FORT LAUDERDALE/BROWARD EMA BROWARD HIV
HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

System of Care Committee Meeting

Thursday, April 4, 2024 - 9:30 – 11:30 AM
Meeting at Broward Regional Health Planning Council and via Microsoft Teams

Chair: Jose Castillo • Vice Chair: Kendra Hayes

https://teams.microsoft.com/l/meetup-join/19%3ameeting_Mzg0MGMzNTctZDJkOS00ZmQwLWIxMzctYmE3N2FkZWQwMjA0%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%221bcbe6d6-8962-41e8-b7e5-3cd660df997c%22%7d

Meeting ID: 293 299 873 949 Passcode: CtiXEM
Call In: +1 561-437-3349 Phone Conference ID: 211 684 990#

This meeting is audio and video recorded.

Quorum for this meeting is 4

DRAFT AGENDA

ORDER OF BUSINESS

I. Call to Order/Establishment of Quorum
   a. Welcome from the Chair
   b. Meeting Ground Rules
   c. Statement of Sunshine
   d. Introductions & Abstentions
II. Moment of Silence
III. ACTION: Approval of Agenda for April 4, 2024
IV. ACTION: Approval of Minutes from March 5, 2024 **(Handout A)**
V. Public Comment
VI. Unfinished Business
   a. None.
VII. New Business
   1. Review Service Delivery Models:
      a. Minority AIDS Initiative SDMs **(Handout B1, B2, B3)**
   2. Quality Improvement Projects Overview -FY2023-2024 **(Handout C1, C2, C3)**

Work Plan Activity: 2.4 Receive presentations on Quality Improvement Projects (QIPs) taking place among service providers as needed; 2.6 Conduct annual review and present findings to QMC for potential updates to service delivery models (SDM) as needed.

VIII. Recipient Report

IX. Data Request

X. Public Comment

XI. Agenda Items for Next Meeting

a. Review Service Delivery Models:
   i. Health Insurance Continuation Program
   ii. Integrated Primary Care and Behavioral Health (IPCBH)
   iii. Universal SDM
   iv. FY2023-2024 Needs Assessment Overview
   v. How Best to Meet the Need Review for FY2024-2025

XII. Next Meeting Date: May 2, 2024, at 9:30 a.m. Location: BRHPC and via Microsoft Teams Video Conference

XIII. Announcements
The 2024 HIVPC Ryan White Part A Listening Tour on April 24, 2024 **(Handout D)**

XIV. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at: HIV Planning Council Website

Please complete your meeting evaluation.
Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

Vision: To ensure the delivery of high-quality, comprehensive HIV/AIDS services to low-income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

Handout A

FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

System of Care Committee Meeting

Thursday, March 7, 2024 - 9:30 – 11:30 AM

Meeting at Broward Regional Health Planning Council and via Microsoft Teams

Chair: Jose Castillo • Vice Chair: Kendra Hayes

SOC Members Present: J. Castillo (Chair), T. Pietrogallo, F. D'Amore, E. Chrispin, Hayes, K (Vice Chair).

Members Absent: A. Murphy

Ryan White Part A Recipient Staff Present: T. Thompson, R. Pena, B. Miller

Planning Council Staff Present: G. Martinez, D. Liao, M. Patel, M. Lacroix

Guests Present: B. Mester, J. Shirley, J. Hidalgo, V. Biggs

Call to Order, Welcome from the Chair & Public Record Requirements

The SOC Chair called the meeting to order at 9:43 a.m. The SOC Vice Chair welcomed all meeting attendees who were present. Attendees were notified that the SOC meeting is based on Florida's "Government-in-the-Sunshine" Law and meets reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. Introductions were made by the SOC Vice Chair, Committee members, Recipient Staff, PCS Staff, and guests by roll call, and a moment of silence was observed.

Public Comment

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters about HIV/AIDS and services in Broward County. There were no public comments.

Meeting Approvals

The approval for the **March 7, 2024,** agenda of the Systems of Care Committee meeting with amendments, was proposed by **J. Castillo**, seconded by **T. Pietrogallo**, and passed unanimously. The approval for the minutes of the **November 2, 2024,** meeting was proposed by **J. Castillo,** seconded by **F. D'Amore**, and approved with no further corrections.

Motion #1: J. Castillo, on behalf of the SOC Committee, made a motion to approve the March 7, 2024, System of Care Committee agenda. The motion was seconded by T. Pietrogallo and adopted unanimously.

Motion #2: J. Castillo, on behalf of the SOC Committee, made a motion to approve the November 2, 2024, System of Care Committee meeting minutes as presented. The motion was seconded by F. D'Amore and adopted unanimously.

Public comment.

None.

Standard Committee Items

None.

Old Business

None

New Business

Discussion: Review Service Delivery Models – Centralized Intake Eligibility Determination (CIED)

Part A Staff explained the modifications made to the CIED SDM in detail. The document was modified to be more streamlined and efficient. The committee discussed concerns about the modifications and all concerns were addressed by the Part A Staff. T. Pietrogallo suggested improvements to the information delivery methods, including additional language options for new clients.

The committee raised concerns about the provision of transportation services for clients by CIED. J. Hidalgo suggested potential transportation options through EEG. Part A Staff addressed all concerns.

Motion #3: T. Pietrogallo, on behalf of the SOC Committee, made a motion to approve the modifications to the CIED SDM as presented. The motion was seconded by J. Castillo and adopted unanimously.

Part A Staff requested an extension of one (1) hour to the following meeting, scheduled for April 4, 2024 at 9:30 a.m., due to the number of items for discussion. The committee agreed to the extension.

Public Comment

The Public Comment portion of the meeting is intended to give the public a chance to express opinions about items on the meeting agenda or to raise other matters pertaining to HIV/AIDS and services in Broward County. There were no public comments.

Agenda Items for Next Meeting

a. Next Meeting Date: Location: Broward Regional Health Planning Council (1 hour longer)
    a. Review Service Delivery Models
        i. Integrated Primary Care and Behavioral Health (IPCBH)
        ii. Universal SDM
        iii. Minority AIDS Initiative SDMs
        iv. Health Insurance Cost Sharing Program (HICP)
    b. Quality Improvement Projects Overview – FY 2023-2024

Announcements

- K. Hayes: Announced. Fort Lauderdale AIDS Walk, Saturday, March 9, 2024: HIVPC Volunteers Needed
- V. Biggs: Announced Holy Cross's Vaccine Clinic Event on Thursday March 7, 2024 from 7:00 to 9:00 p.m. at Bear Cave in Wilton Manors.
- V. Biggs: Announced Holy Cross's Lauderdale Tropical Bear Week on Saturday March 9, 2024 from 3:00 to 7:00 p.m. at Bears in the Park in Wilton Manors.
- T. Pietrogallo: Announced that food system at Poverello is now open for referrals from providers.

Adjournment

There being no further business, the meeting was adjourned at 10:48 a.m.

Consumer	Absences	Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
			Meeting Date	4	C											
0	0	**1**	Chrispin, E.	C	C	X										
0	0	**2**	Pietrogallo, T.	C	C	X										
0	0	**3**	Castillo, J. Chair	C	C	X										
0	0	**4**	D'Amore, F.	C	C	X										
1	1	**5**	Murphy, H.A.	C	C	A										
		6	Hayes, K., V. Chair	C	C	X										
		7	Biggs, V.	C	Z											
			Quorum = 4			5										

Legend:	
X - present	**N - newly appointed**
A - absent	**Z - resigned**
E - excused	**C - canceled**
NQA - no quorum absent	**W - warning letter**
NQX - no quorum present	**Z - resigned**
CX - canceled due to quorum	**R - removal letter**

April 2024

Broward HIV Health Services Planning Council Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1244/1343. Visit http://www.brhpc.org for updates.					
	1	2 Community Empowerment Committee Meeting (CEC) 3:00PM– 5:00PM Location: BRHPC/WebEx	3 Oral Health Network Meeting 3:00PM-4:15PM	4 System of Committee Meeting 9:30AM – 11:30AM Medical Provider Network Meeting 2:30PM-3:45PM	5 South Florida AIDS Network Meeting (SFAN) 9:30AM	6
7	8	9 Behavioral Health Network Meeting 2:00 PM – 3:15 PM	10  Youth HIV/AIDS Awareness Day	11 Membership/Council Development Committee Meeting 9:30AM – 11:30AM	12	13
14	15 Quality Management Committee Meeting 11:30AM– 2:30PM Location: BRHPC/WebEx	16	17	18 Priority Setting & Resource Allocation Committee Meeting 9:30AM -12:30PM Executive Committee Meeting 12:45PM – 2:45PM  National Transgender HIV Testing Day	19	20
21	22	23	24 PSRA/CEC Listening Tour on RW Part A Services	25 HIV Planning Council Meeting 9:30AM – 11:30AM Locations: BRHPC/Webex	26	27
28	29	30				

Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Links are active and lead to meetings or Awareness Day Information.

Meetings in RED are canceled. Meetings in BLUE are for the HIV Planning Council Committees. Meetings in GREEN are for the Provider Network. Holidays and meetings outside of the HIV Planning Council are in BLACK.

April 2024

Broward HIV Health Services Planning Council Calendar

All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Unless otherwise noted, meetings will be held via WebEx.
Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1292 or 1343. Visit http://www.brhpc.org for updates.

TODOS ESTAN BIENVENIDOS!	ALL ARE WELCOME!	BON VINI!
A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en:	Unless otherwise noted on the calendar, all meetings are held at:	Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fét:
Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020	Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020	Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Para confirmar información acerca de la reunión de Consejo de Planeación HIV, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.	To confirm HIV Planning Council meeting information, or reserve special needs services such as Translation from English to Spanish or Creole, or are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.	Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and ser- vices provided to all patients receiving Part A and MAI-funded services.

Executive Committee - Sets agenda for Council meetings, addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.

Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.

Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system-based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.

Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes. Function as a primary level of appeal for unresolved grievances relative to the Council's decisions regarding Ryan White Part A funding.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Handout B1

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Medical Case Management
Service Delivery Model

Approved by HIVPC on 12/5/2023

Table of Contents

I. Service Definitions

HRSA Definition[1]

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities undertaken in this service category may be provided by an interdisciplinary team that includes other specialty care providers. MCM includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication), as well as activities taken on behalf of the client (e.g., multidisciplinary case conferences, referrals to other personnel or agencies).

Key activities include:

- Initial assessment of service needs
- Develop a comprehensive, Individualized Care Plan (ICP)
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the ICP
- Re-evaluate the ICP plan at least every six months, with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of service utilization

In addition to providing the medically oriented activities above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. Such programs may include Florida Medicaid Managed Care Organizations (MCOs), Medicare Part D, Florida AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's Patient Assistance Programs (PAPs), other state or local healthcare and supportive services, and insurance plans through the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), Marketplaces/Exchanges.

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds the Medical Case Management and provides a system of coordinated healthcare interventions to assist clients in self-managing their HIV and preventing complications

Commented [RP1]: It would be feasible to include the MAI initiative purpose under Part A as defined by HRSA. I was unsure where this definition would best be suited for placement.

Formatted: Highlight

Formatted: Highlight

Formatted: Highlight

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

stemming from co-morbid chronic disease conditions. MCM includes assessment of client needs, development of a coordinated plan of care, and care coordination. Key activities include:

- Conducting a Comprehensive Health Assessment (CHA)
- Developing and maintaining a comprehensive ICP
- Supporting healthcare monitoring, such as prescription dispensing documentation, medication adherence coaching, and attendance at healthcare appointments
- Coordinating essential medical and support services and making referrals when indicated
- Providing adherence counseling to treatment regimens and healthcare and initiating strategies and interventions to improve the client's disease self-management skills pertaining to health maintenance, medication adherence, and drug interactions.

II. Key Service Components and Activities

In addition to the MCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division Provider Handbook for Contracted Services Providers, individual contracts, and applicable contract adjustments. MCM providers must refer to their individual contract for service-specific client eligibility requirements. MCM providers must comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

All MAI funded programs are expected to adhere by the above service standards.

