Broward County HIV Health Services Planning Council

Broward Regional Health Planning Council, Inc.
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Quality Management Committee
Meeting Agenda
October 15, 2012 at 12:30 P.M

1. **Call to Order**
2. **Welcome and Introductions**
3. **Moment of Silence**
4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
   B. Review Public Comment Requirements (Please Sign-in)
   C. Excused Absences
   D. Approval of Today's Agenda
   E. Approval of 9/24/12 Meeting Minutes
5. **Review Revisions to Outcomes and Indicators – Update (WP2) (HANDOUT A) (40 Minutes)**
   A. Outreach
   B. Oral Health Care

   Action Item: Discuss Outreach Outcomes and Indicators and Update on Oral Health Care Outcomes and Indicators
6. **Update on 2012-2015 Comprehensive Plan Implications for QM Committee Work Plan (HANDOUT B) (45 Minutes)**

   Action Item: Review NHAS Goals, Comprehensive Plan Summary, and Joint Executive Committee Directives
7. **Review Annual QM Work Plan (HANDOUT C) (10 Minutes)**

   Action Item: Review Revised Annual Work Plan and Discuss Pending Activities for FY 2012-2013
8. **Unfinished Business**
9. **New Business**
10. **Grantee Report (10 Minutes)**
11. **Resources and Announcements (10 Minutes)**
    A. **Review 2012 Client Survey Tool**
    B. **MCM Resource Fair**
12. **Public Comment**
13. **Reminder:** ***Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date***
14. **Request for Information/Directives (5 Minutes)**
15. **Identify Agenda Items for Next Meeting**
16. **Next Meeting Date: Monday, November 19, 2012 at 12:30 p.m.**
17. **Adjournment**

IMPORTANT NOTICE:

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

Quality Management Committee
Monday, September 24 2012 at 12:30 P.M.
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
	Gammell, B. ,HIVPC Vice Chair	X		Bonnie Majcher	Degraffenreidt, S.
1	Grant, C., Vice Chair	X		Brian Freedman	Strong, K.
2	Johnson, K.	X		Jamie Finkelstein*	Jones, L.
3	Katz, H.B.	X			
4	Martin, M.	X			**CQM Staff**
5	Mitchell, T.	X			Eshel, A.
6	Quintana-Jefferson, M.	X			Desa, G.
7	Rajner, M.	X			
8	Schweizer, M.	X			
Quorum = 5		**8**			

*Attended via phone

1. **Call to Order**
   The meeting was chaired by the HIV Planning Council Vice-Chair with the assistance of the QM Committee Vice-Chair. The Chair called the meeting to order at 12:36 P.M.

2. **Welcome and Introductions**
   The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law. 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, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

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

4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
      The Chair reviewed Meeting Ground Rules and Statement of Sunshine.

   B. Review Public Comment Requirements (Please Sign-in)
      There was no Public Comment.

   C. Excused Absences
      There were no requests for excused absences.

   D. Approval of Today's Agenda
      The agenda was approved via consensus.

   E. Approval of 07/16/12 Meeting Minutes
      The minutes were approved via consensus.

5. **Review Retention Data Report on the Aging (25-49 yrs) Population**
The Committee reviewed data presented by the Grantee on Part A clients between the ages of 25-49 as a follow up to discussion regarding the retention needs of the aging population. The data showed a total of 533 clients between the ages 25-49, 327 clients in the 25-44 age group and 206 clients between the ages of 45-49. Clients were also divided by gender, race/ethnicity, primary language, risk category, and education level. Data on the report was self-reported. A committee member noted that the data suggested that the Haitian population was compliant with medical care once linked. It was noted the data overall did not indicate a need for an improvement project focused specifically on the 25-49 age group.

6. **Review NQC Retention Rates Report**
The Committee reviewed a National Quality Center (NQC) In+Care Campaign retention rates report summarizing data from all five submission dates. Additionally, the Committee was updated on the findings from a Medical Case Management (MCM) client-level Gap Measure analysis and the next steps being conducted by the MCM Network to address them.

7. **Review Revisions to Outcomes and Indicators-Update**
The Committee reviewed a complete history of revisions made to the Oral Health Care and Food Bank outcomes and indicators. Representatives from both service categories were present to provide the rationale for the revisions. The Outreach service category was tabled until the next meeting.

The following is the revised Food Bank outcome and indicators presented to the committee for approval:

FOOD BANK	
Revised Outcome	**Revised Indicators**
Increase and/or maintain retention in OAMC *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*	**1.1** 85% of clients are retained in OAMC. **1.2** 100% of those clients not retained in OAMC will be referred to the appropriate provider (i.e., medical case management, physician, Treatment Adherence Program, etc.).

Members voiced concern regarding the lack of referral to nutrition services within the outcomes and indicators verbiage. Through research of other EMA's and lengthy Network discussion, it was agreed that the outcome and indicators should focus on the impact Food Bank services has on retention. The Food Bank Network provider will continue to provide education on nutrition and the link between food and ARV treatment; however this will not be measured. Data collection logistics will be determined with the provider and GTI.

Motion 1	To approve the revised Food Bank Outcome and Indicators
First	Marlinda Quintana-Jefferson
Second	Marcel Martin
Action	4 passed, 4 against
Initial Motion Failed	

The outcome and indicators were approved by the Committee after discussion and a re-vote.

Motion 2	To approve the revised Food Bank Outcome and Indicators
First	Marlinda Quintana-Jefferson
Second	Marcel Martin

Action	6 passed, 1 opposition

The following are the revised Oral Health outcomes and indicators presented to the committee for approval:

ORAL HEALTH	
Revised Outcome 1	**Revised Indicator 1**
1. Reduction in number of teeth with untreated caries (tooth decay).	1. 90% of caries identified in the Phase I (Disease Control) treatment plan will be treated upon completion of the Phase I plan.

The providers offered justification for revisions to the first outcome and indicator. The committee amended the indicator percentage and timeframe to ensure realistic and timely completion of treatment plans and approved the outcome and indicator via consensus.

Motion 3	To approve the revised Oral Health Care Outcome 1 and Indicator 1 as amended in Amendment 2.
First	Claudette Grant
Second	Marcel Martin
Amendment 1	1. 90% of caries identified in the Phase I (Disease Control) treatment plan will be treated ~~upon completion of the Phase I plan~~ within 12 months.
Amendment 2	1. ~~90%~~ 75% of caries identified in the Phase I (Disease Control) treatment plan will be treated within ~~12~~ 6 months.
First	Marlinda Jefferson
Second	Marcel Martin
Action	7 Passed, 1 Abstention

Revised Outcome 2	Revised Indicator 2
2. Improved Periodontal Health.	**2.** 80% of clients will have a 50% reduction in the number of bleeding sites at the completion of the Phase I (disease control) Plan.

Justification for the second outcome and indicator included aligning language with HRSA guidelines and removing the specificity of tool used to determine pocket readings. There was no agreement reached between providers on this outcome and indicator; it will be brought back to the QM Committee following further research and recommendations for discussion and approval.

8. **Update on 2012-2015 Comprehensive Plan Implications for QM Committee Work Plan**
   This item was tabled to the next committee meeting.

9. **Review Annual QM Work Plan**
   This item was tabled to the next committee meeting.

10. **Unfinished Business**
    None.

11. **New Business**
    None reported.

