Broward County HIV Health Services Planning Council
Quality Management Committee

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Michael Rajner
Chair

Agenda

Monday, January 23, 2012 at 12:30 P.M.

1.	**Call to Order**	Michael Rajner
2.	**Moment of Silence**	Michael Rajner
3.	**Welcome and Introductions** A. Review Meeting Ground Rules and Statement of Sunshine B. Review Public Comment (Please Sign-in at Front of Room) C. Committee Member Introductions D. Guest Introductions E. Excused Absences F. Approval of Today's Agenda G. Approval of 12/19/11 Meeting Minutes	Michael Rajner
4.	**Public Comment**	Members of the Public
5.	**Part A Grantee Report**	Part A Grantee Staff
6.	**Work Plan Update (Handout A)**	Committee Members
7.	**NQC In+Care Campaign Retention Rates (Handout B)**	Committee Members
8.	**Summary of QM Challenges and Accomplishments (Handout C)**	Committee Members
9.	**Review Client Level Outcomes/Indicators (WP 3A) (Handout D)** - Outreach, Food Bank, Transportation	Committee Members
10.	**Old Business/New Business**	Committee Members
11.	**Resources and Announcements**	Committee Members
12.	**Agenda Items for Next Meeting**	Michael Rajner
13.	**Next Meeting Date: February 27th 2012 at 12:30 P.M.**	Michael Rajner
14.	**Adjournment**	Michael Rajner

** Items with "WP" pertain to the committee work plan*

Please complete meeting evaluation forms.

Please be aware this meeting and all of the information stated thereof is a matter of public record under Florida's Government in the Sunshine Law. Florida Statute, Chapter 119.01
Acknowledgement by participants of HIV status is not required, and if disclosed becomes a part of the public record.

Quality Management Committee
Monday, December 19th, 2011 at 12:30PM
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
1	Michael Rajner, Chair	X		Amy Pont	Leonard Jones
2	Claudette Grant	X		Brad Gammell	Shaundelyn Degraffenreidt
3	H. Bradley Katz	X		Laurie Yadoff	Scott Silverman
4	Khia Johnson		X	Kara Schickowski	
5	Marcel Martin	X		Dr. Curtis Barnes	**CQM Staff**
6	Mark Schweizer	X		James Vellequette	Ariela Eshel
7	Marlinda Quintana-Jefferson	X			Gladria De Sa
Quorum = 5		**6**			

1. **Call to Order**
   The Chair called the meeting to order at 12:48 PM.

2. **Moment of Silence**
   A moment of silence was observed.

3. **Welcome and Introductions**
   - **A.** Review Meeting Ground Rules and Statement of Sunshine
     The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law and it was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, they were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

   - **B.** Review Public Comment
     The Chair informed attendees of the Public Comment sign in sheet which was available for guests to fill out if they wished to comment during the meeting.

   - **C.** Committee Member Introductions
     Self-introductions of committee members were made.

   - **D.** Guest Introductions
     Self-introductions of guests were made.

   - **E.** Excused Absences
     There were no excused absence requests submitted.

   - **F.** Approval of 12/19/11 Agenda
     Approve 12/19/11 Agenda:

Motion #1	To "approve 12/19/11 Meeting Agenda."
Proposed By:	Claudette Grant
Seconded By:	H. Bradley Katz
Action:	Passed unanimously

   a. Approval of 11/21/11 Meeting Minutes
   Approve 11/21/11 Meeting Minutes:
   The minutes were amended to reflect the resignation of Jamie Finkelstein effective 11/21/11.

Motion #2	To "approve 11/21/11 Meeting Minutes with amendment."
Proposed By:	H. Bradley Katz
Seconded By:	Claudette Grant
Action:	Passed unanimously

4. **Public Comment (Up to 10 Minutes)**
None.

5. **Part A Grantee Report**
The Part A Grantee reported on data sharing efforts with ADAP; a request was sent December 1st 2011 to obtain data regarding ADAP drugs dispensed to Part A clients. There has been no response thus far and the request will be followed up and reported on during the next QM meeting. ADAP currently has 1,700 active clients.

Compliance with Part A data entry requirements in Provide Enterprise (PE) is being tracked on a monthly basis. The Part A Grantee is working with GTI on using billing data in the reporting of various data elements.

The Chair added that the ADAP Workgroup will be looking into enrolling in the NQC in+Care Campaign; further information will be provided as received.

6. **Review Client Level Outcomes/Indicators (WP 3A) (Handout A)**
The committee reviewed the Client Level Outcomes and Indicators for the following service categories: Medical Case Management, Legal Services, and Outreach.

Medical Case Management
Outcomes and indicators for Medical Case Management were reviewed by the committee during its last meeting and sent to the Network for review. A Network representative attended to discuss changes made to the indicators via network consensus.

The committee made the following formal motion:

Motion #3	To "set Medical Case Management Indicator 2.1 at 70%."
Proposed By:	Mark Schweizer
Seconded By:	Claudette Grant
Amendment to Motion:	To "set Medical Case Management Indicator 2.1 at 80%."
Action:	Passed unanimously

OUTCOMES	**INDICATORS**
Medical Case Management	
1. Improved ability to independently navigate and access needed services.	1.1 80% of clients achieve POC goals by designated target dates. Tabled for further discussion during next meeting.
2. Increased and/or maintain, retention to Outpatient/Ambulatory Medical Care. *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	2.1 80% ~~85%~~ of clients remain enrolled in Outpatient/Ambulatory Medical Care. *The justification for mirroring the initial 85% rate agreed upon by MH/SA for Indicator 2.1 is that a higher rate may be difficult to achieve since in addition to MH/SA issues, MCM clients may also experience additional complexities such as homelessness, cognitive issues, and incarceration.* *The QMC oscillated between 75% and 85% as a result of reviewing the NQC In+Care retention rates before agreeing on 80%.* *2.1 mirrors 1.1 percentage.*

The committee will continue discussion about Indicator 1.1 during their next meeting.