Coordination of Medical and Healthcare Improvement Services

Providers must ensure coordination of medical and healthcare improvement services to support clients in meeting their ICP goals and maintaining their engagement in care. Case coordination and case conferencing includes communication, information sharing, and collaboration that occurs regularly with case management and other providers serving the client within and between agencies in the community. Coordination includes, but is not limited to:

- Managing HIV and co-morbid condition (chronic and acute) treatments
- Communicating with the client's primary care and behavioral health providers and other service providers to support client adherence, understanding, motivation, access to services and optimal engagement in care to include case coordination and case conferencing activities
- Coordinating medical and support service use within the RWHAP system of care, addressing barriers to obtaining services, and linking the client to services
- Coordinating specialty medical services outside the RWHAP system of care
- Coordinating with prescribing medical providers to prioritize HIV treatment, ARV adherence, and goal setting for other medical conditions, including but not limited to, diabetes, chronic renal failure, chronic obstructive pulmonary disease, cardiovascular conditions, neurocognitive disorders, and cancer

Case conferences include multi-disciplinary service providers, including providers within the agency and those from other agencies when possible and relevant. Case conferences must be face-to-face or via conference call and must be held at routine intervals or during significant care changes

Commented [RP2]: Fulton County EMA (the EMA where MAI was first launched) includes MAI language in its service delivery models for services that offer MAI and the core service. https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Additionally, the Miami-Dade EMA and the Palm Beach EMA does the same format.

https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf

Commented [MB3]: Update hyperlinks

Commented [RP4]: The Fulton County EMA includes this language to ensure that MAI funded programs adhere to the Universal SDM in addition to fulfilling the expectations of MAI.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Formatted: Highlight

Formatted: Highlight

or transitions. High acuity levels established by the Acuity Scale informs the frequency of case conferences. The client and their family members, significant others, or designated caregiver(s) should also be included in case conferences when possible and appropriate. These activities must be recorded in the client's progress notes in the designated HIV Human Services Support Services (HSSS). Case conferences can be used to:

- Identify or clarify issues about client health status, needs, and goals
- Review activities, including progress and barriers towards attaining goals
- Resolve conflicts or strategize solutions

Adherence Counseling to Support Medical Care and Treatment
MCMs must integrate adherence counseling throughout the ICP to support prescribed treatment regimens and healthcare service delivery to assist clients in achieving sustained viral suppression and maintain retention in medical care. Adherence counseling includes, but is not limited to:

- Providing evidence-based treatment adherence interventions
- Using adherence assistance devices including pillboxes and alarms
- Evaluating barriers to treatment adherence and medical appointment attendance and addressing those barriers
- Evaluating clients for medication side effects and drug interactions
- Documenting all adherence counseling activities in the designated HIV HSSS

Client-Centered Education and Training on HIV Self-Management
MCMs must provide clients, their family members, and/or identified support persons with culturally and linguistically appropriate HIV-related treatment, care, and preventative health information. Providers must assess the client's needs and learning preferences to ensure that materials are in alignment with client literacy, linguistics, and cultural needs. Accommodations must be made to address all client disabilities, including sensory impairments. HIV self-management topics must include at a minimum:

- Basic information about HIV and important lab terminology
- Medication adherence and strategies to improve and sustain adherence
- Health benefits of medication adherence for durable viral suppression
- Retention in HIV and primary medical care, including health promotion activities
- Self-management of medication side effects and strategies to minimize drug-drug interactions
- Strategies to reduce and/or eliminate the harmful use of substances known to cause deleterious effects
- Healthy relationships, disclosure of HIV status, HIV/STI prevention and family planning
- Recognizing the signs of stress, distress, anxiety, and depression and strategies to access emotional support services
- Adequate nutrition, regular exercise, and the benefits of stress reduction and self-care.

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measures

Outcome	Indicator(s)	Measure

1. Increased access, retention, and adherence to primary medical care.	1.1. 85% of clients achieve one (1) or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV HSSS. ~~1.1.1.~~1.1.2. Data obtained from the MAI Annual Report.
	1.2. 90% of clients are retained in primary medical care.	~~1.1.2.~~1.1.3. Client appointment record in designated HIV HSSS.

IV. Assessment and Individual Care Plan

Comprehensive Health Assessment (CHA)

MCMs must assess client needs by conducting a CHA within 14 days of the client's initial visit. The CHA must be completed within the designated HIV HSSS. The CHA is used to evaluate each client's access to medical care, health status, health maintenance, health knowledge, treatment adherence, behavioral health needs, and environment. Assessment findings are used to inform the acuity scale component.

Progress Notes

Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress including, assistance provided, and communication with clients in the designated HIV HSSS, including phone calls, mail, face-to-face, and electronic communication. Additionally, providers are responsible for checking and verifying lab reports (ensuring correct lab value entry, trending viral load, and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up.

On a monthly basis, Case Management supervisors must review a 5% sample of open client action plans to identify opportunities for improvement. To ensure a high quality of progress notes, MCM must write effectively to include:

- Protected privacy of the client
- Detailed and organized notes documenting activities. All activities must be documented in the client file.
- Facts about your encounter with the client
- The purpose and clear observations of the client interaction
- Describe next steps, including, the purpose and/or goal for the next encounter

Acuity Scale

The Acuity Scale is a component of the CHA to be used to inform and develop the ICP. The acuity scale translates the CHA into a level of support to aid in the development of an appropriate ICP to best assist the client in achieving self-management. MCMs must complete the Acuity Scale within 14 days of the client's initial visit. Acuity levels must be reviewed and updated at each reassessment. Twenty-four (24) domains are counted towards the acuity score for a minimum of 24 points and a maximum of 96 points. The following chart details the 4 levels of acuity based on score, with corresponding management and client contact guidance.

Formatted: Font: 11 pt, Font color: Auto, Pattern: Clear

Formatted: Highlight

Commented [RP5]: According to the HRSA website's official guidelines for MAI programs. The MAI annual report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and the outcomes achieved.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Please note from the previous links to other EMA SDMs that additional outcomes are not created for MAI-funded programs. It appears that the current outcomes for each service that includes MAI are expanded to include the goals of MAI.

Additionally I found a resource from the Henry J. Kaiser Family Foundation that highlights possible complications when creating too many restrictions for MAI.

https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf

Table 2: Acuity Scale Scoring and MCM Management Levels

Management Level	Points	Health Status/ Medical Condition	Client Contact Frequency	Chart Review Frequency
Self-Management	24-34 Points	Medically stable without need of MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up at least once every six months for reassessment	Once every six months
Basic Management	35-49 Points	Medically stable with minimal MCM assistance and is virally suppressed	Face-to-face or telehealth visual follow-up every six months with a minimum of 1 phone contact every 3 months	Every 3 months
Moderate Management	50-73 Points	At risk of becoming medically unstable without MCM assistance including documented detectable viral load or risk for viremia	Face-to-face or telehealth visual follow-up every 3 months at a minimum with at least 1 phone contact every month	Every 3 months
Intensive Management	74-96 Points	Medically unstable and in need of comprehensive MCM assistance with an accompanying detectable viral load	Face-to-face at least once a month with phone contact weekly	Monthly

Reassessment

Reassessments provide an opportunity to review the client's progress, consider successes and barriers, and to evaluate the previous timeframe of activities. Providers must reevaluate the client's unmet needs and related barriers by conducting reassessments every six months after completion of the initial assessment, or sooner if the client's circumstances change significantly. Reassessment findings are used to update the ICP.

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Formatted: Font: Italic, Highlight

Formatted: Highlight

Commented [RP6]: According to the HRSA guidelines for MAI programs, Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Individual Care Plan (ICP)

Providers must develop an ICP within 30 days of completing the initial client visit. MCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The MCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. MCMs

must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV HSSS.

For MAI programs, The ICP must address potential barriers to access and reduce disparities in health outcomes.

Formatted: Font: Italic, Highlight

Formatted: Highlight

V. Standards for Service Delivery

Table 3. MCM Standards for Service Delivery

Standard	Measure
1. Provider completes a CHA with each client within 14 days of their initial visit.	1.1. Completed CHA in the designated HIV HSSS.
2. Provider develops an ICP with each client within 30 days of completing the initial CHA with time-specific, measurable goals. The ICP is signed and dated by the provider and client.	2.1. ICP signed and dated by the provider and client in the designated HIV HSSS.
3. Provider completes a reassessment with the client every six months after completion of the initial CHA, or sooner if the client's circumstances change.	3.1. Completed CHA in the designated HIV HSSS. 3.2. Progress notes in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	4.1. All client records will contain at a minimum the following documentation: brief intake, current notice of eligibility, confidentiality forms (if applicable), case closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 4.4. Confidentiality releases in client file/designated HIV HSSS.
5. Medical Case Managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	5.1. Medical Case Managers will receive, within 6 months of hire, the following required training : annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency

Standard	Measure
	policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (500 and 501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. As needed, case managers routinely coordinate all necessary services along the continuum of care, including institutional and community-based, medical, and non-medical, social and support services	6.1. Evidence of timely case conferencing with key providers is found in the client's records through case note documentation in the designated HIV HSSS.
7. Client health needs are assessed and reassessed using the Acuity Scale as outlined in *Appendix A.*	7.1. Acuity Scale completed and scored in the designated HIV HSSS.
8. Client has contact with the provider at the frequency specified by client's management level as detailed in *Appendix A.*	8.1. Documentation of client communication in the designated HIV HSSS.
9. Provider conducts healthcare monitoring as specified by the ICP.	9.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
10. Provider coordinates medically appropriate levels of medical and support services to assist clients in meeting ICP goals and retention in care.	10.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
11. Provider conducts adherence counseling to support treatment regimens and medical care.	11.1. Documentation of the ICP and progress notes in the designated HIV HSSS.
12. Assistance provided to client and progress made toward achieving ICP goals is documented in the client file within three business days of meeting with the client.	12.1. Documentation of client communication, services provided, and progress made towards ICP goals in the designated HIV HSSS.
13. Provider follows up with clients within two business days of the client's requested communication.	13.1. Documentation of client communication in the designated HIV HSSS.

Standard	Measure
14. Provider conducts medical chart reviews to ensure appropriate documentation of all services, including referrals, follow-up, and reassessments, in accordance with client management levels as detailed in *Table 2.*	14.1. Documentation of client communication, referrals, follow-up, and reassessments in the designated HIV HSSS.
15. Client case management conferences to be scheduled and held in accordance with client management levels as detailed in *Table 2.*	15.1. Documentation of client case management conference in the designated HIV HSSS.
16. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	16.1. Closed cases include documentation stating the reason for closure and a closure summary. 16.2. Supervisor signs off on closure summary indicating approval. 16.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 16.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
17. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care and outcomes.	17.

17 Establish and maintain a system that tracks and reports the following for MAI Services:

Funds expended.

Number of clients served.

Units of service provided overall by race/ethnicity, women, infants, children, and youth.

Client-level outcome within each minority population and/or subpopulation.

Formatted: Highlight

Formatted Table

Commented [RP7]: The Palm Beach EMA includes the National Standards for MAI in their SDM format.

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf

Formatted: Highlight

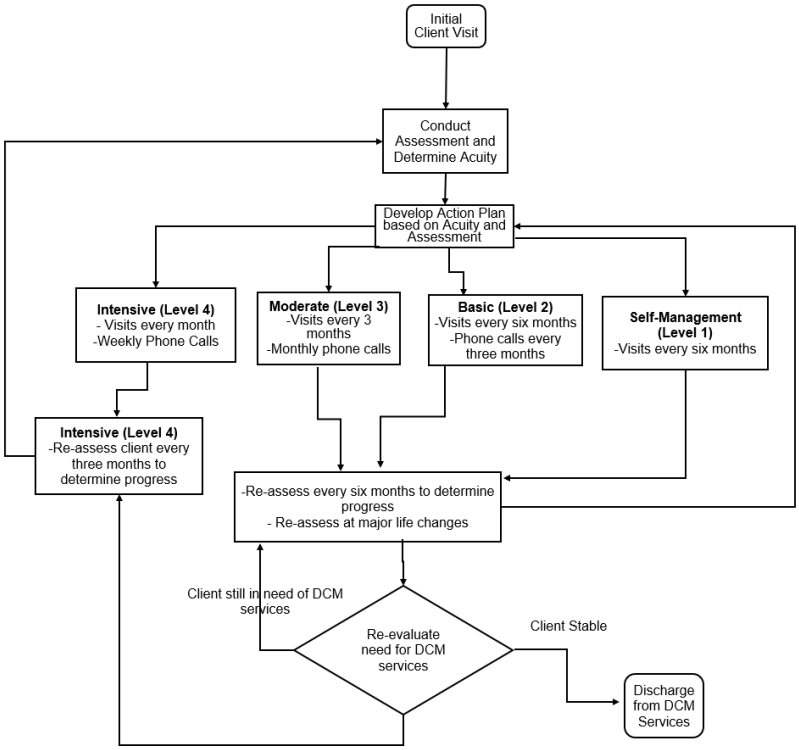
Commented [RP8]: Please note the formatting of this document seems to be thrown off after adding the number 17 Standard and Measure fields. I will work on resolving the issue soon. For now, I have placed the number 17 measure underneath the table.

Formatted: Highlight

Formatted: Highlight

VI. Appendix A

The Medical Case Management Assessment Model



Handout B2

GET CARE
BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Non-Medical Case Management
Service Delivery Model

BROWARD COUNTY
FLORIDA
Health Care Services
Ryan White Part A Program

Table of Contents

I. Service Definitions

HRSA Definition[1]

Non-Medical Case Management (NMCM) services are the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services.

NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities for this service category include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

- Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D,

Formatted: Highlight

Formatted: Normal, No bullets or numbering

Commented [RP1]: It would be feasible to include the MAI initiative purpose under Part A as defined by HRSA. I was unsure where this definition would best be suited for placement.

Formatted: Font: (Default) Times New Roman

Formatted: Highlight

Commented [RP2]: Fulton County EMA (the EMA where MAI was first launched) includes MAI language in its service delivery models for services that offer MAI and the core service. https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Additionally, the Miami-Dade EMA and the Palm Beach EMA does the same format.

https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services).

