaniel Hendley

Community Connections ..... Page 13 ..... Veronica Hicks

EIIHA .....Page 15 ..... Beth Parker

OUR MISSION: The mission of the Planning Council is to provide a means for planning and implementing a coordinated response to the needs of people living with and affected by HIV.

INTEGRATED CONTINUOUS QUALITY IMPROVEMENT
REPORT TO THE PLANNING COUNCIL ..... Graham Watts

UNFINISHED BUSINESS ..... Kendall Guthrie

NEW BUSINESS ..... Kendall Guthrie

- Decide on date of next Executive Committee meeting – either April 4 or during week of April 17. Will any other committee meetings need to be moved, or added to the schedule?

PUBLIC COMMENTS ..... Members of the Public

ANNOUNCEMENTS ..... All

ADJOURNMENT ..... Kendall Guthrie

MEET and GREET ..... Guests and Members

Ryan White

Metropolitan Jacksonville Area HIV Health Services PLANNING COUNCIL

MINUTES

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Thursday, March 23, 2017

Council Members Present: Kendall Guthrie (*Chair*), Nathaniel Hendley (*Vice-Chair*), Sharon Hunter (*PLWHA Rep*), Michael Bennett, Ne'Tosha Dopson, Veronica Hicks, Christie Mathews (*Telephone*), Beth Parker, Torrencia Shiloh, Linda Williams, and Max Wilson

Council Members Absent: Dana Barnes, Terri Mims, and Heather Vaughan

Proxy Pool Present: Steven Greene

Support Staff Present: Sandy Arts, Lourdes Diaz, Mary Martinez, Sandra Sikes, and Graham Watts

Guests: Debbi Carter, Erakal Goodman, Yvonne Henderson, Aleida Nelson, Katrina Odell, DeWeece Ogden, and Herb Smith

Call to Order

The Jacksonville Planning Council was called to order at 3:05 p.m. by Chair Kendall Guthrie. Following a moment of silence, Ne'Tosha Dopson read the NHAS (*National HIV/AIDS Strategy*) Goals.

Roll Call

Nathaniel Hendley took the roll. Proxy Pool member Steven Greene was called to the Table and a quorum was declared.

Approval of Minutes

Motion was made and seconded to accept the February 23, 2017 Minutes as presented.

Administrative Agency Report

Sandy Arts, Program Manager for Part A, said that the HRSA site visit has now been confirmed for April 17 – 20. Staff is having a conference call Monday with our Project Officer, Andy Tesfazion, to work on the agenda, so they'll have more details by the end of next week. Ms. Arts stated that the Project Officer wanted to meet with Ryan White consumers, with members

of the Executive Committee, and with as many Planning Council members as possible. He also wants to tour a couple of agencies and meet with a representative from the Mayor's Office. Ms. Arts suggested doing a combined meeting of the Executive Committee to include Planning Council members as well as PLWHA's. The Medical Case Managers will be meeting Thursday, April 20, and HRSA will probably sit in on their meeting. Our Project Officer is also interested in the Jail Link program, and if possible, we will schedule a brief tour of the area within the jail where this work takes place.

Ms. Arts next spoke about membership recruiting, and directed the attendees' attention to a flip chart that listed all support groups, consumer advisory boards, and organizations that deal with PLWHAs in our area. Her thought was that there were people attending some of those meetings who might not be aware of the Planning Council or the Community Connections committee, and that this might be another area to recruit from. She asked those present to please provide a contact for each of these organizations so that she may reach out to them. NFAN has volunteered to sponsor a recruitment luncheon for potential new members.

Lead Agency Report

Max Wilson attended the semi-annual HAP-C (*HIV/AIDS Program Coordinators*) meeting in Tallahassee this week. Questions are coming in about what is going to happen with the state budget as it relates to the HIV program? Information is very limited at this point. The Florida State Legislature's session just began this week and we have had a couple of good years during the past two sessions, so hopefully that will continue. Right now there is debate on the floor about turning the law on intentional HIV transmission from a felony to a misdemeanor act. The HAP-Cs offered some minor changes on the routine testing statute. There is an effort underway to explore the possibility of further expanding the ADAP Formulary and we're in the early stages of that question; the preliminary conversations look like the Formulary is going to be expanded again, and it could be significant this time, adding a lot of medications. It is being referred to as 'Stage 2' of the ADAP Formulary.

There is a new Minority AIDS Media Marketing contract that has been established with a company to provide social media. We're getting a new website and a significant media purchase in Northeast Florida, so we're going to get billboards, radio and T.V. ads, and there are rumors that they will be able to stich in social media apps, like banners and pop-ups for Twitter and Instagram, etc.

If anyone has had difficulty getting their clients' ADAP medication in five (5) days or less, please give Max a call. We are doing a time study for ADAP-direct refills, so if anyone has a client in outlying areas who is getting ADAP meds shipped directly to them and there's a problem with delivery time, please advise Max.

Lastly, headquarters is engaged in a pretty extensive study of PrEP and we are going to have new PrEP products available before the end of the fiscal year (June 30), so one of the things the Department of Health wants to do is to encourage local providers, particularly private providers, to register on the national PrEP registry. This registry is on the Greater Than AIDS website maintained by Emory University; www.greaterthan.org.

This is the tenth anniversary of 'Silence Is Death'. Ten years ago the Department of Health released a groundbreaking study and accompanying media campaign which looked at the crises of HIV among Black Floridians. The Department of Health is now in the process of revising that report so we can show the progress we've made in reducing the increases of new infections that we saw at the time. Northeast Florida is one of those areas that has experienced some of the most significant turn-around in our rates of infection for African-Americans and that's due in part to the work of many of the folks who are in this room today. So, thank you!

The Part B report was then turned over to Torrencia Shiloh. In 2015, RTI launched a study called 'Integrating to Improve' or I2I, and several of you participated in this. The study has now been completed and FCCAPP hosted a webinar in February which unveiled these results. Torrencia distributed copies of this slide presentation for members of the Planning Council. Information for this study was gleaned from a number of surveys, interviews, and surveillance data. This study examined how public health, primary care, and community organizations in our regional service area work as a collaborative system to identify linkage to care and to continue providing care to persons living with HIV. The four areas involved were Area 3/13, Area 4, Area 7, and Area 9. There is a link to the webinar posted in YouTube, if you'd like to watch it at your convenience. The site is https://youtu.be/S1f0nnHNL1c. Max Wilson was one of the Co-Investigators on this webinar.

During the month of March, there were two awareness days: National Week of Prayer for the Healing of AIDS (March 5-12), and National Women & Girls HIV/AIDS Awareness Day (March 10). As part of our efforts in Area 4, there were six churches who participated in the Week of Prayer; one church displayed panels from the AIDS Memorial Quilt. For NWGHAAD, the Department of Health partnered with Edward Waters College to host an educational event and Dr. Kelli Wells was guest speaker. AHF conducted HIV testing on site; 22 people were tested with no reactives. PrEP information and services was also discussed. There was another

NWGHAAD event at the Jacksonville Housing Authority in the Brentwood area. Twelve people were tested at that event with no reactives. CREED held a youth forum in Nassau County. And on April 1, several agencies are partnering to present a health fair to kick off Public Health Week in Nassau County.

Committee Reports

Executive	Nathaniel Hendley

The committee met March 7; this was a combination meeting and training for officers and committee chairs. Handbooks were provided to the committee that included bylaws, policies & procedures, the roster, Council responsibilities, job descriptions, priority and allocations service categories, etc. Question had been asked whether there was language in the Administrative Agency's contracts with the Providers that require the Provider to have an employee be a part of at least one committee.

Waiver was granted to allow Nathaniel Hendley to serve as Membership Committee Chair for the third consecutive year. This brought up a question as to whether the Executive Committee has the authority to waive a bylaw, and this question will be sent to the Bylaws Committee for their review.

Membership	Nathaniel Hendley

The committee met March 1 and reviewed the unaligned ratio which is currently at 28%. Committee is tracking seven applications; Nathaniel and Sharon have contacted each applicant to let them know what the next steps are in completing the application process. Right now there are only five members of this committee, and Nathaniel asked Planning Council members to please consider joining the Membership Committee as they need help. There are several mandated seats that are now vacant: Hospital Planning, Medicaid, Part C, Social Services, and Non-Elected Community Leader. Should all five of these seats be filled, then we would need to bring on four non-aligned consumers to reach the 33% ratio. Nathaniel will be putting together a recruitment and retention plan which should be completed by the summer. Ne'Tosha Dopson was selected as committee co-chair.

Question was asked about the Planning Council booklets that were distributed last year to one of the agencies; are these brochures still being used, and if so, are they distributed to other agencies? Part A staff answered that about a dozen or so booklets were distributed to all agencies last year, but no one ever called back to get a refill, so no additional booklets were copied. If there is an interest to do this again, then Part A will run off additional copies and

distribute. This document can also be emailed to agencies if they can make copies for their clients as needed.

Community Connections — Veronica Hicks

During their March 9 meeting, the committee did a give-a-way; Veronica held a contest and the winner received a small gift. Their guest speaker was Curtis James from New York Life Insurance who discussed different policy coverages for people living with HIV. Torrencia spoke briefly about PrEP and provided some information.

The committee continues holding fund raising events, and was able to select two members this month to receive the Positive Living scholarships; they were Sharon Hunter and Gloria Coon. The Positive Living Conference is scheduled for September 15-17, at Fort Walton Beach, Florida. Additional scholarships will be awarded every month or so, as funds become available.

EIIHA — Beth Parker

Beth stated that the minutes from the January 20 EIIHA meeting were included in the Planning Council packet. The goals worksheet was updated; there were several uncompleted items that were moved to the March agenda.

EIIHA met again March 17 and it was quite a detailed meeting with a lot of items covered. The Occupational Hazard flyer is being removed from the *HIV & Your Practice* booklet. Another list included in the booklet is now outdated; Rod Brown took possession of all 55 booklets and he will replace the list showing HIV testing sites with the updated version. Rod and Joe Mims volunteered to distribute these booklets at a couple of upcoming medical association meetings. Aleida Nelson and Katrina Odell volunteered to compile a list of family care physicians in outlying counties and a list of urgent care and walk-in clinics located in Jacksonville. Once identified, these doctor's offices and clinic could also receive the *HIV & Your Practice* booklet.

There are still plans to go forward with a block party, aimed at teens and young adults, to disseminate prevention and testing messages. There was a discussion that EIIHA and the Integrated Comp Plan Committee (ICPC) might be duplicating efforts and it was suggested that EIIHA be annexed into ICPC so that we might work together and not step on each other's toes. Question asked on when EIIHA and ICPC were planning this merge and Beth answered that EIIHA passed a motion to merge, and it goes to ICPC next for their consideration. If ICPC makes a similar motion, it will then come before the Planning Council to make a final decision on if EIIHA can be annexed into the ICPC.

Another topic that came up during the EIIHA meeting was the Youth Advisory Methodology. This is how to test youth, how to message youth, and how to link youth to care. The committee will talk about this more in the coming months.

Program: Integrated Continuous Quality Improvement

Dr. Graham Watts gave a report to the Planning Council on how the TGA has developed into a more competent, service delivery entity over the past few years. Local Ryan White agencies work well together and collaborate on a number of projects. Dr. Watts presented a power point presentation, copy of which is attached to these minutes.

Unfinished Business:

There was no unfinished business.

New Business:

- Discussion on whether to change the Executive Committee's meeting date from April 4 to sometime during the week of April 17. That would allow HRSA to talk with the Executive Committee members and examine one of the meetings in progress. **Motion** was made by Max Wilson, seconded by Beth Parker, **to move the Executive Committee meeting to April 18**. Discussion was that all other members of the Planning Council who could, to please attend that meeting as well. There was no further discussion and a voice vote was taken; all were in favor, and the motion passed.

Public Comments:

- Council Staff Sandy Sikes asked for the Planning Council's guidance on whether she should continue processing the membership applications already received on mandated categories other than unaligned consumers? Members were asked to email or call Sandy with their thoughts.

ANNOUNCEMENTS

- Apple is coming out with an iPhone 7 in the color red. If you purchase this iPhone, a percentage of the cost will be donated to the Global Fund to support HIV/AIDS programs.

- On April 20, the i2i Team will be presenting the detailed results from all four participating areas of Florida to an audience of the public health systems' policy makers.

- There will be a Health Fair Saturday, April 1 from 4:00 to 7:00 p.m. at the Peck Center in Fernandina Beach. The following agencies are working together for this event, which kicks off Public Health Week: Florida State College at Jacksonville, Florida Department of Health Duval and Nassau Counties, Baptist Medical Center – Nassau, AHF, and CREED. Flyers are available to post in your agencies.

- The U.S. House of Representatives is scheduled to vote this evening on the American Health Care Act. If you can, please call your representative and tell them that you are living with, or concerned about HIV, and that you ask that they oppose this Act.

- April 14th UNF will be hosting an event concerning HIV/AIDS. Debbi Carter has some flyers and she asked if agencies could please post one in their waiting room.

ADJOURNMENT
The meeting ended at approximately 4:35 p.m.

Approved by:  4/27/17

Nathaniel Hendley, Planning Council Vice-Chair (date)

Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

EXECUTIVE COMMITTEE

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Tuesday, March 7, 2017
Summary of Meeting

Committee Members Present: Kendall Guthrie (*Chair*), Nathaniel Hendley (*Vice-Chair*), Sharon Hunter (*PLWHA Rep*), Michael Bennett (*Integrated Comp Plan*), Beth Parker (*EIIHA*), and Heather Vaughan (*Priority & Allocations*)

Support Staff Present: Sandy Arts and Sandra Sikes

CALL TO ORDER

The meeting was called to order at 3:05 p.m. by Chair Kendall Guthrie. Following a moment of silence, members did self-introductions.

TRAINING

Staff presented training for committee chairs and for the officers of the Planning Council. Binders were distributed that contained current bylaws, policies and procedures, job descriptions, application forms, the HRSA Planning Council Primer, list of core and support services categories and descriptions, list of acronyms and terms specific to the Ryan White program, and an overview of the local ethics, Sunshine and Public Records laws.

A question was brought up during the training, asking if providers who have a contract with the City of Jacksonville to provide services for Part A, are required to sit on the Planning Council or be a member of one of the Council's sub-committees? If a provider is not required to be seated on the Planning Council, is there still a contractual requirement that someone employed by the agency participate on at least one of its sub-committees? If that's the case, should the Executive Committee be monitoring that, or is it something that is being monitored by the Administrative Agency? Members discussed further; all remembered that the contracts say providers have to refer **clients** to the Planning Council and committees, but not that the provider had to be seated on the Planning Council. Providers are required by their contract to meet on a regular basis with the Part A Program Manager; this is generally done at the Providers Meeting. Sandy Arts will check the contracts and see what the exact wording is. The Executive Committee agreed that if language requiring the providers to be on a committee isn't already in the contract, maybe it should be. The feeling was that this is a good direction to move toward. It was also brought up that there have

been management changes at several agencies, with new people coming on board or taking on new roles. It might be time to re-visit which meetings are Planning Council related, and which are Administrative Agency. People may be showing up for Providers or Jail Link meetings, and think that they are attending a Planning Council sub-committee meeting.

PROGRAM MANAGER'S REPORT

Sandy Arts advised the Executive Committee that the date of the HRSA site visit is being pushed back to the middle of April. She will let everyone know when the new date is finalized, either the week of April 10 or April 17. In the meantime, the next Executive Committee meeting had been set for April 4, which would have allowed the E-Board to meet with HRSA. Sandy asked if this committee wanted to still meet on April 4, and also have a second meeting during the site visit? Members chose to wait until HRSA finalizes their site visit, and then decide whether to move the next E-Board meeting to coincide with the site visit, or keep the original April 4 date.

Sandy also offered to be available for a Question and Answer session if any committee has a need. She is aware that in the past few months, several questions have come up regarding services. If a committee chair would like to have a five or ten minute Q&A session with the Program Manager, please let her know a few days before hand.

COMMITTEE REPORTS

Membership: Nathaniel Hendley reported that Membership Committee met March 1; the Council currently has 14 members and is at 28% for their unaligned ratio. The committee is tracking seven applicants, one of which was scheduled to be interviewed during the meeting.

Nathaniel volunteered to put together a formal recruitment and retention plan for the Planning Council; this should be completed by the summer. Ne'Tosha Dopson was selected committee co-chair. The committee will have a brief meeting March 23, shortly before the next Council meeting, in order to interview an applicant.

EIIHA: Beth Parker reported on the January 20 EIIHA meeting. Committee is still working on *HIV and Your Practice* booklet. One member volunteered to compile a list of family practice physicians in the Jacksonville area, and another member will report on the National Week of Prayer for the Healing of AIDS at the next meeting. EIIHA meets again on March 17.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

- Nathaniel Hendley was appointed committee chair for Membership. Since this is his third year in that position, the Executive Committee needs to waive the bylaws to allow him to serve. Beth Parker made a **motion**, seconded by Sharon Hunter, **to waive Article X, Section 1 of the bylaws to allow Nathaniel Hendley to serve a third year as Membership Chair.** In the discussion that followed, it was brought up that this committee only has four members. One member was seeking the co-chair slot, and neither of the remaining two members wanted to chair. Another issue brought up during discussion was whether the Executive Committee had the authority to waive a particular bylaw. Staff said that this had been done in the past; there is nothing in the bylaws that prevents this action. The committee then moved forward and took a vote on the motion; five were in favor, none opposed, and Mr. Hendley abstained. The motion carried.

- Per discussion above, Michael Bennett made a **motion**, seconded by Nathaniel Hendley, **to ask the Bylaws Committee to meet and see if we need to add language in the bylaws that allows the Executive Committee to waive a particular article or section of the bylaw**. There was no further discussion; the motion was voted on and passed unanimously.

WRAP UP

Public Comments: There were no public comments.

Announcements:

- The University of Florida's HRSA site visit will be next week. Kendall has learned that their new HRSA Project Officer is Ty Smith Barnes, and Mr. Barnes will be the PO for all five Part C recipients in Northeast Florida.
- Heather Vaughan will be absent from the March 23 Planning Council meeting.

Adjournment: The meeting was adjourned at 4:45 p.m.

Committee Recommendation To The Planning Council: None

Committee Recommendation To The Bylaws Committee:

That the Bylaws Committee meet to see if we need to add language in the bylaws that allows the Executive Committee to waive a particular article or section of the bylaw.

Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

MEMBERSHIP COMMITTEE

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Wednesday, March 1, 2017
Summary of Meeting

Committee Members Present: Nathaniel Hendley (*Chair*), Ne'Tosha Dopson (*Co-Chair*), Veronica Hicks, and Sharon Hunter

Committee Members Absent: None

Support Staff Present: Sandy Arts and Sandra Sikes

CALL TO ORDER

The meeting was called to order at 10:00 a.m. by Chair Nathaniel Hendley, and was followed by a moment of silence.

REVIEW OF UNALIGNED RATIO

Committee reviewed the unaligned ratio and the Planning Council representation. One person was added to the Planning Council at their last meeting, and six members rolled off, effective today. The Council membership is now at 14, which is below the minimum of 17 listed in the bylaws.

		Epi Data for the TGA		*Planning Council Representation*	
Total Membership:	14	White:	28%	43%	White
		Black:	64%	50%	Black
Total Unaligned:	4	Hispanic:	05%	00%	Hispanic
		Other:	03%	07%	Other
Unaligned Ratio:	28.6%	Male:	65%	29%	Male
		Female:	35%	71%	Female

MEMBERSHIP APPLICATION LOG

- Committee reviewed the log of active applications. Seven applications are being tracked:

2 individuals have requested more information before proceeding with the process,
1 person recently submitted application but has not attended orientation or required number of meetings,
1 applicant has attended orientation but not the required number of meetings, and
3 applicants have attended the required number of meetings and orientation.

Nathaniel and Sharon volunteered to contact the applicants and let them know what their next steps will be as far as the application process goes.

- Committee looked at the mandated seats that are now open on the Planning Council. They are for Hospital, Medicaid, Part C, Social Service, and Non-Elected Official categories. Members discussed several possible candidates, and will continue to look for viable candidates over the next several months.

- Staff advised that if all five seats listed above are filled, then the Planning Council will need another four members in the unaligned consumer category to reach 33% unaligned ratio.

INTERVIEW

Eric Peeples was not able to make the interview due to a scheduling conflict.

UNFINISHED BUSINESS

There was no unfinished business.

NEW BUSINESS

- Recruitment and Retention: Nathaniel volunteered to put together a formal recruitment and retention plan for the Planning Council, and he hopes to have this completed by the summer. This plan will assist the Council in identifying potential applicants, evaluating barriers that prevent people from attending or getting involved, and keeping new members engaged in the work of the Jacksonville Planning Council.

- Co-Chair: Members selected Ne'Tosha Dopson as the committee co-chair.

WRAP-UP

- There were no public comments.

- Committee agreed to meet again on March 23 at 2:30 p.m., if Mr. Peeples is available for interview. Sandy Sikes will talk to Eric and will notify the committee if this meeting is set.

- The meeting ended at 10:45 a.m.

COMMITTEE RECOMMENDATION TO THE PLANNING COUNCIL: None

Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

COMMUNITY CONNECTIONS

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Thursday, March 9, 2017
Summary of Meeting

Committee Members Present: Veronica Hicks (*Chair),* Gloria Coon, Steven Greene, Nathaniel Hendley, Elinor Holmes, Sharon Hunter, Marion Kent-Davis, Terri Mims, Torrencia Shiloh, Rikki Stubbs, Zane Urbanski, Thomas Washington, and Linda Williams

Guests: Toni Gibbs and Curtis James

Support Staff Present: Rona Revels

CALL TO ORDER

The meeting was called to order at noon by Chair Veronica Hicks, and was followed by a moment of silence. Steven Greene read the Community Connections' Mission Statement. The Chair introduced the guest speaker to the members.

ANNOUNCEMENTS

Nathaniel Hendley announced that there is a support group at the Florida Department of Health every third Wednesday for substance abuse and mental health.

Sharon Hunter presented a list of support groups and the committee tried to determine if these groups are still operating.

Gloria Coon thanked everyone for all the kind words after the death of her niece recently.

Gloria Coon is selling jewelry and the profits will help Helping Hands support group.

OLD BUSINESS

Auction

Veronica announced that there are two silent auction items. One is the Bluetooth speaker that has a minimum bid of $65. The second item is a painting, and it has a minimum bid of $100. Everyone was again reminded to bring in auction items; the money will be used for Positive Living scholarships.

Positive Living Conference
This is the 20th anniversary of the conference and the applications are now available. The conference will be held September 15 – September 17, 2017. Two names were drawn to attend the Conference. They were Gloria Coon and Sharon Hunter. Depending on the fund raising activities, there will be more scholarships given.

NEW BUSINESS
The guest, Curtis James from New York Life, presented life insurance possibilities for positive people. Other companies have similar policies and Curtis can help with those, also. He explained the difference between term life and whole life.

Happy birthday to Marion Kent-Davis.

Things to Remember
"OUCH RULE" "QUIET ZONE"
No sick or shut-ins that were known.
The only bereavement was Gloria Coon's niece.

Wrap-Up
The next meeting will be on Thursday, April 13th.

The meeting was adjourned at 1:45 p.m.

Committee Recommendations To The Planning Council:	None

Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS COMMITTEE

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Friday, January 20, 2017
Summary of Meeting

Committee Members Present: Ellen Schmitt (Co-*Chair*), Rod Brown, Rayland Cunningham, Logan Hopkins, Vivian Lanham, Christie Mathews, Chanel Scott-Dixon, and Heather Vaughan

Guests: Aleida Nelson and Ella Russell

Support Staff Present: Sandy Arts, Brian Hopkins, Sandra Sikes, and Graham Watts

CALL TO ORDER

The meeting was called to order at 10:45 a.m. by Co-Chair Ellen Schmitt.