Legal Services

The committee reviewed client level outcomes and indicators for the Legal Services category. Indicator 1.1 was increased based on Legal Services' history of surpassing the original benchmark. Indicator 1.2 remained the same with the justification that if the case is lost at the hearing level (measured in indicator 1.1), it is very unlikely it will be reversed (as measured in indicator 1.2). The following formal motions were made via consensus:

Motion #4	To "set the Legal Services Indicator 1.1 at 80%."
Proposed By:	H. Bradley Katz
Seconded By:	Marcel Martin
Action:	Passed unanimously

Motion #5	To "approve the Legal Services Indicator 1.2 at 60%."
Proposed By:	H. Bradley Katz
Seconded By:	Marcel Martin
Action:	5 passed, 1 opposed

OUTCOMES	INDICATORS
Legal	
1. Increased access to benefits for which the client is eligible.	1.1 80% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability.
	1.2 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.

Outreach

The committee reviewed client level outcomes and indicators for the Outreach service category. An outreach representative was present to explain the process of linking clients to care through outreach.

OUTCOMES	INDICATORS
Outreach	
1. Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	1.1 80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder). 1.2 25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing

	eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).

The committee considered creating separate indicators for new clients and returning clients. The Committee will continue discussion about this service category during its next meeting.

7. Old Business/New Business

i. NQC in+Care Campaign Measures Update

The Grantee stated that NQC retention data will be discussed at each Network meeting.

A summary of the Needs Assessment will be shared with the committee.

The Chair asked that representatives of the following networks/committees be invited to the next meeting: OAMC, JCCR, Outreach, MCM, Food Bank.

8. Resources and Announcements

None.

9. Agenda Items for Next Meeting: Review of Client-Level Outcomes and Indicators (*Medical Case Management Indicator 1.1, Outreach, Food Bank, CIED, HICP and Transportation),* Summary of Consumer Survey, Summary of QM Challenges and Accomplishments as pertaining to the Comprehensive Plan.

10. Next Meeting Dates: 1/23/12 at 12:30p.m. at the Ryan White Part A Program Office.

11. Adjournment

Consent Item #1	To "adjourn at 4:40 PM."
Action:	Passed unanimously.

	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
1. Develop 3-Year QM Plan						
A.	Review and make recommendations for changes to 3 Year QM Plan	Grantee Staff, CQM Support Staff & QMC	Complete Review of 3 Year QM Plan	02/2011	03/2011	**COMPLETED**
B.	Update 3 Year QM Plan & Annual QM Work Plan	Grantee Staff , CQM Support Staff & QMC	Update 3 Year QM Plan	02/2011	03/2011	**COMPLETED**
C.	Approve updated 3 Year QM Plan	QMC	Approve 3 Year QM Plan	02/2011	03/2011	**COMPLETED:** 3/21/11 – QMC Approved 3/24/11 – HIVPC Approved
2. Review & Analyze Annual Measures and Chart Review Data						
	Objectives	**Accountability**	**Outcome**	**Start Date**	**Due Date**	**Status**
A.	Select annual measures and data for tracking and evaluation	CQM Support Staff & QMC	Measures to develop Quality Improvement Projects (QIP)	03/2011	03/2011	**COMPLETED:** HAB Core Clinical Performance Measures
B.	Review and analyze annual measures and data	QMC, CQM Support Staff, Grantee Staff, QI Networks	Data analysis to determine QIP	04/2011	05/2011	**COMPLETED:** 2/28/11 - Reviewed medical chart review results. 3/21/11 - Reviewed HAB Core Clinical Performance Measures.
C.	Review and analyze core category assessment chart review results	QMC, CQM Support Staff, Grantee Staff, QI Network	Data analysis to determine QIP	11/2011	FY 2012-2013	Core Category is Oral Health
D.	Identify service delivery deficiency and assess whether QIPs are necessary based on the measures evaluated and assessment results	QMC, QI Networks, Grantee Staff, CQM Support Staff	QIP recommendation	09/2011	Ongoing	Recommended QIPs based on measures from medical chart review results.
E.	Develop a plan to improve system-wide service delivery deficiency (PLAN)	QMC, Grantee Staff, CQM Support Staff	Task List to complete plan	TBD	Ongoing	
			Predict desired plan results	TBD	Ongoing	

2. Review & Analyze Annual Measures and Chart Review Data (Continued)						
	Objectives	**Accountability**	**Outcome**	**Start Date**	**Due Date**	**Status**
F.	Implement system-wide QIP (DO)	QI Network Members	QIP Results	TBD	Ongoing	
G.	Evaluate QIP results (STUDY)	QMC, QI Networks, Grantee Staff, CQM Support Staff	Analysis of QIP results to prediction	TBD	Ongoing	
H.	Repeat another PDSA Cycle if QIP results do not meet prediction (ACT)	QMC, Grantee Staff, CQM Support Staff	See Work Plan Objectives B, C and D above.	TBD	Ongoing	
I.	Implement system-wide service delivery change if QIP results meet predication	QMC, QI Networks, Grantee Staff, CQM Support Staff	Updated Service Delivery Model	TBD	Ongoing	
3. Review & Assess Client-Level Data						
	Objectives	**Accountability**	**Outcome**	**Start Date**	**Due Date**	**Status**
A.	Review HAB Performance Measures and Outcomes/Indicators	QMC, CQM Support Staff, Grantee Staff	Identify possible QIPs	9/2011	Pending completion of client level outcomes and indicators review	**HAB Performance Measures:** Reviewed Core Clinical 2/28/11 **Outcomes/Indicators: In progress**
B.	Analyze HAB and Outcome/Indicator Findings	QMC, CQM Support Staff, Grantee Staff	Identify possible QIPs	Quarterly	Quarterly	**HAB Performance Measures:** Analyzed Core Clinical 2/28/11
C.	Develop mechanism to share data, findings and methodologies with Part B, C, D, and HOPWA Grantees	QMC, CQM Support Staff, Grantee Staff	Data shared among EMA Grantees	09/2011	01/2012	**Recommended Data:** • Client medication info • Part D wraparound info • AICP Data • Housing Info • Client contact info • Data presented at SFAN
D.	Review and modify Outcomes/Indicators as submitted by	QMC, QI Network, CQM Support	Updated Outcomes & Indicators	07/2011	Ongoing	**Medical QI:** 3/21/11 – Approved update to