12. Grantee Reports

A. Part A Grantee Report

There was no formal report from the Grantee.

13. Resources and Announcements

A. MCM Training

Support staff provided feedback on the mandatory case manager training held at Delevoe Park on September 18th 2012. Attendees included medical case managers, HOPWA case managers and peers.

B. MCM Resource Fair

The MCM Resource Fair will be held on October 24th 2012 at Central Broward Regional Park. The session times are 11:00 a.m. to 1:00 p.m. or 1:00 p.m. to 3:00 p.m. This fair is mandatory for all medical case managers, HOPWA case managers and peers.

14. Public Comment

None.

15. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

16. Request for Information/Directives

There were no requests for information or directives.

17. Identify Agenda Items for Next Meeting

A. Update on 2012-2015 Comprehensive Plan Implications for QM Committee Work Plan
B. Review Annual QM Work Plan
C. Review NQC Retention Rates Report
D. Review Revisions to Outcomes and Indicators-Oral Health and Outreach

18. Next Meeting Date: Monday, October 15, 2012 at 12:30 p.m.

19. Adjournment

The meeting was adjourned at 2:48 P.M.

Save the Date!

Resource Fair

This fair is **mandatory** for Ryan White Program and HOPWA Case Managers, Peers, and Supervisors

Date: Wednesday, October 24th, 2012

Location: Central Broward Regional Park
3700 North West 11 Place,
Lauderhill, FL 33311

Time: 11:00AM-1:00PM OR 1:00PM-3:00PM

Please RSVP to the morning OR afternoon session

Please RSVP to Gladria Desa at gdesa@brhpc.org or 954-561-9681, Ext. 1244

Quality Management Committee Work Plan for FY 12/13

1. Develop 3-Year QM Plan				Accountability: Grantee Staff, CQM Support Staff, QMC
Objectives	Outcome	Start	Due	Status
1a. Review and make recommendations for changes to 3 Year QM Plan	3 Year QM Plan Review Completed	2/13	12/13	FY11-13 3-Year Plan in effect
1b. Update 3 Year QM Plan & Annual QM Work Plan	Update 3 Year QM Plan	2/13	12/13	FY11-13 3 Year Plan in effect
1c. Approve updated 3 Year QM Plan	Approve 3 Year QM Plan	2/13	12/13	FY 11-13 3-Year Plan in effect
2. Review and Analyze Annual Measures, Chart Review Data, and QI Network Activities				
Objectives	Outcome	Start	Due	Status
Select annual measures and data for tracking and evaluation	Identification of areas for improvement	3/212	12/12	HAB Core Clinical Performance Measures, Client Level Outcomes, NQC In+Care Measures, NHAS Indicators
Review and analyze annual measures and data	Identification of areas for improvement	QTR	10/12	HAB Core Clinical Performance Measures, Client Level Outcomes, NQC In+Care Measures , NHAS Indicators
Review and analyze core category assessment chart review results	Identification of areas for improvement	11/11	10/12	**PENDING: Core** Category is Oral Health. Draft report submitted 07/12; final report pending.
Identify service delivery deficiency based on data	Identification of areas for improvement	3/12	2/13	OAMC QIP in the Plan stage: **COMPLETED** Review of PE and EMR cervical screening data for data integrity **IN DEVELOPMENT** Improvement in Cervical Screening Rates QIP
Review QI Network Activities	Identification of areas for improvement	10/12	QTR	Summary provided quarterly
Complete revisions to Broward Client Level Outcomes and Indicators	Client Level Outcomes and Indicators appropriate to each service category and include OAMC client retention measure	10/11	2/13	1. Final revisions to be presented to QMC on 09/12 2. PE programming completed 02/13
3. Review and Implement QM Committee Policies and Procedures				**Accountability**: QMC, CQM Support Staff
Objectives	Outcome	Start	Due	Status
3a. Review, update, and approve policies and procedures to conform to updated QMC purpose and mission	Updated QMC policies and procedures	12/12	2/13	Review annually at end of FY or sooner if needed
4. Approve Service Delivery Model Modifications				**Accountability**: QMC, QI Networks, Grantee Staff, CQM Support Staff, HIVPC
Objectives	Outcomes	Start	Due	Status
4a. Review and approve modified service delivery models submitted by QI Networks	Updated Service Delivery Models annually	10/12	2/12	1. Networks to review and revise as needed the following SDM's: OAMC; MCM; OHC; MH; SA; APA; Outreach 2. Network to develop Food Bank SDM
5. Recommendations from Needs Assessment Analysis				**Accountability:** QMC, QI Networks, CQM Support Staff, Grantee staff
Objectives	Outcomes	Start	Due	Status
Evaluate and assess annual survey results	Data analysis to identify service delivery deficiency determine QIP and inform PSRA	2/12	/13	Survey tool is being developed

Quality Management Committee Work Plan for FY 12/13

6. Identify Areas of Improvement and Modify Processes to Support Linkage and Retention Accountability: QMC, QI Networks, CQM Support Staff, Grantee Staff				
Objectives	Outcomes	Start	Due	Status
NQC Measure 1: Reduce the percentage of patients who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year	Gap Measure Reduced to 15%*	10/11	10/13	-Quarterly report to QMC on the Gap Measure -QIP's to improve retention are in the Plan stage for -MCM; MH/SA; and Combined Networks MH/SA: Development of PE trigger for additional support to assist clients who are depressed remain in care; Development of a presentation for all Networks on identifying signs of mental illness MCM: Gap Measure data analysis Combined: Identify ways for support services to impact OAMC retention
NQC Measure 2: % of patients 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	Medical Visit Frequency Increased to 63%*	10/11	10/13	**PENDING** Quarterly report to QMC on medical visit frequency Planning in progress to identify ways to improve medical visit frequency
NQC Measure 3: % of patients newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in measurement year	Patients Newly Enrolled in Medical Care Increased to 60%*	10/11	10/13	**PENDING** Quarterly report to QMC on newly enrolled patients rates Planning in progress to identify barriers to enrolling new patients
NQC Measure 4: Percentage of patients with a viral load less than 200 copies/mL at last viral load test during the measurement year	Viral Load Suppression Increased to 72%*	10/11	10/13	**PENDING** Quarterly report to QMC on VL suppression rates Planning in progress to identify barriers to VL suppression
Incorporate the Partners In+Care Campaign into linkage and retention efforts	Peer focused interventions to improve retention	5/12	TBD	09/12: Provide recommendations to QMC on how to incorporate Partners In+Care in Network activities
7. Conduct Annual QM Plan Evaluation				**Accountability**: QMC
Objectives	**Outcomes**	**Start**	**Due**	**Status**
Describe Committee annual accomplishments and challenges	Submit to Grantee for inclusion in RW Progress Report	1/13	2/13	To be completed by FY end

***Percentages reflect the average among Part A participants of the In+Care Campaign as of the latest submission date (08/01/12)**

2012-2015 Broward County Ryan White Part A Comprehensive Plan

SUMMARY

Introduction

- Mandated by HRSA as a part of the Ryan White Legislation
- Per this legislation, HAB expects EMAs to develop multi-year comprehensive plans that:
  - Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities
  - Ensure the availability and quality of all core medical services within the EMA
  - Address the needs of those who know their status and are not in care as well as the needs of those who are currently in the care system
- Currently required to be submitted every 3 years
- Should develop a road map for the maintenance and improvement of a system of care that is responsive to the changing epidemic and the unmet health care needs of those not currently in care in the EMA