MOMENT OF SILENCE OBSERVED

UNFINISHED BUSINESS

- Occupational Hazard Flyer: A subcommittee was formed at the September meeting to develop a flyer to insert in the HIV & Your Practice booklet. This flyer would be geared to first responders and medical professionals to encourage annual HIV testing. Flyer was presented to committee, and several revisions were requested. The sub-committee of Rod Brown, Joe Mims, and Ellen Schmitt will meet in the near future to finalize and submit to EIIHA Committee March 17.

UPDATE GOALS WORKSHEET

- Aleida Nelson volunteered to look up Family Practice physicians in the Jacksonville area and provide a list of their names and contact information. This will be shared with FCCAPP for their effort in developing a list of potential health care providers who could offer routine HIV testing to youth. Target date for this list is February 7.
- Torrencia Shiloh will provide a report at the March 17 meeting on local churches who participated in the National Week of Prayer for the Healing of AIDS.
- Proposed concert to attract youth and disseminate HIV prevention message is on hold. Joe Mims will advise if and when planning can proceed.

- Waiting to hear back from Duval County School Board about doing a week-long testing even at area high schools.
- Rod Brown did not receive any information from committee members on venues or organizations that could host event. Rod to contact Stephanie Reese to see if she has any contacts. Sandy Sikes to print address list from attendees of the July Youth Summit.

NEW BUSINESS

- Graham questioned the members about forming an executive sub-committee of EIIHA, to meet a week or so before the next regular committee meeting and make sure the group stays on track. Since the 2017 committee chair has not yet been named, this conversation will be tabled for the time being.

WRAP UP

- There were no public comments.

- Announcements:
  February 7 is National Black HIV Awareness Day; if your agency is doing an activity, please let Ron Brown know.

- Meeting was adjourned at 11:55 a.m.

COMMITTEE RECOMMENDATIONS TO THE PLANNING COUNCIL: None.

Ryan White

Metropolitan Jacksonville Area HIV Health Services
PLANNING COUNCIL

EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS COMMITTEE

Ryan White Part A and B Programs
1809 Art Museum Drive, Suite 100 • Jacksonville, FL 32207

Friday, March 17, 2017
Summary of Meeting

Committee Members Present: Beth Parker (*Chair*), Manny Andrade, Rod Brown, Rayland Cunningham, Logan Hopkins, Vivian Lanham, Joe Mims, Aleida Nelson, Katrina Odell, Ella Russell, and Chanel Scott-Dixon

Support Staff Present: Sandy Arts, Brian Hopkins, Sandra Sikes, and Graham Watts

CALL TO ORDER

The meeting was called to order at 10:31 a.m. by Chair Beth Parker. Following a moment of silence, members did self-introductions.

UNFINISHED BUSINESS

Members reviewed the list of activities that were to be accomplished since the last meeting, and advised if each activity was completed, still in progress, or should be deleted from the list.

Activity	Respon.	Task	Activity Value	Completed?
1.1.1 - #3 Distribute ….. EIIHA routine testing packet to listed providers	Brown Mims Schmitt	*Occupational Hazard* Flyer – Several members were to meet prior to March 17 and finalize the flyer.	**0**	Remove *Occupational Hazard* Flyer from this list. It will <u>not</u> be included in the **HIV & Your Practice** packet. Committee agreed *Occupational Hazard* flyer is a good idea, but members need to focus on other assigned activities for time being. An individual, agency, or other committee can take over the development & distribution of this flyer, or the EIIHA Committee can look at it again at a later date.

Activity	Respon.	Task	Activity Value	Completed?
1.1.1 - #3 Distribute ….. EIIHA routine testing packet to listed providers	Sikes	Put ***HIV & Your Practice*** packets together & add the *Occupational Hazard* flyer when finished. Members will distribute packets to providers/ PCP's who offer HIV testing.	**0**	Part A has put together 54 *HIV & Your Practice* packets. Rod advised that the Testing Site info sheet that's included, is now outdated. He will take all packets and replace old sheets with the updated one. Rod and Joe will take *HIV & Your Practice* packets to upcoming local medical association meetings & distribute there. Rod stated the FDOH has a similar product. After this supply of packets are depleted, committee can get a sense of whether these packets are still needed, or if the FDOH product will suffice.
1.1.1 - #1 Assist FCCAPP in developing a list of potential health care providers who could offer routine HIV testing to youth	Nelson	Compile a list of Family Practice Physicians in the Jacksonville area, including address and phone number	**1**	This list was completed and emailed to Mims and Brown on 2/28 for routing on to FCCAPP. Committee decided to go a step further and develop a list of Family Practice Physicians in Nassau, Clay, and St. Johns Counties, and develop a list of walk-in clinics, urgent care centers, etc. in Duval County. Aleida volunteered to do list for outlying counties. Katrina volunteered to put together a list of urgent care & walk-in clinics.
1.1.2 - #1 Ask clergy to raise awareness about HIV during Nat'l Week of Prayer for Healing of AIDS, March 5-11	Shiloh	Provide report on local churches who participated in this event	**0**	Torrencia provided a written report that was distributed to committee members, listing the five churches participating in Nat'l Week of Prayer for Healing of AIDS.

Activity	Respon.	Task	Activity Value	Completed?
1.1.1 - #7 Sponsor block parties to disseminate prevention & care messages	Mims	Plan concert or block party to attract youth and disseminate HIV prevention message. Plans were put on hold in January; is this still on hold, moving forward, or being cancelled?	**1**	Joe has been talking with JASMYN about a tentative date of June 27 for block party. Possible location might be downtown @ Heming Park. Still in early planning stage; 6/27 date would coincide with NHTD. Joe asked Logan's help in planning. Katrina offered to contact a local band, and Vivian offered to help where needed. Joe will contact them & JASMYN and continue with the plans. Brian asked about doing something during one of the Art Walks. Crowds, food, entertainment, and security are already in place. Joe will look into that as well. There was a question on whether the HIV testing van can set up in or near Heming Park, and if FDOH can run interference with City Hall to allow the van access, if needed?
1.1.1 - #4 Encourage youth to participate in testing events	Brown	FDOH was approached by DCSB about doing a week-long testing event at several area high schools. R. Brown waiting to hear back for more details.	**0**	Rod heard back from Duval County School Board – the week-long testing event has been scrapped. However, the activity of encouraging youth to participate in testing events (1.1.1 - #4) is considered completed. The HS Teen Clinics continue to encourage testing. Torrencia provided a written report on recent events the community engaged in for NWGHAAD.
1.1.1 - #5 Identify venues where target youth congregate	Brown Sikes	Brown: To contact Stephanie Reese for list of locations & contacts. Sikes: To provide address list of those invited to the July Youth Summit.	**0**	Brown: Heard back from Ms. Reese who stated she did not have a list. The committee then identified the Art Walk and several local college campuses as venues where target youth congregate. Sikes: Emailed Youth Summit address list 1/31 and 2/23 to Brown, Mims, and Wilson. 1.1.1 - #5 has been completed.

- **EIIHA Work Plan**: Members looked over the EIIHA Work Plan that was recently revised. Graham Watts explained that the Part A Office would like to start a conversation on streamlining the efforts of this committee, along with that of the Integrated Comp Plan Committee (ICPC). EIIHA developed their work plan in 2015-2016. The ICPC finalized their Plan in the summer of 2016, and they used a number of EIIHA activities, tweaking the EIIHA goals and activities which primarily dealt with youth, and making them more for all age groups. There are a number of ICPC activities where EIIHA has an assigned part.

  The idea is to annex EIIHA as a sub-committee under ICPC. EIIHA can either meet just before the ICPC meeting, or they can be embedded within the ICPC committee. Currently, EIIHA meets every other month, five to six times a year. ICPC meets on a quarterly basis. There would be less number of meetings to attend, but then the ICPC committee meetings would probably run longer. If EIIHA committee members would like to do this, then the next step would be to present this idea at the next ICPC meeting, and get an affirmative decision from that committee.

  Graham Watts made a **motion**, seconded by Joe Mims, **to annex the EIIHA Committee to the Integrated Comp Plan Committee, as a sub-committee of ICPC**. There was no further discussion, and a voice vote taken; all were in favor, there were no nays or abstentions. This item will be brought before the ICPC's next meeting, which is scheduled for Wednesday, April 12 at 2:00 p.m.

NEW BUSINESS

- **Youth Advisory Methodology**: Graham recently met with Max Wilson regarding how to get youth participation. The first step would be getting all the stakeholders together who work with youth and focus on three questions: (1) How do we test youth, (2) How do we message youth, and (3) how do we link youth? We need to figure out how we get these questions out to youth, so they can answer us on how to best do that. As the youth groups guide us about prevention messages to youth, their guidance should become the working document for us to figure out how to accomplish what we want to do.

  Logan brought up a point that most youth are on their cell phones quite a bit, so the best method to reach youth is to utilize their phones, such as text messaging or through an app, such as Snapchat or Instagram.

Rod suggested that students in the Teen Clinics could also be asked to work on this project. Rod, Logan, and Chanel from JASMYN will take on this task with the Teen Clinics and Camp Blanding. Another plan would be to have a focus group, and perhaps have APEL take the lead on that.

WRAP UP

- There were no public comments.

- Announcements:

  Joe Mims and Timothy Jefferson are coordinating a 1-day conference for men of color. More information will be provided at a later date as details are finalized.

  Dining Out for Life is Thursday, April 27. NFAN is doing an ad campaign called 'Follow the Fork'.

- Meeting was adjourned at 11:54 a.m.

Committee Recommendation To The Planning Council: None

Committee Recommendation To The Integrated Comp Plan Committee:
Request that the Integrated Comp Plan Committee (ICPC) annex the EIIHA Committee, allowing it to become a sub-committee of ICPC.

The Jacksonville Planning Council

APRIL 2017

Mon	Tue	Wed	Thu	Fri
3	**4**	**5**	**6**	**7**
10 **HB:** Sharon Hunter Nat'l Youth HIV & AIDS Awareness Day	**11**	**12** **2:00 Integrated Comp Plan**	**13** **12:00 Community Connections**	**14**
17 HRSA Site Visit for Part A	**18** **2:30 Executive**	**19** **HB:** Kendall Guthrie	**20** 9:00 MCM Meeting	**21**
24 2:00 Jail Link	**25**	**26**	**27** **3:00 PLANNING COUNCIL** **Dining Out For Life**	**28**
			Events in **bold** are Planning Council / committee meetings held at Art Museum Dr. **MEETINGS ARE SUBJECT TO CHANGE**. To verify a meeting's start time, or to see if a meeting is still scheduled, con-	

THE STATE OF HIV HEALTH SERVICES IN THE JACKSONVILLE TRANSITIONAL GRANT AREA—RYAN WHITE PART A FOCUS

Audience: JTGA HIV Health Services Planning Council
March 23, 2017

Graham F. Watts, Sr., Ph.D

Last updated February 17, 2017

ABSTRACT

Administrative Agency leaders, including quality and data managers, the HIV Health Services Planning Council, coupled with Part A provider's commitment to Ryan White stakeholders, which includes PLWHAs, have had a positive impact on the maturation of the Jacksonville Transitional Grant Area HIV Health Services system. In the last five years, (2012-2016), more PLWHAs in Jacksonville, Florida have experienced the salutary benefits of antiretroviral therapy (ART). Clearly, ART is the pharmacological agent of improved immune system functioning; however, ART alone without the network of local, community-based ecological resources would not reach distressed groups most severely impacted by barriers of access to HIV care. Hence, this presentation sets forth the coordinated efforts by multiple participants and the cumulative impact of those efforts on PLWHAs. Notwithstanding the enormity of the work that has been in progress, more remains to be accomplished to continue closing gaps in access to care and health outcomes for the most vulnerable.

TABLE OF CONTENTS – MAJOR THEMES

3

PURPOSE OF PRESENTATION

- The purpose of this presentation is to demonstrate how the Jacksonville Transitional Grant Area, (JTGA), has matured as a competent, service delivery entity. From its rudimentary beginning, in 1994, as a miscellany of independent providers, operating is silos, and competitively pursuing Ryan White funding; today, Part A network Providers operate as a cohesive and collaborative unit that shares ideas, co-develops strategies, and works across funding streams for ensuring that HIV health services pursue the 90-90-90 policy to improve access to a continuum of care and quality of care outcomes for people living with HIV/AIDS. The role of Ryan White Part A Continuous Quality Management, with its continuous quality management, (CQM), research focus has been pivotal to the development of the JTGA. Much of this maturation would not have occurred without Mayor Ed Austin's Executive Order, 94-186, management and supervision by Division Chiefs, beginning with Virgil Green, and the transformational leadership of Deidre V. Kelley, retired City of Jacksonville Ryan White Program Manager, (1995 to 2016).

4

TERMINOLOGY

- Health Equity
  - "The absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality."[1]
- Health Disparities
  - "Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations"[2]
- Social Determinants of Health
  - "The conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.[3]
- Quality Assurance
  - The focus on compliance with minimum, regulatory standards
- Quality Improvement
  - The systematic process defining, implementing, evaluating, & refining efforts to become better in the areas of structure, processes, outputs, and outcomes of HIV care and services
- Gap Analysis
  - The discrepancy between current and future states—where we are now and where we want to be in the future
- EBDM
  - "Evidence-based [decision-making] is the [using] the best available evidence together with a clinician's expertise and a patient's values and preferences in making health care decisions"[3]
- 90-90-90 Policy ("framed as the HIV care and treatment cascade)
  - 90% of people with HIV worldwide are diagnosed, 90% of those diagnosed start ART, and 90% of those taking ART achieve virologic suppression.[4]

5

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

BACKGROUND: RUDIMENTARY BEGINNING

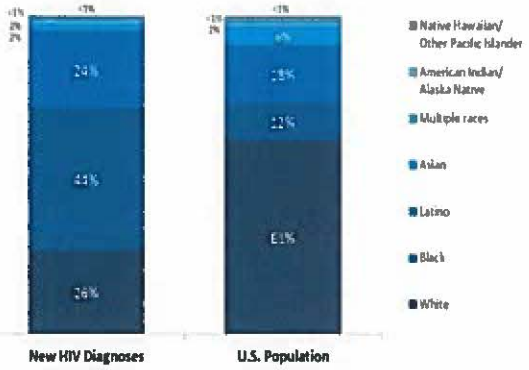
- Bids and Fierce Provider Competition
  - Service providers shared little, if any health services delivery knowledge and did not work collaboratively on projects
- Culture of Independence
  - Before the CAREWare era, no case consultations existed, standardization of practices such as Medical Case Management assessments were a novel idea, and tracking client service encounter were practically impossible
- Policy Free Era
  - No requirement existed to tie utilization of ancillary service to enrollment in HIV primary medical care
  - Unit cost reimbursement unknown
  - No standards existed for delivery of Medical Case Management
  - No local, centralized online resource for Ryan White Part A quality managers and quality teams
- Outsourced Quality Improvement Monitoring
  - Inspection based
  - Problem oriented, (focused on fault finding)
  - Lacked conceptual focus

6

SNAPSHOT OF THE U.S. HIV EPIDEMIC

- "Today, **more people are living with HIV than ever before** as people are living longer with the disease, new infections continue to occur, and diagnoses surpass deaths each year.
- Number of new HIV diagnoses, 2014: **44,784**
- **Number of people living with HIV: 1.2 million**
- Percent of people infected with HIV who don't know it: **13%**
- Percent of people with HIV who are **virally suppressed: 30%.**"[1]

Figure 1
New HIV Diagnoses & U.S. Population, by Race/Ethnicity, 2015

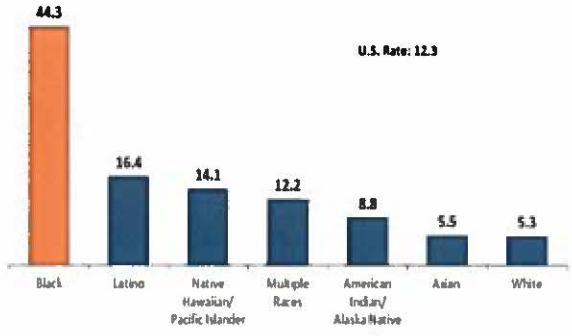


SOURCE: CDC. *HIV Surveillance Report, Diagnoses of HIV infection in the United States and Dependent Areas, 2015.* Vol. 27. November 2016. HIV diagnosis data are preliminary estimates from 50 states, the District of Columbia, and 6 U.S. dependent areas. KFF State Health Facts; accessed January 2017.

7

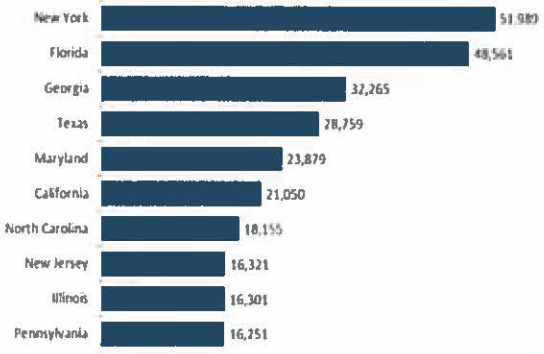
SNAPSHOT OF THE U.S. HIV EPIDEMIC

Figure 2
Rates of New HIV Diagnoses per 100,000, by Race/Ethnicity, for Adults/Adolescents, 2015



NOTE: Data are estimates for adults/adolescents aged 13 and older and do not include U.S. dependent areas.
SOURCE: CDC. *HIV Surveillance Report, Diagnoses of HIV Infection in the United States and Dependent Areas, 2015.* Vol. 27; November 2016

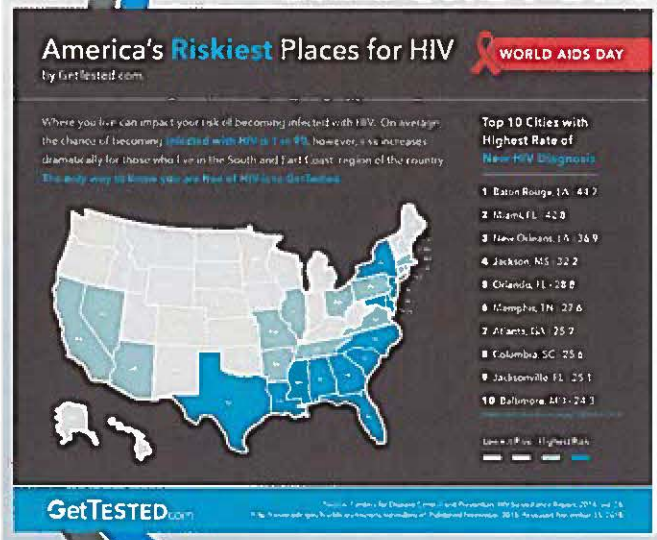
Figure 3
Number of Black Adults/Adolescents Estimated to be Living with an HIV Diagnosis, Top 10 States, year-end 2014



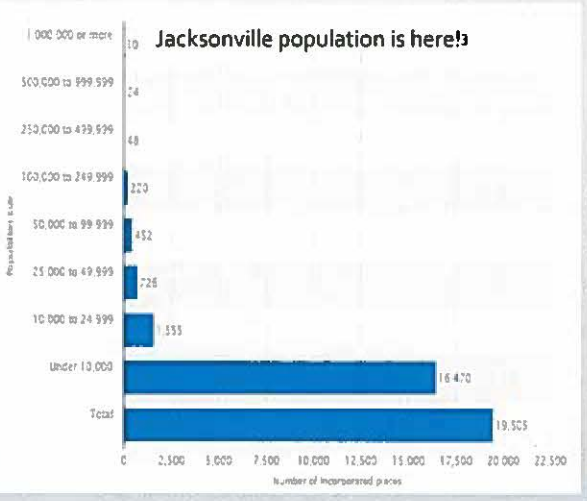
NOTES: Data are estimates for adults/adolescents aged 13 and older.
SOURCE: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Atlas Plus; accessed February 2017.