	QI Networks	Staff				outcome indicator 1.1.
4. Provide Quality Assurance and Quality Improvement Training to All Stakeholders						
	Objectives	**Accountability**	**Outcome**	**Start Date**	**Due Date**	**Status**
A.	Identify and recommend trainings	QMC, CQM Support Staff, Grantee Staff	A list of prioritized trainings	Ongoing	Ongoing	Recommended PE training after reviewing medical chart review results.
B.	Conduct QI/QA Principles trainings	Grantee Staff, CQM Support Staff	QMC & consumers will refresh and obtain new QA/QI knowledge	TBD	01/2012	Survey other HIVPC Committees to determine topic of training and interested audience.
5. Review and Implement QM Committee Policies and Procedures						
	Objectives	**Accountability**	**Outcome**	**Start Date**	**Due Date**	**Status**
A.	Review QMC purpose and mission statement	QMC	Updated QMC purpose and mission statement	05/2011	06/2011	**COMPLETED** 6/20/11 – Committee reviewed; there were no changes.
B.	Review and update policies and procedures to conform to updated QMC purpose and mission statement	QMC, CQM Support Staff	Updated QMC policies and procedures	05/2011	06/2011	**COMPLETED** 6/20/11 – Revisions made to reflect revised annual plan and committee no longer has a grantee co-chair.
C.	Approve QMC policies and procedures	QMC	Improved administration of QM Program policies and procedures	05/2011	06/2011	**COMPLETED** 6/20/11 – Approved the revised policies and procedure and forwarded to HIVPC for approval.
6. Approve Service Delivery Model Modifications						
	Objectives	**Accountability**	**Outcomes**	**Start Date**	**Due Date**	**Status**
A.	Review and approve modified service delivery models as submitted by QI Networks (See CQM Monthly Update for more details)	QMC, QI Networks, Grantee Staff, CQM Support Staff, HIVPC	Updated Service Delivery Model	As Needed	As Needed	3/21/11 – Approved Outreach SDM 4/16/11 – Approved MCM SDM **Completed** – Outpatient Ambulatory Medical Care SDM

						Approved by HIVPC on 10.27.11
7. Evaluate Client Survey from Needs Assessment						
	Objectives	**Accountability**	**Outcomes**	**Start Date**	**Due Date**	**Status**
A.	Evaluate and assess 2011 survey results	QMC, QI Networks, CQM Support Staff, Grantee staff	Data analysis to determine QIP	10/2011	02/2012	Reviewed 2010 survey results. These results will be used to compare results from 2011 survey. 2011 results will be provided for review and discussed on 02/12.
B.	Identify service delivery deficiency and assess whether QIPs are necessary	QMC, QI Networks, CQM Support Staff, Grantee Staff	Identify possible QIPs	10/2011	Ongoing	
8. Apply QM methods to identify areas of improvement and modify processes to support EIIHA Strategy						
	Objectives	**Accountability**	**Outcomes**	**Start Date**	**Due Date**	**Status**
A.	Review and assess whether QIPs are necessary for rapid Linkage To Care (LTC) activities undertaken by Part A-funded outreach in collaboration with public health and health care provider HIV testing sites	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
B.	Review and assess whether QIPs are necessary for the time from initial HIV+ test to the first OAMC visit with a physician	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
C.	Review and assess whether QIPs are necessary for engagement and retention in OAMC in the first year following initial HIV testing	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
D.	Review and assess whether QIPs are necessary for linkage and retention methods tailored to the unique needs of racial, ethnic, and sexual minority men and racial and ethnic minority	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction

	women					
E.	Inform Outreach QI Network of QIP recommendations	QMC, QI Networks, CQM Support Staff, Grantee Staff	Improved service delivery	TBD	TBD	Pending Further Instruction
9. Conduct Annual QM Plan Evaluation						
	Objectives	**Accountability**	**Outcomes**	**Start Date**	**Due Date**	**Status**
A.	Describe QM Committee Annual Accomplishments (HRSA Conditions of Award)	QMC	Submit to Grantee for inclusion in RW Progress Report HRSA COA	08/2011 (HRSA)	11/2011 (HRSA)	*Dates contingent upon release of grant guidance from HRSA Will be discussed on 11/11
B.	Define QM Committee challenges (HRSA Conditions of Award)	QMC	Submit to Grantee for inclusion in RW Progress Report HRSA COA	08/2011 (HRSA)	11/2011 (HRSA)	*Dates contingent upon release of grant guidance from HRSA Will be discussed on 11/11
C.	Review Grantee Annual Contract/Program Evaluation Findings	Grantee	Develop potential QIP	TBD	02/2012	
D.	Review 3-Year QM Plan progress	QMC	Update 'rolling' 3-Year QM Plan	12/2011	02/2012	
10. Participate in the development of the Clinical Quality Management section of the Ryan White Grant Application						
	Objectives	**Accountability**	**Outcomes**	**Start Date**	**Due Date**	**Status**
A.	Review and compare Annual Work Plan to criterion for QM section of Ryan White Grant Application.	QMC, CQM Support Staff, Grantee Staff	Integration of QM Committee input into QM Section of grant application	09/2011	11/2011	
B.	Provide data and information to the Joint Priorities Committee to assist in the PSRA process.	QMC, CQM Support Staff, Grantee Staff	Data summary report	12/2011	02/2012	

Accomplishments: Please see FY 2011-2012 Accomplishments and Challenges Report

Challenges: Please see FY 2011-2012 Accomplishments and Challenges Report

In+Care Campaign Retention Measures

Gap Measure
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year.
Medical Visit Frequency
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.
Patients Newly Enrolled in Medical Care
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year.
Viral Load Suppression
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year.