Introduction

- The Plan must be compatible with State or local plans for the provision of services to individuals with HIV/AIDS
- The Comprehensive Plan is a living document
  - The Part A Grantee and HIVPC may revise, amend, and/or add goals, objectives, and activities throughout the implementation period to improve the health outcomes and quality of life for PLWHA as needed.
- Implementation and oversight are the responsibility of the Grantee, HIVPC, Committees, and QI Networks
- Proper oversight will require development of Committee work plans incorporating goals into their regular activities
- Evaluation of the plan includes addressing clinical quality measures
- NHAS goals are the foundation of the Comprehensive Plan

Introduction

- Comprehensive Plan should include strategies that:
  - Identify individuals who know their HIV status but are not in care, inform them of services, and enable their use of HIV-related services
  - Eliminate barriers to care and disparities in services for historically underserved populations
  - Provide goals, objectives, and timelines
  - Coordinate services with HIV prevention programs including outreach and EIS
  - Coordinate services with substance abuse prevention and treatment programs
  - Are compatible with existing State and local service plans including and in particular the Statewide Coordinated Statement of Need (SCSN)

Introduction

- The Part A Grantee works in partnership with the HIVPC to plan, prioritize, and assess the HIV/AIDS service system.
- The HIVPC is guided by a vision directing a coordinated and effective community response to the HIV epidemic to ensure access to a high quality system of care
- Every grant year, the HIVPC establishes service priorities and a plan for resource allocations through the Priority Setting Resource Allocation (PSRA) process
- The Comprehensive Plan goes beyond the annual process and provides a road map for developing a broad and responsive system of care over time. It provides an opportunity for the EMA to review the current system of care, envision an ideal system, and develop a three-year work plan towards achieving its goals

New to the 2012-2015 Plan

Monitoring and Evaluation

- Evaluation of the 2009-2011 Comprehensive Plan to identify successes and challenges experienced in the implementation of the plan and the strategy to meet those challenges.

Early Identification of Individuals with HIV/AIDS (EIIHA)

- A legislative requirement that focuses on individuals who are unaware of their HIV status, and how best to link HIV+ individuals into care and refer HIV negative individuals into services that will keep them negative.

The National HIV/AIDS Strategy (NHAS)

- The Strategy includes three primary goals: 1) Reducing the number of people who become infected with HIV, 2) Increasing access to care and optimizing health outcomes for PLWH, and 3) Reducing HIV-related health disparities and health inequities. A fourth goal calls for achieving a more coordinated response to the HIV epidemic.
- The NHAS recognizes that new prevention methods must be identified and put into place. Moreover, the NHAS recognizes the importance of getting PLWH into care early after infection to protect their health and reduce the potential of transmitting the virus to others.

New to the 2012-2015 Plan

Healthy People 2020 (HP 2020)

- HP 2020 is a national initiative led by the Department of Health and Humans Services (HHS) that sets priorities for all HRSA programs.
- HP 2020 establishes new 10-year national objectives for improving the health of all Americans.
- The initiative has two major goals: 1) To increase the quality and years of a healthy life, and 2) To eliminate health disparities.
- The program consists of 28 topic areas, one of which is HIV, and 467 objectives.

Affordable Care Act (ACA)

- The Patient Protection and Affordable Care Act aims to expand health insurance coverage while also reforming the health care delivery system to improve quality and value.
- It includes provisions to eliminate disparities in health care, strengthen public health and public health access, invest in the expansion and improvement of the health care workforce, and encourage patient wellness in the community and workplace.
- The law aims to increase coverage to approximately 94% of Americans.

Plan Development

- Development of the 2012-2015 Comprehensive Plan included review of various sources of data including epidemiological, needs assessment, utilization, performance measures and evaluation data; consumer needs and priorities; and analysis of the cost and outcomes effectiveness of services

- In addition, input from HIVPC and Committee members, service providers, funders, and other key stakeholders as well as the community, including PLWHA and specifically consumers of Ryan White Part A services, was elicited through a series of full day retreats that promoted open dialogue on Comprehensive Plan related topics such as identified special populations, EIIHA strategy, continuum of care, and quality of care

Plan Structure

- The Comprehensive Plan has four chapters designed to answer the following questions:

Where are we now? (What is the EMA's current system of care?)

- This section describes the status of the HIV epidemic, the needs of PLWHA, and available HIV services.
- The subsections are : epidemiologic profile and emerging populations; EMA response to the epidemic; health care needs of both those in and out of care, estimated unmet need, gaps in care, and prevention needs; the current continuum of care; available core and support services; provider capacity and capability; and service gaps and barriers to care.

Plan Structure

Where do we need to go? (What is the EMA's vision of an ideal system?)

- This section of the plan describes how the EMA would like its system of care to function including an operational definition of 'continuum of care', reflecting the context in which the HIVPC works, and a description of how Part A services will be coordinated with other services available to PLWHA.
- This section also includes an evaluation of the 2009-2011 Comprehensive Plan and proposes solutions to identified challenges.

Plan Structure

How will we get there? (What steps can we take to develop an ideal system of care?)

- This section outlines goals for developing a comprehensive continuum of care and activities to help achieve these goals. These include system, planning, evaluation, and service-related goals and objectives and outcomes and the strategies and activities needed to implement the plan.

Plan Structure

How will we monitor our progress? (How will we evaluate success in meeting goals?)

- This last section outlines a plan to assess progress in achieving goals and objectives and to update the Comprehensive Plan.
- The monitoring and evaluation plan describes the process for tracking changes using client-level data and measurement of clinical outcomes.

Summary

- The Comprehensive Plan serves as the roadmap to guide HIV care and treatment in the Broward County EMA over the course of the next three years.
- The Plan acknowledges the need for adaptability to respond to changes in funding and priorities, the state of the epidemic, and barriers and challenges identified throughout the monitoring process.
- The Plan reflects the EMA's successes and challenges thus far, its future goals, and its commitment to continuous evaluation of its success in achieving these goals within a changing healthcare landscape.

National HIV/AIDS Strategy

"New HIV infections will be rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

Coordinating services, targeted funding, and united focus will help fulfill the NHAS Vision

NHAS Goals and Measures to be Met by 2015

Reduce the number of people who become infected with HIV

- Lead efforts to lower the number of new infections by 25%
- Reduce the HIV transmission rate by 30%
- Increase the number of people who know their serostatus to 90%

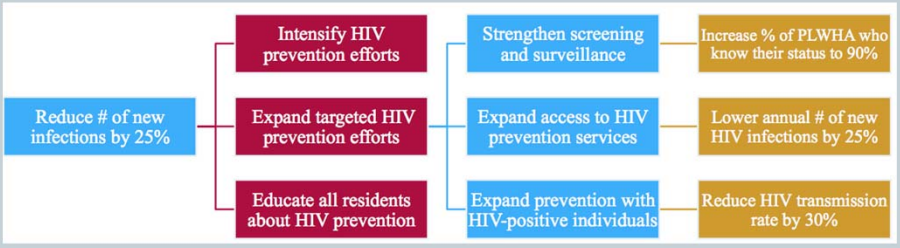
Increase access to care and improve health outcomes for PLWHA