8

SNAPSHOT OF THE U.S. HIV EPIDEMIC



Number of Cities, Towns, & Villages In the U.S. In 2015[3]



9

Sources: 1. [illegible] 2. [illegible] 3. [illegible]

WEATHERING THE BLIZZARD OF DISEASES

10 Leading Causes of Death by Age Group, United States – 2014

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,745	Unintentional Injury 1,711	Unintentional Injury 730	Unintentional Injury 750	Unintentional Injury 11,839	Unintentional Injury 17,157	Unintentional Injury 20,614	Malignant Neoplasms 44,834	Malignant Neoplasms 118,282	Heart Disease 489,722	Heart Disease 614,348
2	Short Gestation 4,173	Congenital Anomalies 399	Malignant Neoplasms 436	Suicide 425	Suicide 5,078	Suicide 6,569	Malignant Neoplasms 11,267	Heart Disease 34,791	Heart Disease 74,473	Malignant Neoplasms 415,858	Malignant Neoplasms 591,699
3	Maternal Pregnancy Comp. 1,574	Homicide 384	Congenital Anomalies 192	Malignant Neoplasms 418	Homicide 4,144	Homicide 4,159	Heart Disease 10,368	Unintentional Injury 20,611	Unintentional Injury 18,030	Chronic Low. Respiratory Disease 134,883	Chronic Low. Respiratory Disease 147,101
4	SIDS 1,545	Malignant Neoplasms 321	Homicide 123	Congenital Anomalies 156	Malignant Neoplasms 1,589	Malignant Neoplasms 3,624	Suicide 6,706	Suicide 8,787	Chronic Low. Respiratory Disease 18,482	Cerebro-vascular 113,308	Unintentional Injury 136,053
5	Unintentional Injury 1,105	Heart Disease 149	Heart Disease 89	Homicide 156	Heart Disease 983	Heart Disease 3,341	Homicide 2,588	Liver Disease 8,627	Diabetes Mellitus 13,342	Alzheimer's Disease 82,604	Cerebro-vascular 133,103
6	Placenta Cord. Membranes 965	Influenza & Pneumonia 108	Chronic Low Respiratory Disease 68	Heart Disease 122	Congenital Anomalies 377	Liver Disease 729	Liver Disease 2,582	Diabetes Mellitus 6,052	Liver Disease 12,782	Diabetes Mellitus 54,181	Alzheimer's Disease 93,541
7	Bacterial Sepsis 544	Chronic Low Respiratory Disease 69	Influenza & Pneumonia 57	Chronic Low Respiratory Disease 71	Influenza & Pneumonia 199	Diabetes Mellitus 708	Diabetes Mellitus 1,999	Cerebro-vascular 3,349	Cerebro-vascular 11,727	Unintentional Injury 48,295	Diabetes Mellitus 76,488
8	Respiratory Distress 480	Septicemia 53	Cerebro-vascular 48	Cerebro-vascular 63	Diabetes Mellitus 181	HIV 583	Cerebro-vascular 1,745	Chronic Low. Respiratory Disease 4,402	Suicide 7,527	Influenza & Pneumonia 44,836	Influenza & Pneumonia 55,227
9	Circulatory System Disease 444	Benign Neoplasms 38	Benign Neoplasms 36	Influenza & Pneumonia 41	Chronic Low Respiratory Disease 178	Cerebro-vascular 579	HIV 1,174	Influenza & Pneumonia 2,731	Septicemia 5,709	Nephritis 39,967	Nephritis 48,146
10	Neonatal Hemorrhage 441	Perinatal Period 38	Septicemia 33	Benign Neoplasms 36	Cerebro-vascular 177	Influenza & Pneumonia 549	Influenza & Pneumonia 1,125	Septicemia 2,514	Influenza & Pneumonia 5,390	Septicemia 29,124	Suicide 42,773

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™

Source: 1. [illegible]

POPULATION HEALTH DISPARITIES ARISING FROM SDH

- **Social Morbidities**
  - Dropping out of school
  - Unemployment or underemployment
  - Homelessness
  - Food Insecurity
- **Psychological Morbidities**
  - Depression
  - Suicidal ideation/attempts
  - Anxieties: GAD
- **Physiological Morbidities**
  - HIV
  - NIDDM
  - HTN
  - Syndrome X
- **Emotional Morbidities**
  - Stigma
  - Fear of rejection
  - Low health literacy
  - Family dysfunctions
- **Behavioral Morbidities**
  - Low engagement in primary prevention
  - Poor history of health care engagement
  - Not proactive (wait & see posture)
- **Community Morbidities**
  - Perpetrated Violence
  - Unintentional Injuries
  - Drug Use Culture
  - Criminal Justice Involvement

11

SDH: Social Determinants of Health are the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality of life outcomes and risks.
PETUNIA Specific

PRIORITIZED HEALTH NEEDS IN NORTHEAST FLORIDA-2016

Exhibit 1: Significant Community Health Needs by Hospital

	Baptist Beaches - Duval and St. Johns	Baptist Jacksonville - Duval	Baptist Nassau - Nassau	Baptist South - Clay, Duval, and St. Johns	Brooks Rehabilitation - Baker, Clay, Duval, Nassau, and St. Johns	Mayo Clinic Florida - Duval and St. Johns	St. Vincent's Clay - Clay	St. Vincent's Riverside - Duval	St. Vincent's South Side - Duval	UF Health Jacksonville - Duval	Wolfson Children's - Baker, Clay, Duval, Nassau, and St. Johns
Access	•	•	•	•	•	•	•	•	•	•	•
Alcohol/Substance Abuse			•								
Built Environment					•						
Cancer			•	•			•				
Communicable Diseases	•	•		•		•		•	•	•	
Dental Care			•	•			•				•
Diabetes	•	•		•		•	•	•	•	•	
Health Disparities	•	•	•	•	•	•	•	•	•	•	•
Maternal and Child Health	•	•	•	•		•	•	•	•	•	•
Mental Health	•	•	•	•	•	•	•	•	•	•	•
Nutrition, Physical Activity, and Obesity	•	•	•	•	•	•	•	•	•	•	•
Poverty	•	•		•		•		•	•	•	•
Smoking		•		•		•		•	•	•	•
Stroke Prevention					•						
Transportation	•	•	•	•	•	•	•	•	•	•	•
Unintentional Injury					•						•
Unprotected Sex/Teen Pregnancy											•

Jacksonville Metropolitan Community Benefit Partnership
Summary of CHNA Findings

4

11

SERVICE CAPACITY & RESOURCES TO ADDRESS NEEDS

- Plethora of support services wrap around HIV ambulatory medical care in Duval County
- Largely adult oriented system of HIV care
- Prevention and patient care foci operated apart
- Availability of and accessibility to quality dental care remains limited
- Food pantry services is a new addition
  - Not 100% uniquely tailored to complex needs of PLWHAs
- Medical transportation remains an ongoing challenge in Jacksonville
  - Jacksonville is the largest city by area in the contiguous United States – 840 square miles[1]
- Up to 2014, only three HIV medical providers existed
  - Year 2015 saw addition of another medical provider
  - Year 2017, another medical provider is expected, along with another dental provider
- For most of our history, the program funded only one dietitian
  - A second dietitian was added in 2014 to service 4400 clients

13

1. http://www.coj.net/[illegible]/fact.aspx

SIGNIFICANCE OF JTGA CQM RESEARCH FOCUS

- A researched based continuous quality management focus rests on a quality improvement framework, (QIF). In turn, the framework relies on evidence derived from programmatic questions and/or issues that originate in specific service delivery settings, within defined HIV subgroups in the context of each provider's strengths, weaknesses, opportunities, and threats to service effectiveness. Thus, the annual Administrative Agency site visits with funded providers offer tailored feedback, both oral and written, to planned improvement activities. This approach values the uniqueness of each provider context and mix of resources, creates a framework for dialog about problem definition and potential solutions, and incentivizes application of new understanding to the PDCA, (Plan, Do, Check, Act), quality improvement process.

14

SIGNIFICANCE OF JTGA CQM RESEARCH FOCUS CONT'D

- The JTGA research-based quality improvement framework, (QIF), centers around five principles—PACTT[1]:
  - Proportionality: Service delivery improvements have defined scope and are time bound
  - Accountability: Improvement planning focuses on evidence of need from structure, process, and outputs
  - Consistency: Provider are incentivized to work from a multi-year quality agenda operationalized annually
  - Transparency: Providers submit an annual CQI plan for review and approval before implementation
  - Targeting: Providers focus improvement activities in at least one of eight quality domains:

15

Notes: HCC is HIV ... Linked to Care, In-Care, On-Art, Viral Suppression

SIGNIFICANCE OF JTGA CQM RESEARCH FOCUS CONT'D

- Targeting: Providers focus improvement activities in at least one of eight quality domains:
  - Involvement in care and services: Clients are engaged as partners in the development of individualized service plans
  - Effectiveness of care and services: Benefits outweigh risks
  - Efficiency of care and services: Wastes are minimized (doing things right and doing them consistently)
  - Efficacy of care and services: Service contribute to ultimate outcomes as defined by the HCC
  - Continuity of care and services: Wrap around services are based on accurately assessed needs
  - Accessibility of care and services: Elimination of barriers to care and services
  - Safety of care and services: Do no harm philosophy
  - Timeliness of care and services: Right time, right intensity of service dose, right frequency

16

Notes: HCC is HIV ... Linked to Care, In-Care, On-Art, Viral Suppression

SIGNIFICANCE OF JTGA CQM RESEARCH FOCUS CONT'D

- In laypersons terms, the practical implementation of CQM in the JTGA is analogous to the bread making process. "Bread is the product of baking a mixture of flour, water, salt, yeast and other ingredients. [Similarly, service delivery excellence is the product of managing a mixture of delivery systems, training, motivators & rewards, employee roles and expectations, policies and procedures, and management support].[1] With bread, the basic process involves mixing ingredients until the flour is converted into a... dough, followed by baking the dough into a loaf."[2] The yeast, (a.k.a., leavening agent), is to the dough what quality management is to service excellence—the structures and processes of HIV care and services. Leaven expands dough; CQM expands performance-improvement strategies to close service gaps and increase client outcomes.

17

Source: 1 [illegible] 2 - http://www.bakerlo.co.nz/Learn/Bread-making/Science-of-bread-making

QUALITY ASSURANCE & IMPROVEMENT

- **The practical application of JTGA's research-based quality improvement framework/focus is:**
  1. Find a process, an opportunity, a regulatory requirement, and so on to improve
  2. Organize an effort, led by a team, to work on the improvement
  3. Clarify current knowledge and understanding of the process as it currently exists
  4. Understand the etiology of process variation and process capabilities
  5. Select a top priority and alternative improvement strategies
  6. Plan the improvement
  7. Do the improvement
  8. Check the results of the improvement
  9. Act to hold gains
  10. Move on to next process, opportunity, or requirement and repeat steps 1 to 9

18

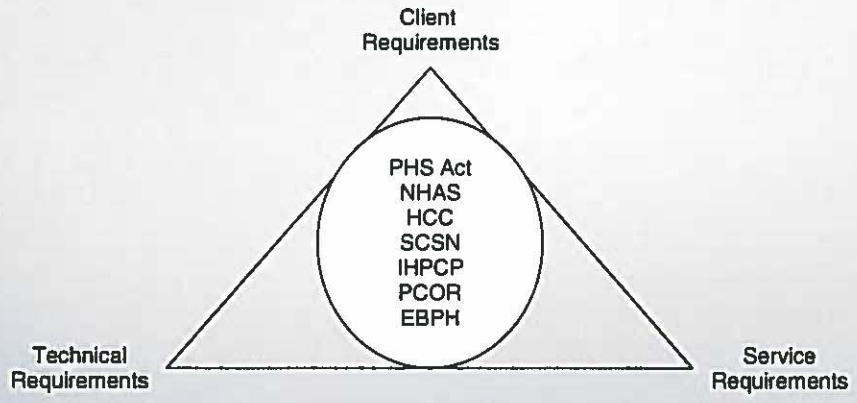
QUALITY ASSURANCE & IMPROVEMENT

Stakeholders	EBDM Role/s	Responsibilities
JTGA Admin Agency & CQM Coordinator	Leadership & Management	Instigator: Provides vision, direction, motivation, supervision, CQM site visit, and feedback to Community Based Organizations, (CBOs).
Agency Executive Directors	Facilitation & Empowerment	Podium Personality (Out Front): They are the champions of each agency CQM program activities. Aligns operational CQM with the business case; maintains and supports a culture of service delivery excellence
JTGA HIV Planning Council	Governance, Monitoring & Feedback	Surveyor: Evaluates the direction and progress of the TGA's implemented CQM plan to determine whether it aligns with the National HIV/AIDS Strategy goals and indicators.
Provider CQM Team Lead	Host, Information and Ideation Repository	Work Horse: Works collaboratively with peers and subordinates to design, tailor, implement, and monitor an approved quality management plan using tools such as FOCUS PDCA, gap analyses, root cause analyses, Gantt charts, Processing Mapping, IPO charts, Six Sigma DMAIC tools, etc., consistent with COJ RW Quality In Service Policy Nos. III A & B, approved Nov 13, 2013 & Jan 15, 2015, respectively.
CAREWare Data Manager	Data Security & Management	Photographer: Captures repeated snapshots of service processes, outputs, and outcomes using a centralized, enterprise level database that allows for documentation of billing, data sharing, project management, and IT, (Information Technology) management
PLWHA	Cultural Expert, Critical Reviewer, Sounding Board, & Service Advisor	Spot Checker: Provides checks and balances by helping out on Provider's Consumer Advisory Boards and the JTGA Client Advocacy Committee and the local Peer Navigator's Cooperative.

EBDM is Evidence-based Decision Making

QUALITY ASSURANCE & IMPROVEMENT

- The JTGA research-based quality improvement framework, (QIF), centers around three domains—CTS:

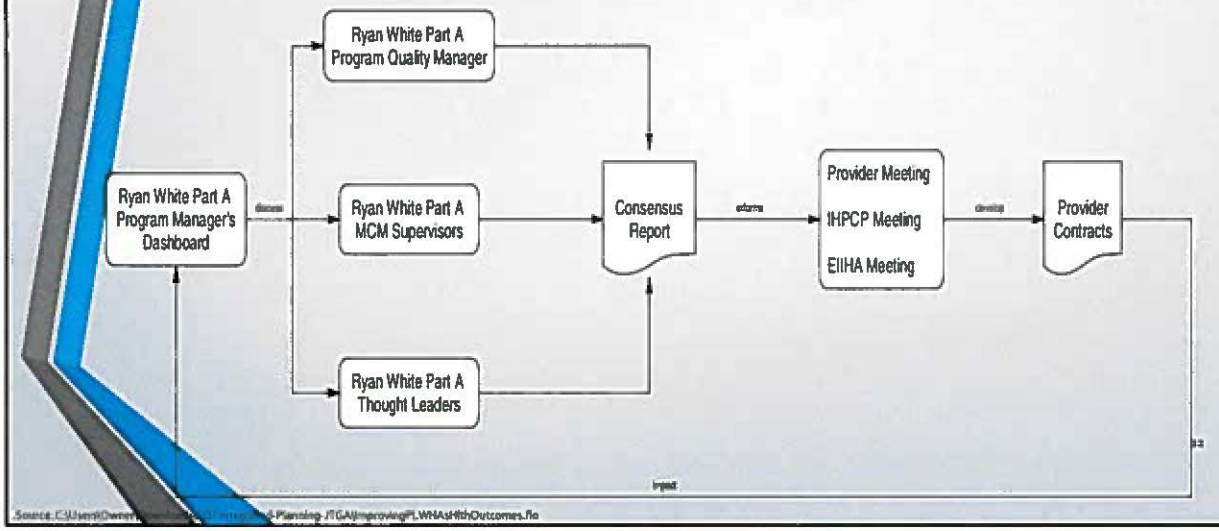


METHODS: SYSTEM LEVEL FOCI

- Leadership: Directing, Implementing, & Motivating
  - Challenges, motivates, honoring teamwork, visioning, setting goals, evaluating strategies
- Identification of Task Forces
  - Inviting people with expertise to voluntarily take ownership for change
- Define a Manageable Scope of Work
  - Not asking for too much for too long
- Facilitate Meetings
  - Part A support staff prepare agendas & Minutes, send out meeting reminders, and set up the room with refreshments
- Honor Stages of Group Development
  - Forming, Storming, Norming, Performing, & Dissolving
- Acknowledge Excellence
  - Verbal praise, submit candidates for numerous community awards, write letters of reference, agency recognition, offer prestigious appointments on Ryan White committees, and so on

METHODS CONT'D: SYSTEM LEVEL FOCI

Framework for Improving Health Outcomes & Reducing Health Related Disparities among PLWHAs in the Jacksonville Transitional Grant Area

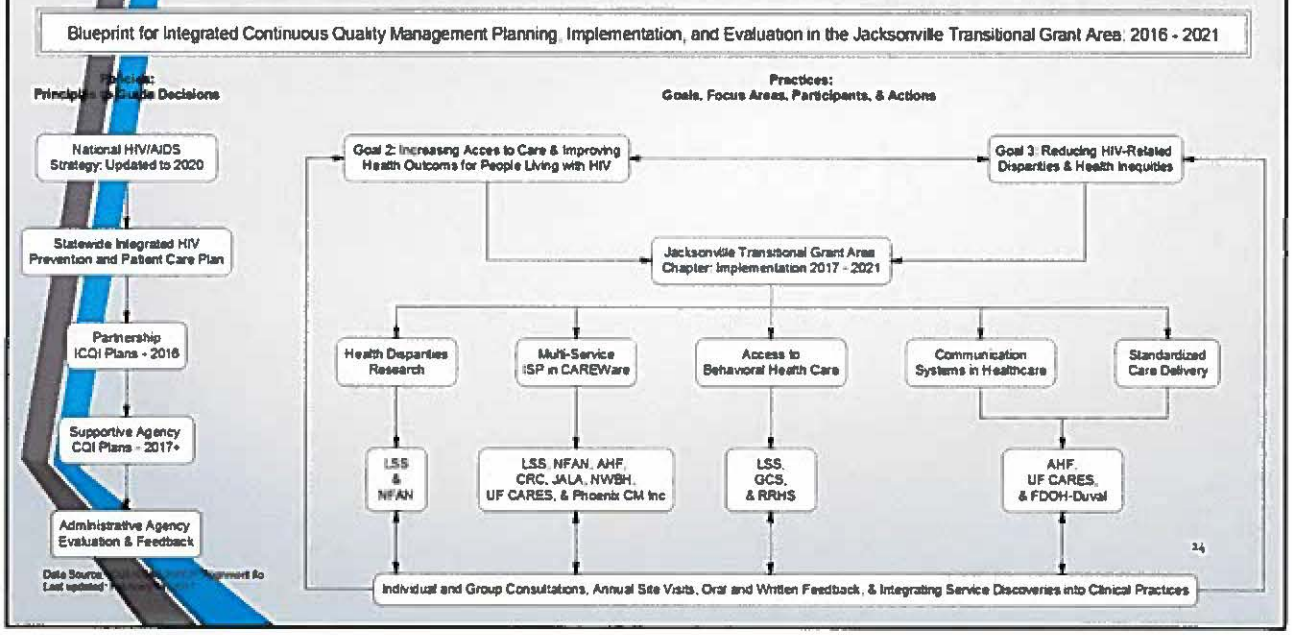


METHODS CONT'D: SYSTEM LEVEL FOCI

Table 1: JTGA System Level Gap Analysis & Gap Closing Quality Improvement Strategies

Gap #	Identified Gap	Gap Closing Quality Improvement Strategy
1	Incarceration	CAPRICE Intervention
2	Eligibility Only Service	ID third-party Provider at Client Eligibility
3	Lost to Care	Retention In Care Coordination
4	Medical Case Management Quality	Local MCM Manual & Certification Process
5	Agency Only Quality Improvement	Installation of Integrated Continuous Quality Management in 2016
6	Health Disparities Barriers	Refocused MAI
7	Non-Alignment of RFP Process with Quality Improvement	Revised Year 2017 Renewal Proposal
8	No Local Compendium of Quality Improvement Resources	Developed, Published, & Maintaining qualityinservice.com
9	Professional Silence	Publishing Results of Our Work
10	Adult Oriented HIV Care System	Initiated Planning for Development of Youth Centric HIV Care System

METHODS CONT'D: PROVIDER LEVEL FOCI



METHODS CONT'D: PROVIDER LEVEL FOCI

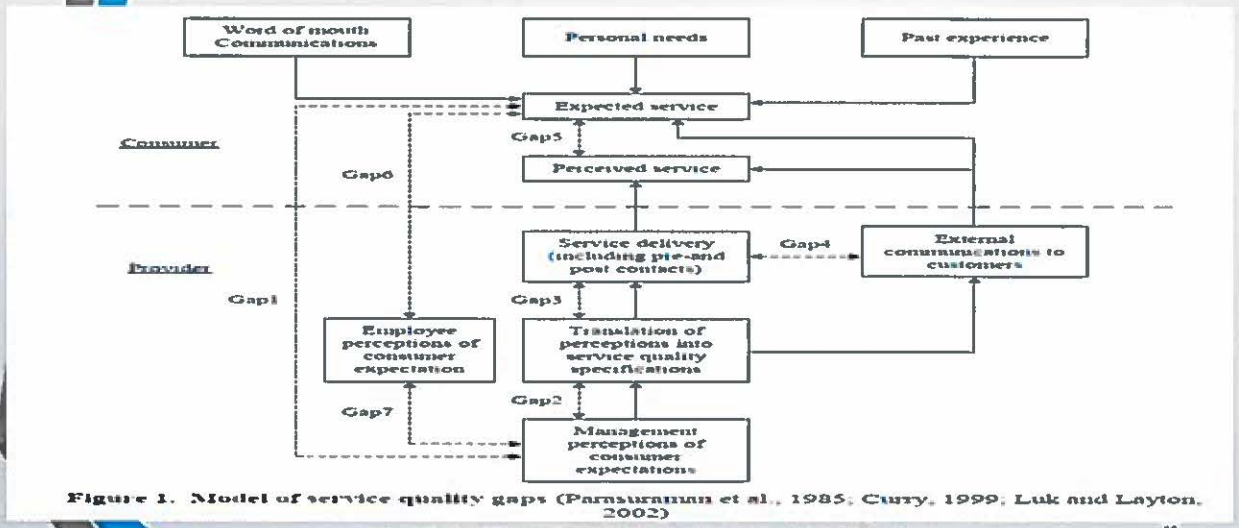


Figure 1. Model of service quality gaps (Parasuraman et al., 1985; Curry, 1999; Luk and Layton, 2002)

The Place Where the Quality Rubber Meets the Road

Source: https://www.linkedin.com/pulse/identifying-your-service-quality-gaps-atanu-nandy

METHODS CONT'D: PROVIDER LEVEL FOCI

Table 2: JTGA Provider Level Gap Analysis & Gap Closing Quality Improvement Strategies

Gap #	Identified Gap[1]	Provider Level Gap Closing Quality Improvement Strategy
1	Customers' expectations vs. management perceptions	Closing communication gaps by creation of Client Advisor Boards; staff training, employment of model PLWHAs as Peer Navigators and Case Management Associates & comment boxes
2	Management perceptions vs. service specifications	For standardization of Medical Case Management encounters, the JTGA produced an disseminated an MCM manual, and hosts MCM supervisor's meeting monthly
3	Service specification vs. service delivery	For commitment to service quality, providers have a dedicated FTE for a quality manager and a QI team that is responsible for definition, implementation, and sustainability of quality
4	Service delivery and external client communications	For maintaining therapeutic/helping relationships with clients, providers send appointment reminders and you missed your appointment notices to help clients reschedule visits
5	Discrepancy between what clients perceived services should be and what they encounter	For promoting realistic service expectations by clients, providers do service orientation, offer client centered care, & involve clients in decisions that affect their well-being on the front end. On the backend, providers review clients' complaints and make service adjustments
6	Discrepancy between clients expectations vs. provider staff perceptions client expectations	For closing cultural barriers to services,, agencies diversify staff, offer cultural competency workshops, and host support groups where such efforts promote retention in medical care.
7	Discrepancy between staff and management perceptions of customer expectations	For developing a cadre of competent service professionals, providers annual employee evaluations, supervision, and on-going professional development training minimize staff performance gaps

Source: 1. https://www.linkedin.com/pulse/identifying-your-service-quality-gaps-atanu-nandy

RESULTS: PART-A TREATMENT CASCADE, JTGA 2016

Number & Percentage of PLWHAs in JTGA Year 2016 Treatment Cascade by Aggregate and Demographics				
	Linked2Care	In Care	On ART	VL Suppression
TGA's Aggregate	4155/4349 = 95.5%	3903/4349 = 89.7%	3696/4349 = 85%	3309/4349 = 76.1%
Demographics				
Female	1587/1626 = 97.6%	1461/1626 = 89.9%	1404/1626 = 86.3%	1245/1626 = 76.6%
Male	2526/2671 = 94.6%	2402/2671 = 89.9%	2253/2671 = 84.4%	2030/2671 = 76%
Transgender	42/52 = 80.8%	40/52 = 76.9%	39/52 = 75%	34/52 = 65.4%
Black	2966/3105 = 95.5%	2784/3105 = 89.7%	2642/3105 = 85.1%	2356/3105 = 75.9%
White	996/1044 = 95.4%	941/1044 = 90.1%	886/1044 = 84.9%	801/1044 = = 76.7%
Other	193/200 = 96.5%	178/200 = 89%	168/200 = 84%	152/200 = 76%
Less than 2 Years	52/52 = 100%	52/52 = 100%	0/52 = 0%	30/52 = 57.7%
2- 12 Years	38/44 = 86.4%	38/44 = 86.4%	15/44 = 34.1%	38/44 = 86.4%
13-24 Years	255/287 = 88.9%	255/287 = 88.9%	143/287 = 49.8%	133/287 = 46.3%
25-34 Years	779/829 = 94%	718/829 = 86.6%	718/829 = 86.6%	630/829 = 76%
35-44 Years	826/864 = 95.6%	754/864 = 87.3%	750/864 = 86.8%	673/864 = 77.9%
45-54 Years	1188/1237 = 96%	1085/1237 = 87.7%	1074/1237 = 86.8%	995/1237 = 80.4%
55-64 Years	844/861 = 98%	828/861 = 95.8%	825/861 = 95.8%	671/861 = 77.9%
65+ Years	173/175 = 98.9%	173/175 = 98.9%	171/175 = 97.7%	139/175 = 79.4%

The JTGA is o 3% away from meeting the NHAS minimum standard of 90+% PLWHAs in-Care & 3.9% away from meeting the NHAS[17] minimum standard of 80+% PLWHAs with viral suppression! Two components of the 90-90-90 policy are within reach.