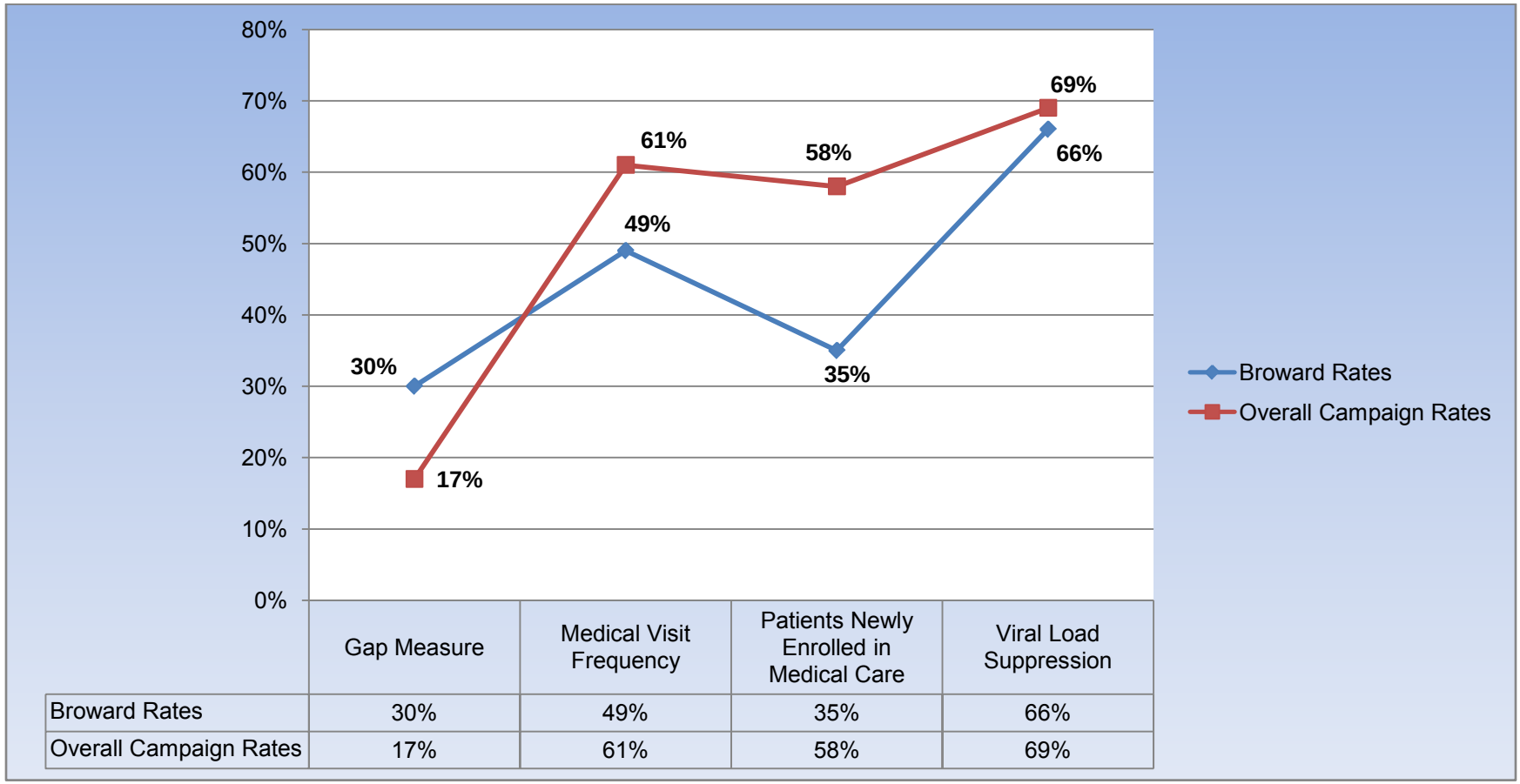
Data Submission Dates

Submission Due Date	Measurement Year*	24 Month Measurement Period**
12/01/2011	10/01/2010 - 09/30/2011	10/01/2009 - 09/30/2011
02/01/2012	12/01/2010 - 11/30/2011	12/01/2009 - 11/30/2011
04/02/2012	02/01/2011 - 01/31/2012	02/01/2010 - 01/31/2012
06/01/2012	04/01/2011 - 03/31/2012	04/01/2010 - 03/31/2012
08/01/2012	06/01/2011 - 05/31/2012	06/01/2010 - 05/31/2012
10/01/2012	08/01/2011 - 07/31/2012	08/01/2010 - 07/31/2012
12/03/2012	10/01/2011 - 09/30/2012	10/01/2010 - 09/30/2012

*applies to the following measures: Gap Measure, Patients Newly Enrolled in Medical Care, and Viral Load Suppression