The goals of this intervention are retention in care, sustained viral suppression, compliance with medical care and addressing any service needs.

II. Key Service Components and Activities

In addition to the NMCM Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A Universal SDM. Providers must also adhere to standards and requirements set forth in the Broward County, Human Services Department, Community Partnerships Division, Housing Options, Solutions and Supports Division, individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service-specific client eligibility requirements. Providers of NMCM services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

All MAI funded programs are expected to adhere by the above service standards.

Commented [RP3]: The Fulton County EMA includes this language to ensure that MAI funded programs adhere to the Universal SDM in addition to fulfilling the expectations of MAI.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Formatted: Highlight

Peer Counseling

Peer counseling is a required component of NMCM services. It is recommended that providers of NMCM services utilize at least 30% of all NMCM personnel funds provided under the Ryan White Part A program for Peer Counseling services.

Peer counseling services assist clients with navigating the system of care and meeting action plan goals. A Case Management supervisor must oversee all peer counseling activities. Peer counseling activities include:

- Assist clients in navigating the health care system
- Assist clients in adhering to medical appointments and treatment
- Support clients in achieving and maintaining viral suppression
- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals
- Facilitating peer counselor-led client support groups

Formatted: Font: Italic

Formatted: Font: Not Italic, Highlight

Commented [RP4]: According to the HRSA website's official guidelines for MAI programs. The MAI annual report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and the outcomes achieved.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Please note from the previous links to other EMA SDMs that additional outcomes are not created for MAI-funded programs. It appears that the current outcomes for each service that includes MAI are expanded to include the goals of MAI.

Additionally I found a resource from the Henry J. Kaiser Family Foundation that highlights possible complications when creating too many restrictions for MAI.

https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf

Formatted: Font: Not Italic

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Human Services Support Services (HSSS), ~~1.1.1.~~1.1.2. Data obtained from the MAI Annual Report.

Outcomes	Indicators	Measure
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV HSSS.
2. Supports viral suppression.	2.1. 90% of clients on ART for more than six months will have a viral load less than 200 copies/ml.	2.1.1. Client viral load test result in designated HIV HSSS. 2.1.2. Client prescription of ART documented in the designated HIV HSSS.

IV. Assessment and Action Plan

Assessment

Providers must conduct an assessment of the client's service needs including a review of medical, financial, social, emotional, resources, and other needs within three sessions of the initial visit. The assessment must be documented using the "Client Assessment" form in the designated HIV HSSS and include, at minimum, the following components:

- STI/HIV Health Literacy Assessment, including U=U (undetectable equals untransmittable), knowledge of HIV and STI testing, prevention, and treatment
- Barriers to accessing primary medical care medication adherence and other service needs
- Medical information, including overall health, laboratory results, and prescribed medication regimen
- Pregnancy information for female clients, including pregnancy history
- Additional core service needs, including, mental health, oral health, nutritional therapy
- Education and guidance to support a successful transition to an Affordable Care Act (ACA) Insurance, Medicare, and Medicaid
- Support service needs, including advice and assistance in obtaining medical, social, community, legal assistance, finances/benefits, support groups, food bank, vocational, and transportation
- Quality of life, including factors related to finances, culture, language, housing status, and need for assistance with activities of daily living
- Interpersonal Violence

Reassessment

A reassessment must be conducted every six months, at a minimum. A reassessment may occur more than once every six months if significant changes occur. Reassessments require the participation of the client and provider to evaluate client health and identify changes since the last assessment to determine new or ongoing needs. Activities, notations of discussions, conclusions, and recommendations must be documented during the reassessment.

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Formatted: Font: Italic, Highlight

Formatted: Highlight

Commented [RP5]: According to the HRSA guidelines for MAI programs, Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Relevant Areas of Concern
Following the completion of the assessment or reassessment, the designated HIV HSSS generates a list of the clients "Relevant Areas of Concern." Providers must utilize the "Relevant Areas of Concern" list to assist the client with prioritizing areas to be addressed in the action plan.

Action Plan
Providers must work with each client to develop an action plan with goals related to the needs identified in the assessment. The action plan must be developed the same day the assessment is completed and signed and dated by the provider and client. The action plan must be individualized, culturally appropriate, and goal-oriented with measurable objectives. Providers must assist clients to develop appropriate strategies to accomplish established goals. The action plan must be documented in the designated HIV HSSS and contain, at minimum, the following components:

- Date the action plan was initiated and completed
- Case Manager and Supervisor review and date
- Life areas with identified difficulties as indicated in coordination with client
- Date client entered case management
- Date of client's first medical appointment and documentation of client's retention/ engagement in medical care while receiving case management services
- Goals must contain, at minimum, the following components:
    - Goal category (access, adherence, and retention)
    - Goal statement that is SMART (specific, measurable, attainable, realistic, and time-based)
    - Specified interventions to achieve the goal statement
    - Date goals are established
    - Target date for goal completion

All completed action plans must be reviewed, signed, and dated by Case Management supervisors.

Progress Notes
Providers must maintain ongoing monitoring and communication with clients to ensure linkage to and retention in needed services. Providers must document action plan progress including, assistance provided, and communication with clients in the designated HIV HSSS, including phone calls, mail, face-to-face, and electronic communication. Additionally, providers are responsible for checking and verifying lab reports (ensuring correct lab value entry, trending viral load, and CD4 values and sharing trends with clients) and validating medication pick-ups at the pharmacy constitute follow-up.

On a monthly basis, Case Management supervisors must review a 5% sample of open client action plans to identify opportunities for improvement. To ensure a high quality of progress notes, NMCM must write effectively to include:

- Protected privacy of the client
- Detailed and organized notes documenting activities. All activities must be documented in the client file.
- Facts about your encounter with the client
- The purpose and clear observations of the client interaction
- Describe next steps, including, the purpose and/or goal for the next encounter

Action Plan Review
An action plan review must be conducted every six months, at a minimum, to assess the efficacy of the action plan. An action plan review may occur more than once every six months if significant changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

For MAI programs, the action plan must address potential barriers to access and reduce disparities in health outcomes.

Formatted: Font: Italic, Highlight

Formatted: Highlight

V. Standards for Service Delivery

Table 2. NMCM Standards for Service Delivery

Standard	Measure
1. Provider conducts an assessment with each client within three sessions of the initial visit and at least every six months thereafter.	1.1. Completed assessment in the designated HIV HSSS.
2. Provider works with each client to develop an action plan the same day the assessment is completed.	2.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
3. Provider conducts an action plan review every six months, at minimum.	3.1. Action plan signed and dated by the provider and client in the designated HIV HSSS.
4. All client records/files will be neatly maintained and organized.	4.1. All client records will contain at a minimum the following documentation: brief intake, current notice of eligibility, confidentiality forms (if applicable), case closure (if applicable), and other documentation an agency deemed appropriate in the designated HIV HSSS. 4.2. Detailed case notes documenting activities. Memory recall is not an option. All activities must be documented in the designated HIV HSSS. 4.3. Progress notes in the client file/designated HIV HSSS. 4.4. Confidentiality releases in client file/designated HIV HSSS.
5. Case managers will participate in case management professional development activities that focus on HIV/AIDS/STI updates and service delivery.	5.1. Case managers will receive, within 6 months of hire, the following required training : annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to

Standard	Measure
	applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); Department of Health sponsored case management training; code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
6. Peer Counselors will participate in professional development activities that focus on HIV/AIDS/STI updates and service delivery.	6.1. Peer Counselors will receive, within 6 months of hire, the following required training: annual confidentiality with attestation signed by staff person; initial agency orientation including job duties and responsibilities, agency policies and procedures; introduction to applicable local, state, and federal resources (includes ADAP, AICP, and HOPWA programs); basic and advanced information on HIV/AIDS (501); code of ethics including cultural diversity and professional boundaries Additional recommended trainings include: peer counseling trainings, mental health, substance abuse, Medicaid, Medicare (includes Part D), HIV treatment and trends, medical terminology, lab interpretation, documentation, AETC Medical Case Management training, local resources.
7. Case Management supervisors review a 5% sample of open client action plans each month to identify opportunities for improvement.	7.1. Open action plans in the designated HIV HSSS. 7.2. Documentation of monthly reviews and identified opportunities for improvement.
8. Completed action plans are reviewed by Case Management supervisors.	8.1. Completed action plans signed and dated by Case Management supervisor in the designated HIV HSSS.

Standard	Measure
9. Assistance provided to client and progress made toward achieving action plan goals is documented in the client file within three business days of meeting with the client.	9.1. Documentation of client communication, services provided, and progress made towards action plan goals in the designated HIV HSSS.
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
11. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	11.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

Commented [RP6]: The Palm Beach EMA includes the National Standards for MAI in their SDM format.

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf

Formatted: Highlight

Formatted: Highlight

Formatted: Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.29"

Formatted: Indent: Left: 0.29", Bulleted + Level: 1 + Aligned at: 0.8" + Indent at: 1.05"

Formatted: Indent: Left: 0.29", Bulleted + Level: 1 + Aligned at: 0.8" + Indent at: 1.05"

Formatted: Indent: Left: 0.29", Bulleted + Level: 1 + Aligned at: 0.8" + Indent at: 1.05"

Formatted: Indent: Left: 0.29", Bulleted + Level: 1 + Aligned at: 0.8" + Indent at: 1.05"

Handout B3

BROWARD COUNTY
RYAN WHITE PART A PROGRAM

Minority AIDS Initiative Substance Abuse – Outpatient
Service Delivery Model

Table of Contents

I. Service Definitions

HRSA Definition[1]

The Ryan White HIV/AIDS Program includes the Minority AIDS Initiative (MAI). The MAI was codified in 2006 and provides additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

MAI Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders within the minority population. Activities under Substance Abuse Outpatient Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder.
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy.
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Local Definition

MAI

Substance Abuse – Outpatient services are medical or other treatment and/or counseling services provided to clients of the minority population to address substance use disorders (SUDs) (i.e. recurrent use of alcohol, opiates, stimulants, or other controlled or uncontrolled substances causing clinically significant distress or impairment in physical, social, or occupational functioning). These services will be provided by appropriately credentialed and/or licensed treatment professionals. MAI Substance Abuse – Outpatient services include culturally competent psychological assessment and evaluation, drug testing, diagnosis, treatment planning with written goals, crisis counseling, periodic reassessments, outpatient day treatment, intensive day/night treatment, re-evaluations of plans and goals documenting progress, and referrals to psychiatric and/or other services as appropriate to improve adherence to treatment and improve client health outcomes.

II. Key Service Components & Activities

In addition to the MAI Substance Abuse – Outpatient Service Delivery Model (SDM), all providers must adhere to the minimum requirements set forth in the Broward County Ryan White Part A

Formatted: Font: (Default) +Body (Times New Roman), 12 pt, Font color: Auto, Highlight

Formatted: Justified

Formatted: Font: (Default) +Body (Times New Roman), 12 pt, Font color: Auto, Highlight

Formatted: Font: (Default) +Body (Times New Roman), 12 pt, Font color: Auto

Formatted: Justified, Space After: 0 pt

Formatted: List Paragraph, Justified, Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Space After: 0 pt

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

Universal SDM. Providers are subject to Florida's Statute Title XXIX, Chapter 394[2]. Per Florida Law, professional staff providing treatment, counseling, or support group facilitation must be a licensed professional or supervised by a licensed professional. Providers must also adhere to standards and requirements set forth ~~in Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook,individual contracts, and applicable contract adjustments. Providers must refer to their individual contract for service specific client eligibility requirements.~~ Providers of MAI Substance Abuse – Outpatient services are expected to comply with applicable State and/or Federal standards and guidelines relevant to services delivered within this service category.

Field Code Changed

Outpatient Care
Outpatient substance abuse care mitigates negative symptoms from SUDs and restores effective functioning in persons diagnosed with substance-use dependency or addiction. Outpatient care is appropriate as an initial level of care for clients with less severe disorders, in early stages of change (as a "step down" from more intensive services), or stable and ongoing monitoring or disease management. Outpatient care is provided less than nine hours weekly.

Intensive Outpatient Services
Intensive outpatient services provide essential addiction education and treatment to clients with SUDs and have gradations of intensity. At a minimum, intensive outpatient services provide a support system including medical, psychologic, psychiatric, laboratory, and toxicology services within 24 hours via telehealth or within 72 hours in-person. Intensive outpatient services are provided from 9 – 19 hours weekly.

Day Treatment
Day treatment services differ from intensive outpatient services in the intensity of clinical services that are directly provided. Day treatment is appropriate for clients who are living with unstable medical and psychiatric conditions. Day treatment, at a minimum, meets the same treatment goals as described in *Intensive Outpatient Services*, with psychiatric and other medical consultation services available within eight hours via telehealth or within 48 hours in-person. Day treatment services must be continuously provided at a minimum from 9:00 a.m. until 10 p.m. during a single 24-hour period.

III. Broward Outcomes & Indicators

Table 1. Outcomes, Indicators, and Measure

Outcomes	Indicators	Measure
1. Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	1.1. 85% of clients achieve treatment plan goals by designated target date and are part of the target populations for MAI.	1.1.1. Treatment plan documented in designated Human Services Software System (HSSS).
2. Increased access, retention, and adherence to primary medical care.	2.1. 85% of clients are retained in primary medical care and are part	2.1.1. Client appointment record in designated HSSS.