Source: C:\[illegible]\Annual-CAREWare-Jan-DataRequest\Completed-AnnualCAREWareDataReport-2017rev1.xlsx

RESULTS: PART-A TREATMENT CASCADE, JTGA 2016

Comparison of Selected HIV Continuum of Care Measures by TGA & Provider During Calendar Year 2016

HCC 2016	In Care	On ART	VL Suppression
JTGA (Part-A)	89.7%	85.0%	76.1%
Medical Provider 1	Lower	Higher	Higher
Small MCM Agency	Higher	Lower	Lower
Medical Provider 3	Higher	Lower	Higher
Other Agency 1	Higher	Higher	Lower
Other Agency 2	Lower	Lower	Lower
Large MCM Agency	Equal	Higher	Higher
Large MCM Agency	Higher	Higher	Higher
Large MCM Agency	Higher	Higher	Higher
Medical Provider 2	Higher	Lower	Lower
Total Providers Exceeding the JTGA Rate	67%	56%	56%

Note: Agency names are masked for privacy for comfort during the presentation

Source: C:\[illegible]\Annual-CAREWare-Jan-DataRequest\Completed-AnnualCAREWareDataReport-2017rev1.xlsx

RESULTS: PART-A LINKED TO CARE-VIRAL SUPPRESSION RATE DIFFERENCES, JTGA 2012 vs. 2016

Groups	LKTC-VLS % Rate Diff_2012	LKTC-VLS % Rate Diff_2016	Percentage Reduction
JTGA	41.6	19.4	53.4%
Female	44	21	52.3%
Male	41.4	18.6	55.1%
Trans	53.5	15.4	71.2%
Black	43.9	19.6	55.4%
White	40.8	18.7	54.2%
Other	47.4	20.5	56.8%
< 2	94.9	42.3	55.4%
2 to 12	76.7	0	100.0%
13 to 24	48.6	42.6	12.3%
25 to 34	47	18	61.7%
35 to 44	42.4	17.7	58.3%
45 to 54	39.5	15.6	60.5%
55 to 64	26.4	20.1	23.9%
65+	36.9	19.5	47.2%

LKTC-VLS % Rate Diff is the gap in percentage of PLWHAs linked to care and those who experience viral suppression!

Source: C:\Users\...\Annual CAREWare Jan DataRequest\Completed\AnnualCAREWareDataReport-2017rev1.xlsx

RETURN to ...

29

RESULTS: PART-A DATA COMPLETENESS RECORD

For January 1, 2016, through October 11, 2016, only three entities had missing data elements greater than 10%—the threshold set by HRSA. The data elements included:

1. Race—Hispanic, (76%), Asian (30%), and Native Hawaiian/Pacific Islander subgroups (17%),
2. Health insurance, (15%), and
3. HIV Risk factors, (13%).

CAREWare has 45 RSR data elements, and of these, 40, (89%), have at least 90% data completeness. The JTGA continues to exercise vigilance regarding data completeness and validity.

30

RESULTS CONT'D: QUALITY ASSURANCE, JTGA 2016

Figure 1: Percentages of Outpatient Medical Care Records In 2016 that Fully Met Seven Chart Review Requirements

Chart Review Requirements	Medical Provider 1	Medical Provider 2
Number of Records Examined	10	10
Proof of Positivity	100%	1000%
Notice of Eligibility	100%	1000%
Payer of Last Resort	100%	1000%
In-Care (2+ OAMC/Year)	100%	1000%
Treatment Progress Monitoring	100%	1000%
HAB Measures Documentation	100%	1000%
Services Consistent with Eligibility	100%	1000%

Source: [illegible] Part-A-2016SiteVisitChartReview.xlsx in desktop Grant-Appln folder & Website CQI folder

RESULTS CONT'D: QUALITY ASSURANCE, JTGA 2016

Figure 2: Percentages of Medical Case Management Records In 2016 that Fully Met Seven Chart Review Requirements

Chart Review Requirements	MCM Provider 1	MCM Provider 2
Number of Records Examined	10	10
Proof of Positivity	100%	100%
Notice of Eligibility	100%	100%
Payer of Last Resort	100%	100%
In-Care (2+ OAMC/Year)	100%	100%
Treatment Progress Monitoring	100%	100%
HAB Measures Documentation	100%	100%
Services Consistent with Eligibility	100%	100%

Source: [illegible]

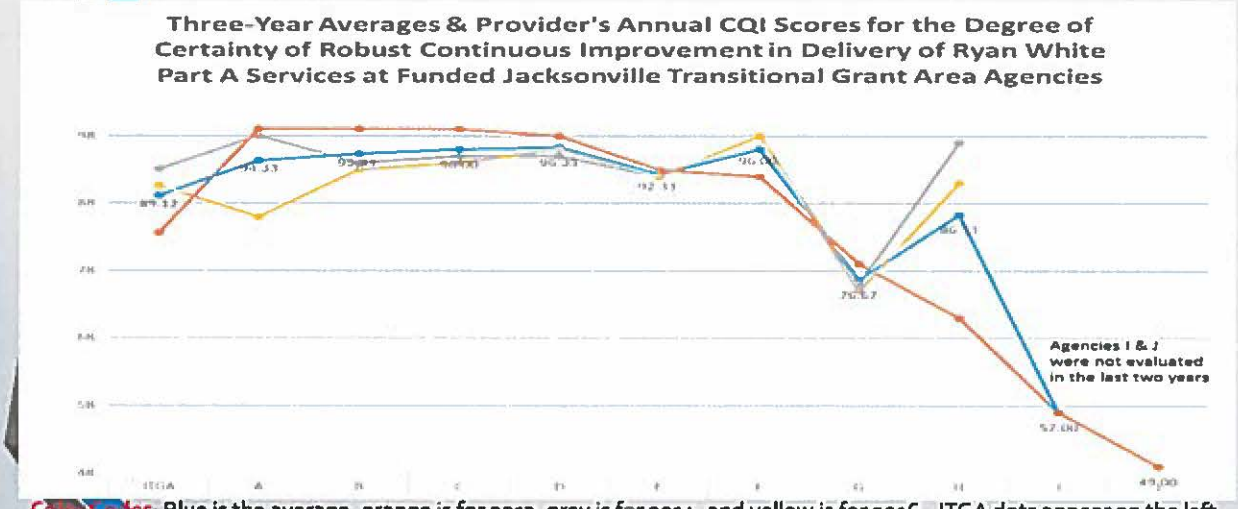
RESULTS CONT'D: QUALITY ASSURANCE, JTGA 2016

Figure 3: Percentages of Medical Case Management Records In 2016 that Fully Met Seven Chart Review Requirements

Chart Review Requirements	Medical Provider 1	Medical Provider 2
Number of Records Examined	8	10
Proof of Positivity	100%	100%
Notice of Eligibility	100%	100%
Payer of Last Resort	100%	100%
In-Care (2+ OAMC/Year)	100%	100%
Treatment Progress Monitoring	100%	90%
HAB Measures Documentation	100%	100%
Services Consistent with Eligibility	100%	100%

Source: https://qual[illegible]/default/files/CQI/QualityAssuranceSiteVisitRpt_2016.pdf

RESULTS CONT'D: QUALITY MANAGEMENT, JTGA 2016

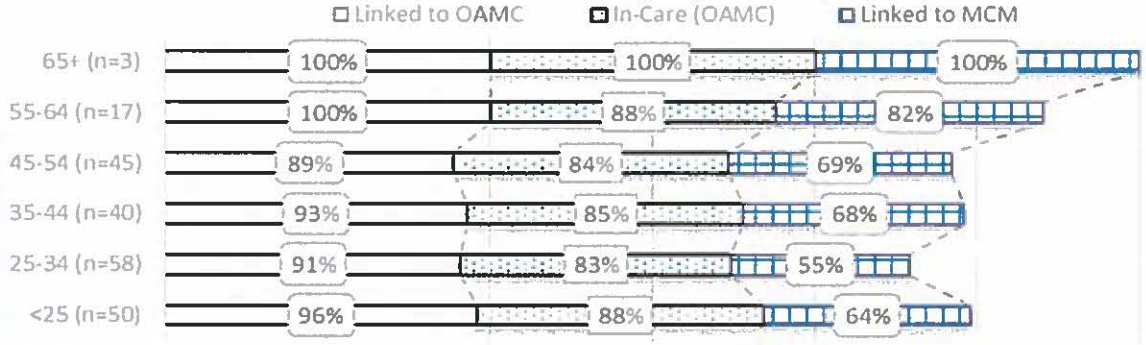


Color Codes: Blue is the average, orange is for 2013, grey is for 2014, and yellow is for 2016. JTGA dots appear on the left.

Source: C:\Users\[illegible]\Integrated Planning-JTGA\Graphs2014, 2016CQISiteVisitScores.xlsx; Prepared June 27, 2016

RESULTS: QUALITY MANAGEMENT, JTGA

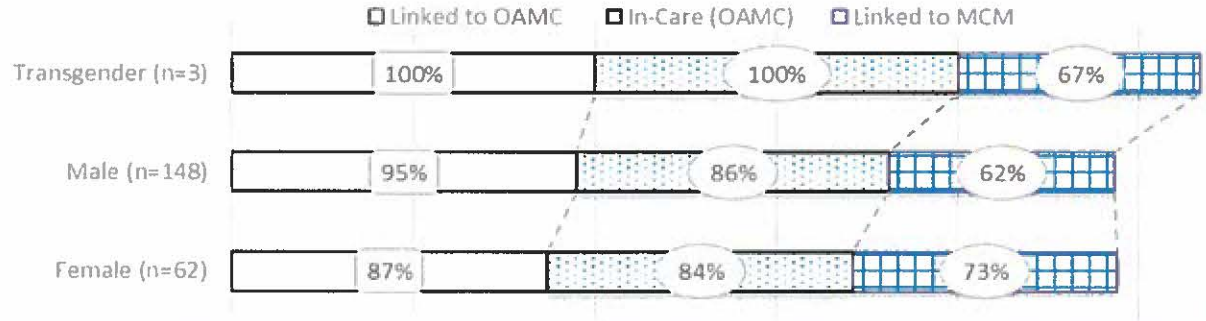
Figure 1: JTGA Year 2015 Outpatient Medical Care & Medical Case Management Utilization for 213 Newly Diagnosed PLWHAs by Age-Groups



JTGA disparities analyses provided to MCM Supervisors Task Force & Agency Quality Managers

RESULTS CONT'D: QUALITY MANAGEMENT, JTGA

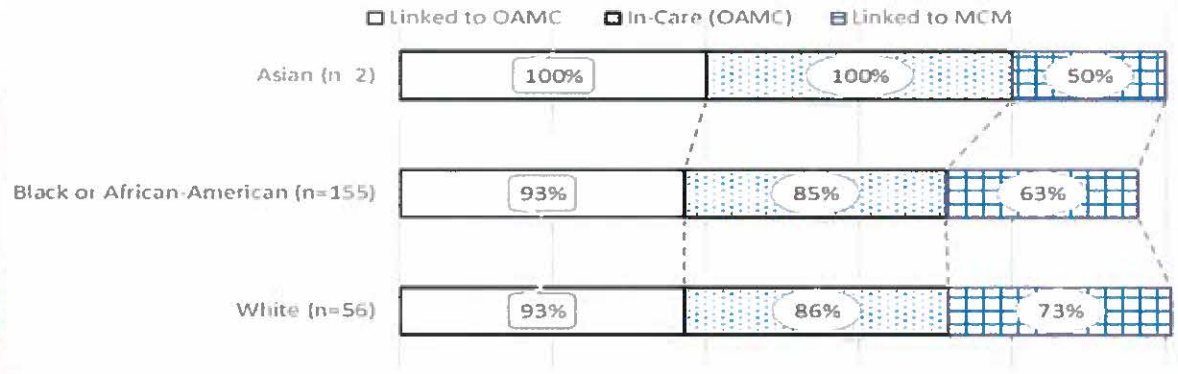
Figure 2: JTGA Year 2015 Outpatient Medical Care & Medical Case Management Utilization for 213 Newly Diagnosed PLWHAs by Gender



JTGA disparities analyses provided to MCM Supervisors Task Force & Agency Quality Managers

RESULTS CONT'D: QUALITY MANAGEMENT, JTGA

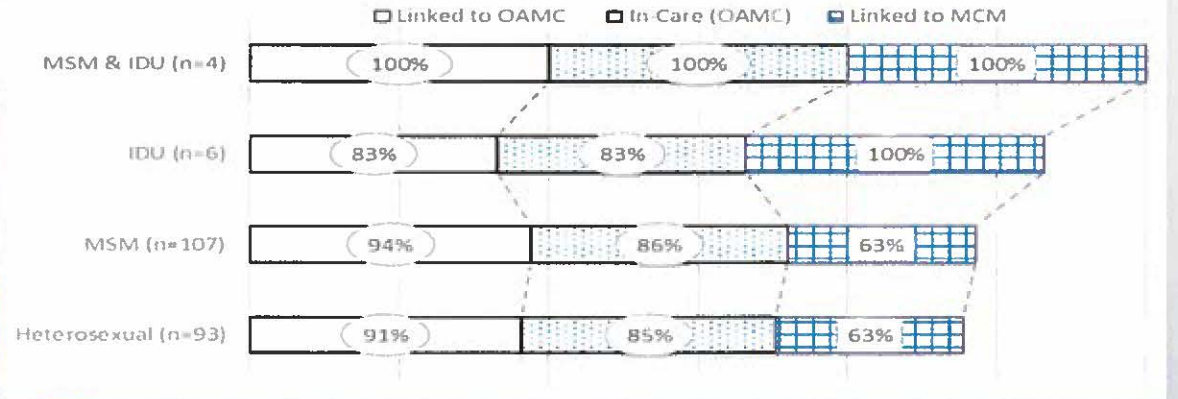
Figure 3: JTGA Year 2015 Outpatient Medical Care & Medical Case Management Utilization for 213 Newly Diagnosed PLWHAs by Race



JTGA disparities analyses provided to MCM Supervisors Task Force & Agency Quality Managers

RESULTS CONT'D: QUALITY MANAGEMENT, JTGA

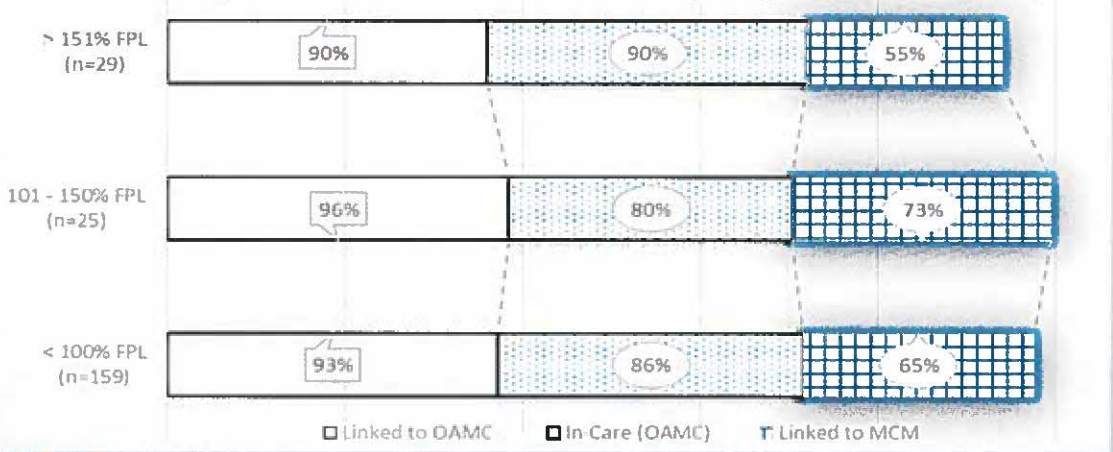
Figure 4: JTGA Year 2015 Outpatient Medical Care & Medical Case Management Utilization for 213 Newly Diagnosed PLWHAs by Risk Factors



JTGA disparities analyses provided to MCM Supervisors Task Force & Agency Quality Managers

RESULTS CONT'D: QUALITY MANAGEMENT, JTGA

Figure 5: JTGA Year 2015 Outpatient Medical Care & Medical Case Management Utilization for 213 Newly Diagnosed PLWHAs by FPL



JTGA disparities analyses provided to MCM Supervisors Task Force & Agency Quality Managers

RESULTS CONT'D - SPECIAL PROJECTS_1, JTGA 2016

Parks, Recreation and Community Services
Social Services Division
Ryan White Part A Grant Program

Policy No. MCM 006
Review Responsibility: MCM
Policy Development Committee
Approval Date: April 8, 2014
Approved By: MCM Policy Development Committee
Revised Date:

TITLE: ACUITY LEVEL

POLICY STATEMENT:
Individuals with HIV face a complex array of medical, psychological, and social challenges. Medical Case Managers (MCM) will complete a comprehensive assessment of needs every 6 months, resulting in measurements for acuity. This acuity level will provide MCMs with an ability to gauge client need, severity of illness, and progression with treatment compliance. The acuity level provides Ryan White (RW) Supervisors and Managers with the ability to equally distribute or redistribute client cases to ensure effective case load management.

REFERENCES: STATE OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION POLICIES GOVERNING Acuity Levels are the Project AIDS Care (PAC) Wavier Program Guidelines.

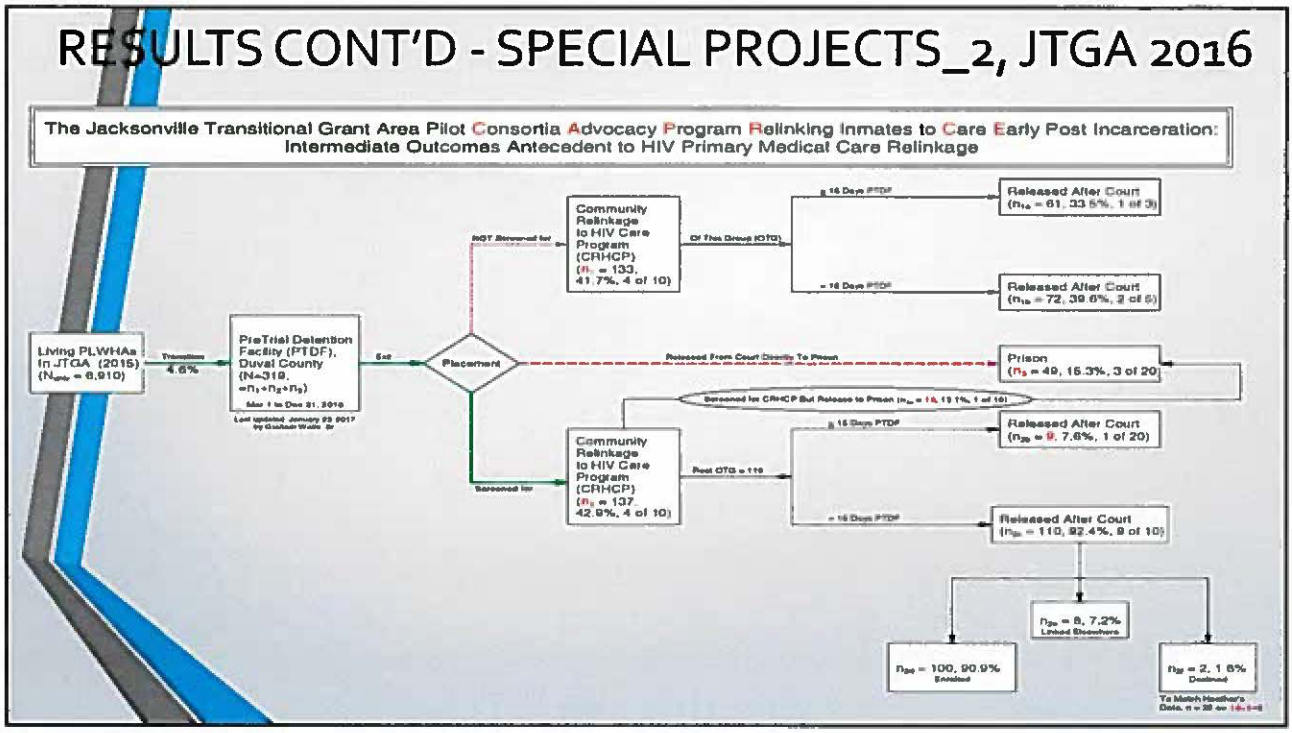
PROCEDURES:

1. MCM will complete comprehensive assessment at enrollment, and at least every 6 months thereafter.
2. Assign Acuity Level based on the following four categories:

a. Acuity Level I (Raw Score 1 to 10) – BRIEF INTERVENTION

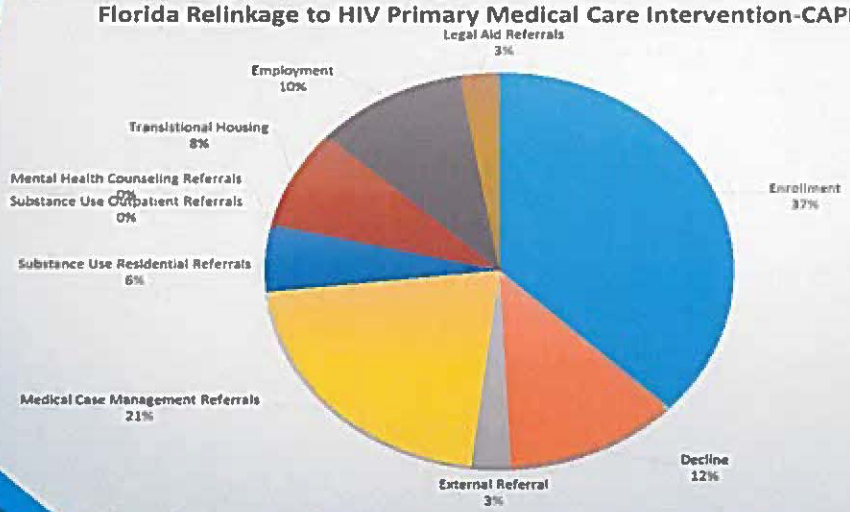
Cases in this category receive the following services:
1) Brief assessment, orientation into the RW continuum of care, referral for financial eligibility and information about the local HIV service system.
2) Comprehensive Assessment and Individualized Service Plan every 6 months.
3) Referral for identified needs (Potential Client).
4) Monthly to Bi-monthly contact depending upon client self-sufficiency.
5) Monthly counseling related to medication copays, office visit copays, and occasional transportation needs.

RESULTS CONT'D - SPECIAL PROJECTS_2, JTGA 2016



RESULTS CONT'D - SPECIAL PROJECTS_2, JTGA 2016

Figure 1: Percentages for 95 Formerly Incarcerated PLWHAs Screened for Northeast Florida Relinkage to HIV Primary Medical Care Intervention-CAPRICE



Relinking the formerly incarcerated to HIV medical care is costly, complex, time and energy consuming.