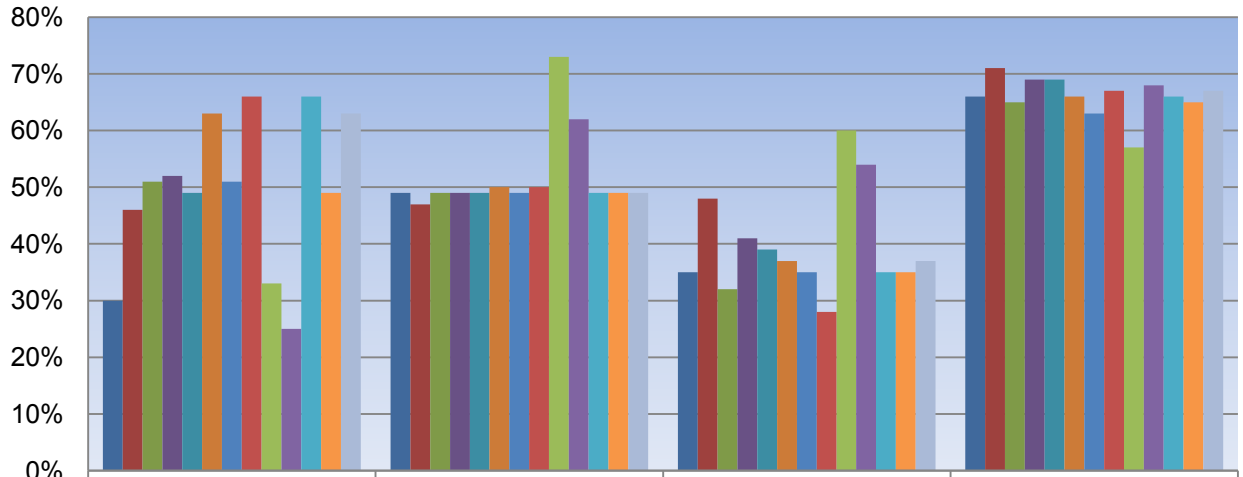
** applies to the Medical Visit Frequency measure

Broward County Rates Compared to Overall Campaign Rates



	Gap Measure	Medical Visit Frequency	Patients Newly Enrolled in Medical Care	Viral Load Suppression
Broward Rates	30%	49%	35%	66%
Overall Campaign Rates	17%	61%	58%	69%

Broward County Rates Compared to Other Campaign Participants



	Gap Measure	Medical Visit Frequency	Patients Newly Enrolled in Medical Care	Viral Load Suppression
Broward	30%	49%	35%	66%
DC Collaborative	46%	47%	48%	71%
South Texas	51%	49%	32%	65%
Upstate NY	52%	49%	41%	69%
Eastern PA	49%	49%	39%	69%
Chicago Part C/D	63%	50%	37%	66%
Mississipppi	51%	49%	35%	63%
Massachusetts	66%	50%	28%	67%
Puerto Rico	33%	73%	60%	57%
New Jersey	25%	62%	54%	68%
Rhode Island	66%	49%	35%	66%
Michigan	49%	49%	35%	65%
Two Rivers	63%	49%	37%	67%

Accomplishments and Challenges Fiscal Year 2011-2012	
Fort Lauderdale/Broward County EMA Assessments	
Assessment	**Status**
Ryan White Part A, Part B & HOPWA Needs Assessment	• A total of 1,161 surveys were conducted. Results have been disseminated to all HIVPC Committees.
Oral Health Care Services Quality Outcomes and Cost Assessment	• Oral Health was identified as the core category assessment for FY2011. The purpose of this assessment was to evaluate the effectiveness of the Fort Lauderdale/Broward County EMA Part A funded Oral Health Care services. The primary focus was the manner in which services are provided to ensure consistency with standards. • RFP was announced and a contractor provided a proposal however it was decided the study be postponed to align with the establishment of Oral Health Care benchmarks by AETC.
Quality Management Assessment	• The Ryan White Part A Program commissioned an assessment of the Quality Management (QM) programs of Part A funded providers. Positive Outcomes, Inc. (POI) adapted the HIVQUAL HIV Organizational QM Program Self-Assessment for use by HIV programs operating in Broward County. Part A, C, and D-funded core and support service providers participated in the assessment. The aim of the self-assessment was to: 1) Identify the extent to which HIV providers have undertaken key domains of QM program development and implementation; 2) Evaluate the QM infrastructure of Part A-funded providers; 3) Ascertain the strengths and weakness of the QM programs; and 4) Determine the extent to which training, capacity development, and technical assistance (TA) are needed by Part A providers. The results from the assessment were used to guide the development and implementation of QM programs at Part A funded agencies. An evaluation of agencies' QM plans is pending.
QM Plan and Mission	
• Three-year QM Plan developed and approved • QM Committee purpose and mission statement reviewed and revised • Policies and procedures revised to conform to updated QMC purpose and mission statement	
Service Delivery Model (SDM) Revisions	
The following Service Delivery Models have been revised and approved: o Medical Case Management Services o Food Bank Services o Medical Transportation Services o Outpatient Ambulatory Medical Services o Outreach	
Quality Improvement Networks Activities	
• <u>Mental Health/Substance Abuse QI Network:</u> o Developed a Mental Status Exam which was programmed in PE as well as a Lethality Assessment o Tracked No-Show data aimed at determining reasons for missed appointments • <u>Pharmacy QI Network:</u> o Began developing a patient medication card to ensure medications are being used appropriately, to reduce drug-	

drug interactions, and to improve patient safety

- Oral Health Care QI Network:
  - Modifications made in PE to allow documentation of Episode of Care:
    1) Emergency
    2) Phase 1
    3) Phase 2
    4) Dentures
    5) Maintenance (Non-Emergency)
  - Presentation on Oral Health Care and HIV developed for MCM's and Peers
- Medical Case Management (MCM) QI Network:
  - CIED Eligibility Documentation Checklist completed
  - Completion of Needs Assessment in PE
- Outpatient/Ambulatory Medical QI Network:
  - A QIP in development to address cervical screening no-show rates