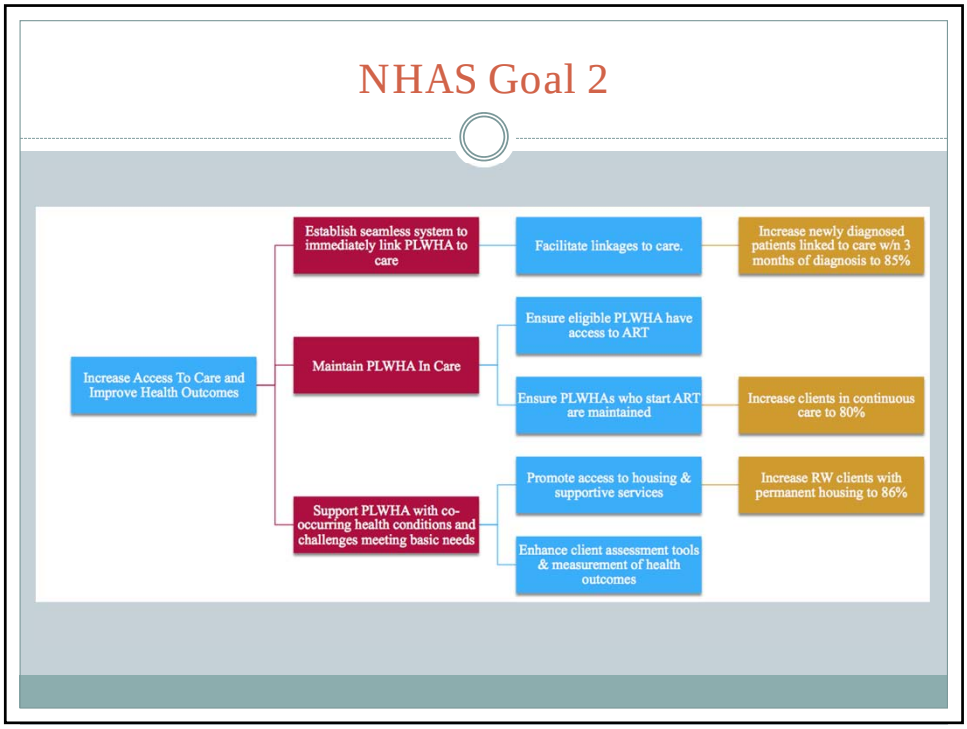
- Increase to 85% the number of people newly diagnosed with HIV receiving clinical care within 3 months of diagnosis.
- Increase to 80% the proportion of Ryan White clients in continuous care (2 HIV medical visits in 12 months, at least 3 months apart)
- Increase the number of PLWHA in permanent housing to 86%

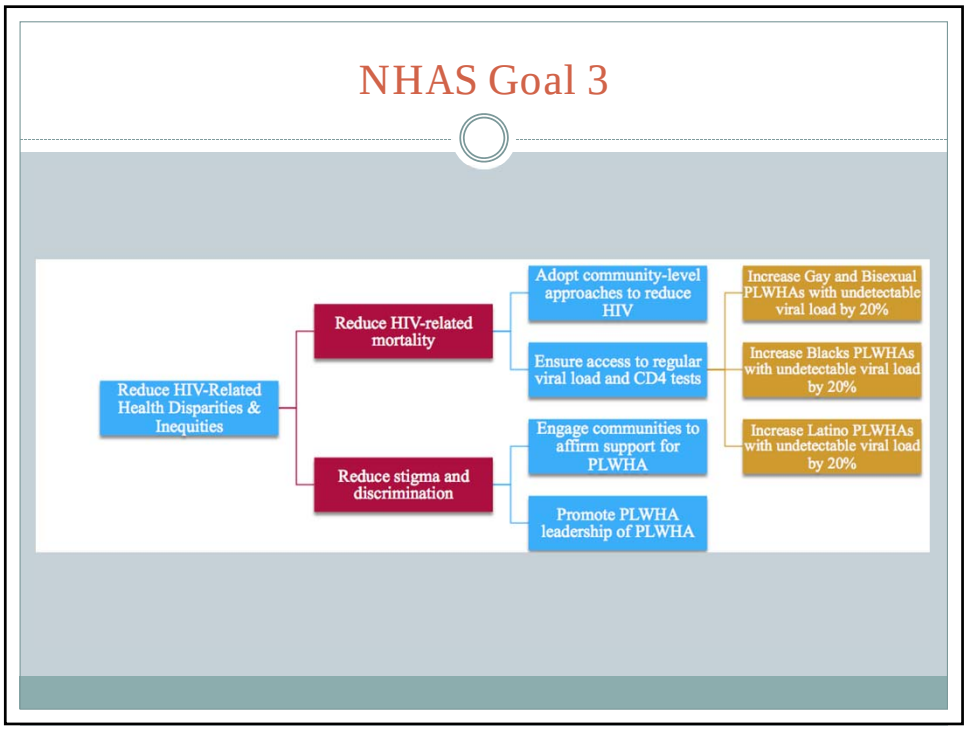
Reduce HIV-related health disparities

- Increase access to prevention and care services
- Increase the number of gay and bisexual men, Blacks, and Latinos who have undetectable viral loads by 20%

NHAS Goal 1




NHAS Goal 2
Increase Access To Care and Improve Health Outcomes
Establish seamless system to immediately link PLWHA to care
Facilitate linkages to care.
Increase newly diagnosed patients linked to care w/n 3 months of diagnosis to 85%
Maintain PLWHA In Care
Ensure eligible PLWHA have access to ART
Ensure PLWHAs who start ART are maintained
Increase clients in continuous care to 80%
Support PLWHA with co-occurring health conditions and challenges meeting basic needs
Promote access to housing & supportive services
Increase RW clients with permanent housing to 86%
Enhance client assessment tools & measurement of health outcomes


NHAS Goal 3
Reduce HIV-Related Health Disparities & Inequities
Reduce HIV-related mortality
Adopt community-level approaches to reduce HIV
Increase Gay and Bisexual PLWHAs with undetectable viral load by 20%
Ensure access to regular viral load and CD4 tests
Increase Blacks PLWHAs with undetectable viral load by 20%
Reduce stigma and discrimination
Engage communities to affirm support for PLWHA
Increase Latino PLWHAs with undetectable viral load by 20%
Promote PLWHA leadership of PLWHA

HRSA Recommendations for Ryan White to Achieve NHAS Goals

- Ryan White providers offer culturally competent, quality health care that includes HIV services and access to antiretroviral drugs and links to health care specialists and services such as transportation and housing
- Concentrate resources where the epidemic is most severe, coordinating Federal resources and actions across agencies; scaling up effective HIV prevention, care, and treatment strategies; and leveraging innovative approaches to accelerate the implementation process and reduce HIV/AIDS incidence and mortality
- Participate in needs assessments that will help them target and tailor services to the high-risk populations that contribute to our local community's viral load, especially hard-hit populations such as MSM and communities of color
- Utilize needs assessment to ensure that services reach areas and populations with the greatest burden. Work with CDC-funded prevention grantee to define the size of the most heavily affected populations within, ensuring that statistical data is updated and performance metrics remain on target
- Purpose: Demonstrate improvement in access to and retention in high quality, competent HIV care and services for hard-to-reach populations of HIV-infected persons who are unaware of status, have never been in care, or who have dropped out of care.