RESULTS CONT'D - SPECIAL PROJECTS_2, JTGA 2016

JTGA Linkage & Retention In HIV Primary Medical Care among CAPRICE Participants During Year 2016

	One OAMC Visit (Linked to Care)	Two + OAMC Visits (Retained in Care)
Aggregate	38/46 = 82.6%	30/46 = 65.2%
Demographics		
Female	9/12 = 75%	8/12 = 66.7%
Male	29/34 = 85.3%	22/34 = 64.7%
Transgender		0 0
Black	30/36 = 83.3%	23/36 = 63.9%
White	8/10 = 80%	7/10 = 70%
Other		0 0
Less than 2 Years		0 0
2- 12 Years		0 0
13-24 Years	6/6 = 100%	4/6 = 66.7%
25-34 Years	13/16 = 81.3%	10/16 = 62.5%
35-44 Years	7/8 = 87.5%	6/8 = 66.7%
45-54 Years	10/12 = 83.3%	8/12 = 66.7%
55-64 Years	2/4 = 50%	2/4 =505%
65+ Years		0 0

Notes: OAMC means outpatient ambulatory medical care

Recall that formerly detained PLWHAs, the JTGA links 8 of 10 and retains 6 of 10 in OAMC. However, clinical staff report that the biopsychosocial needs of this group is complex, often exceeding that of the average PLWHA

43

RESULTS CONT'D - SPECIAL PROJECTS_3, JTGA 2016

Cumulative Report of Tracking & Relinking Clients Formerly Lost to Care

No. Cases	Linkage	Linkage %
67	65	97.01%

Algorithm: No. Cases Found refer to the number of dates entered for the item, Date Case Was First Contacted (Face-to-Face & Confirmed Alive)? Linkage refers to count of the number of Yes responses to the question, Was the appointment kept? Linkage % refers to linkage divided by number of cases contacted.

44

Source: https://[illegible]content/tracking-relinking-plwhas-to-care

RESULTS CONT'D - SPECIAL PROJECTS_4, JTGA 2016

Community Planning for HIV/AIDS Health Services System Transformation

Graham F. Watts, Sr., PhD; Deidre Kelley, MA; Cindy Watson, BA

ABSTRACT

HIV is a public health concern. Duval County schools Youth Risk Behavior Surveillance data on middle and high school students for 2013 reveal high-risk sexual activity, yet, one in five received no formal instructions about HIV/AIDS. Knowing one's HIV status is pivotal for HIV prevention and treatment. HIV positive youth who seek treatment, and achieve viral suppression have optimal health outcomes and are less infectious. Northeast Florida joins the national initiative to reduce HIV infection. The City of Jacksonville, Ryan White Part-A Program, Florida Department of Health-Duval, and local HIV/AIDS organizations convened a Youth Summit. Conversations focused on how HIV prevention and treatment may integrate for seamless access and transition of youth into services. Six open-ended questions guided the summit. Three eight-member, moderated focus groups explored answers to two questions during one hour. From a healthcare access barriers perspective, structural and cognitive opportunities exist for health system integration. Almost twice as many solution strategies emerged for barriers to care and prevention-and-treatment attrition factors, compared to gaps in prevention, treatment, and health education. The Youth Summit is a first step in the journey toward a seamlessly integrated youth and adult HIV prevention, treatment, and health education system.

Florida Public Health Review, 2017; 14, 13-21.

BACKGROUND

The Jacksonville Chapter of the Florida Department of Health, Integrated HIV Prevention, and Care Plan 2017-2021 states that the health of youth and young adults is a local priority (unpublished). However, health disparities related to race, gender, sexual orientation, and age exist in the populations most impacted by the HIV epidemic in Duval County – namely, African-American men and women. The National HIV/AIDS Strategy 2020 identifies youth, ages 13 – 24 as a key population, noting the particularly high burden of HIV among young black gay and bisexual men (https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf). The Jacksonville support the health of HIV infected youth and young adults.

Purpose

In Florida, HIV affects a significant number of today's youth. Data on the prevalence of HIV and AIDS among adolescents (ages 13-19) and young adults (20-24 years) tell a compelling story. According to Florida Department of Health, in 2014, persons under the age of 25 years accounted for 16% of all newly reported cases of HIV infections (http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/2014/2014-adolescents-and-young-adults-fact-sheet.pdf). In Florida Partnership 4, a title for Baker,

45

RESULTS CONT'D - SPECIAL PROJECTS_5, JTGA 2016

JTGA Client Satisfaction Survey Completion Trends

Answer Choices	Responses	
AHF	9.76%	4
BCCC	0.00%	0
UF Cares	0.00%	0
Community Rehabilitation Center	0.00%	0
Gateway Community Services	0.00%	0
Jacksonville Area Legal Aide	0.00%	0
Lutheran Social Services	4.88%	2
Northeast Florida AIDS Network	85.37%	35
Northwest Behavioral Health Services	0.00%	0
River Region Human Services	0.00%	0
AHF Pharmacy	0.00%	0
BCCC Pharmacy	0.00%	0
Kings St Dental Clinic	0.00%	0
Total		41

Main Message: More publicity is needed to improve Client Satisfaction Survey data collection!

Prepared September 14, 2016 by Graham Watts, Sr

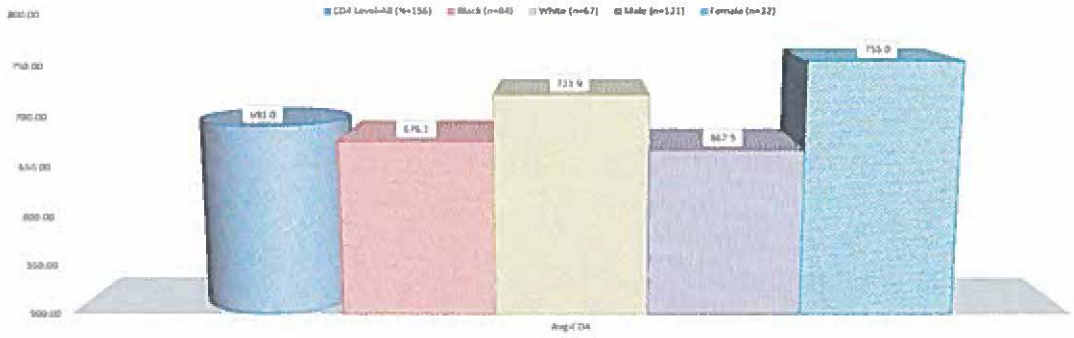
Give Clients Links to JTGA Provider Client Satisfaction Survey

46

RESULTS CONT'D - SPECIAL PROJECTS_6, JTGA 2016

HIPAP Disparities Results-Cont'd

FIGURE 2: AVERAGE CD4 CELL COUNTS BY SOCIO-DEMOGRAPHIC GROUPS FOR NORTHEAST FLORIDA PLWHS ENROLLED IN HIPAP: JANUARY 2015 - SEPTEMBER 2016



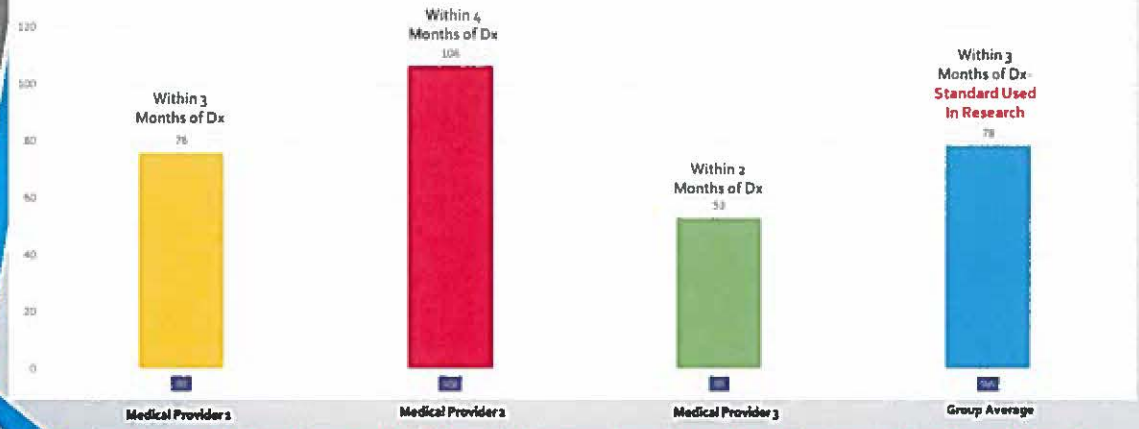
- Female PLWHs had higher average CD4 cell count than male PLWHs, but the difference was not significant.
- White PLWHs had higher average CD4 cell count than Black PLWHs, but the difference was not significant.
- Average CD4 cell counts for female and White PLWHs exceeded the group average

47

HIPAP | Health [illegible] Assistance Program

RESULTS CONT'D: SYSTEM LEVEL MEASURES, JTGA 2016

Average Days between HIV Diagnosis & Linkage to Medical Care Per Medical Home in 2016:
Average Number of Days to Access OAMC Care



Assuming accuracy of the dates on which these findings are based, are disparities in provider elapsed time to linkage after HIV diagnosis an indicator of need for more proactive identification of PLWHAs at risk for delayed entry to care?

48

Data Source: FDOH [illegible] Computation used 30 days per month.

RESULTS CONT'D: SYSTEM LEVEL MEASURES, JTGA 2016

Table 1: System Level Quality Management Measures Monitored by the JTGA in 2016

Measures	Statistics	Med Provider _1	Med Provider _2	Other Med Provider	Palacio et al., 1999	Mugavero et al., 2007	Yehia et al., 20084
Elapsed time to Linkage	Minimum # of Days (NOD)	7	1	[redacted]	1	-	0.5
	Average NOD	17	16.97	[redacted]	-	27 (SD ± 13.8)	8.9
	Median NOD	-	12	[redacted]	14 (2 wks)		5
	Maximum NOD	36	93	[redacted]	91 (13 wks)	68.4 (3 SDs)	22.5
AIDS Diagnosis at Initial OAMC	Number	?	9	[redacted]	-	-	-
	Percentage	?	19.15% (⅕)	[redacted]	-	-	-

1. Time to Linkage, (is number of days newly diagnosed PLWHAs waited to receive an OAMC encounter with a qualified physician, physician assistant or ARNP in calendar year 2016 after scheduling the appointment).
2. [illegible] at Initial OAMC, (is number of PLWHAs with an AIDS diagnosis at time of initial OAMC visit as a function of the number of newly enrolled PLWHAs for the calendar year).
3. [illegible] of days & wks is weeks
4. [illegible] from Table 3. Average Wait for Appointments, New Patients (days)

"The [illegible]alth Fund, a New York-based foundation, ...compared wait times in the United States to those in 10 other countries [in 2013]. The study found that [illegible] of 2,002 Americans adults surveyed said they waited six days or more for appointments, better only than Canada, (33%), and Norway, (28%), and much worse than in other countries with national health systems like the Netherlands, (14%), or Britain, (16%).[2] 49

Source: 1. http://[illegible]/media/files/publication/in-the-literature/2015/nov/pdf_schoen_2015_chp_survey_chartpack_final.pdf

RESULTS CONT'D: ICQI PLANS SUBMITTED, JTGA 2016

Submission Status of ICQI Plans By JTGA Ryan White Providers

Agency Partnerships	Due Date (June 7, 2016) vs. Date Submitted	ICQI Plan Submission Status	Focus Area	NHAS Emphasis
LSS & N[illegible]AN	June 7, 2016	Accepted	Health Disparities Research	Reduce HIV Disparities
NFAN, LSS, AHF, UF CARES, NWBH CRC, [illegible], & Phoenix CM Inc.	June 7, 2016	Accepted	Multi-Service ISP in CAREWare	Comprehen Coord Client Care
LSS, [illegible], & RRHS	June 7, 2016	Accepted	Access to Behavioral Health Care	Improve Health Outcomes
[illegible]HF, FDOH-Duval, & UF CARES	July 1, 2016	Accepted	Communication Systems in Healthcare	Increase System Capacity
	February 10, 2017	Accepted	Standardized Care Delivery	Improve Health Outcomes

*After the August 2016 Provider meeting, Karen, Alma, Sandra, & Graham discussed preparation of on an integrated HIV OAMC plan for submission to COJ. The original ICQI plan, focusing on *Communication Systems in Healthcare* was amended to include a focus on OAMC, and submitted for approval on February 10, 2017

ICQI Or[illegible] October 21, 2016
What is th[illegible] planning in your work group, year-to-date? The question assumes three things about the work-group's activities:
1) It reviewed [illegible]ment, formal or informal, to establish a baseline, (status quo);
2) It reviewed [illegible]mal or informal, to establish needs to address, and
3) It defined at [illegible] (problem areas), to establish a common language for communication. 50
4) At the Jan 2017 [illegible] meeting Graham, Todd, Aleida, & Gonzales discussed specific themes not reflected in the August 16, 2016 approved plan that prompted the June 23, 2016 request from the Administrative Agency for a specific integrated [illegible] plan. The February 10, 2017 resubmitted plan addressed deficiencies identified January 2017.

DISCUSSION

- The JTGA pursues health equity, (the elimination of disparities in health), by the creation of… an equitable system of service delivery. This approach supplies services matched to community needs. Hence, the local Priorities and Allocations Committee is on solid ground. However, the barriers to care are NOT static, and they vary by subgroups affected by the HIV epidemic; hence, on-going development of strategies and approaches aim to reach disadvantaged PLWHAs for whom service availability does little for linkage and retention in HIV primary medical care. Admittedly, the JTGA is moving closer to achieving the minimum NHAS Indicators 5 & 6 standards. Nevertheless, we remain assertive in our quest to reduce and ultimately eliminate barriers to care so that gaps such as ***In-care, (49.8%),*** and **Viral Suppression, (46.3%),** among 13-24 year-olds and **Viral Suppression, (65.4%),** among transgender people get better.

DISCUSSION CONT'D

- It is reasonable to query why On-ART percentages are lower than In-Care percentage. "…Many individuals who start treatment with CD4 counts less than 350 cells/mm³ never achieve CD4 counts greater than 500 cells/mm³ after up to 6 years on ART and have a shorter life expectancy than those initiating therapy at higher CD4 counts. …Findings from two large, randomized controlled trials that addressed the optimal time to initiate ART—START, (Strategic Timing of Antiretroviral Therapy) and TEMPRANO[1]—"…now demonstrate that earlier treatment with ART is most beneficial to boost immune recovery and prevent clinical event. [The START study had] …more than 50% decrease in… AIDS related or non-AIDS related outcomes or death in the [treatment] group vs the delayed group. [In] the TEMPRANO study…, the hazard of death or serious HIV-related disease was substantially lower with the early ART initiation group compared with the deferred ART group."[2] "[These data] have led the [U.S.] Panel [on Antiretroviral Guidelines for Adults and Adolescents to recommend] ART… for all HIV-infected individuals, regardless of CD4 cell count, to reduce the morbidity and mortality associated with HIV infection".[1] Therefore, what accounts for disparities in In-Care and On-ART percentages on Provider level HCCs?

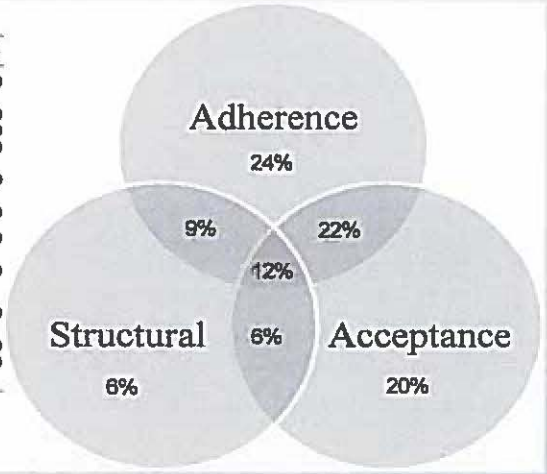
1 http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/0/initiation-of-antiretroviral-therapy
2 http://www.nejm.org/doi/full/10.1056/NEJMoa1506816

DISCUSSION CONT'D

Table 2. Reasons for Delaying Antiretroviral Therapy for Clinically Eligible Patients.[a]

Themes	Subthemes[b]	No. (%)
Adherence concerns		424 (68)
	Substance abuse	216 (35)
	Mental health	178 (28)
	General nonadherence (anticipated or history of)	148 (24)
	Chaos/instability (lifestyle and social situation)	106 (17)
	Appointment adherence	63 (10)
Acceptance concerns		378 (60)
	Readiness/refusal to start/commit	347 (56)
	Denial/fear/lack of knowledge	34 (5)
Structural concerns		209 (33)
	Cost/insurance/medications	122 (20)
	Homelessness/unstable housing	81 (13)
	Other[c]	23 (4)

Abbreviation: MMP, Medical Monitoring Project.
[a]N = 625—MMP Provider Survey 2009.
[b]Participants could have identified more than one subtheme.
[c]Other includes incarceration, referral to other care source, and transportation.



In the Journal of the International Association of Providers of AIDS Care, Volume 14, Issue 3, Beer et. al. (2014), stated that "...reasons for delay fell into 3 broad categories, namely, provider concerns about patient adherence (*adherence concerns* mentioned by 68%), patient acceptance of ART (*acceptance concerns* mentioned by 60%), and provider concerns about structural barriers to ART use (*structural concerns* mentioned by 33%).[1]

51

DISCUSSION CONT'D

TABLE 3. Barriers to Receiving HIV Medical Care Self-Reported on the 6-Month Survey for Participants Who Had Not Entered into Care (N = 60) or Had Entered into Care but Missed 1 or More HIV Medical Appointments in the Past 6 Months (N = 117) (ARTAS-II): 2005 to 2006

Barriers to Care Self-Reported During 6-Mo Survey*	Had Not Entered Into HIV Care (N = 60) n (%)	Had Entered Into Care but Missed ≥1 HIV Medical Care Appointment (N = 117) n (%)
Felt well or had no symptoms	42 (70)	67 (58)
Lacked transportation to get to the clinic	22 (37)	46 (39)
Not ready to start taking HIV medications	22 (37)	39 (33)
Takes too long to get another appointment if you miss one	12 (20)	45 (38)
No insurance/could not afford the cost of care	20 (33)	36 (31)
Could not take time off of work	15 (25)	38 (33)
People at clinic would know or recognize me	12 (20)	34 (29)
Had to wait too long in the clinic to be seen	4 (7)	41 (35)
Child care was not available in the clinic	10 (17)	33 (29)
Felt too sick to go to the clinic	12 (20)	29 (25)
Had to wait too long to get an appointment	7 (12)	34 (29)
Did not feel comfortable being around the other patients in the clinic	8 (13)	31 (27)
Clinic hours were not convenient	7 (12)	24 (21)
Did not want to take a day off work because my employer might find out I have HIV	7 (12)	19 (16)
Did not like the clinic (eg, too hot/cold, too dirty, in a bad neighborhood)	6 (10)	15 (13)
Clinic staff were not friendly or helpful	5 (8)	14 (12)
Was too high or drunk to go to the clinic	4 (7)	10 (9)
Did not feel culturally accepted at the clinic	6 (10)	4 (3)
Afraid to go because I do not have US citizenship	2 (3)	6 (5)

*These barrier-to-care items were answered by a subset of the 442 participants who completed the 6-month survey (n = 177). Participants could endorse more than 1 barrier to care.

54

*Study sites included five health departments and CBOs located in the following US cities: Anniston, AL; Atlanta, GA; Baltimore, MD; Baton Rouge, LA; Chicago, IL; Columbia/Greenville, SC; Jacksonville, FL; Kansas City, MO; Miami, FL; and Richmond, VA" (Crew et al., (2008) in J Acquir Immune Defic Syndr, Vol 00, Number 0, Month, 0, 2008).

CONCLUSION

- JTGA HIV health services network is not just treating HIV in the infected, but treating the whole person with HIV and other comorbidities. The local quality improvement processes, which drives our service delivery system are cyclical, meaning Plan-Do-Check-Act is an unending cycle. Translated, our jobs of making improvements in the structure, processes, outputs, and outcomes of care and services are never finished, and always a work in progress! The cadre of stakeholders at all levels of the JTGA horizontal HIV Health Services System may pause to take note of the journey and to recognize important milestones reached, but never to rest on laurels because a services improvement outlook, much like a personal fitness outlook, requires a mindset similar to the professional athlete, who works systematically and tirelessly to overcome innate and cultivated weaknesses. Our work as a prevention and treatment health services community is unfinished; therefore, we stick to the task of continuous improvement in HIV/AIDS service delivery!

55

CONCLUSION CONT'D

Facilitators to Retention In Care for People Living With HIV

Facilitator
1. Positive Relationship with Clinic Staff including Provider
2. Social Support
3. Patient-friendly Clinic Services
4. Patient Initiated Reminder Strategies
5. Flexible Schedule

Yehia et al., 2015, p. 6

TABLE 3. STRATEGIES TO FACILITATE ENGAGEMENT TO HIV CARE

Dispelling myths and improving knowledge
Helping with HIV care
Building skills and ability to deal with HIV
Providing services to reduce barriers
Providing support networks

Rajabiun et al., 2007, p. S-26

"...[Quality] improvements require process reforms that enable [providers] and [clients] to work together from the start."[3]

56

Sources: 1. [illegible] 3. [illegible] Innovations in Investing in Young Children Globally: Proceedings of a Workshop—in Brief, p. 6

NEXT STEPS, FUTURE DIRECTIONS, & PRIORITIES

- "Dealing with the difficult patient" (Smith, Postgrad Med J, 1995; 71:653-657)
- Become a comprehensive care network for preventing and treating HIV-related disparities
- Advance youth centric HIV/AIDS health services
- Involve youth in the activities of the Early Identification of Individuals with HIV/AIDS task force
- Publish the results of our work to support the science based of HIV/AIDS service delivery
- Reduce the slope of the HCC line by attainment of NHAS Indicators 5 & 6
- Evaluate Integrated Continuous Quality Improvement, (ICQI), efforts currently on-going
- Tightly align the JTGA Comprehensive Plan with the ICQI focus starting at Provider meetings
- Expand the role of Nutrition in addressing health disparities among JTGA PLWHAs
- Service delivery system anticipate client needs rather than simply react to events

WRAP UP

- Clarifications and Questions
- Observations
- Critiques
- Controversies and Challenges:
  - From a Diffusion of Innovation perspective, laggards are the last to adopt innovation!
- Opportunities
- Recommendations

RTI INTERNATIONAL

Project Summary

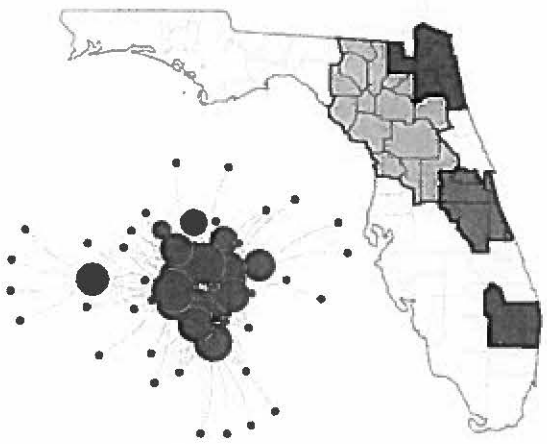
Measuring Integration between Primary Care and Public Health to Improve HIV Early Detection and Control

Executive Summary

The Integrating to Improve (i2i) study is examining how public health, primary care, and community organizations in four regional service areas of Florida work as collaborative systems to identify, link to care, and provide continuous care for persons living with HIV/AIDS (PLWHA). This study determines the extent to which characteristics of the organizations and systems influence levels of coordination and service integration that, ultimately, contribute to health outcomes. This research addresses issues associated with the lack of coordination that can contribute to:

- Late diagnosis of HIV
- Delayed entry of persons with HIV/AIDS into care
- Poor retention of persons with HIV/AIDS in care

Results will highlight the breadth of organizations that are involved in HIV systems of care, noting the importance of funding to support their work and the critical nature of relationships between organizations that can either facilitate or hinder a patient's movement along the spectrum of engagement in care.



Background

In 2015, the White House introduced the National HIV/AIDS Strategy for the United States that identified a set of priorities and strategic action steps that were directly connected to outcomes. To help reduce disparities and new infections, the strategy set the goal of coordinated systems of care that would improve access to care and health outcomes. The lack of coordination among public health and community-based organizations that conduct HIV prevention and screening and the organizations that provide primary care has been identified as primary factor contributing to late diagnosis, delayed entry into care, and poor retention in care for significant numbers of PLWHA.