[2] FLA. STAT. § 394.

	of the target populations for MAI.	

IV. Assessment and Treatment Plan

Assessment

During the first encounter with a client, the provider must establish a provisional diagnosis and treatment plan goal. The provider is required to provide language assistance if needed in the assessment. Prior to the development of a comprehensive treatment plan, providers must conduct a biopsychosocial assessment. The biopsychosocial assessment must be completed in the designated HIV MIS within 30 calendar days of the first encounter with a client and be reviewed and signed by a licensed professional. The biopsychosocial assessment, at minimum, must include the following:

- Presenting problems
- Primary care post-traumatic stress disorder (PC-PTSD) screening[3]
- Biological factors
- Psychological factors
- Social factors
- Summary of findings
- Diagnostic impression
- Treatment recommendations

When clinically indicated, additional assessments may be completed as indicated within the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Treatment Plan

Providers must work with each client to develop an individualized treatment plan based on the needs identified in the biopsychosocial assessment. The treatment plan must address the needs of the client in a culturally sensitive manner. The treatment plan must be goal-oriented with measurable objectives. The provider must assist the client to define goals and document the progress and assistance provided to the client. Treatment plans become effective on the date the plan is signed and dated by the licensed professional and the client. Treatment plans must contain, at minimum, the following components:

- The client's diagnosis code(s) consistent with assessments
- A list of the services to be provided to client (treatment plan development and review, and evaluation/assessment services provided to establish a diagnosis; however, information gathered by the provider for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service to be provided to the patient as part of the six-month in duration treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the client will receive a service "x to y times per week"

[3] Health Resources and Services Administration. *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5).* https://www.hrsa.gov/behavioral-health/primary-care-ptsd-screen-dsm-5-pc-ptsd-5.

- Goals that are individualized, strength-based, and appropriate to the client's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the client
- Measurable objectives with target completion dates identified for each goal
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed provider
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs
- Discharge criteria (individualized, measurable criteria that identifies the client's readiness to transition to a new level of care or out of care)
- Read as culturally competent

Treatment Plan Review

A formal review of the treatment plan must be conducted every six months, at a minimum. Treatment plans may be reviewed more than once every six months when significant changes occur. The treatment plan must continue to reflect cultural competency and address any concerns the client may have due to differences in culture. The treatment plan review requires the participation of the client and the treatment team members identified in the client's individualized treatment plan. Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan made during the review must be documented. The treatment plan must be signed and dated by a licensed practitioner and the client.

The formal treatment plan review must contain, at minimum, the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Client progress toward meeting individualized goals and objectives
- Client progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings/interpretive summary
- Recommendations
- Dated signature of the client or client's parent, guardian, or legal custodian (if client is under 18 years of age)
- Dated signature of licensed practitioner who participated in the review of the plan
- A signed and dated statement by the licensed practitioner stating services are medically necessary and appropriate to the client's diagnosis and needs

V. Standards for Service Delivery

Table 2. Substance Abuse – Outpatient Service Delivery Standards

Standard	Measure
1. Client is asked to give express and informed consent for treatment, with language assistance provided if needed.	1.1. Signed informed consent form in the client file.

Standard	Measure
2. Provider conducts a biopsychosocial assessment with each client prior to the development of a treatment plan within 30 calendar days of the first encounter.	2.1. Completed biopsychosocial assessment signed by licensed practitioner in the designated HSSS.
3. Provider works with each client to develop a detailed treatment plan that is culturally sensitive.	3.1. Treatment plan signed and dated by licensed practitioner and client in the designated HSSS.
4. Provider conducts a formal treatment plan review at least every six months.	4.1. Updated treatment plan with signature and date of licensed practitioner and client in the designated HSSS.
5. Assistance provided to client and progress made toward achieving treatment plan goals is documented in the client file within three business days of meeting with the client.	5.1. Documentation of client communication, services provided, and progress made towards treatment plan goals in the designated HSSS.
6. All client communication is documented in client file and include: a date, length of time spent with client, person(s) included in the encounter, summary of what was communicated, and provider signature.	6.1. Detailed documentation with provider signature of all client communication in the designated HSSS.
7. Progress notes in the client file are linked to a treatment plan goal.	7.1. Progress notes in the designated HSSS.

SDM
Presentation

Presented by Broward County Ryan White Part A Office

Fiscal Year 2023-2024

Medical Case Management

Non-Medical Case Management

MAI

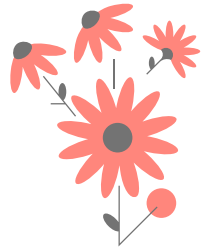
- **The Minority AIDS Initiative (MAI) was created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. It provides new funding to strengthen organizational capacity and expand HIV-related services in minority communities. This began a new initiative and the culmination of a community-based advocacy campaign that began more than six months earlier in Atlanta, Georgia.**

- **The MAI's principal goals are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV-related health disparities.**

HRSA Guidelines

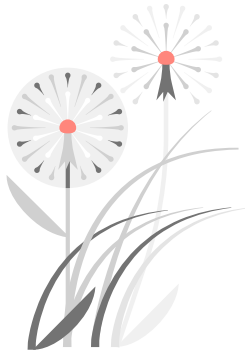
- MAI improves access to HIV care and health outcomes for disproportionately affected racial and ethnic minority populations. The MAI was codified in 2006 and provides additional funding under the RWHAP Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

- Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.



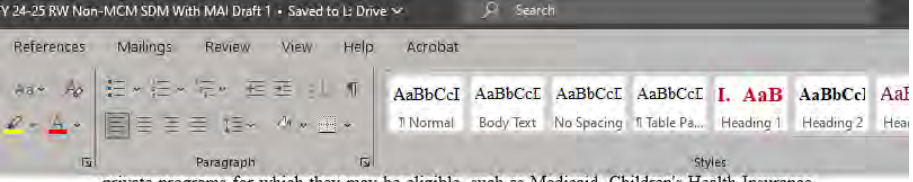
Reporting

- **The language in the HRSA Part A Manual states the MAI Annual Report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and achieved outcomes.**



SDM Changes

- **The current SDM changes to both Medical Case Management and Non-Medical Case Management are only additions to language pertaining to MAI; please note that the SDM changes for MAI do not subtract any current language in the prior approved SDM.**



private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities for this service category include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Minority AIDS Initiative (MAI) - additional funding under the Ryan White HIV/AIDS Program Parts A, B, C, D, and F to improve access to HIV care and health outcomes for racial and ethnic minority populations disproportionately affected by HIV.

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

Local Definition

The Broward County Ryan White HIV/AIDS Part A Program (RWHAP) and Minority AIDS Initiative (MAI) funds NMCM services support client achievement of wellness and autonomy by facilitating social service needs of clients. NMCM is a collaborative process of assessment, planning, facilitation, and evaluation of service options for addressing clients' medical and social needs including benefits/entitlement, counseling, and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services).

[1] *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02*. Health Resources and Services Administration (HRSA)/ HIV/AIDS Bureau (HAB). [Online] October 22, 2018. https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

SDM Changes

Including the MAI initiative purpose under Part A as defined by HRSA would be feasible. I was unsure where this definition would best be suited for placement.

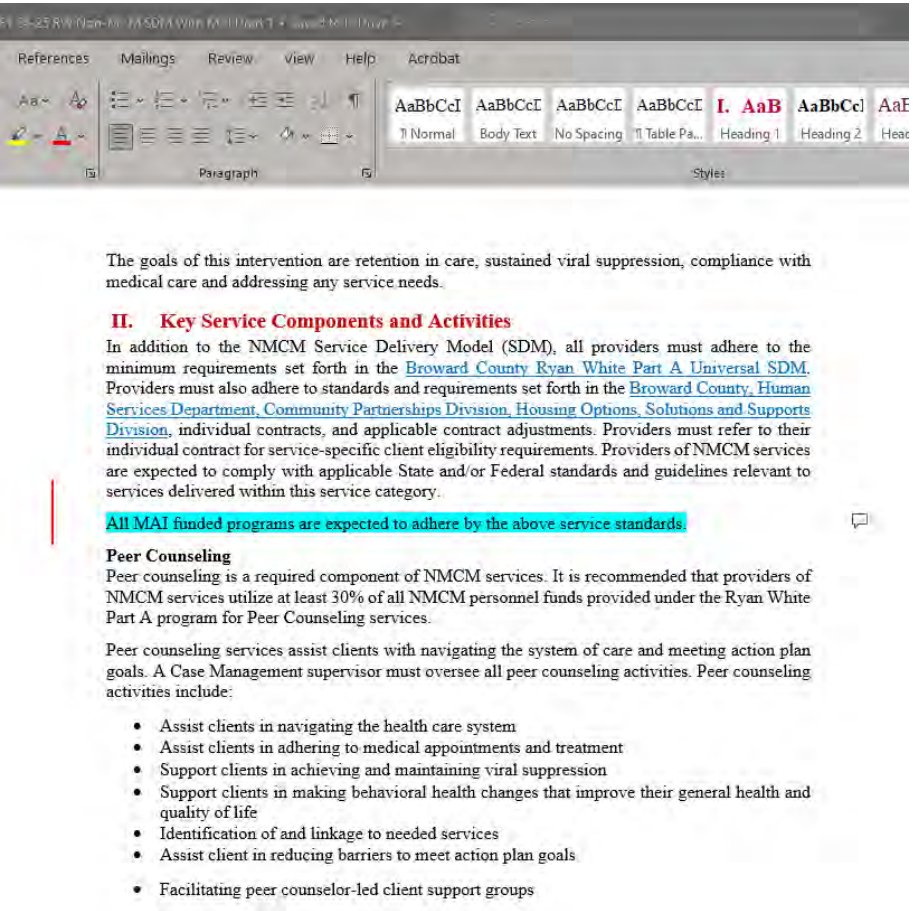
Fulton County EMA includes MAI language in its service delivery models for services that offer MAI and the core service.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

Additionally, the Miami-Dade EMA & the Palm Beach EMA use the same format.

https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf

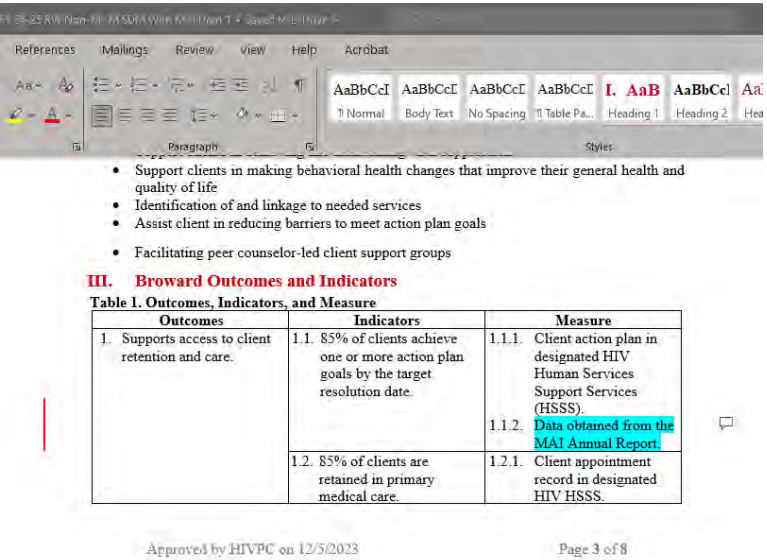


SDM Changes

The Fulton County EMA includes this language to ensure that MAI-funded programs adhere to the Universal SDM and fulfill the MAI's expectations.

https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

SDM Changes



- Support clients in making behavioral health changes that improve their general health and quality of life
- Identification of and linkage to needed services
- Assist client in reducing barriers to meet action plan goals
- Facilitating peer counselor-led client support groups

III. Broward Outcomes and Indicators

Table 1. Outcomes, Indicators, and Measure

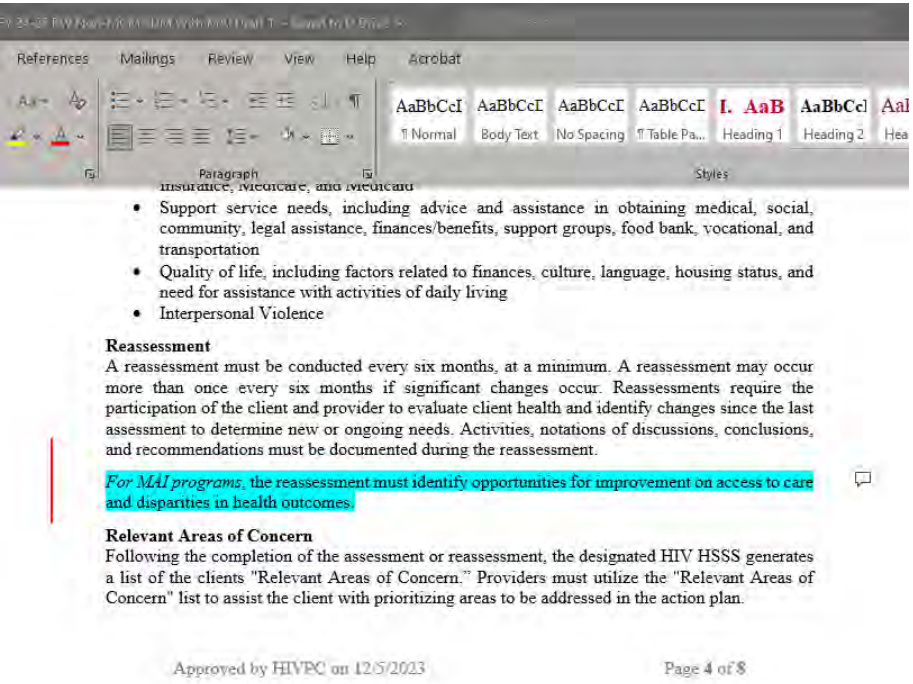
Outcomes	Indicators	Measure
1. Supports access to client retention and care.	1.1. 85% of clients achieve one or more action plan goals by the target resolution date.	1.1.1. Client action plan in designated HIV Human Services Support Services (HSSS). 1.1.2. Data obtained from the MAI Annual Report.
	1.2. 85% of clients are retained in primary medical care.	1.2.1. Client appointment record in designated HIV HSSS.