Ryan White Target Populations

Target Population

- The primary target population for this initiative is individuals who are unaware of their HIV status (same definition as the EIIHA definition):
  - any individual who has not been tested for HIV in the past 12 months,
  - or any individual who has not been informed of their HIV test result (HIV positive or HIV negative),
  - or any HIV positive individual who has not been informed of their confirmatory HIV test result.
- Secondary target populations include, but are not limited to, those who:
  - Are aware of their HIV-positive status but have yet to be successfully linked to HIV care;
  - May be receiving other medical care but not HIV care;
  - Entered HIV care but later dropped out of care (lost to follow-ups); or
  - Are in and out of HIV care (sporadic or infrequent users of HIV care).

Ryan White Outcomes

Primary outcome:

- Improved access to and retention in quality HIV care for target populations.

Secondary outcomes:

- Facilitating timely entry into HIV care
- Preventing vulnerable clients from dropping out of care.
- Enhanced systemic linkage plan will demonstrate an increase in the number of:
- 1. People living with HIV who know their serostatus;
- 2. Newly diagnosed individuals linked to care within three months of diagnosis;
- 3. Individuals living with HIV who are virally suppressed; and
- 4. People living with HIV retained continuously in quality HIV/AIDS care.

- Increase collaboration among all Parts of the Ryan White HIV/AIDS Program, ensure the Parts' alignment with the NHAS, and eliminate duplication and gaps in services.

- The work toward a seamless continuum of care will enable Ryan White grantees to more quickly and efficiently identify PLWHA, recruit them into care, and retain them in treatment. This work is essential to improving the health, and reducing the viral load, of these communities. It also will reduce HIV transmission, because PLWHA who are in care and adherent to treatment are much less likely to transmit the virus to others.

In+Care Campaign

- HRSA launched the In+care Campaign, a year-long project focused on retaining PLWHA in primary care, to facilitate organizational interaction and collaboration.

- The In+care Campaign, run by the National Quality Center, seeks to foster integrated primary care programs at the local, State, and national levels through voluntary quality improvement efforts.

- These efforts will help participating Ryan White HIV/AIDS Program grantees and subgrantees nationwide build their capacity to bring PLWHA back into care and keep other patients from falling out of care.

- **The In+care Campaign strengthens providers' capacity to not only help patients but also accelerate the goals of the NHAS.**

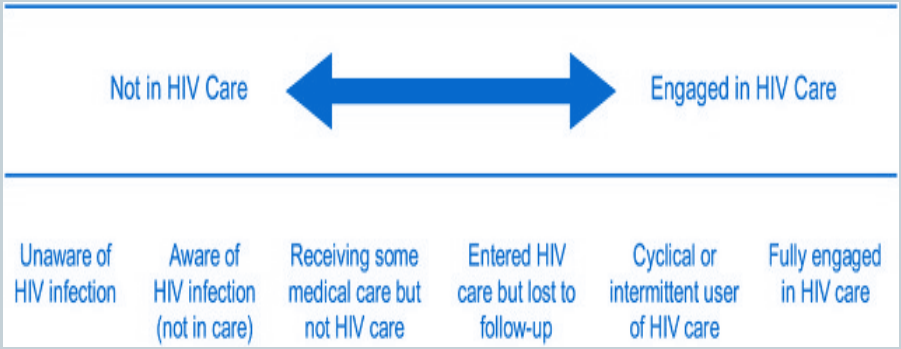
- Providers receive access to national real-time bench-marking data on retention measures, as well as toolkits containing retention literature and resources.

- National conference calls allow participants to access expert training and coaching, share lessons learned, and engage in peer-to-peer technical assistance about best practices.

- The campaign further ensures that local agencies nationwide are aligned programmatically with the NHAS and are in step with the efforts of the national agencies addressing HIV/AIDS.

- Most important, participants in the campaign will be able to provide greater access to more streamlined and higher quality HIV and related services for PLWHA, which in turn will help dramatically and immediately lower community—and individual—viral loads.

Treatment Cascade



Monitoring and Evaluation

- The Comprehensive Plan functions as the foundation for each HIVPC committee's work plan. As appropriate, committees will be tasked with coordinating the implementation and monitoring of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals.

Joint Executive	Joint Planning	Quality Management	Joint Priorities
Oversee committee goals and objectives	Plan and address coordinate care across diverse groups by engaging community resources to provide quality care Increase access to care Decrease disparities Decrease unmet need	Develop and monitor system based outcomes and indicators Develop standards of care Improve client health outcomes Provide oversight of standards of care and client satisfaction	Analyze service utilization Address changes in priorities and resources

Monitoring and Evaluation

- While the HIVPC assumes overall responsibility for monitoring progress to implement the goals, objectives, and activities of the Comprehensive Plan, a coordinated approach will be needed to implement, monitor, and evaluate the Plan and its goals:
  - The HIVPC and its committees, Grantee, and support staff will define roles, responsibilities, tasks, timeline, evaluation measures, and indicators for each plan goal, objective, and strategy.
  - Each HIVPC committee will develop an annual work plan that includes monitoring and evaluation of Comprehensive Plan goals. Review of the Plan goals will be a standing agenda item for all committees.
  - The annual work plans will be modified as needed to reflect: 1) Identified successes and challenges achieving plan goals, 2) Changes in resources and priorities, 3) Changes in the implementation process of each goal and activity, and 4) Roles and responsibilities.
  - Each committee will report progress achieving Comprehensive Plan goals as well as identified challenges, barriers, and next steps to the HIVPC on a regular basis.
  - An annual review of the Comprehensive Plan goals will identify system-wide accomplishments, challenges, barriers, and next steps to be reported to the HIVPC.
  - Client-level data and clinical outcomes will be used to assess the EMA's success in promoting access to and retention in care.

Quality Statement: The purpose of the QM Program is to monitor, evaluate, and systematically and continuously improve the quality and appropriateness of HIV care and services provided to consumers

Quality Mission: Our mission is to ensure access to and retention in high quality HIV core and support services for Part A and MAI eligible Broward County residents living with HIV

Quality Goals and Objectives:

Develop a planning mechanism incorporating baseline data from external and internal sources and input from department leadership, staff and patients. Clinical, operational and programmatic aspects of patient care will be reviewed

Emphasize design needs associated with new and existing services, patient care delivery, work flows and support systems which maximize results and satisfaction on the part of the patients and their families, physicians and staff

•Evolve and refine measurement systems for identifying trends in care by regularly collecting and recording data (through a valid sampling program when appropriate)

•Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered and whether opportunities for improvement exist

•Focus on improving quality in all of its dimensions by implementing multidisciplinary, data driven, project teams and encouraging participatory problem solving

•Promote communication, dialogue and informational exchange throughout the organizations reporting structure, with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement

•Strive to establish collaborative relationships with diverse community agencies for the purpose of collectively promoting the general health and welfare of the community served

Support EIIHA strategy and objectives by reviewing and evaluating linkage activities and processes for improved service delivery

HHS Common HIV Indicators

Measure	Numerator	Denominator
HIV Positivity	Number of HIV positive tests in the 12-month measurement period	Number of HIV tests conducted in the 12-month measurement period
Late HIV Diagnosis	Number of persons with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12-month measurement period	Number of persons with an HIV diagnosis in the 12-month measurement period
Linkage to HIV Medical Care	Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis	Number of persons with an HIV diagnosis in 12-month measurement period
Retention in HIV Medical Care	Number of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequent 6 month period	Number of persons with an HIV diagnosis with at least one HIV medical care visit in the first 6 months of the 24-month measurement period
Antiretroviral Therapy (ART) Among Persons in HIV Medical Care	Number of persons with an HIV diagnosis who are prescribed ART in the 12-month measurement period	Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period
Viral Load Suppression Among Persons in HIV Medical Care	Number of persons with an HIV diagnosis with a viral load <200 copies/mL at last test in the 12–month measurement period	Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period
Housing Status	Number of persons with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period	Number of persons with an HIV diagnosis receiving HIV services in the last 12 months

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.