System Improvements – In place or In development

- Revision of Broward County Client Level Outcomes and Indicators – In progress
  - Ad-Hoc MCM Committee developed to revise MCM indicators
  - Mental Health/Substance Abuse Network revised indicators; approved by QM Committee
  - Legal Services and Outreach representatives attended QM Committee meetings; Legal Services indicators approved
  - Food Bank representative to attend upcoming meeting
  - Pharmacy Network revised its indicators; pending QM Committee approval of revisions, the Pharmacy Network will meet to develop non-pick up adherence spreadsheet
- QI Network Restructuring
  - The structure of the QI Networks was changed to promote greater collaboration among Networks and ensure Network activities reflect Comprehensive Plan, three-year QM plan, and annual QM Plan goals. All activities to be guided by the theme of increased access, adherence, and retention in care. The first theme guiding all Network activities is retention, which will align with the National Quality Center (NQC) In+ Care campaign.
  - Development of a Combined Network comprised of CIED, Legal Services, Food Bank, HOPWA, Transportation, and Pharmacy
  - Collaborative meetings to exchange information and promote collaboration
    - Oral Health Care Network developed a presentation on HIV/AIDS and Oral Health Care for MCM's and Peers
    - Oral Health Care representative attended Medical Network meeting to discuss the importance of lab results for Oral Health Care service provision
    - Oral Health Care representative attended MCM Network to promote improved communication and collaboration
    - Mental Health/Substance Abuse Network attended Medical Network meeting to provide information on available services and the referral process
    - Medical Network attended Local Pharmacy Advisory Committee (LPAC) to assist with formulary revisions
    - Central Intake and Eligibility Determination (CIED) attended MCM Network meeting leading to the development of a CIED eligibility documentation checklist for MCM's
    - HOPWA representative attended MCM Network meeting to provide a review of available housing services and their eligibility requirements
    - Legal Services attended MCM and Medical Network to discuss the information needed to facilitate applications for public benefits

Training Initiatives

Medical Case Management Training

- Two trainings focused on Plan of Care development took place August 5 and December 8, 2011. The MCM Network requested additional training on this topic. Technical Assistance will be provided to help identify areas for improvement.

SOAR Training

- SOAR (SSI/SSDI Outreach, Access, and Recovery) training was provided on August 25 and 26, 2011 to Ryan White Part A and HOPWA MCM's.
  - A follow-up survey has been developed to determine whether the Part A MCM's and HOPWA case managers who attended the SOAR training have initiated disability applications for their clients.

Other Initiatives

- **In+Care Campaign**
  - The EMA has signed up to participate in a year-long retention campaign led by NQC
  - Data will be reviewed and reported regularly to identify improvement strategies
- **HOPWA and Part A Data Sharing Agreement**
  - Completed in PE
- **Health Literacy**
  - Three-year Health Literacy plan developed
  - Combined Network charged with leading the initiative
  - Site visits conducted at nine agencies to introduce the plan and gauge health literacy activities already in place
- **Formulary revisions**
  - LPAC formed to review the Part A Formulary to identify areas for cost reductions

Challenges

- The role of the QM Committee in monitoring Comprehensive Plan activities
  - How will we monitor progress? – Plan for ongoing monitoring (evaluation, achieving goals, identifying challenges)
  - EIIHA activities and their impact
  - Collaboration with appropriate HIVPC Committees
- Accurate data entry to facilitate better data analysis
- Improvement in retention rates

OUTREACH, FOOD BANK, AND TRANSPORTATION
COMPARISON TO OTHER EMA'S

EMA	Transportation Outcomes	Transportation Indicators
Broward	Provide access to primary medical care appointments via van transportation.	95% of all clients receiving medical transportation arrive on time for their medical appointment
	Support adherence to primary medical care appointments via van transportation.	100% of medical appointment 'no-shows' will be reported to their medical case manager
Miami-Dade	Transportation Services (Vans) Increase in the percentage of clients retained in care (i.e., accessing a core service).	Transportation Services (Vans) 90% of the clients receiving van transportation services to attend medical and support service appointments during the reporting period had at least two (2) visits to a core service
	Transportation Voucher Services Increase in the percentage of clients retained in care (i.e., accessing a core service).	Transportation Voucher Services 90% of the clients receiving transportation voucher services to attend medical and support service appointments during the reporting period had at least two (2) visits to a core service.
Houston	Increased/maintained utilization of primary care services	Van Based Transportation A minimum of 75% of clients will utilize Part A/B/C/D primary care services after accessing transportation services. Bus Pass Transportation A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing transportation services.
	Increased or maintained utilization of other core medical services	Van Based Transportation A minimum of: 35% of clients will utilize oral health care services after accessing Van Transportation services. 10% of clients will utilize professional counseling services after accessing Van Transportation services. 35% of clients will utilize Part A/B LPAP services after accessing Van Transportation services.

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		Bus Pass Transportation A minimum of: 20% of clients will utilize Part A/B LPAP services after accessing Bus Pass services. 20% of clients will utilize oral health care services after accessing Bus Pass services. 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services.
Hartford	90% of clients will show increased/maintained enrollment in Primary Care and other support services as a result of Transportation Services reported on a quarterly basis.	The number of clients who enroll in Primary Care as a result of obtaining transportation to services.
	For the percent of clients who do not meet this outcome expectation above, a continuous quality improvement plan will design program changes, sampled at six-month intervals, adopted to improve outcomes in the future.	The number of clients who maintain their medical care regimen as a result of obtaining transportation to services. The number of clients who keep Supportive Services appointments as a result of Transportation Services measured at six-month intervals.
Dallas	**Definition:** Medical Transportation Services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. Conveyance services provided for a client in order to accommodate access to primary medical care, or other HIV-related psychosocial services.	
	Standards **Access – The agency:** **g.** shall provide a method of toll-free communication for clients to contact the agency to request transportation service; and	

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	h. shall provide access to its system of care for persons with HIV/AIDS twenty-four (24) hours/day, and shall directly provide transportation to address urgent client needs, excluding medical emergencies that require paramedic and/or ambulance assistance.	
	Agencies that provide transportation of people: **d.** shall ensure that its operation hours accommodate transportation needs of clients to and from all appointments scheduled at primary medical facilities and agencies providing other services; **e.** shall allow non-HIV infected significant others to accompany HIV-infected persons, as necessary; **f.** shall ensure that client transportation is conducted based on scheduled appointments, and that clients are aware of the maximum amount of time that the driver will wait; and **g.** shall ensure that, if the transportation vehicle will not be available for an appointment, the client will be provided as much notice as possible.	
	The agency: **c.** shall ensure that clients requesting transportation for outpatient medical, dental, or vision care, mental health counseling, or outpatient substance abuse treatment will be given first priority	
Boston	The objective of the agency licensing and policies standard of care for Transportation is to ensure that transportation programs serving children are Medicaid providers or that they use Medicaid eligible transportation services. A.1 Transportation programs serving children are Medicaid providers or use a Medicaid-eligible transport service.	A.1 Documentation of Medicaid status.
	The objective of the program safety standards of care	