According to the HRSA website's official guidelines for MAI programs. The MAI annual report documents how RWHAP A MAI funds were used during the grant year to reach and serve priority populations, the viral suppression rates of MAI populations, and the outcomes achieved.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

Please note from the previous links to other EMA SDMs that additional outcomes are not created for MAI-funded programs. It appears that the current outcomes for each service that includes MAI are expanded to include the goals of MAI. Additionally, I found a Henry J. Kaiser Family Foundation resource highlighting possible complications when creating too many restrictions for MAI.

https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf



SDM Changes

According to the HRSA guidelines for MAI programs, Under RWHAP Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas most affected by HIV/AIDS.

https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

changes occur. Any modifications or additions to the action plan made during the review must be documented. The action plan must be signed and dated by the provider and client.

For MAI programs, the action plan must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

findings are used to update the ICP.

For MAI programs, the reassessment must identify opportunities for improvement on access to care and disparities in health outcomes.

Individual Care Plan (ICP)
Providers must develop an ICP within 30 days of completing the initial client visit. MCMs may partner with primary or other healthcare providers when conducting assessments and developing ICPs. The MCM, in conjunction with the client, their authorized family member, and treatment team, must prioritize the client's needs to be addressed in the ICP.

The ICP must be client-centered and in alignment with the client's specific needs, strengths, and resources based on the CHA. The ICP must address needs that can be met through specified and measured goals in a time frame agreed upon with the client and authorized family member. MCMs

must work with clients to update ICPs based on the results of reassessments. All ICPs must be signed and dated by the provider and client.

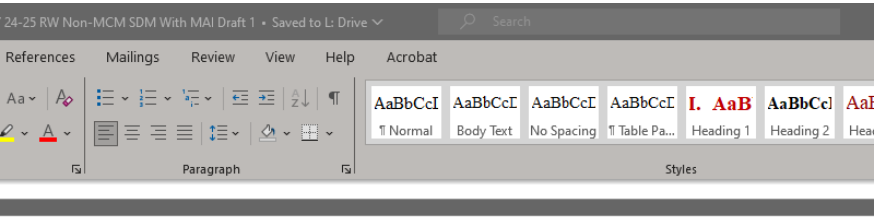
Providers must assist the client to define clear goals and realistic outcomes for the needs identified and prioritized in the ICP. Expected outcomes and progress made toward meeting outcomes must be documented in the client's ICP. All assistance provided to clients must be documented in the designated HIV HSSS.

For MAI programs, The ICP must address potential barriers to access and reduce disparities in health outcomes.

V. Standards for Service Delivery

SDM Changes

This Language was included to expand upon Action Plans, Reassessments, & Individual Care Plans to reflect MAI goals.



SDM Changes

Standard	Measure
within three business days of meeting with the client.	
10. Upon termination of active case management services, a client's case is closed and contains a closure summary documenting the case disposition.	10.1. Closed cases include documentation stating the reason for closure and a closure summary. 10.2. Supervisor signs off on closure summary indicating approval. 10.3. Supervisor review is completed in situations where provider intends to terminate services related to a client who threatens, harasses, or harms staff. 10.4. Documentation of Case Closure Form and client case is recorded in the designated HIV HSSS.
11. Minority AIDS Initiative (MAI) funds must be used to address the disproportionate impact of HIV on racial and ethnic minority populations and subpopulations, in addition to disparities in access, treatment, care, and outcomes.	11.1. Establish and maintain a system that tracks and reports the following for MAI Services: • Funds expended. • Number of clients served. • Units of service provided overall by race/ethnicity, women, infants, children, and youth. • Client-level outcome within each minority population and/or subpopulation.

- **The Palm Beach EMA includes the National Standards for MAI in their SDM format.**

- **https://discover.pbcgov.org/communityservices/PDF/CURRENT-%20PBC%20RW%20Part%20A-MAI%20Program%20Manual%20GY24.pdf**

Resources

1) Aragón, R., & Kates , J. (2004, June). The minority aids initiative. The Minority AIDS Initiative. https://www.kff.org/wp-content/uploads/2013/01/minority-aids-initiative-policy-brief.pdf

2) Department for HIV Elimination, Quality Management Staff, & Metropolitan Atlanta HIV Health Services Planning Council, Quality Management Committee The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) provides funding for Ryan White DHE Services in the A. (2024). Ryan White project. Ryan White Project. https://endhivatl.org/quality-management/ema-standards-of-care/?seq_no=2

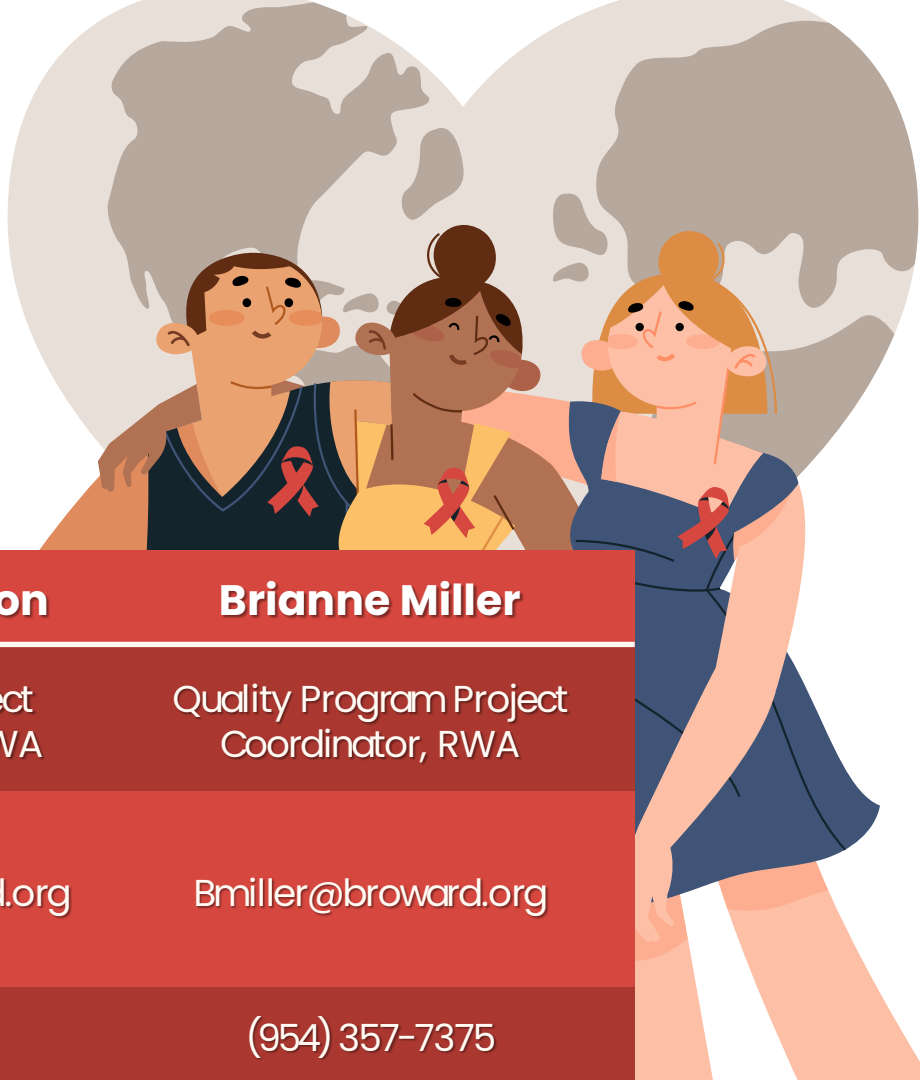
3) Miami Dade County Ryan White Program. (2018, April 30). Medical Case Management (MCM) standards - Miami-Dade ... Miami Dade County Medical Case Management Standards of Service. https://www.miamidade.gov/grants/library/ryanwhite/service-delivery-section-III-mcm-standards.pdf

4) Palm Beach County HIV Elimination Services. (2024, March 1). RYAN WHITE PART A/MAI PROGRAM MANUAL Community Services Department Board of County Commissioners Palm Beach County. Discover Palm Beach County. https://discover.pbcgov.org/carecouncil/PDF/PBC_RWHAP_Manual_GY21.pdf

5) U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau. (2023, March). Part A manual - Ryan White HIV/AIDS Program - HRSA. Ryan White HIV/AIDS Program Part A Manual. https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf

THANKS!

Do you have any questions?



Richard Pena	Timothy Thompson	Brianne Miller
Quality Program Project Coordinator, EHE/RWA	Quality Program Project Coordinator Senior, RWA	Quality Program Project Coordinator, RWA
Ripena@broward.org	Timthompson@broward.org	Bmiller@broward.org
(954) 357-5393	(954) 357-7811	(954) 357-7375

Handout C1

Broward EMA Ryan White Part A Program

FY2023-2024

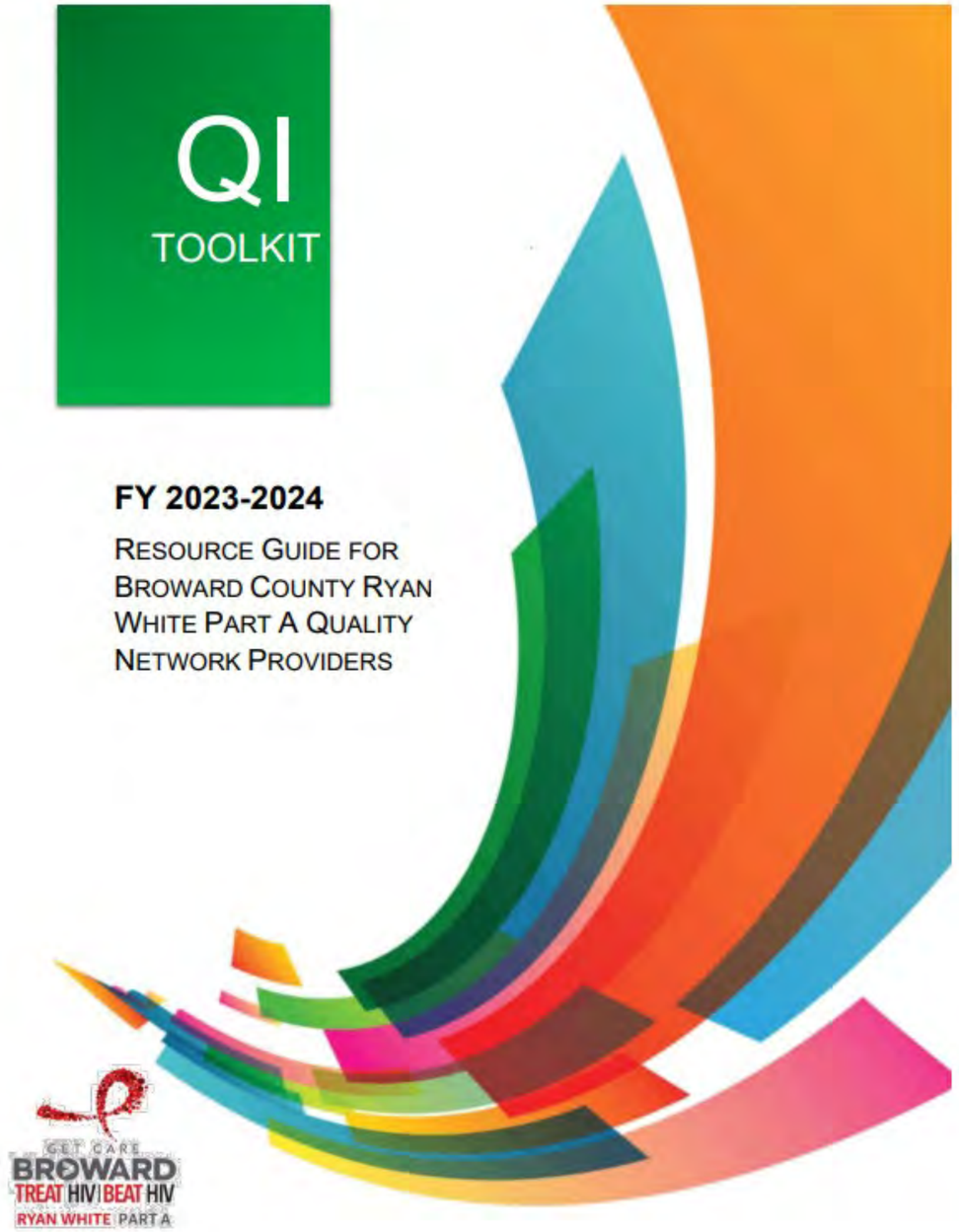
Ryan White Quality Network:

Quality Improvement Project Presentation

PRESENTED BY
DANIELLE LIAO,MPH

FY 2023-2024
QIP Review

The purpose of this presentation is to discuss and review selected Quality Improvement Projects from the Quality Network within the 2023-2024 fiscal year.