HAB Measures

Core Clinical Performance Measures For Adults And Adolescents: Group 1	
Indicator	**How Measured**
Antiretroviral Therapy for Pregnant Women#	Percentage of pregnant women with HIV infection who were prescribed antiretroviral therapy (ART)
CD4 T-Cell Count#	Percentage of clients with HIV infection who had two or more CD4 T-cell counts performed in the measurement year
Antiretroviral Therapy#	Percentage of clients with AIDS who were prescribed ART
Medical Visits#	Percentage of clients who had two or more medical visits in an HIV care setting in the measurement year
PCP Prophylaxis#	Percentage of clients with HIV infection and a CD4 count below 200 cells/µL who were prescribed PCP prophylaxis
Viral Load Monitoring#	Percentage of patients, regardless of age, with viral load test performed at least every six months during the measurement year
Viral Load Suppression#	Percentage of patients, regardless of age, with viral load below limits (<200 copies/mL) at last test during measurement year

HAB Measures

Core Clinical Performance Measures for Adults and Adolescents: Group 2	
Indicator	**How Measured**
Adherence: Assessment and Counseling#	Percentage of clients on ARVs assessed and counseled for adherence two or more times in measurement year
Cervical Cancer Screening#	Percentage of women who had a Pap screening in the measurement year
Hepatitis B Vaccination#	Percentage of clients with HIV infection who completed the vaccination series for hepatitis B
Hepatitis B Screening#	Percentage of patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity
Hepatitis C Screening#	Percentage of clients for whom hepatitis C screening was performed at least once since the diagnosis of HIV infection
HIV Risk Counseling	Percentage of clients with HIV infection who received HIV risk counseling within the measurement year
Lipid Screening	Percentage of clients with HIV infection on ART who had a fasting lipid panel in the measurement year
Oral Examination#	Percentage of clients with HIV infection who received an oral examination by a dentist at least once in the measurement year
Syphilis Screening#	Percentage of adult clients with HIV infection who had a test for syphilis performed in the measurement year
Tuberculosis Screening	Percentage of clients who received testing with results documented for latent tuberculosis infection since HIV diagnosis

HAB Measures

Core Clinical Performance Measures for Adults and Adolescents: Group 3	
Indicator	**How Measured**
Chlamydia Screening	Percentage of clients with HIV infection at risk of sexually transmitted infections who had a test for chlamydia in the measurement year
Gonorrhea Screening	Percentage of clients at risk of sexually transmitted infections who had a test for gonorrhea in the measurement year
Hepatitis/HIV Alcohol Counseling	Percentage of clients hepatitis B or hepatitis C infection who received alcohol counseling in the measurement year
Influenza Vaccination	Percentage of clients with HIV infection who have received influenza vaccination in the measurement period
MAC Prophylaxis	Percentage of clients with CD4 <50 cells/µL who were prescribed Mycobacterium avium complex prophylaxis in the measurement year
Mental Health Screening#	Percentage of new clients with HIV infection who have had a mental health screening
Pneumococcal Vaccination	Percentage of clients with HIV infection who ever received pneumococcal vaccine
Substance Use Screening	Percentage of new clients with HIV infection who have been screened for substance use (alcohol & drugs) in the measurement year
Tobacco Cessation Counseling	Percentage of clients with tobacco cessation counseling within year
Toxoplasma Screening	Percentage of clients with Toxo screening at least once since HIV diagnosis

HAB Measures

Oral health Performance Measures for Adults and Adolescents	
Indicator	**How Measured**
Dental and Medical History	Percentage patients with a dental and medical health history (initial or updated) at least once in measurement year
Dental Treatment Plan	Percentage of patients who had a dental treatment plan developed or updated at least once in measurement year
Oral Health Education	Percentage of oral health patients who received oral health education at least once in measurement year
Periodontal Screening or Examination	Percentage of oral health patients who had a periodontal screen or examination at least once in measurement year
Phase 1 Treatment Plan Completion	Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months

ORAL HEALTH CARE OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Original Indicators	Network Discussion	Revised Outcomes	Revised Indicators
Reduction in number of teeth with unrestored caries (tooth decay)	**1.1** 90% of caries identified in the initial treatment plan will be restored upon completion of the initial treatment plan. *(Initial Indicator)* **1.2** 90% of patients will be free of new recurrent caries on restorations placed in the initial treatment plan upon examination at a period of six to twelve months after completion of the initial treatment plan. *(Long-Term Indicator)*	**1.1** The Network recommended keeping the indicator but changing the language; the indicator should not be associated with initial treatment plan only **1.2** The Network noted that the indicator as it is now seems to measure the quality of the dentist's work, not improved oral health. The Network suggested changing the indicator to show improvement in overall oral health as would be indicated by no new caries (as opposed to recurrent caries on previously restored teeth)	**1.** Reduction in number of teeth with ~~unrestored~~ untreated caries (tooth decay)	**1.** 90% of caries identified in the ~~initial~~ the Phase I (Disease Control) treatment plan will be ~~restored~~ treated upon completion of ~~the initial that treatment~~ the Phase I plan. ***The above was amended to read: 75% of caries identified in the Phase I (Disease Control) treatment plan will be treated within 6 months***
Improved periodontal disease status.	75% of clients will have a 50% reduction in the number of teeth that initially presented with a pocket depth of 5mm or greater, at the completion of active periodontal treatment. (Intermediate Indicator)	The Network recommended changing 'periodontal disease status' to 'periodontal health' **2.2** Members agreed that a reduction in papilla bleeding, as indicated through the use of the PBI, would be an adequate measure for improved periodontal health. It was noted measurement of bleeding was included in the HAB measure definition as one of the signs of poor periodontal health	**2.** Improved Periodontal ~~Disease Status~~ Health	**2.** 80% of clients will have a 50% reduction in the number of bleeding sites ~~identified using the Periodontal Bleeding Index (PBI)~~ at the completion of the Phase I (disease control) Plan. ***Agreement could not be reached.***

OUTREACH OUTCOMES AND INDICATORS (PENDING)

Currently, the outreach outcomes and indicators programmed in the Provide Enterprise (PE) data system are:

Outreach	
Outcomes	**Indicators**
Facilitate client access to outpatient/ambulatory medical care and/or medical case management	1.1 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).

An outreach representative was present at the December 19, 2011 QM committee meeting to provide recommendations for revisions.

At the December 2011 meeting, the QM committee discussed the process of linking clients to care through outreach. The committee considered creating separate indicators for new clients and returning clients. The committee discussed the various outreach scenarios in each category:

- Clients who have fallen out of care but are still eligible for services
- Clients who have fallen out of care and are no longer eligible for services
- New clients who are new to Broward County and new clients who are also newly diagnosed

It was noted that the process of connection to Central Intake Eligibility Determination (CIED) and linkage to care may be different for new clients, clients whose Part A eligibility has expired and are being reconnected to care, and clients whose eligibility is current and are being reconnected to care.