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	for Transportation is to ensure the safety of clients, including those with mobility impairments or other disabilities. B.1 Program has the capacity to provide transportation that is accessible to individuals with disabilities, as required by the ADA. B.2 Volunteer ride programs are provided by trained volunteers who possess valid driver's licenses, liability insurance, and safe driving records. B.3 Volunteer drivers receive training on the agency's policies and protocols for health and safety related incidents. B.4 Vehicles that are part of van or volunteer ride programs contain first aid kits. B.5 Volunteer and private transportation is provided in registered and insured vehicles. B.6 Volunteers who transport clients understand their responsibilities and obligations in the event of an accident, including the extent of their liability. B.7 Operators of volunteer and private transportation agree to follow the established agency policy in the event of an accident.	B.1 Funder site visit and/or contract monitoring process. B.2 Documentation on file, including copies of driver's license, liability insurance coverage, and driving record. B.3 Emergency protocol for health and safety related incidents is reviewed with all staff at least once per year and is posted in the agency. B.4 First aid kits in van or volunteer ride vehicles. Funder site visit or contract monitoring process. B.5 Copies of registrations and insurance coverage on file. B.6 Signed and dated form on file that outlines responsibilities, obligations, and liabilities. B.7 Program has a written accident policy on file; policy reviewed and signed by volunteer and private transportation operators and kept on file.
Detroit	**Definition:** Transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health	Improve medical compliance and reduce social isolation.

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	care or support services.	
	Services will be provided based on a client's level of need 1.1 All clients will be screened for transportation eligibility using the Level of Need tool and will receive bus, cab, or van services as Appropriate 1.2 All HIV+ clients who do not meet the criteria will be appropriately referred.	The completed Level of Need form will be in all transportation clients' files A documentation of referrals given for other transportation resources will be on file
	Transportation services will be accessible to clients with disabilities 1.1 Providers are responsible for ensuring that medical transportation services are available to all clients including those who may require assistive devices. 1.2 **Direct –** All handicapped transportation services will provide curb to curb assistance.	Presence of handicapped equipment on vehicle in the service provider's fleet. Evidence that proper maintenance of transport mechanisms are available and documented. Agency policy and procedure and notification to client of limitation of drivers on file.
	Transportation services will be accessible to clients with immediate needs and after business hours. 2.1 All clients in need of immediate transportation services due to an unexpected appointment will have access to same day services. 2.2 Transportation services will be made available for all clients with needs outside of normal business hours.	There will be policy and procedure for the provision of same day services. There will be policy and procedure for accommodating clients between 5 p.m. and 7 a.m.
EMA	**Food Bank Outcomes**	**Food Bank Indicators**
Broward	Improve and/or maintain a client's adherence to medication when food is required.	80% of clients report an improved ability to take medications when food is required.

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	Improve client's knowledge of food handling.	Initial: 100% of clients will receive food handling information as indicated by clients signature.
Miami-Dade	Increase in the percentage of clients receiving food needed to help meet their daily living needs.	25% of the clients receiving food bank services during the reporting period will be new to this service category.
Hartford	75% of clients will show improved nutritional status documented in 6 month intervals.	The number of clients who improve nutritional status as a result of food services and nutritional counseling.
New Haven/Fairfield	75% of clients show improved Activities of Daily Living (ADL) as a result of increased nutritional status, hygiene or cleaning supplies at 6 and 12 months.	Number of requests completed for food bank/nutrition/ home delivered meals. Number of requests at reduced urgency (emergency need, frequency).
Dallas	Food Bank/Home-Delivered Meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item as well as vouchers to purchase food	
	Standards **The agency shall**: **1.5** ensure that its food pantry program meets all requirements of the local health department for food handling and storage; **1.6** maintain and show evidence that all required inspections are current, and resulted in acceptable findings; **1.7** provide adequate space and equipment to store food in a sanitary manner; **1.8** ensure that services continue to be appropriately utilized by eligible persons, by reevaluating and documenting each client's eligibility at least annually, and the appropriateness of continuing to provide	

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	services at least every six months; **1.9** if bulk foods are repackaged, all handlers should be licensed food handlers; and **1.10** have in place a Food Product Establishment Permit, if required by the local municipality.	
	The agency: **g.** shall provide for emergency food pantry services when deemed necessary by the agency.	
	The agency: **d.** shall have in place a written schedule for food distribution, and ensure that clients are notified at least three (3) days ahead of time of any anticipated changes to the schedule, except in the case of an unforeseen emergency; **e.** shall ensure that available foods are selected taking into account factors such as special nutritional needs (incorporating generally accepted nutritional standards), religious requirements, and ethnic food preferences, as appropriate; and **f.** shall provide nutritional supplements to clients, with a written referral from a physician, or registered and/or licensed dietitian, to the extent resources allow	
Boston	The objectives of the standards for agency licensing and policies for Food and Nutrition are to: demonstrate compliance with state sanitation standards and registration/licensing regulations; and provide services to clients in need.	
	A.1 Agency complies with local, state, and federal sanitation and safety regulations.	A.1 Food and safety inspections by state agency and/or city agency.
	A.2 Eligibility requirements include criteria for those who are unable or less able to purchase foods and/or prepare their own nutritionally adequate meals. Supplements are provided to those	A.2 Written eligibility policy on file at agency. Clients receiving nutritional supplements have documentation of eligibility to receive supplements in their files.