Fiscal Year 23-24

The Broward EMA Ryan White Part A Program quality improvement focus for FY 2023-2024 is closing the gap between linkage to care and retention in care, specifically among subpopulations, including:

- Black-African American Non-Hispanic/Latinx Cis-Gender Adolescent Adult Male and Female who acquired HIV infection due to heterosexual contact
- Hispanic/Latinx Adolescent Adult MMSC
- White Non-Hispanic/Latinx Adolescent Adult MMSC

Quality Improvement Projects (QIPs) should focus on addressing this gap.

QIP PLANNER 2023-2024

This planner is a recommended timeline for deliverables related to the QIP process.

Checkpoint check-ins are one on one virtual check ins and provide an opportunity to check in with the CQM team. Time slots are available from 10am to 3pm

QIP PHASE	STARTING	ENDING
STEP 1: GEARING UP FOR QIPS	3/1/23	4/17/23
STEP 2: IDENTIFYING THE PROBLEM	4/18/23	5/8/23
STEP 3: AIM STATEMENTS	5/9/23	6/26/23
STEP 4: PDSA CYCLES	6/27/23	10/2/23
STEP 5: PRELIMINARY DATA REVIEW AND EVALUATION	10/3/23	1/8/24
STEP 6: QIP POSTER	1/9/24	2/17/24

CHECKPOINT CHECK-INS	DATE 1	DATE 2
IDENTIFY FOCUS AREAS FOR QIPS	3/27/23	3/31/23
DRIVER DIAGRAM	5/1/23	5/5/23
AIM STATEMENT	5/29/23	5/31/23
DRIVERS/CONTRIBUTING FACTORS	6/21/23	6/23/23
PDSA CYCLE PLANNING FORM	8/7/23	9/30/23
PRELIMINARY DATA REVIEW & EVAL	11/1/23	12/18/23
QIP POSTER	1/8/24	2/9/24

Checkpoint due dates are in highlighted.

MARCH

M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE

M	T	W	T	F	S	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST

M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER

M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER

M	T	W	T	F	S	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER

M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER

M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JANUARY

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY

M	T	W	T	F	S	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29			

Home Visits Med Reconciliation & Education

Agency F

BACKGROUND

Problem statement

Our agency focused on this because we wanted to increase compliance within the Ryan White caseload seen at Agency F. We wanted to improve our numbers and retain in care patients who have not had a medical visit and/or do not have current viral load and CD4 values within six months from their last visit.

AIM STATEMENT

Agency F seeks to increase compliance improvement by 1%, from 92% to 93% compliance, within the Ryan White caseload seen at Agency F, focusing on retaining in care patients who have not had a medical visit and/or do not have current viral load and CD4 values within six months from their last visit, by 1/31/24 by implementing interventions.

MEASURES

Process Measures

Medication reconciliation during home visits will help ensure that the client is safely taking medication as prescribed by provider(s). Effectiveness will be measured by improved viral load and lab values, checking lab results and reports that shows follow up appointment was made on same day as kept appointment.

Outcome Measures

Medication reconciliation and tracking viral load suppression, follow up appointments. Provide Enterprise (PE), Tracking appointment reports.

PDSA CYCLES

Cycle 1

Plan: Implementing home visits to re-reengage clients, assess change in level of care, and medication reconciliation.

Do: We did home visit to reconcile medication and interview patients

Study: Improvement in viral load suppression and compliance with treatment plan and scheduled medical appointments.

Act: We identified several barriers to care and worked to overcome them in order to reengage and retain patients in care.

_____

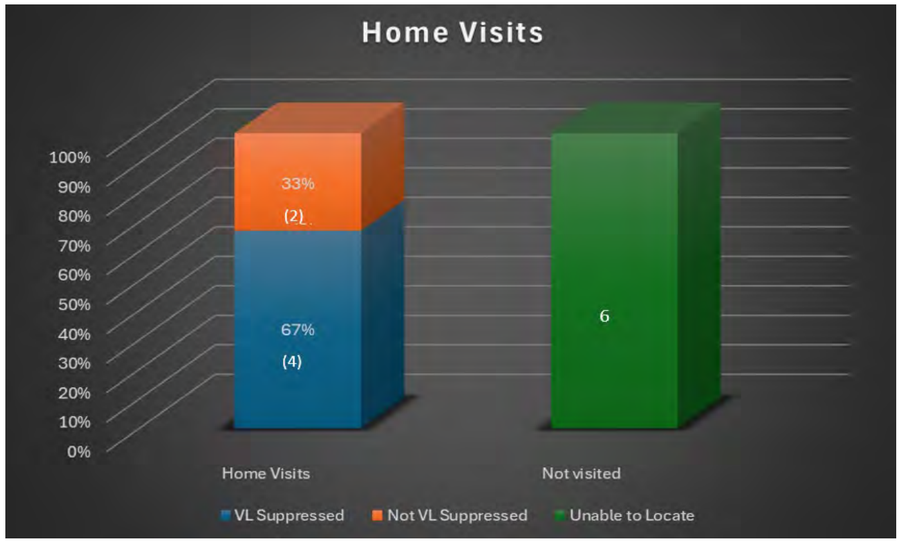
Plan: Pairing Behavior health Peers with patients brought back into care for a smoother transition

Do: When the home visit was over, we offered patients an appointment with a BH peer

Study: This improved compliance with appointments and assisted patients emotionally

Act: We identified that some of patients had emotional barriers and the best way to over come them was reengaging the patient with a provider and BH peer to retain in care

RESULTS



Explanation 1: Out of 12 home visits we have seen 6 patients, 2 brought back to care, the other 4 retained, and 6 unsuccessfully reached.

SUCCESSES, CHALLENGES, & NEXT STEPS

62.5% of the patients were either VL suppressed or retained in care because of the intervention We increased our retention in care by 0.5% from 92% to 92.5%. This was lower than our target goal, however given the success of the intervention we are doing another cycle to determine if we adopt or abandon the solution.

We had issues receiving the authorization from the county to start the home visits. Moreover, we had issues with obtaining necessary equipment to mobilize.

ACKNOWLEDGEMENTS

Thank you to:

Tackling Mental Health

Agency J

BACKGROUND

- The Division of Infectious Disease noticed that a percentage of our patients that are not virally suppressed also had a positive PHQ 2/9 results and no linkage to Mental Health services.

AIM STATEMENT

Agency J's Division of Infectious Disease aims to increase viral suppression on patients with a positive PHQ 2/9 result from 77% to 85% by December 2023.

MEASURES

Process Measures

Through our EHR system, No-show and Lab results reports were run to track patients' compliance.

Outcome Measures

We tracked compliance by reviewing lab results and compliance with Mental Health appointments.

PDSA CYCLES

Cycle 1

Plan: How does linking patients with a positive score and detectable viral load to mental health impacts their viral load.

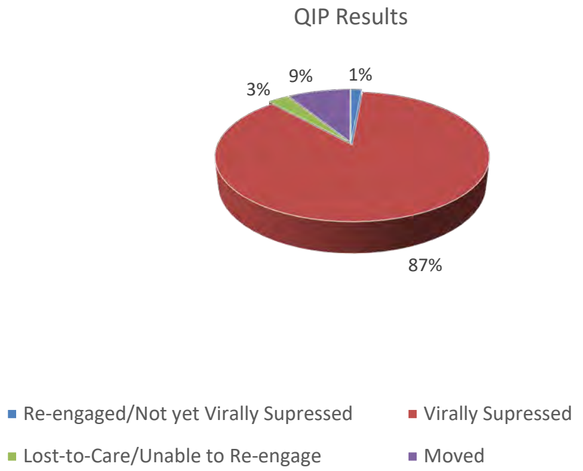
Do: Refer and provide mental health services to the patients as well as address any additional barriers to care

Study: The data has shown us that patients who agree to mental health services and maintain compliance with MH care have successfully lowered or suppressed their overall VL.

Act: We adopted the cycle as we noticed that with MH counseling the patient became more compliant in their medical care. This led the patient to ultimately become virally suppressed.

RESULTS

Our QIP was successful! We were able to achieve and exceed our original goal of achieving 85% of VL suppression and ended up with 87% of patients who had a positive PHQ2/9 become virally suppressed.



SUCCESSES, CHALLENGES, & NEXT STEPS

- Once of the successes was the patients being receptive to appointments with the Mental Health counselor.
- The main roadblock that we faced with this specific patient population was the co-morbidities that come along with it.
- It has shown that linking patient's who have a positive PHQ2/9 to MH care can improve their VL suppression as well as their overall medical/health compliance.

ACKNOWLEDGEMENTS

Any Questions?

Thank you!

The services provided by Broward Regional Health Planning Council, Inc. is a collaborative effort between Broward County and Broward Regional Health Planning Council, Inc. with funding provided by the Broward County Board of County Commissioners under an Agreement.

Handout C2

Broward Ryan White Part A FY2023-2024

All Agency Quality Improvement Projects

GET CARE BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

PRESENTED BY
DANIELLE LIAO,MPH

Increasing Viral Suppression of BAA Males & Females

Agency A

BACKGROUND

- BAA males and females have a lower viral suppression rate than other demographic groups (80%)

AIM STATEMENT

Increase the number of virally suppressed BAA males and females by 28 clients by June 2024

MEASURES

Outcome Measure:

- Viral load suppression
- Barriers to care

PDSA CYCLES

Cycle 1
Plan: DCMs & NMCMs to identify barriers to care within cohort of unsuppressed.

Do: Provide adherence education through individualized care to remove barriers.

Study: Increased viral suppression amongst cohort by 48 clients.

Act: Adopt/Adapt

Cycle 2
Plan: For the 5 clients with noted MH barriers, refer into MH care to increase VLS

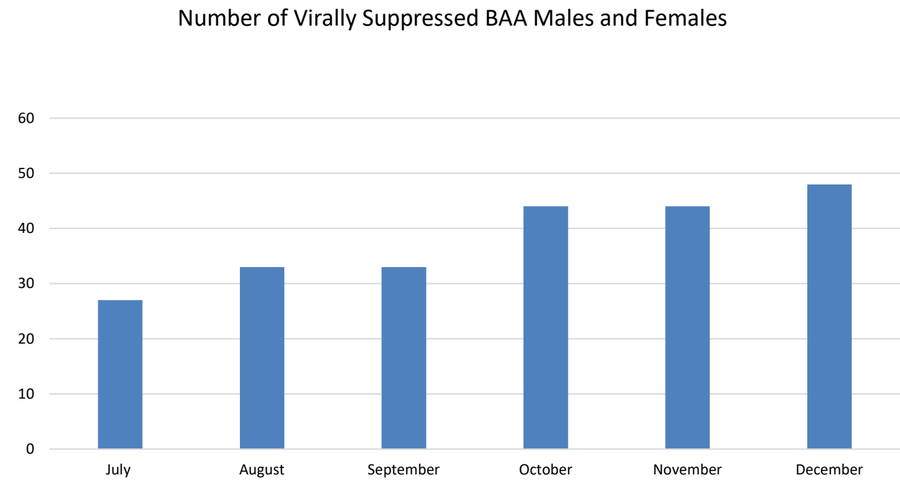
Do: Provide MH staff with clients list, for them to contact and provide care

Study: Clients did not engage in MH

Act: Abandon

RESULTS

Increase of virally suppressed BAA males and females from July (n=27) to December (n=48) 2023



SUCCESSES, CHALLENGES, & NEXT STEPS

- We exceeded our goal of bringing 28 unsuppressed clients to viral suppression by 20 clients through December 2023.
- Engaging clients with MH barriers is a challenge

ACKNOWLEDGEMENTS

PrEP Patient Enrollment and Retention

Agency B

BACKGROUND

Did you know?
The CDC reported that in 2021 less than ¼ of black & Hispanic/Latino people who were eligible for PrEP were prescribed it. Agency B wanted to engage the medical providers, counselors and other clinicians to refer, and prescribe PrEP to patients when it was necessary to.

AIM STATEMENT

To increase PrEP patient services from 6 to 15 by December 31, 2023, in high- risk patients between the ages of 18 to 64".