More information

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Research Triangle Park, NC 27709-2194

Methods

The project team is composed of investigators from RTI, University of Florida, and the Florida Department of Health (FDOH), in partnership with the Florida Public Health Practice Based Research Network and leadership of four (4) HIV service areas in Florida.

The i2i study applies a mixed methods approach that combines primary and secondary data for each area to identify organizations, services, and key factors in each system of care based on:

- **Key Informant Interviews.** The project team conducted interviews with key informants in each area, including Ryan White lead agencies, health department staff, HIV/AIDS Program Coordinators, and case management agencies.
- **Web-Based PARTNER Survey.** The project team used a web-based survey program, PARTNER, to collect data about each service provider in the participating areas, e.g., what services it provides, and how organizations work together.
- **Ryan White HIV/AIDS Services Reports.** The project team gathered additional organizational information on agencies funded by Ryan White from the *Ryan White HIV/AIDS Services Report*, which is completed on an annual basis by Ryan White providers. The project team worked with Co-Investigator Dr. Wilson (Evaluation Consultant to FDOH) to submit a report request to FDOH (which maintains the Ryan White CAREWare data system), as well as work with lead agencies and community partners to help fulfill report requests.
- **Area-Level Surveillance Data.** The project incorporates available area-level surveillance data into the analyses, as available from the FDOH.

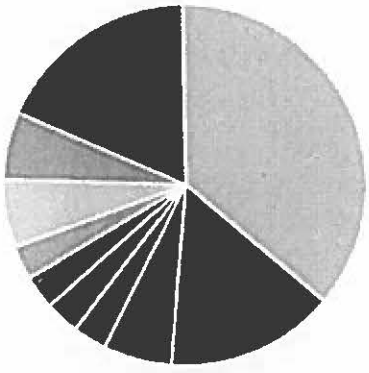
Impact

There is a very limited amount of information about best practices in linkage to care of HIV patients newly diagnosed or in early entry and retention in care. Despite limited evidence, multiple organizations have called for integration or collaborations to achieve these goals. Results of this project will provide insight into the critical mechanisms associated with the integration of services and the inter-organizational system of care for persons living with HIV/AIDS. More specifically, these findings will identify organizational and relational measures associated with early diagnosis, linkage to care, and continuous care for persons with HIV. At the end of the project, the i2i study will develop resources to optimize HIV systems of care and improve health outcomes for persons with HIV/AIDS.

Summary of Data Collected

In total, there are 69 organizations in the Area 4 network. This project surveyed 34 organizations, receiving responses from 19 organizations (blue nodes/dots, ●), yielding an overall response rate of 56%. On average, organizations reported interacting with 16 other providers across the area (range, 1 to 33).

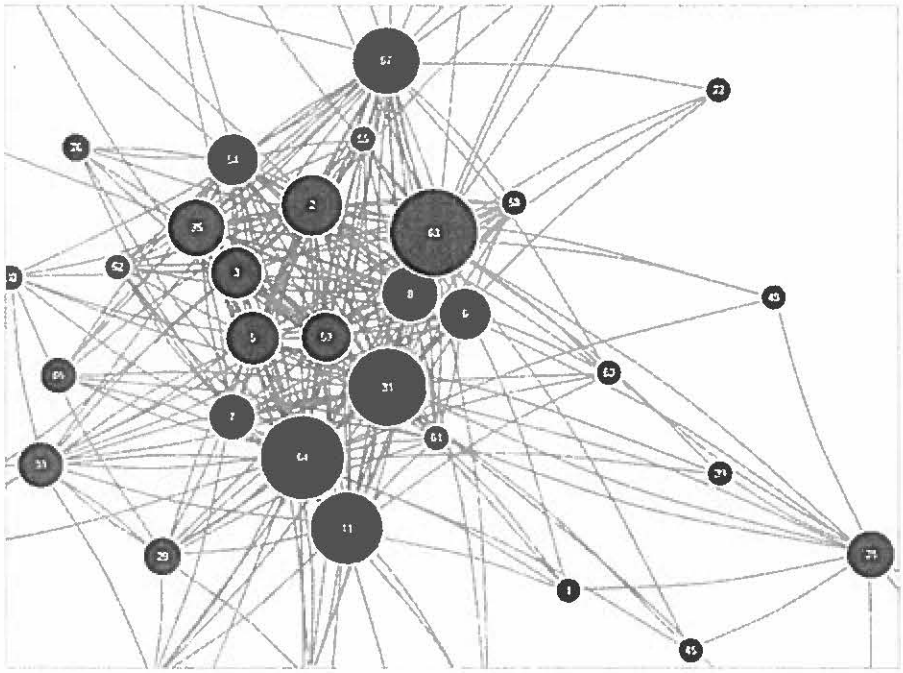
Diversity of Organization Types in Area 4 Network



- Community-based organizations
- County health departments
- Faith-based organizations
- FQHCs
- Government agencies/departments
- HIV clinics (Non-health departments)
- Hospitals
- Prisons/correctional facilities
- Private providers
- University-affiliated clinics

Area 4 Network Graph of Interactions among Providers

Organization nodes are sized based on number of reported interactions with others, non-respondents are indicated by grey colored nodes.



10 Most Common Services Provided

Ranked list of services, based on frequency

1) HIV counseling and testing services
2) Linkage services
3) Risk reduction counseling
4) Medical case management services
5) STD testing/services
6) Adherence counseling
7) Outreach services
8) Outpatient Ambulatory Medical Care (OAMC)——Primary care
9) Outpatient Ambulatory Medical Care (OAMC)——HIV medical care
10) Early intervention services

Ranked List of Facilitators

1) Atmosphere of collegiality/ cooperation
2) Patient-centered focus
3) Participation in committees/ workgroups
4) Responsive communication
5) Working well as a team
6) Data sharing
7) Common goals
8) Local knowledge/ experience in the community
9) Supportive organizational policies
10) Complementary services
11) High retention of staff (i.e. low turnover)
12) Regular meetings

Ranked List of Barriers

1) Limited staff resources/ personnel (e.g. time to engage, participate)
2) Lack of funding
3) Staff turnover, retirement, loss of institutional knowledge
4) Competition for funding, resources, and/ or deliverables
5) Policy and guidance restrictions and rules (e.g. hiring)
6) Similar service provisions (i.e. testing, territoriality)
7) Lack of data sharing/ access
8) Personalities
9) Distance between organizations
10) Lack of local knowledge (e.g. services, coverage, providers)

Key Takeaways for Area 4

- Draw upon the strengths that foster collaboration, including patient-centered focus and participation in meetings/workgroups
- Strive to maintain high average of connections with other organizations, especially given the large number and diversity of organizations across the area
- Work together to contribute to success as a system, sustaining high number of client referrals for services to providers across the area, especially for linkage and OAMC services to support linkage to care and continuous care outcomes
- Take advantage of opportunities for collaboration and cooperation, expand referrals for services and avoid organizational "isolates"
- Face the challenges ahead, making the investment to work together for joint planning and leverage meetings/workgroups as opportunities

RTI INTERNATIONAL

Integrating to Improve

Integration between Health Care and Public Health to Improve HIV Early Detection and Control

Area 4 Findings

UFHealth
UNIVERSITY OF FLORIDA HEALTH

Housekeeping Items

- All participants are in listen-only mode.
- If you have a question, please type it in the chat box in the bottom left of your screen.
- You only will be able to view the questions that you have submitted.
- If you experience technical difficulties, you also may contact us at i2i@rti.org.
- Slides and a recording of the webinar will be shared with participants via email after the event.

Today's Presenters

Deborah Porterfield, MD, MPH
Integrating to Improve, Principal Investigator

Christine Bevc, PhD, MA
Integrating to Improve, Co-Investigator

Welcome

- Show how **organizations** fit within the system of care
- **Visualize collaborations** between organizations, highlighting their work together to provide **linkage** and **continuous care**
- Identify opportunities for organizations to **build new connections** to other HIV service providers
- Provide useful information to inform **integrated HIV prevention and care planning**

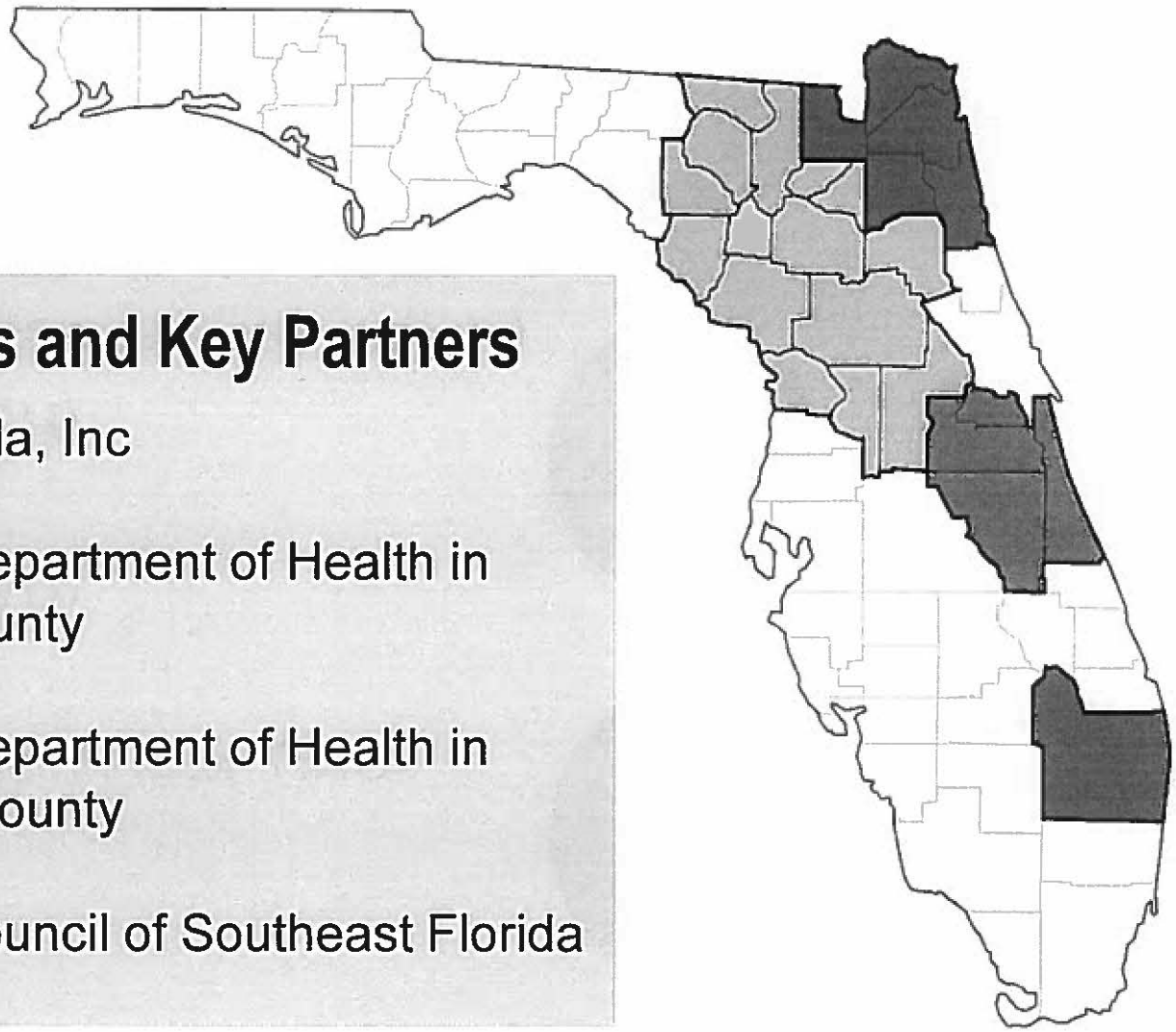


Project Team

- PI: Deborah Porterfield (RTI, UNC)
- Co-Investigators:
  - Christine Bevc (RTI)
  - Lori Bilello (UFL)
  - Max Wilson (FDOH)
- Project Manager: Caroline Husick (RTI)
- Scientific Advisor: Sara Jacobs (RTI)





Participating Areas and Key Partners

- Area 3/13: WellFlorida, Inc
- Area 4: Florida Department of Health in Duval County
- Area 7: Florida Department of Health in Orange County
- Area 9: Health Council of Southeast Florida

We also thank…

HIV/AIDS SECTION
FLORIDA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION BUREAU OF COMMUNICABLE DISEASES

We also thank…

Together with your colleagues in Area 4, you helped shape this project by:

- Participating in a planning meeting with investigators
- Engaging in-depth interviews about Area 4's network
- Completing the PARTNER survey for this analysis

Project Goals

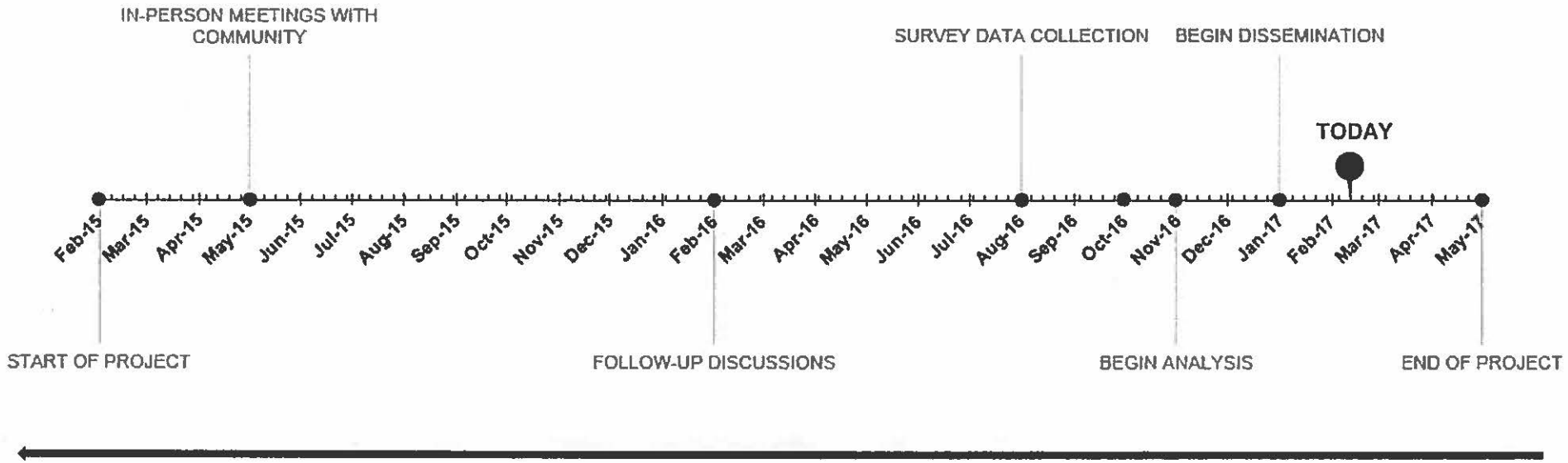
1) Examine how public health, primary care, and community organizations work as a system to identify, link to care, and provide continuous care for HIV patients using social network analysis methods

2) Determine the organizational and system characteristics associated with delivery of continuous care for persons with HIV

3) Develop resources to improve HIV systems of care based on the study findings

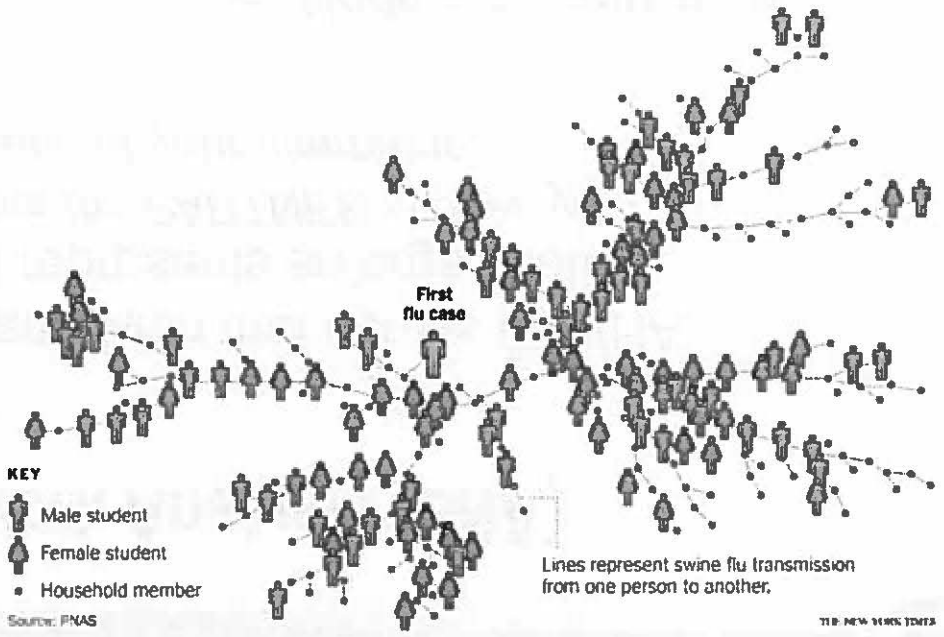
Project Milestones & Methods

- Planning meetings with organizational representatives in four areas
- Follow up discussions to determine size and characteristics of each network
- Survey data collection from all organizations to measure connections
- Collection of secondary data from CAREware and testing sites to measure outcomes



Introduction to Social Network Analysis (SNA)

- Seeks to understand individual actions in the context of structured relationships or the structures directly
- Considerable work on disease epidemics and transmission networks
  - *Examining ways potentially infectious contacts are made strongly influences how fast and how widely epidemics spread in their host population*
- Shift focus toward public health systems and services
  - *How do interorganizational relationships and patterns of interaction within public health delivery systems impact the effectiveness, efficiency, and outcomes of public health strategies delivered at the local, state, and national levels?*

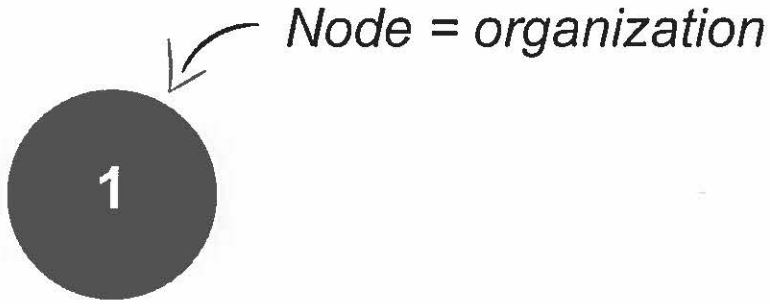


Introduction to Social Network Analysis (SNA)

- Each circle is called a "node."
- Each node represents an organization that serves PLWHA.
- Each node has a number that represents an organization.
  - *If you were invited to complete the PARTNER survey, your number can be found at the end of your username.*

Examples of organizations

- Community-based organization
- Federally qualified health center (FQHC)
- County health department
- Hospital
- K-12 school
- Private provider
- Veterans Administration (VA) medical center
- Legal aid
- Faith-based organization
- Prison



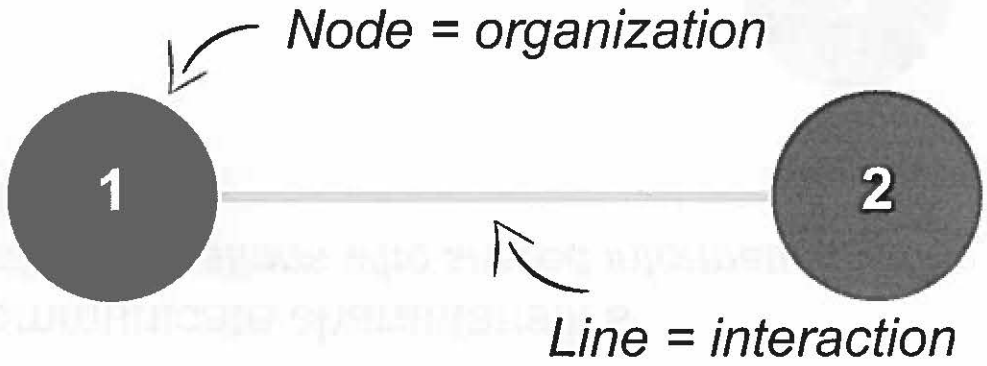
Note: If you do not remember your organization number, send a chat to the moderator.

Introduction to Social Network Analysis (SNA)

- Lines represent relationships between two nodes.
  - *Some organizations can have more than one type of relationship*
- We measured frequency of interactions, as well as 8 different types of relationships.