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	who are unable to eat solid food or require additional nutrition.	
	The objectives of the competencies standards for Food and Nutrition are to: provide clients with the highest quality services through experienced and trained staff; and ensure staff comply with all state and federal licensing guidelines.	
	B.2 Program staff are able to handle food safely (i.e., identify sanitation procedures for the purchase, receipt, storing, issue, preparation, and service of safe food and beverage products as required by state and/or local regulations).	B.2 Procedures on file relating to food preparation and handling. Documentation of staff certification in sanitation and food preparation and handling (e.g., ServSafe certification).
Detroit	**Definition:** Food bank is the provision of actual food, meals, or nutritional supplements.	**Outcome:** Stabilize body weight and maintain optimal nutritional health
	Assess the need of each client 1.1 Food voucher provider will conduct an ongoing financial assessment of need. 1.2 All clients will be referred to the nutritionist	Client File Agency policy and procedure
	Measuring Progress 1.1 Client progress towards weight management goals in follow-up nutritional assessments	Client file
EMA	**Outreach Outcomes**	**Outreach Indicators**
Broward	Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	80% of new or lost to care clients will have an outpatient/ambulatory medical care or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).
Miami-Dade	Increase in the number of clients who know their HIV status [i.e., increase in the number of out of care HIV+	3% of the out of care clients (those who were never in care in the Ryan White Part A or MAI Programs) that are contacted and billed for are actually

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	clients (those who were never in care in the Ryan White Part A or MAI Programs) that are contacted through Ryan White Program outreach efforts and are connected for the first time to a core service provider].	brought into care (connected to a core service) during the reporting period.
	Increase in the number of lost to care HIV+ clients (i.e., those who were previously receiving Ryan White Part A or MAI Program services and had fallen out of care) that are contacted through Ryan White Program outreach efforts and are re-connected to a core service provider.	25% of the lost to care clients that are contacted and billed for are actually brought back into care (i.e., re-connected to a core service) during the reporting period.
New Haven/Fairfield	90% of clients who are new and/or have fallen out of care will be successfully enrolled into Primary Medical Care reported on a semiannual basis	Number of encounters with detail if newly diagnosed or fallen out of care, duration out of care, exposure category, gender and race/ethnicity Number of referrals made to Primary Care Number of clients retained in Primary Care that have 2 Primary Care visits within first year following Outreach
Dallas	Outreach Services (Lost-to-Care) are programs that have as their principal purpose the identification of individuals with HIV disease that are not receiving medical treatment (i.e., case finding) and thus making them aware of available medical and support services and referring them back into treatment, not HIV counseling and testing nor HIV prevention education. Lost to Care clients are individuals with a positive HIV diagnosis who: 1) have never entered primary medical treatment; 2) have been out of primary medical treatment for period of 6 months or longer, or 3) are not following a doctor's medical care plan. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be	

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	targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.	
	The agency: **g.** shall provide access for staff, outreach contacts, and clients to resource information that is current and relevant to the population of the EMA/HSDA; **h.** shall address an outreach contact's specific barriers to accessing services, so as to be able to make appropriate referrals; and **i.** shall establish and maintain an association with prisons, homeless shelters, substance abuse treatment centers, and other entities that have ongoing contact with persons who are known to be disproportionately impacted by HIV and subject to access barriers.	
	The agency: **d.** shall operate its outreach program under a structured referral process, ensuring that contacts are referred to medical care providers, or to other designated intake sites; **e.** shall be flexible regarding the hours during which outreach activities are conducted, to ensure that appropriate and effective contacts are most likely to be made; and **f.** shall review the nature and purpose of each referral with the person contacted.	
Detroit	**Definition:** Outreach Services include programs which have as their principal purpose identification of people with HIV disease so that they may become aware of, and	**Outcome:** 1. Increase the number of clients who know their HIV status and receive HIV related medical care and/or evaluation.

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	may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor H1V prevention education. Outreach programs must be planned and delivered in coordination with state and local HIV-prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiologic data to be at conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.	2. Attempt to reduce the number of patients lost to follow up. 3. Reduce the number of barriers experienced by out-of-care clients in accessing HIV related medical care and/or evaluation
	Standard #1: Program Information to educate the public regarding HIV and the availability of HIV related services 1.1 a. Broad-based dissemination of information regarding HIV and the availability of services. b. Outreach workers shall establish contacts with HIV testing sites, hospitals, substance abuse centers, Case Management Agencies, points of entry as defined by the Ryan White Treatment Modernization Act and other sources for at-risk and HIV infected clients.	Yearly outreach activity plan in place. Documentation which demonstrates broad-based dissemination of information i.e. Memoranda of Agreements (which may include non-Ryan White funded entities.)
	Standard #2: Data Collection to capture data elements which demonstrate efficacy of services 2.1 The provider agency will collect data to document the number of HIV+ individuals identified and contacted as being lost to follow-up. The provider will also collect data on the number of HIV + persons entering care.	Documented number of HIV + contacts. Documented number of HIV + contacts entering care.

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	Standard #3: Client Intake to identify the in-care status of each consumer and their status relative to the continuum of care 3.1 a. Outreach workers bring new clients into care, link clients to needed services and, if required, refer them to case management services. b. The provider will have referral procedures in place for individuals not eligible under Ryan White.	Documentation in client file Agency Intake Policy and Procedure
	Standard #4: Removing barriers to care to support and encourage consumers to remain in care 4.1 The provider agency will identify barriers in accessing HIV related medical care and/or evaluation of each client lost to follow-up.	Barriers identified and documented in client's file.
	Standard #5: Follow-Up Activities to assist consumer's in receiving the benefits of the EMAs continuum of care and remain in care 5.1 a. The provider agency will schedule medical appointments and referrals to appropriate services. b. The provider agency will close out a client's file after 60 days, or after the client has kept two regularly scheduled appointments and is engaged in on-going services.	Documentation in client's file.