Following the discussion, the revisions below were made:

Outreach	
Outcomes	**Indicators**
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).

No additional input was provided from the Outreach Network.

Date: _____ Staff: _____ Site: _____

RYAN WHITE PART A, PART B, and HOPWA

2012 HIV CLIENT NEEDS SURVEY FOR BROWARD COUNTY

Please DO NOT fill out this survey if you are not HIV positive.

If you are HIV positive, this survey is your chance to tell the agencies that fund HIV health care, housing assistance, and support services about the services YOU need.
The results of this survey will help to ensure that future funds go where they are needed.

This survey is voluntary.

You will continue to receive services if you do not complete the survey. Your answers are strictly confidential. No one will know who you are.

You can fill out the form for another person, if she or he is a child or an adult who is too sick to care for her or himself.

Only fill out one survey.

Please DO NOT fill out this survey if you have already completed one.

SETTING PRIORITIES FOR HIV SERVICES IN BROWARD COUNTY

Broward County HIV Planning Council sets priorities to determine how best to use Ryan White Part A funds.
Listed below are the core services that meet the federal government's requirements for Part A funds. Please rank the services in their order of importance to Broward residents living with HIV. The score of 1 is given to the most important service, while the score of 6 is the least important service. **Do not give two services the same rank.**

1. Rank 1-6	Core Services
	Dental care (such as routine check-ups, cleanings, cavities, and extractions)
	Doctor's visits for HIV medical and specialty care and/or nutritional counseling
	Local AIDS pharmaceutical assistance to help pay for HIV-related prescription drugs
	Medical case management
	Mental health services
	Outpatient drug or alcohol addiction treatment

Listed below are support services that meet the federal government's requirements for Part A funding. Please rank the services in their order of importance to Broward residents living with HIV. The score of 1 is given to the most important service, and the score of 4 is the least important service. **Do not give two services the same rank.**

2. Rank 1-4	Support Services
	Centralized Intake and Eligibility Determination (CIED)
	Emergency food bank services
	Legal services about denial of benefits, wills, guardianship, and other issues
	Outreach services to help find HIV positive people and get in them in medical care

YOUR INFORMATION

3. Select your age group: ❒ 0-12 ❒13-19 ❒20-24 ❒25-29 ❒30-39 ❒40-49 ❒50-59 ❒60+

4. In what ZIP code do you live? _____

5. Your gender is: ❒ Female ❒ Male ❒ Transgender (Male to Female) ❒ Transgender (Female to Male)

6. Select ONE response that best describes your race:
❒ White/Caucasian ❒ Native Hawaiian/Pacific Islander ❒ Don't know
❒ Black/African Descent ❒ Asian
❒ American Indian/Alaska Native ❒ More than one race

7. Select ONE response that best describes your ethnic background: ❒ Hispanic/Latino ❒ Non-Hispanic ❒ Don't know

8. Select ONE primary language you speak MOST OFTEN in your home:
❒ English ❒ Spanish ❒ Creole ❒ French ❒ Portuguese ❒ Other _____

9. Select ALL the ways you pay for medical care:
❑ Private health insurance (including managed care plans) ❑ Medicare ❑ Don't know
❑ Veteran's Administration (VA) ❑ Medicaid ❑ No health insurance
❑ Cash/Self-paid ❑ Ryan White ❑ Other (specify) _____

HIV DIAGNOSIS

10. In the past six months, did you get an HIV test? ❑ Yes ❑ No ❑ Don't know ***(If No or Don't know, skip to #11)***

a. If YES, what is the name of the place at which you got an HIV test? _____

b. If YES, were you given information about where to go for HIV medical care, such as where to go for doctor's visits and to get HIV drugs? ❑ Yes ❑ No ❑ Not Applicable

c. If YES, and you did have an appointment with a doctor, how long was it before you were able to see a doctor about your HIV infection? ❑ 0-2 weeks ❑ 2-4 weeks ❑ 4-12 weeks ❑ More than 12 weeks ❑ Don't know

d. If "More than 12 weeks," select ALL reasons why it took this long to see a doctor for your HIV infection:

- ❒ Could not afford it
- ❒ Did not know where to find a doctor
- ❒ Did not want anyone to know you have HIV
- ❒ Did not think it was necessary
- ❒ Could not leave work for an appointment
- ❒ Could not get transportation
- ❒ Was scared
- ❒ Couldn't find doctor who speaks my language
- ❒ Other_____

11. The year you first tested positive for HIV was: _____ (example: 1999)

12. Select the place you were living when you were FIRST tested positive for HIV:

- ❒ Broward County ❒ Somewhere else in Florida ❒ In another country (not in the USA)
- ❒ In another state, District of Columbia, or Puerto Rico (please specify)_____

13. Select ALL that describe your situation when you FIRST tested positive for HIV:

- ❒ During pregnancy
- ❒ Living in a homeless shelter
- ❒ Getting medical care at an emergency room
- ❒ You injected drugs
- ❒ In jail or prison
- ❒ Testing site/doctor's office
- ❒ Admitted to a hospital
- ❒ Getting treated for substance abuse or addiction
- ❒ Getting treated for other STD (such as gonorrhea or syphilis)
- ❒ Don't know or don't remember
- ❒ Other_____

14. Select ONE term that BEST describes your sexual experiences in the last 6 months:

- ❒ Always with men
- ❒ Mainly with men, but sometimes with women
- ❒ Equally often with men and women
- ❒ Always with women
- ❒ Mainly with women, but sometimes with men
- ❒ Did not have sex in the past 6 months

15. How would you describe your sexual orientation?

- ❒ Heterosexual or straight
- ❒ Homosexual, gay, lesbian, or same-gender loving
- ❒ Bi-sexual
- ❒ Other _____

16. How did you hear about where to go for HIV services?

❑ Family ❑ Friend ❑ Advertisement ❑ Internet ❑ Testing site ❑ Other _____

GETTING CARE

17. Is there a place you usually go for your HIV medical care (like a doctor's office, clinic)**?**

❑ Yes ❑ No ❑ Don't know ***(If Yes, skip to #18)***

a. If you DO NOT have usual place to go for most of your HIV medical care select ALL the reasons why:

- ❑ Could not afford HIV medical care
- ❑ Did not know where to find HIV medical care
- ❑ Did not want anyone to know you have HIV
- ❑ The wait for an appointment was too long
- ❑ Couldn't find a doctor who speaks my language
- ❑ Could not leave during work for an appointment
- ❑ Could not get transportation
- ❑ Did not think it was necessary
- ❑ Other _____

18. Thinking back over the last 6 months, about how many visits to a doctor's office, clinic, or emergency room for HIV medical care did you have? ❑0 ❑ 1-2 ❑ 2-4 ❑ 4-6 ❑ More than 6 ❑ Don't know

19. During the past 12 months, have you had at least one of the following: a CD4 count, a viral load test, or a prescription for anti-retroviral therapy? ❑Yes ❑ No ❑ Don't know ***(If No or Don't know, skip to #20)***

a. If YES, has there been a period of at least 12 months over the past five years when you were *not* receiving HIV-related primary medical care, using that same definition? ❑ Yes ❑ No ❑ Don't know

b. What best describes your situation during that period? Select the response that best fits your situation.