MEASURES

Process Measures
PrEP Education/ Prescribing
PrEP Visibility
PrEP Enrollment/Retention.

Outcome Measures
Provider referral process to PrEP worked best for new enrollment. Enrolling patients in case management for monitoring build better patient rapport and increased retention.

PDSA CYCLES

Cycle 1
PrEP Education/Prescribing for providers
For cycle 1 we wanted to Increase our providers knowledge about PrEP and Agency B's internal process. So, we provided self pace training videos with CME credit options.
To set it in action we asked the Chief Medical Director to share the video link with the Providers. The responses to completing the task were low. Instead, we provided the information during the company's all staff meeting and on-site presentations from community liaison.

PrEP Visibility
We increased our program visibility online and throughout the offices. We purchased new tablets to play PrEP Educational videos while patients wait. We also increase our social media postings.

Cycle 2
PrEP Enrollment/Retention.
We asked the medical providers and counselors to use the proposed criteria in referring patients to PrEP. They were asked to use the same process within the EPIC EMR for tracking. This process helped us better analyzed our based line percentage to the new patient enrollments. Ultimately, the case manager was been able to track providers, program initiation, and retention.

RESULTS

- We Started the project with 6 patients and concluded with 16 by December 20th.
- 7 patients were referred by providers based on positive lab results, 3 were self-referred, and zero came from Testing and Counseling.
- 4 patients are on the Apretude injection while the other 12 are taking the oral regimen.

PrEP Enrollment and Monitoring

PrEP Educational Videos/Visibility

SUCCESSES, CHALLENGES, & NEXT STEPS

We faced internal challenges initially with provider buy-ins and navigation through a new EMR system . However, we achieved the level of provider engagement needed to prescribe PrEP. Our next step is rapid PrEP initiation and increasing our patient enrollment to 45 within the next three years. We are glad to have incorporated the Status Neutral approach to PrEP services.

ACKNOWLEDGEMENTS

Data Accuracy Matters In Time

Agency C

BACKGROUND

- Data elements and input into PE are often inaccurate and/or missing.
- Data Accuracy Matters In Time and impacts Broward Outcomes & Exceptions Indicator 1.1 goal of 95%

AIM STATEMENT

Agency C aims to increase Indicator 1.1 from 81.2% to 85% through improvement of data accuracy and input into PE by the end of December 2023.

MEASURES

Process Measures
Agency C communication, client/provider feedback and engagements, lab results, appointments and outcomes.
Outcome Measures
Accurate and timely input of lab results, kept and next scheduled appointments and client outcomes.

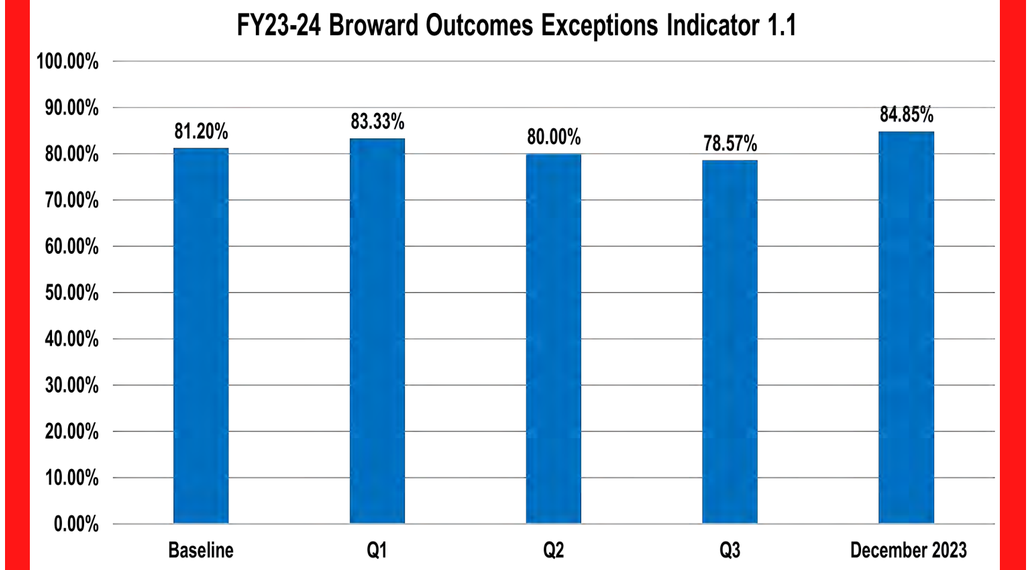
PDSA CYCLES

Cycle 1
Plan: Run Data Reports
Do: Analyze, Monitor, Identify
Study: 25/30 Exceptions for Q-1
Act: Improve communications with clients, providers and Agency C staff to prioritize care compliance; routinely input lab results, appointments kept and scheduled.

Cycle 2
Plan: Run Data Reports
Do: : Analyze, Monitor, Identify
Study: 51/64 Exceptions for Q-2
Act: Improve communications with clients and Agency C staff with private/non-RW providers. Agency C staff will input data for private providers that lack access to PE.

Cycle 3
Plan: Run Data Reports
Do: Analyze, Monitor, Identify
Study:66/84 Exceptions for Q-3
Act: Step-up previous interventions and recognize/identity PE process impacts to “NEW” clients and lack of historical data comparison.

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

- Communications Improved.
- Private Provider impacts to PE
- Identify PE barriers and input processes for “New” clients to PE.
- Prioritized compliance, and timely Agency C input/engagement.

ACKNOWLEDGEMENTS

ACTION PLAN GOAL COMPLETION

Agency D

Consistent Review & Follow-up on Action Plan Goals are Effective

Rationale/ Background

- Patients that developed action plan goals did not complete those goals by the target due date.

AIM Statement

Agency D aims to increase completion of action plan goals from 79.67% (baseline March 2022 – February 2023) to 85% by November 2023.

Measures

Process Measures
Monitor the Action Plan Goals Expiring in Date Range and Action Plan Summary.

Outcome Measures
85% of patients will achieve 1 or more action plan goals by target resolution date.

Use Provide Enterprise to monitor the outcomes.

PDSA Cycles

PDSA Cycle 1
Plan: Consistent review and follow-up on patients' action plan goals.

Do: Medical Case Managers will set realistic action plan goals with patients and review them during office visits and post interactions.

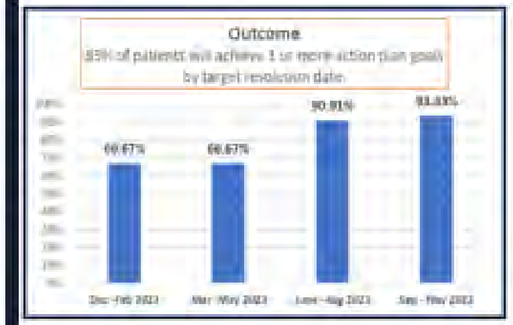
Extend the date range if patient is still active in the program and want to continue with goal.

Study: Monitor/review Action Plan Goals Expiring in Date Range and Action Plan Summary reports.

What we learned: Consistent review of action plan goals with patients, and as needed extend the target date if the patient is still active in the program.

Results

The action plan goal completion increased from 79.67% to 85.42% November 2023.



Acknowledgments

Successes

- Consistent monitoring of Action Plan Goals Expiring in Date Range and Action Plan Summary reports helps to increase goal achievement.
- Medical Case Managers were very receptive and quickly bought into improving patient goal achievement.

Challenges

- Transient patients that show up for care only when meds are depleted.
- Patients that stop showing up for care may not achieve goals.
- Social determinants of health affect goal achievement.

Next Steps

- Adopt and continue to monitor Action Plan Goals Expiring in Date Range and Action Plan Summary reports.
- Conduct a granular assessment between goal completion and viral load suppression.

Accurate Data Leads to Quality Care

Agency E

BACKGROUND

The inability to pull accurate data reports, inhibits direct care staff from being able to proactively identify individuals at risk of, or having already fallen out of medical care.

AIM STATEMENT

Agency E aims to increase the viral suppression rate from 85% to 88% through improved data accuracy and data-driven decision making by Dec. 31, 2023.

MEASURES

Process Measures
Hand-tracked data and compared it to PE reports; reported in weekly case consultations; proposed creative intervention.

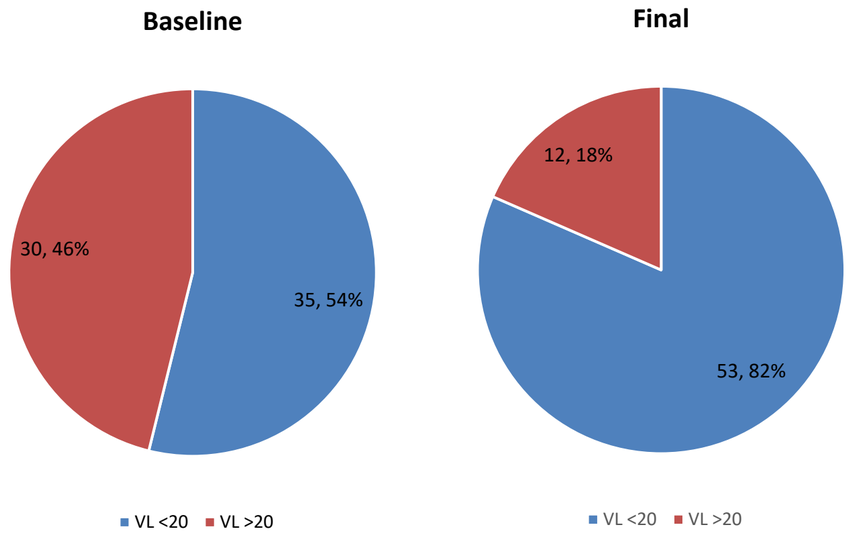
Outcome Measures
Log of viral suppression rates for the sample; case manager feedback; # and frequency of contacts.

PDSA CYCLES

Cycle 1
Plan: Identify case manager and sample.
Do: Gather baseline data and manually track rates.
Study: Compare log to PE reports.
Act: Correct inaccuracies in PE, working with PE staff to improve data pulling.

Cycle 2
Plan: Utilize hand-tracked data in weekly case consultations to identify trends.
Do: Identified the 8 least virally suppressed clients and proposed creative interventions. Increased contact attempts.
Study: Focused on similarities and disparities and proposed new interventions. Supported case managers.
Act: Instituted weekly support meetings for individuals who have engaged in chemsex. The agency extended evening hours to accommodate clients.

RESULTS



Within the sample, there was a 32% increase in clients with VL less than 20.

SUCCESSES, CHALLENGES, & NEXT STEPS

- Increased emphasis on viral loads led to increased suppression rates.
- Homelessness and substance use were the top detractors of medication adherence.
- Case managers do not have the time to hand-track data: this QIP is not scalable.

ACKNOWLEDGEMENTS

Home Visits Med Reconciliation & Education

Agency F

BACKGROUND

Problem statement

Our agency focused on this because we wanted to increase compliance within the Ryan White caseload seen at Agency F. We wanted to improve our numbers and retain in care patients who have not had a medical visit and/or do not have current viral load and CD4 values within six months from their last visit.

AIM STATEMENT

Agency F seeks to increase compliance improvement by 1%, from 92% to 93% compliance, within the Ryan White caseload seen at Agency F, focusing on retaining in care patients who have not had a medical visit and/or do not have current viral load and CD4 values within six months from their last visit, by 1/31/24 by implementing interventions.

MEASURES

Process Measures

Medication reconciliation during home visits will help ensure that the client is safely taking medication as prescribed by provider(s). Effectiveness will be measured by improved viral load and lab values, checking lab results and reports that shows follow up appointment was made on same day as kept appointment.

Outcome Measures

Medication reconciliation and tracking viral load suppression, follow up appointments. Provide Enterprise (PE), Tracking appointment reports.

PDSA CYCLES

Cycle 1

Plan: Implementing home visits to re-reengage clients, assess change in level of care, and medication reconciliation.

Do: We did home visit to reconcile medication and interview patients

Study: Improvement in viral load suppression and compliance with treatment plan and scheduled medical appointments.

Act: We identified several barriers to care and worked to overcome them in order to reengage and retain patients in care.