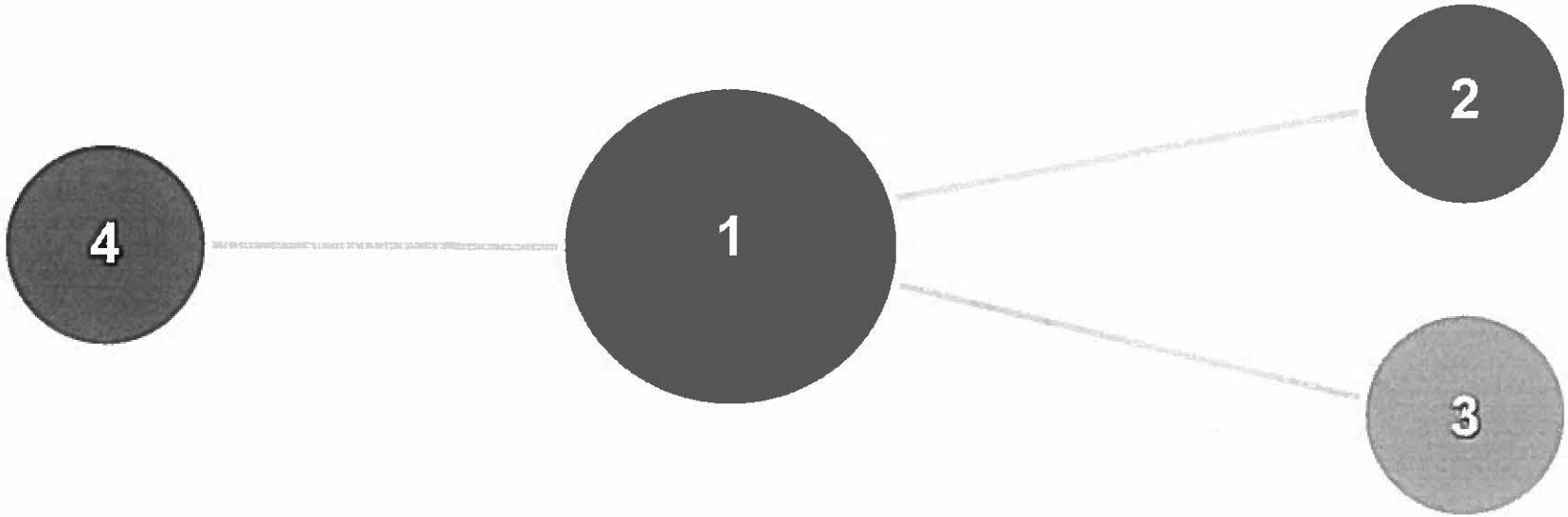
Types of Relationships:

- Collaborating on funding opportunities
- Coordinating outreach and communications
- Establishing formal agreements
- Participating in meetings and groups
- Participating in training and education
- Providing/receiving resources
- Providing/receiving client referrals
- Sharing information and data



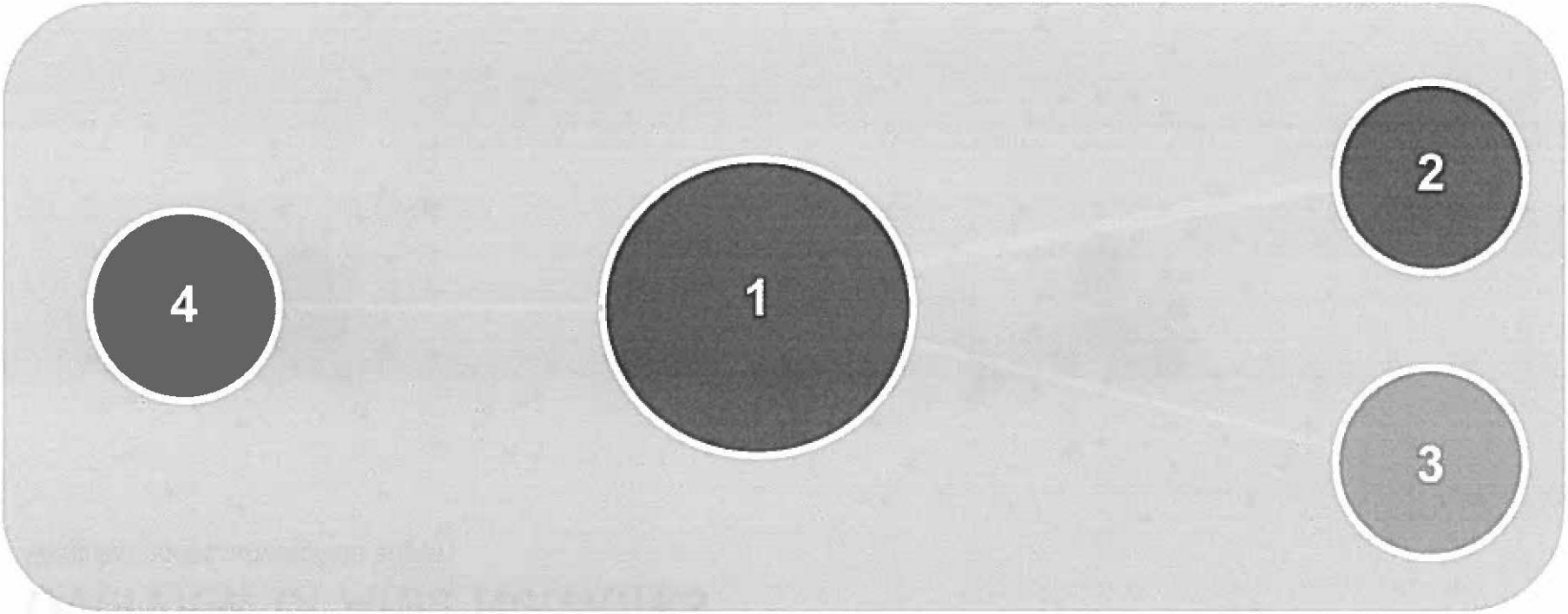
Introduction to Social Network Analysis (SNA)

- When an organization has more connections, shown with a larger node
- Color of the node is used to communicate characteristics
  - *Nodes that are **blue** represent organizations who shared information with us through the PARTNER survey.*



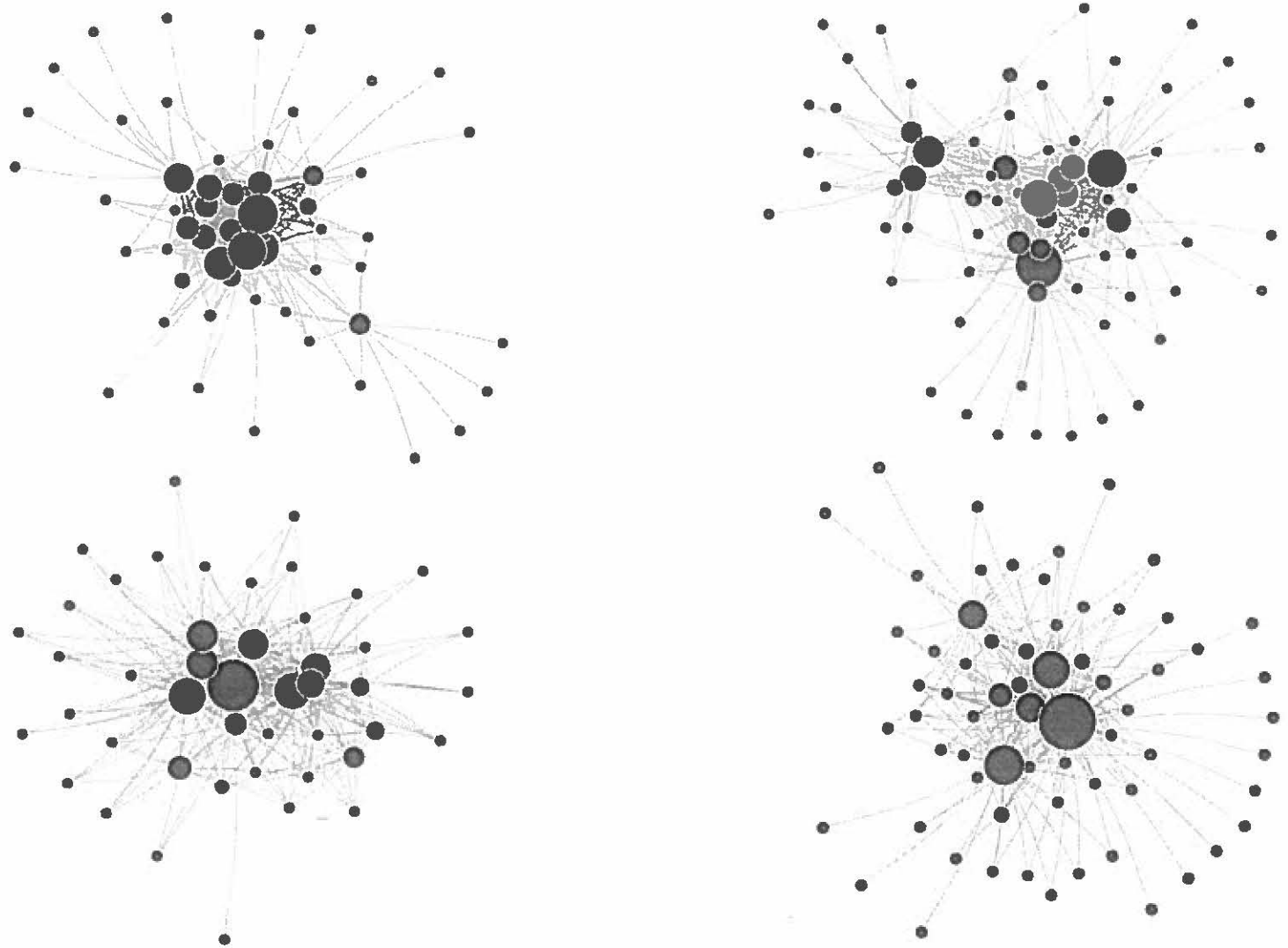
Introduction to Social Network Analysis (SNA)

- Collectively, this forms an image of the entire network, or system of care

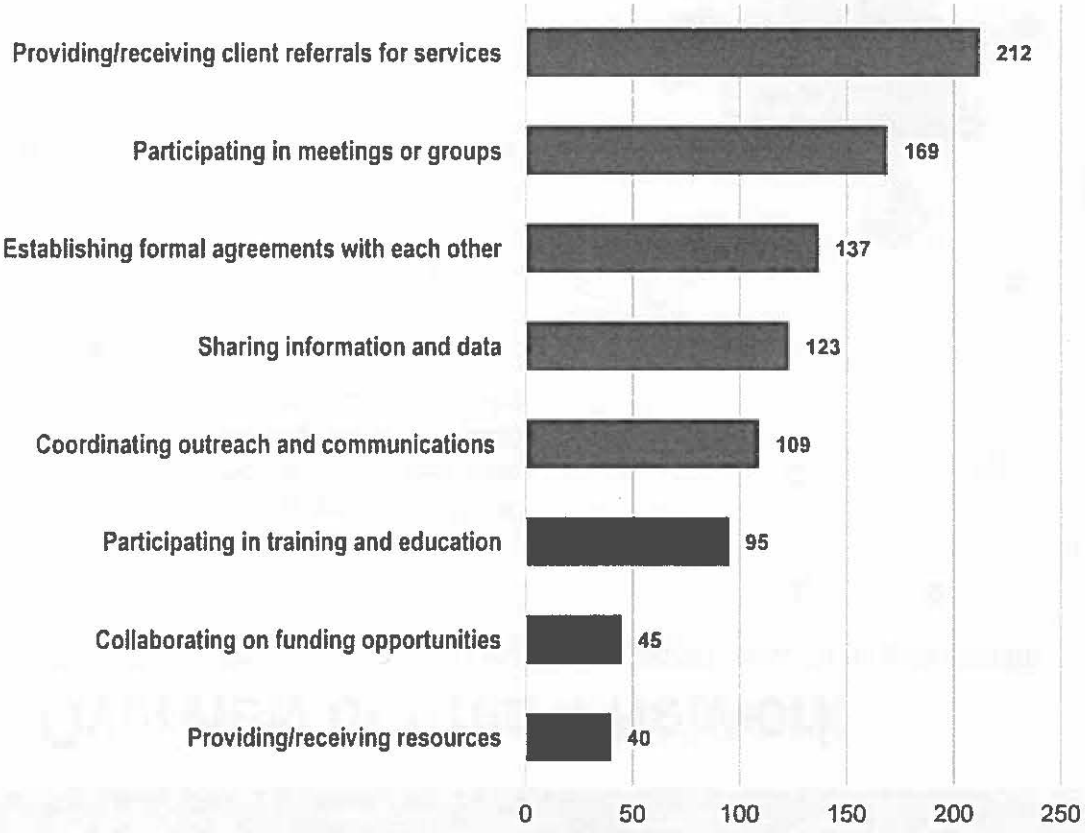


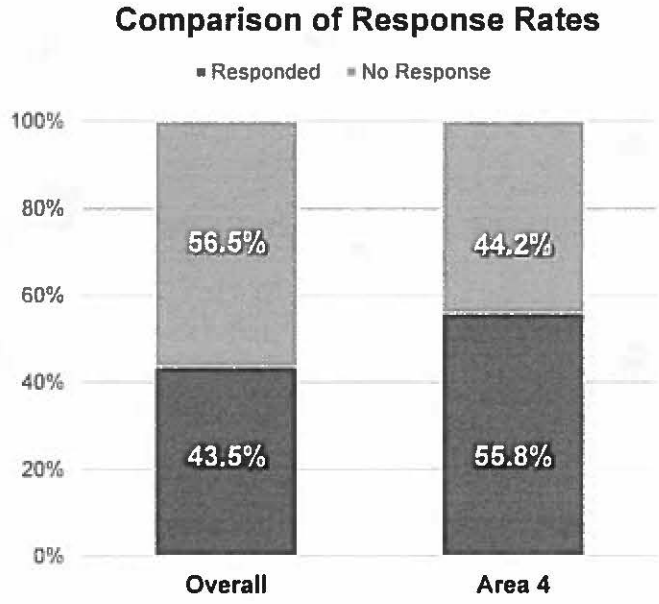
Overview of Area Networks

Weighted nodes, unweighted edges



Summary of Area Descriptives





Top 3 Facilitators

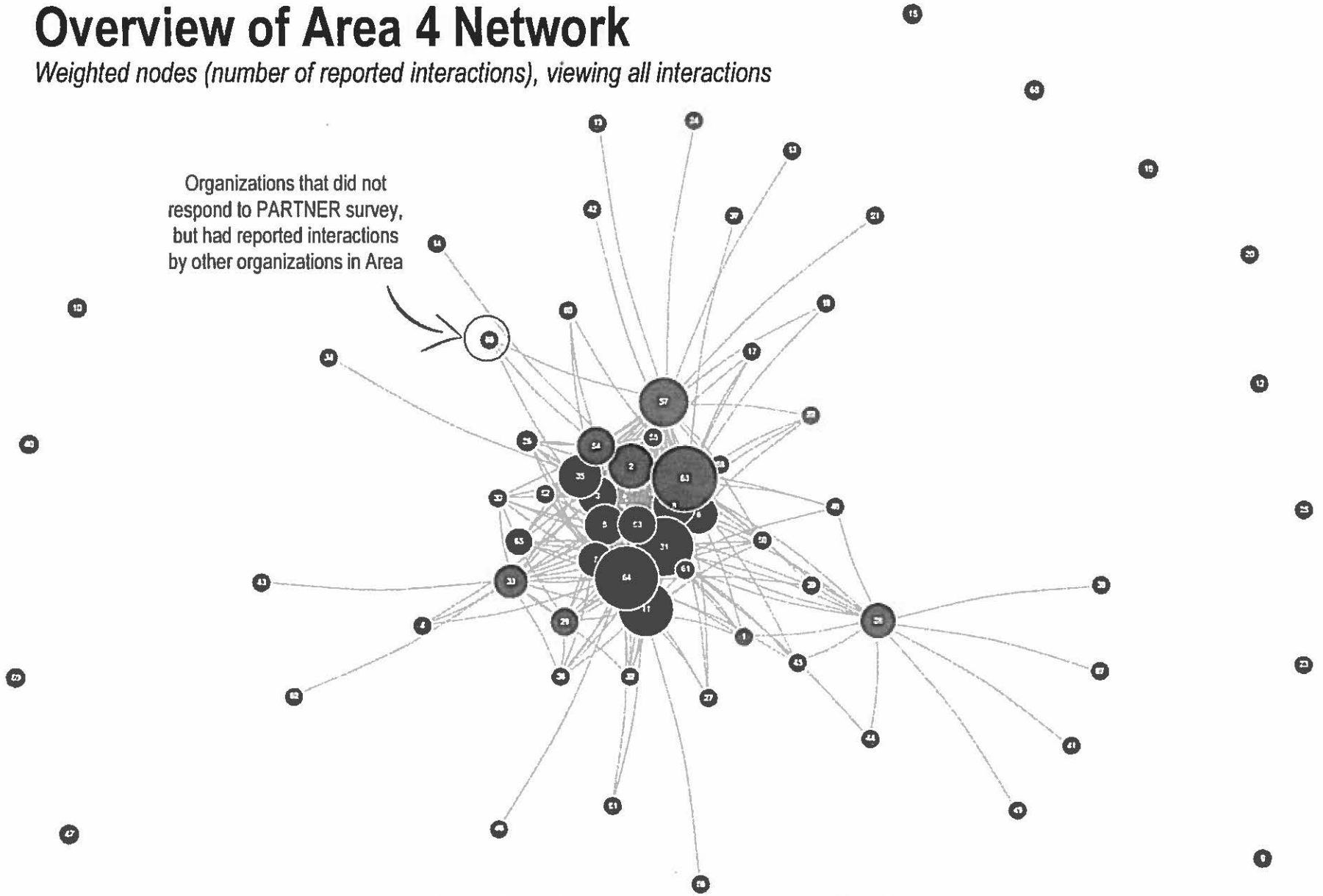
- Atmosphere of collegiality/cooperation
- Patient-centered focus
- Participation in committees/workgroups

Top 3 Barriers

- Limited staff resources/personnel (e.g. time to engage, participate)
- Lack of funding
- Staff turnover, retirement, loss of institutional knowledge

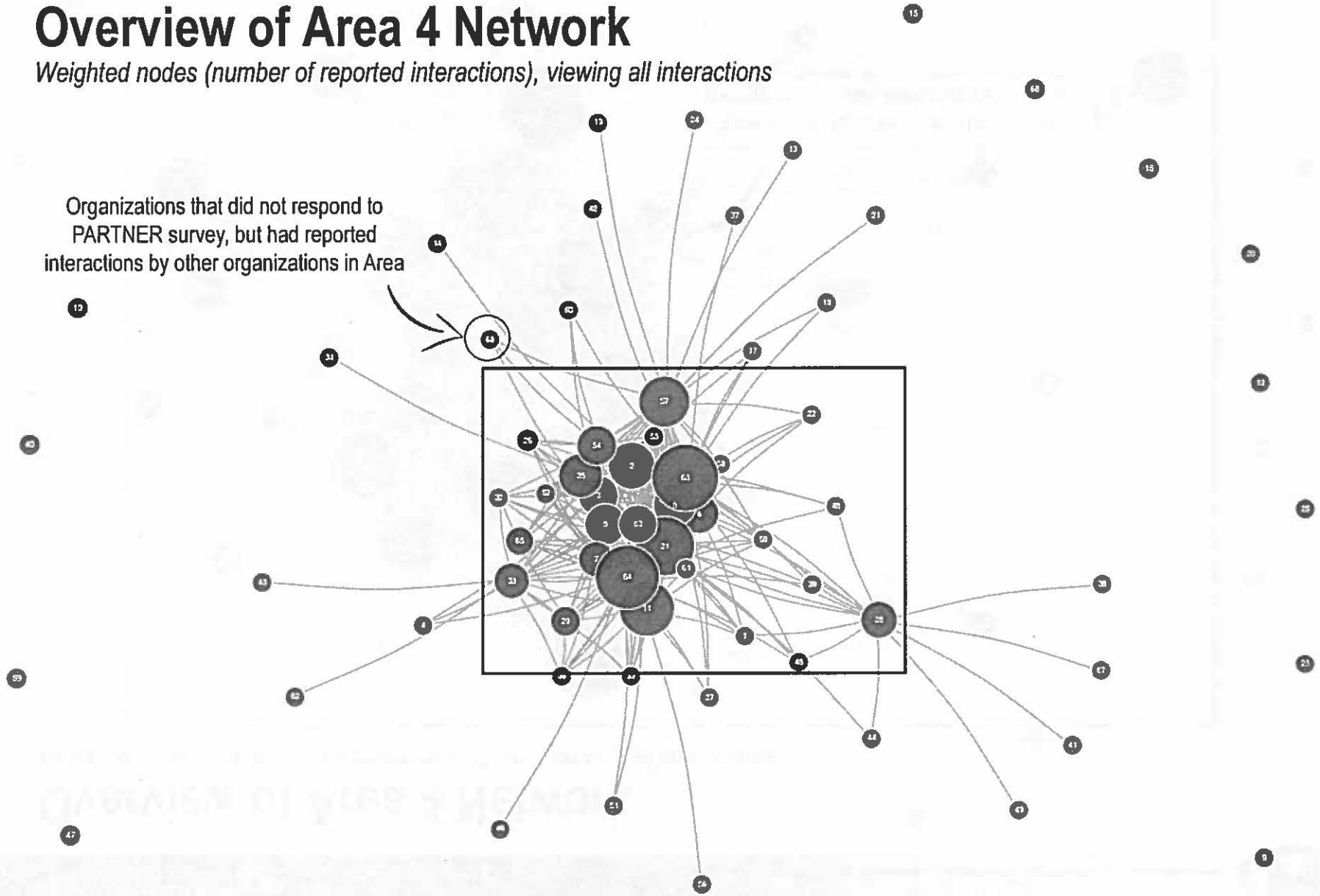
Overview of Area 4 Network

Weighted nodes (number of reported interactions), viewing all interactions



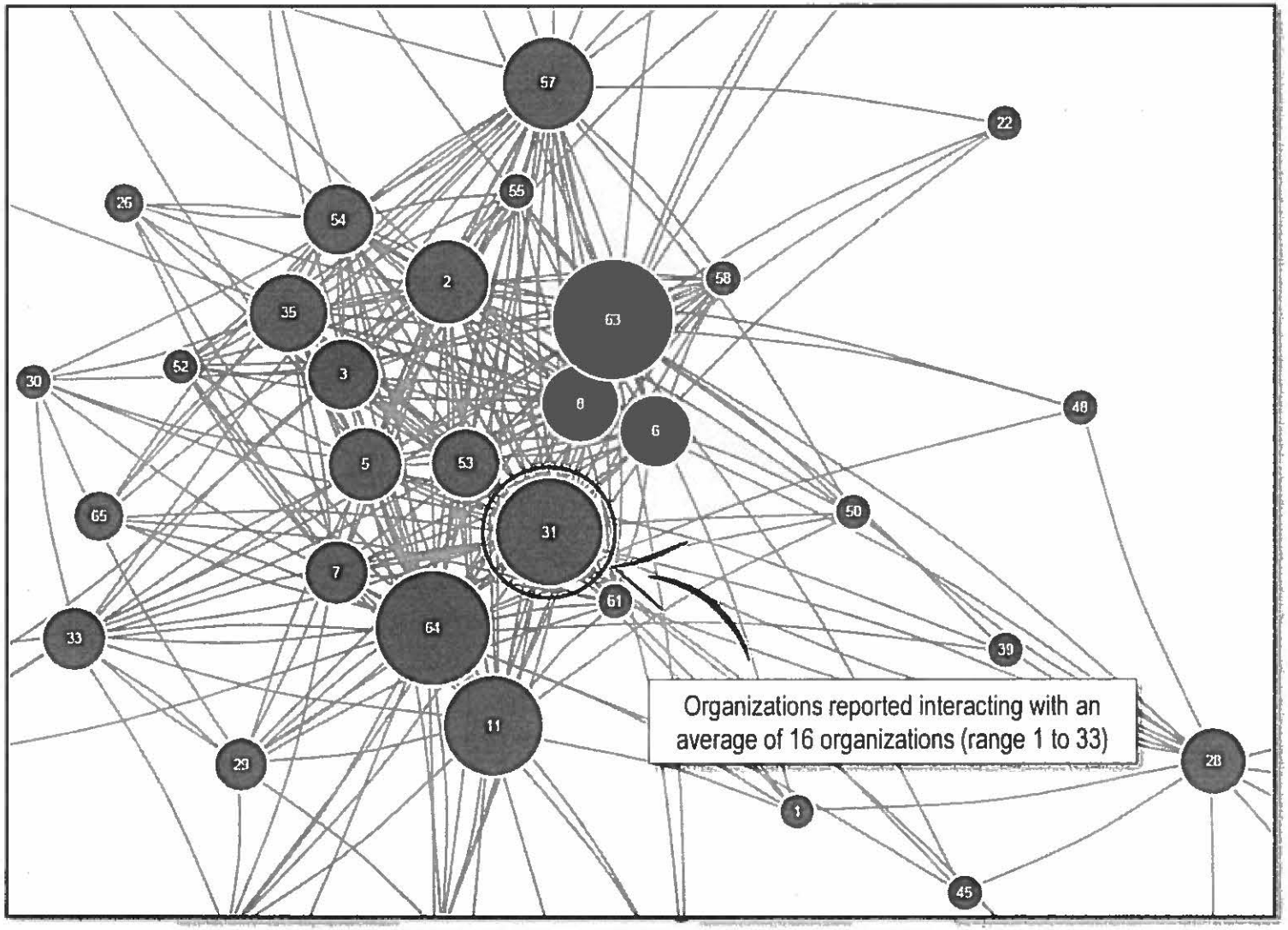
Overview of Area 4 Network

Weighted nodes (number of reported interactions), viewing all interactions



Overview of Area 4 Network

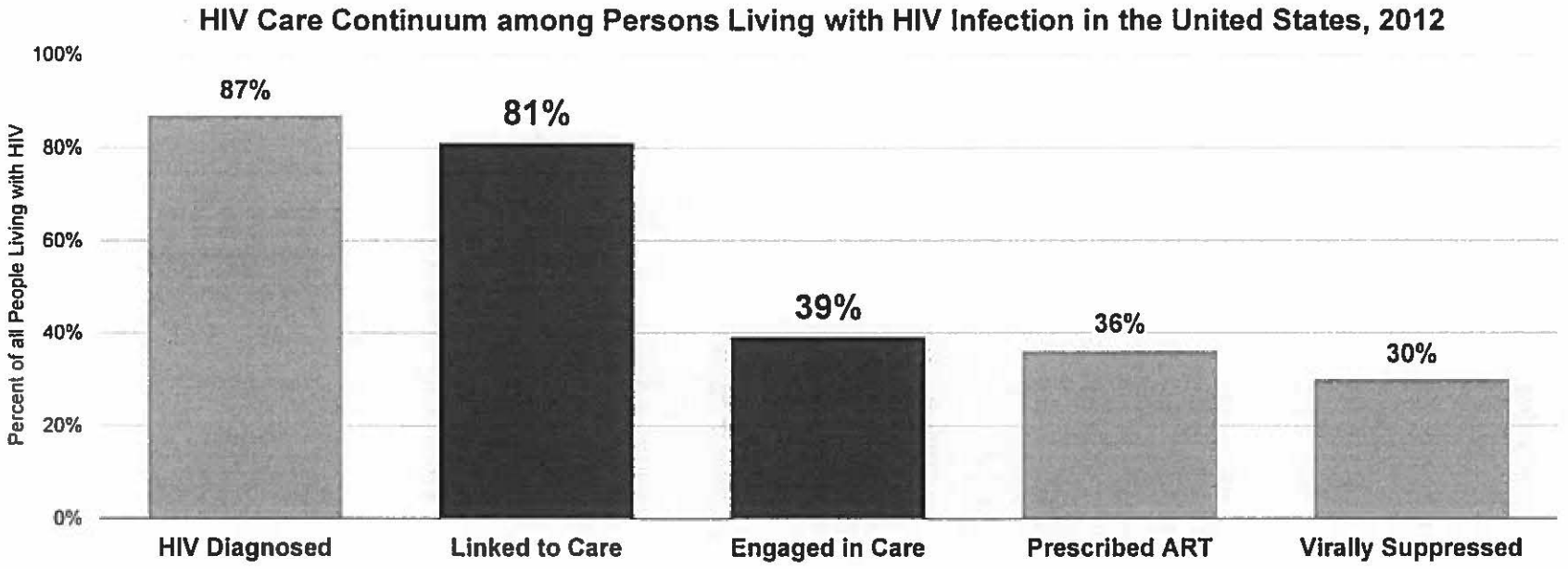
Weighted nodes (number of reported interactions), viewing all interactions



Questions?