- ❑ I had recently been diagnosed with HIV, and had not entered primary care.
- ❑ I had been receiving medical care for HIV, but I dropped out of care.
- ❑ Other (specify) _____

c. Why were you not receiving primary medical care during that period? Please identify up to three reasons that you consider the most important in explaining why you were not in care.

- ❑ I couldn't afford care
- ❑ I didn't know where to go
- ❑ I was not ready to deal with my HIV status
- ❑ I was afraid of being identified as HIV-positive
- ❑ I heard bad things about medications side effects
- ❑ I was in jail or prison and didn't want care There
- ❑ I had a bad experience with my medications
- ❑ Lack of housing
- ❑ There wasn't a medical facility near me
- ❑ It was too hard to get services
- ❑ I had too many other things to worry about
- ❑ I was homeless
- ❑ I was using drugs or alcohol
- ❑ I had mental health problems
- ❑ I had a bad experience with doctor/medical staff
- ❑ Medical facility wasn't a good "fit" for my needs
- ❑ Other (explain) _____

d. Tell us more about your situation – explain what caused you to be out of care. _____

_____

_____

e. While you were out of care, what services other than medical and medications did you need?

- ❑ Substance abuse treatment
- ❑ Dental care
- ❑ Housing
- ❑ Other (specify) _____
- ❑ Mental health services
- ❑ Case management
- ❑ Transportation

f. What caused you to get back into care? Please identify up to three main reasons.

- ❑ I got sick and knew I needed care.
- ❑ I was ready to deal with my illness.
- ❑ I got the information I needed to get into care.
- ❑ I found a doctor or medical facility I liked.
- ❑ A family member/friend helped me get into care.
- ❑ Someone else with HIV/AIDS reached out to me
- ❑ An outreach worker helped me get into care
- ❑ I got out of jail or prison.
- ❑ Other (explain) _____
- ❑ I was able to deal with other problems in my life that had been keeping me out of care.
- ❑ Someone who had been involved in my care followed up, and got me to return to care.

20. In your opinion, what is the most important reason why people with HIV or AIDS in this community sometimes don't get HIV-related primary medical care?

_____

21. Your current CD4 count is: ❒ Under 200 ❒ 200-350 ❒ 350-500 ❒ Over 500 ❒ Don't know

22. Your current viral load is: ❒ Undetectable or below 50 ❒ Between 50-55,000 ❒ Over 55,000 ❒ Don't know

23. HIV antiretroviral drugs are also called protease inhibitors or HAART. Have you ever taken HIV antiretroviral drugs? ❑ Never ❑ Currently ❑ You stopped taking HIV drugs ❑ Don't know

a. If you are CURRENTLY taking HIV antiretroviral drugs, how often do you take your HIV drugs as prescribed by your HIV clinician? ❑ All the time ❑ Most of the time ❑ Some of the time ❑ Never ❑ You do not know how often you are supposed to take the drugs

b. If you are CURRENTLY taking HIV antiretroviral drugs, select ALL of the reasons you missed taking your drugs as prescribed by your HIV clinician?

- ❒ You do not know where to get them
- ❒ You cannot afford the cost
- ❒ You were unable to get an ADAP appointment
- ❒ You lost your enrollment in ADAP
- ❒ You are on the ADAP wait list
- ❒ The drugs make you feel bad
- ❒ You are on a drug holiday directed by your doctor
- ❒ You decided to go on a drug holiday on your own
- ❒ You have abusive spouse or partner who does not want you to take antiretroviral drugs
- ❒ You feel healthy
- ❒ You do not like taking antiretroviral drugs
- ❒ Taking antiretroviral drugs is not a priority for you
- ❒ You have trouble remembering to take them
- ❒ You have trouble understanding how to take them
- ❒ Your doctor wanted to treat another problem first
- ❒ Your religious or cultural beliefs
- ❒ Your medication from a patient assistance program (PAP) was late
- ❒ Other _____

c. If you NEVER took or STOPPED taking HIV antiretroviral drugs, select ALL of the reasons why:

- ❑ Your doctor told you that you did not need them
- ❑ Your health insurance did not pay for them
- ❑ You could not afford to pay for them
- ❑ You are on the ADAP wait list
- ❑ You had side effects from antiretroviral drugs
- ❑ Your doctor did not prescribe them
- ❑ The drugs were too complicated for you to take
- ❑ You did not want anyone to know you have HIV
- ❑ People you know told you the drugs were no good
- ❑ You took a "drug holiday"/break
- ❑ Your HIV was too far advanced to continue
- ❑ Other _____

HOUSING ASSISTANCE

YOUR FEEDBACK

Is there anything else that would be helpful for us to know? Please write your comments or concerns below.

_____

_____

_____

_____

Thank you for taking our survey. Your response is very important to us.

MEETING THE GOALS OF THE NATIONAL HIV/AIDS STRATEGY

HOW WE WILL PUT THEM INTO PRACTICE

A template for Committee chairs based on Joint Executive Committee retreat of 9/20/12

Step 1: What are we doing?

Each Committee of the Planning Council has been asked to come up with specific actions it can take to help Broward County meet the goals of the National HIV/AIDS Strategy, which match the goals of our 2012-15 Comprehensive Plan.

Step 2: Why we are doing this

The NHAS sets specific goals that the federal government would like each Ryan White program to meet, to reduce the HIV epidemic.

We will have to show our progress toward meeting those goals when we apply for Ryan White funds each year. Our results may affect the amount of our Ryan White grant.

Step 3: Extent of Broward's HIV epidemic (We're No. 1)

We continue to struggle to control new HIV/AIDS infections. In 2011, Broward had the nation's highest per-capita rate of new HIV infections and new AIDS infections.

- New HIV cases – 1,040, up by 25% over 2010
- New AIDS cases – 613, up by 7% over 2010
- People living with HIV/AIDS – 17,389
- PLWHAs aware of status but not in medical care – 7,314

Step 4: The Goals of the NHAS

We have a lot of work to do…

Reduce the number of people who become infected with HIV

→ Lead efforts to lower the number of new infections by 25%

→ Reduce the HIV transmission rate by 30%

→ Increase the number of people who know their serostatus to 90%

Increase access to care and improve health outcomes for PLWHA

→ Increase to 85% the number of people newly diagnosed with HIV receiving clinical care within 3 months of diagnosis

→ Increase to 80% the proportion of Ryan White clients in continuous care (2 HIV medical visits in 12 months, at least 3 months apart)

→ Increase the number of PLWHA in permanent housing to 86%

Reduce HIV-related health disparities

→ Increase access to prevention and care services

→ Increase the number of gay and bisexual men, Blacks, and Latinos with undetectable viral loads by 20%

Step 5: Ideas from the Committee Chairs

At the Retreat on 9/20/12, the Chairs of each Committee came up with a list of actions their Committee could take. Here are the ideas for our Committee:

Step 6: The Committee's Ideas

The Committee can break up into groups of three. Take 15 minutes to brainstorm for specific actions that this Committee can take to advance the goals. These ideas should be actions that fall in the Committee's normal subject matter.

Step 7: What's Next

The staff will incorporate the Committee's ideas into the 2013 Work Plan and bring it back for review next month.