Measuring and evaluating success

- Focus of this project on early diagnosis, linkage, and continuous care
- National HIV/AIDS Strategy introduced their HIV Care Continuum



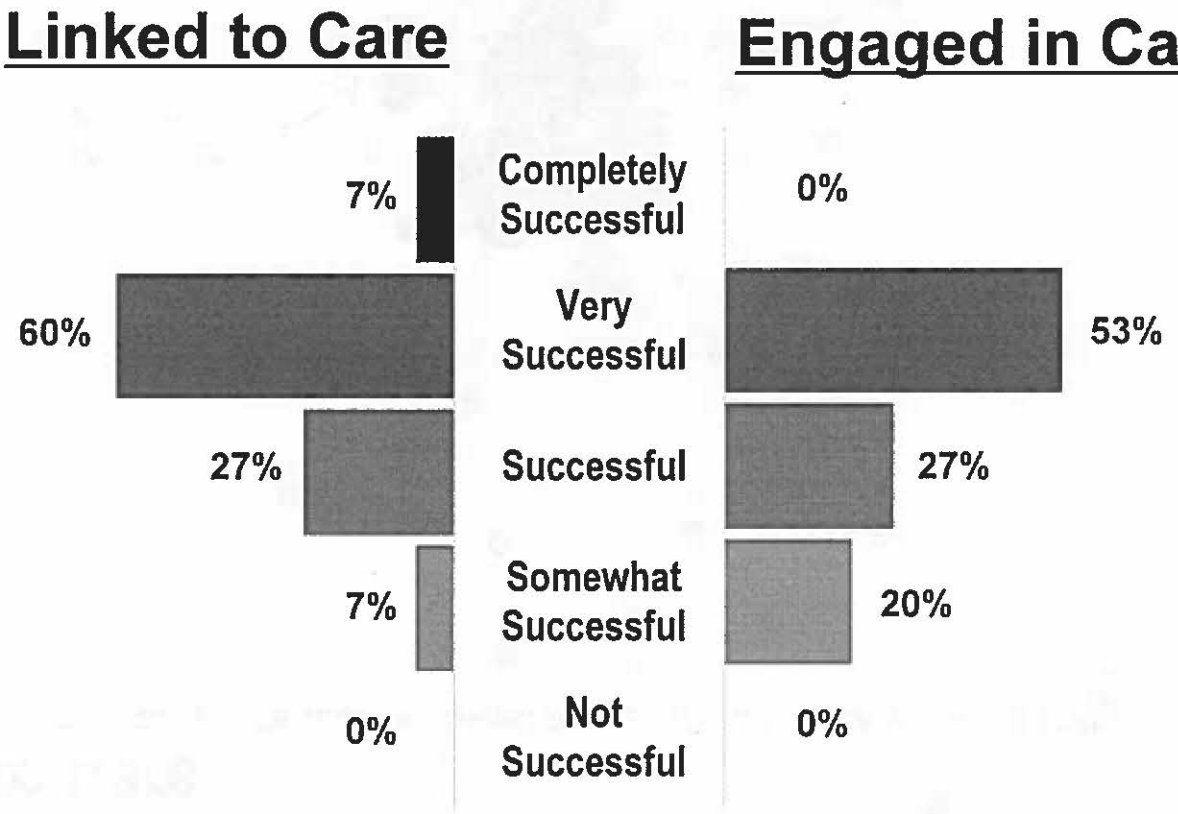
Source: National HIV/AIDS Strategy 2016 Progress Report

* Diagnosed is a calculated estimate based on data reported to the National HIV Surveillance System, the denominator is the estimated number of persons living with HIV (1.2 million).

** Linkage to care is the percentage of persons linked to medical care within 3 months after diagnosis (numerator) among those newly diagnosed in 2012 (denominator). Data are from 28 jurisdictions with complete reporting of CD4 and viral load test results to CDC.

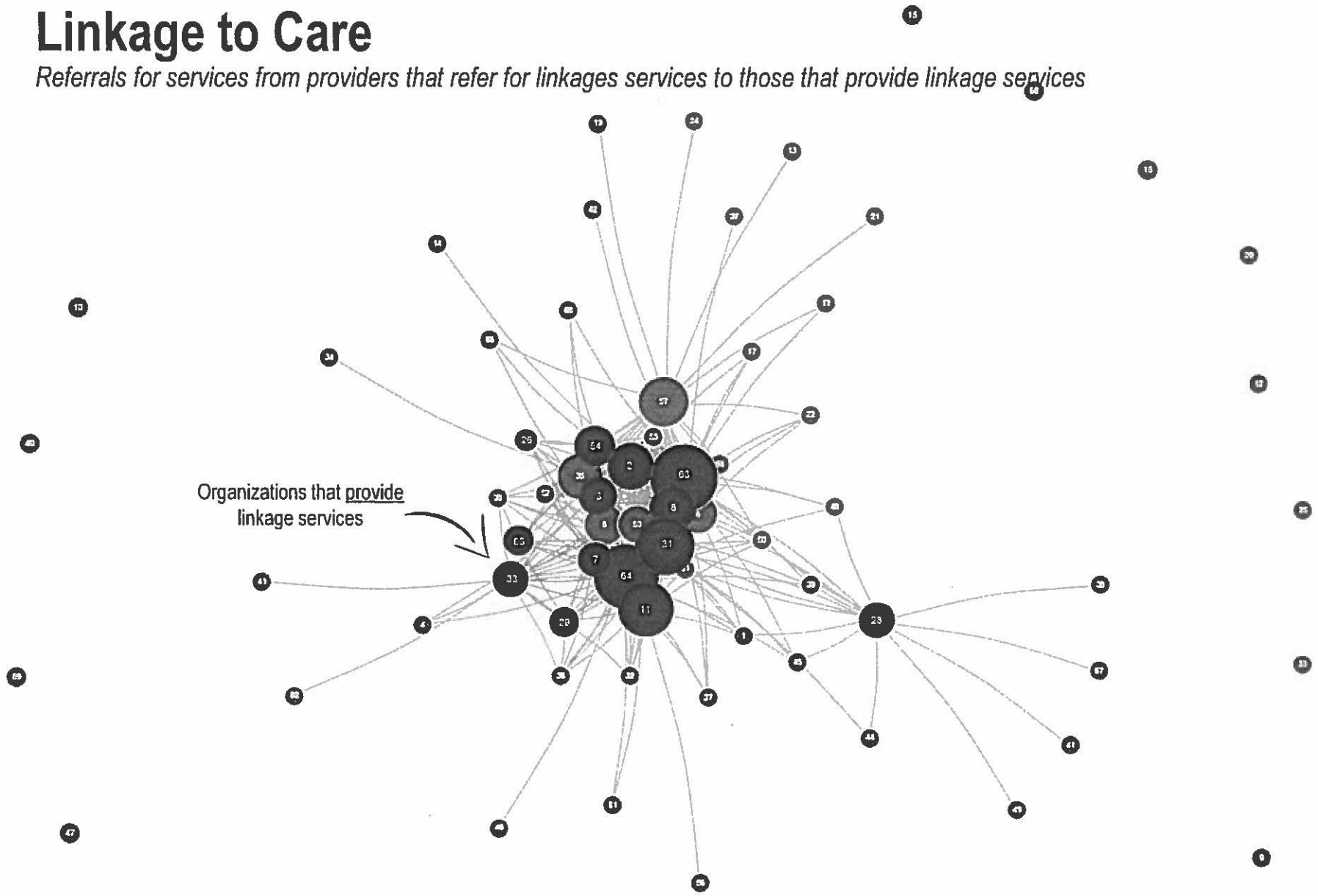
*** Engaged in care, prescribed ART and virally suppressed data (numerators) come from the Medical Monitoring Project and based on people who had at least one HIV care visit during January to April 2012. The dominator is the estimated number of persons living with HIV (1.2 million).

How successful do you think your Area has been at working together as a system…



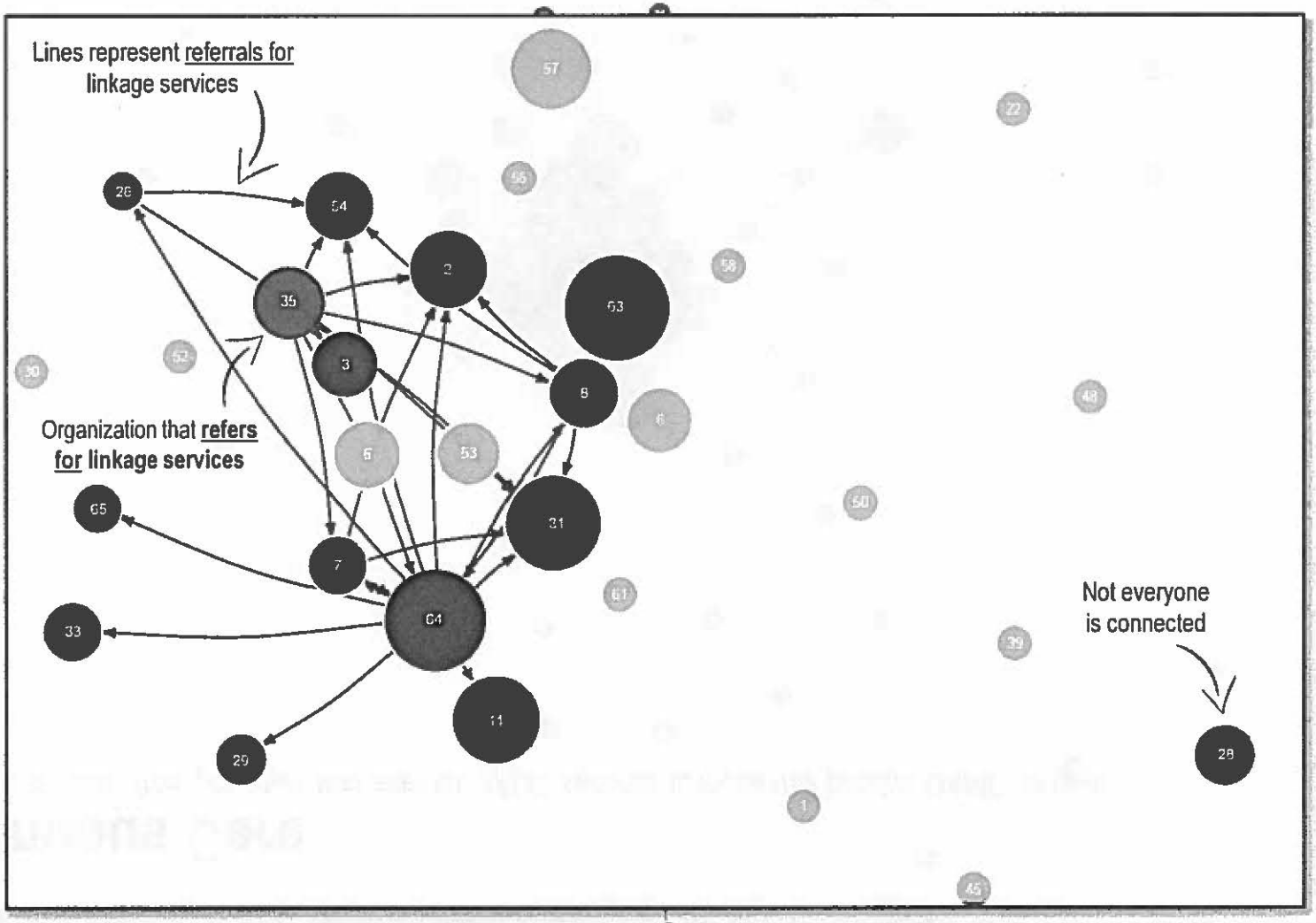
Linkage to Care

Referrals for services from providers that refer for linkages services to those that provide linkage services



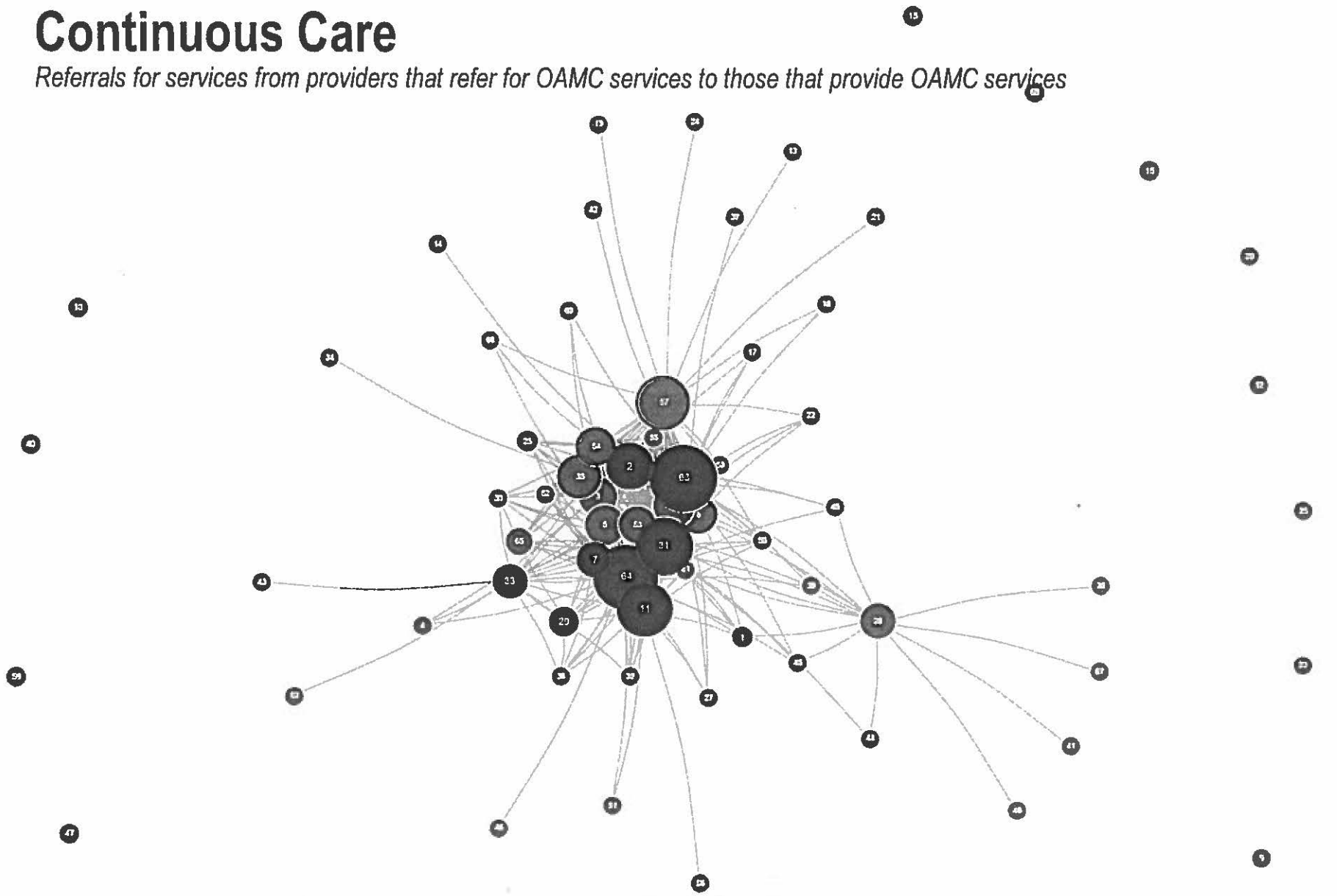
Linkage to Care

Referrals for services from providers that refer for linkages services to those that provide linkage services



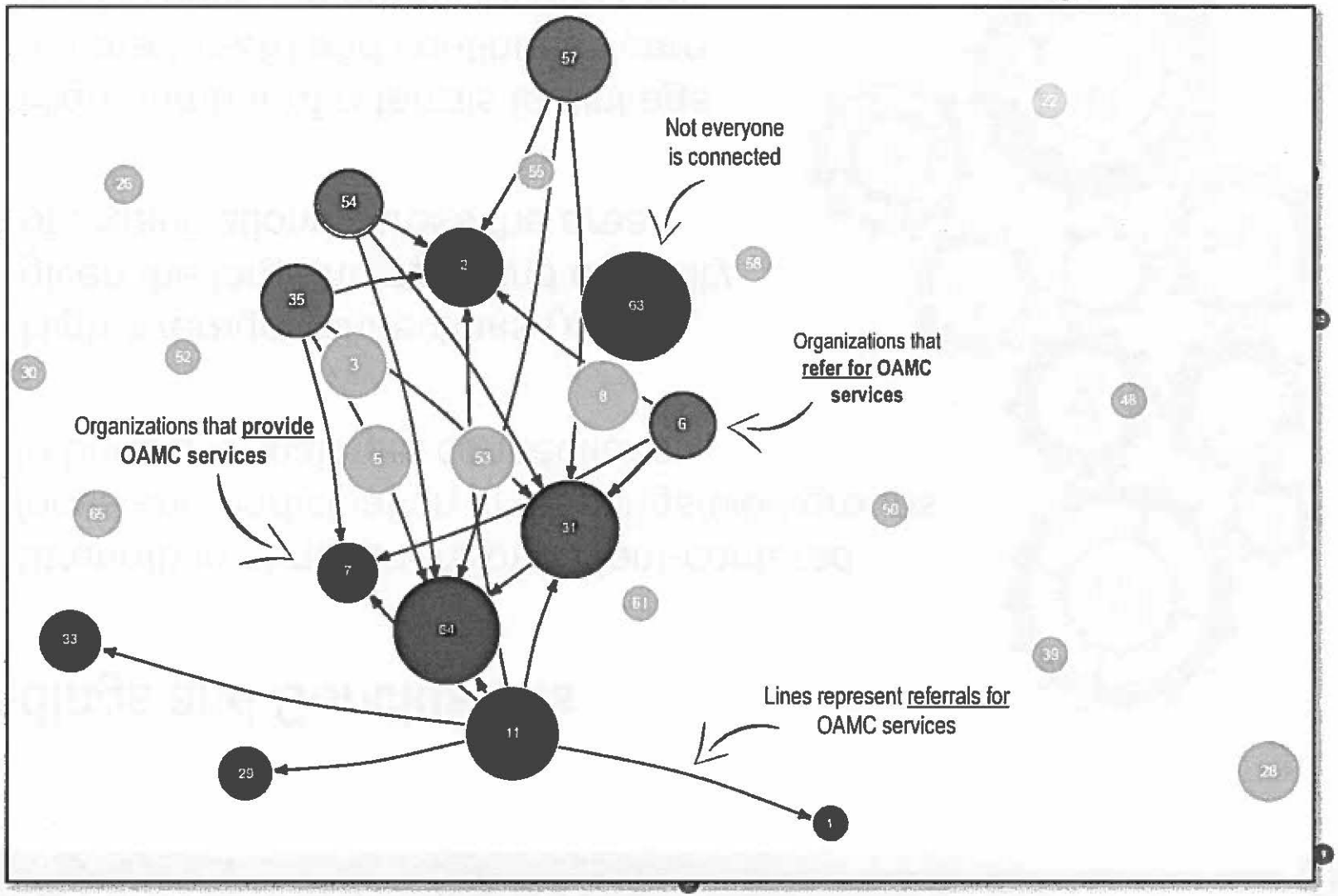
Continuous Care

Referrals for services from providers that refer for OAMC services to those that provide OAMC services



Continuous Care

Referrals for services from providers that refer for OAMC services to those that provide OAMC services



Findings and Conclusions

- Strength in atmosphere of patient-centered focus and participation in meetings/workgroups to build and maintain connections
- High average connections (μ =16), given the large number and diversity of organizations across the area
- High number of referrals for linkage to care (n=26) and continuous care (n=21) between organizations that also provide those services

Implications for Planning and Practices

- Provide the advantage of opportunities for collaboration and cooperation
  - *Identify new providers for service referrals*
- Potential to increase referrals for services and avoid network "isolates"
  - *Opportunities to improve care to clients*
- Face the challenges ahead, together – making the investment for joint planning
  - *Rather than viewing others as competition, potential partners for mutual benefit*

Thank you!

Questions or suggestions?

Interested in Learning More?

Save the Date!

April 20th at 1:00 pm

We will be presenting detailed results from all four participating areas of Florida to an audience of public health systems researchers, along with local and national policy makers.

systemsforaction.org/research-progress-webinars

Contact Us

- You may reach the entire i2i team at i2i@rti.org.
- You may contact individual team members directly using the contact information to the right.

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HEALTH FAIR

PUBLIC HEALTH WEEK – Kick off

Changing a community's health means giving everyone the opportunity to be healthy. Come and learn and be part of the movement for change!

Event will provide free

- **Testing: Blood Pressure checks, HIV testing**
- **Informational pamphlets: Nutrition, Diabetes, High Blood Pressure, Immunizations**
- **Learn how to do *Hands Only CPR***
- **Yoga Pod: *Be seated and Move***

Date: Saturday, April 1st

Where: Peck Center

516 South 10th Street

Fernandina Beach

Time: 4:00pm – 7:00pm

Sponsored by: *Coalition for the Reduction/Elimination of Disparities in Health (CREED) a 501(c)3 nonprofit*

In Partnership with

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