_____

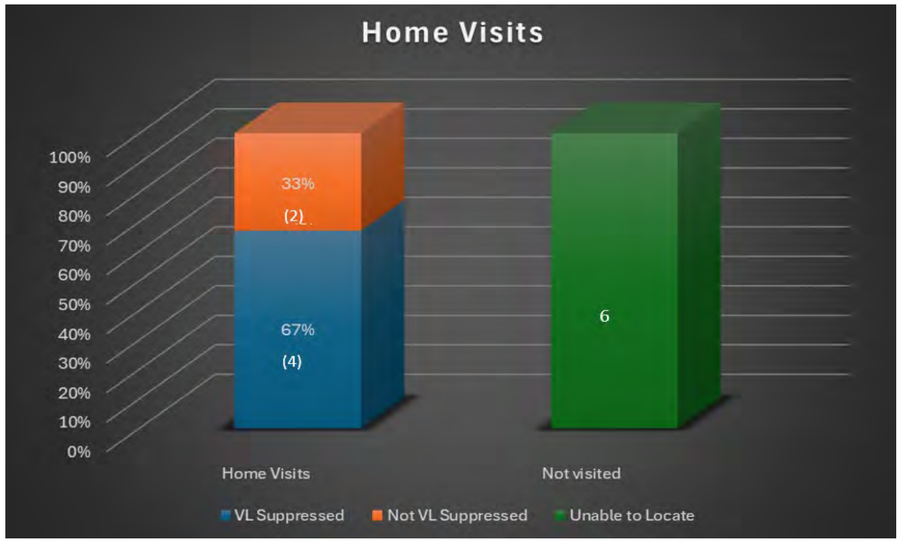
Plan: Pairing Behavior health Peers with patients brought back into care for a smoother transition

Do: When the home visit was over, we offered patients an appointment with a BH peer

Study: This improved compliance with appointments and assisted patients emotionally

Act: We identified that some of patients had emotional barriers and the best way to over come them was reengaging the patient with a provider and BH peer to retain in care

RESULTS



Explanation 1: Out of 12 home visits we have seen 6 patients, 2 brought back to care, the other 4 retained, and 6 unsuccessfully reached.

SUCCESSES, CHALLENGES, & NEXT STEPS

62.5% of the patients were either VL suppressed or retained in care because of the intervention We increased our retention in care by 0.5% from 92% to 92.5%. This was lower than our target goal, however given the success of the intervention we are doing another cycle to determine if we adopt or abandon the solution.

We had issues receiving the authorization from the county to start the home visits. Moreover, we had issues with obtaining necessary equipment to mobilize.

ACKNOWLEDGEMENTS

Increase attendance to Medical Appointments

Agency G

BACKGROUND

- Many clients do not attend their medical appointments.
- Clients out of care are at risk for AIDS.
- Only 65% of our clients attended their medical appointments

AIM STATEMENT

Agency G aims to increase attendance to medical appointments from 65% to 75 % by February 2024.

MEASURES

Process Measures

Monitor the number of clients attending their doctor's appointments monthly.

Outcome Measures

Use PE to track the improvement in medical appointment attendance.

PDSA CYCLES

Cycle 1

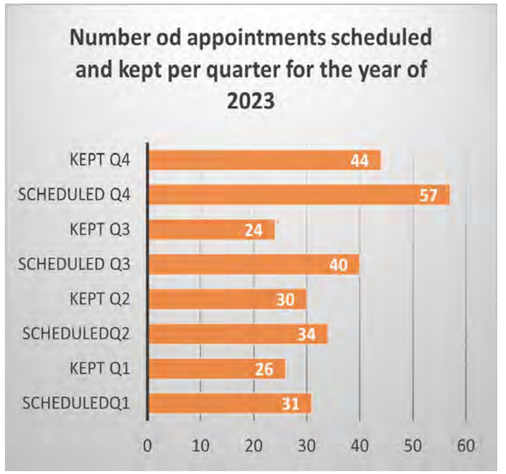
Plan: Educate the clients to understand
HIV, the importance of treatment, and the services related to HIV population.

Do: Clients share with the case manager their own experiences and concerns regarding challenges they are encountering.

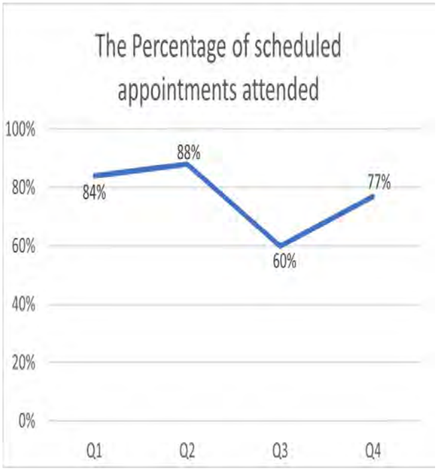
Study: Agency G monitors the attendance via Excel spreadsheet and surveys.

Act: Agency G made more contact with clients to motivate them with their appointment and treatment.
Agency G assisted them on issues such as transportation through bus passes, and communication when language is a barrier.

RESULTS



Increase rate: The attendance of clients to the medical appointments increased by 10%.



In Q3 some clients had their RW expired, and the renewal delayed the appointments attendance.

SUCCESSES, CHALLENGES, & NEXT STEPS

- Transportation has been an issue for clients to attend appointments and some clients even forget appointment time.
- Those issues were overcome by CM providing support for transportation.
- Follow-up of appointment time was done to make sure they did not forget.

ACKNOWLEDGEMENTS

Addressing Client Retention Rate

Agency H

BACKGROUND

- Problem statement: Retention in Care
- Why did your agency focus on this? To ensure clients are In-Compliance with their HIV Care & Treatment and Medications

AIM STATEMENT

To increase the retention rate of clients from 88% to 90% by conducting a client call-back protocol for Hispanics/Latinx and Non-Hispanic White clients utilizing Agency H services by December 2023.

MEASURES

Process Measures
Monthly Calls

Outcome Measures
Data Used: PE , Quarterly Report and Satisfaction Survey

PDSA CYCLES

Cycle 1
Plan: Counselors to continue to be involved in the process for signing up clients for RW Services.

Do: Initial appt with AHF, pre-register with Care Resource

Study: Quarterly Report Q1(Mar-May) & PE

Act: all services have been met

Cycle 2
Plan: Prioritize into Care

Do: Continue to link for appt for HIV Care &Treatment, Labs,30days of Meds, Appt for RW Part A & ADAP

Study: Quarterly Report data Q2 June-Aug 23 96(80.67%)

Act: Additional Service needed (Dental, Food Bank, Bus Passes.

Cycle 3
Plan: Manage small Caseload

Do: Empower Clients

Study: Retention of Care Q3 Sept-Nov increased 98(80.67%)

Act: All services have been met

RESULTS

Quarterly Report Data FY23-24 Q1 & Q3 Results

SUCCESSES, CHALLENGES, & NEXT STEPS

- What went well: Retention in Care has increased as planned.
- What went wrong? Only barriers I face where meetings & training fall on the same day and time
- I was able to move forward with this QIP

ACKNOWLEDGEMENTS

All About Accessibility

Agency I

BACKGROUND

Will utilization of Ryan White-funded legal services increase by identifying and/or eliminating barriers?
Why? Historically, clients that utilize RW Part A support services generally have a higher rate of retention and better viral suppression

AIM STATEMENT

Agency I aims to increase client satisfaction and utilization of "legal services" from FY 22-23 Qs2-3 utilization by 5% by end of FY 23-24 Q3 in client's that use RWA "legal services".

MEASURES

Legal Server *(agency case management software)*
Provide Enterprise *(client utilization)*
Client Surveys *(save in Survey Monkey and Legal Server)*
Excel spreadsheet *(internal tracking for certain PDSA cycles)*

PDSA CYCLES

Increase utilization of Ryan White-funded legal services by improving accessibility

Cycle 1

Plan: Provide options for remote and in-office appointments
Do: track client preference
Study: client survey; track in Excel; results in LegalServer case notes
Act: Adapt/Adopt

Cycle 2

Plan: Identify possible barriers for potential **new** clients
Do: poll case managers/providers
Study: track in Excel (and LegalServer if case file opened)
Act: Adopt

Cycle 3

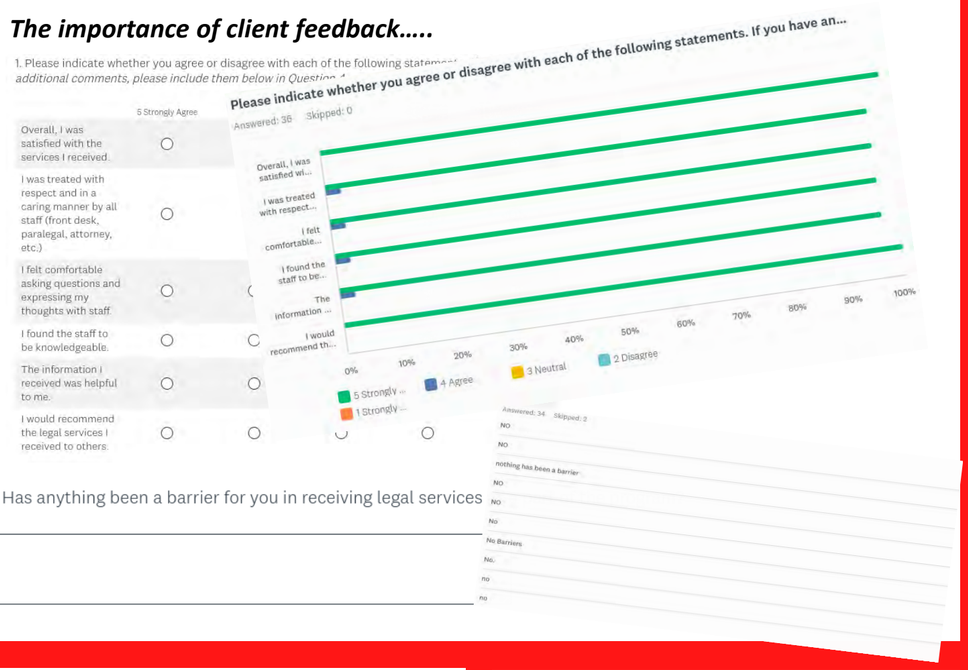
Plan: Track barriers for **potential** or **new** clients
Do: ask client experience at initial intake/call-in
Study: track in Excel (and LegalServer if case file opened)
Act: Adopt

Cycle 4

Plan: Identify/track actual and potential barriers for **current** clients
Do: case closure survey
Study: Survey Monkey
Act: Adopt

RESULTS

The importance of client feedback…..



SUCCESSES, CHALLENGES, & NEXT STEPS

- Surveys! Easy to measure outcomes (quantifiable) but low-completion rates
- Barriers – difficult to quantify; small client sample; incomplete data
- Adopt most activities…

…continue surveys & case notes; Excel tracking to burdensome

"legal services" issue – difficult to find non-medial activities to affect retention and suppression rates

Tackling Mental Health

Agency J

BACKGROUND

- The Division of Infectious Disease noticed that a percentage of our patients that are not virally suppressed also had a positive PHQ 2/9 results and no linkage to Mental Health services.

AIM STATEMENT

Agency J's Division of Infectious Disease aims to increase viral suppression on patients with a positive PHQ 2/9 result from 77% to 85% by December 2023.

MEASURES

Process Measures

Through our EHR system, No-show and Lab results reports were run to track patients' compliance.

Outcome Measures

We tracked compliance by reviewing lab results and compliance with Mental Health appointments.

PDSA CYCLES

Cycle 1

Plan: How does linking patients with a positive score and detectable viral load to mental health impacts their viral load.

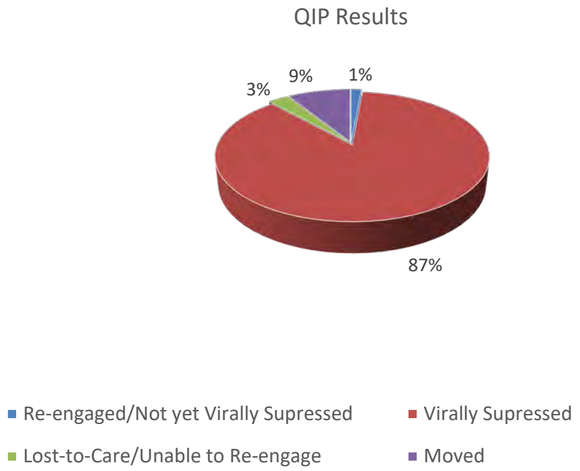
Do: Refer and provide mental health services to the patients as well as address any additional barriers to care

Study: The data has shown us that patients who agree to mental health services and maintain compliance with MH care have successfully lowered or suppressed their overall VL.

Act: We adopted the cycle as we noticed that with MH counseling the patient became more compliant in their medical care. This led the patient to ultimately become virally suppressed.

RESULTS

Our QIP was successful! We were able to achieve and exceed our original goal of achieving 85% of VL suppression and ended up with 87% of patients who had a positive PHQ2/9 become virally suppressed.



SUCCESSES, CHALLENGES, & NEXT STEPS

- Once of the successes was the patients being receptive to appointments with the Mental Health counselor.
- The main roadblock that we faced with this specific patient population was the co-morbidities that come along with it.
- It has shown that linking patient's who have a positive PHQ2/9 to MH care can improve their VL suppression as well as their overall medical/health compliance.

ACKNOWLEDGEMENTS

The C4 Program

Agency K

BACKGROUND

Many of our patients find it hard to manage their oral health due to the extensive amount of care they require. Agency K would like to make this easier for patients to manage by expediting their treatment with weekly appts. and providing them with the tools needed to maintain good hygiene at home.

AIM STATEMENT

Agency K aims to improve agency processes and increase our retention rate by 2% by December 31, 2023.

MEASURES

Process Measures
All patients were tracked to ensure they were coming in for appts. and that their oral health was improving.
Outcome Measures
Each patient in the C4 Program has been tracked at 3-month intervals following the completion of the program.

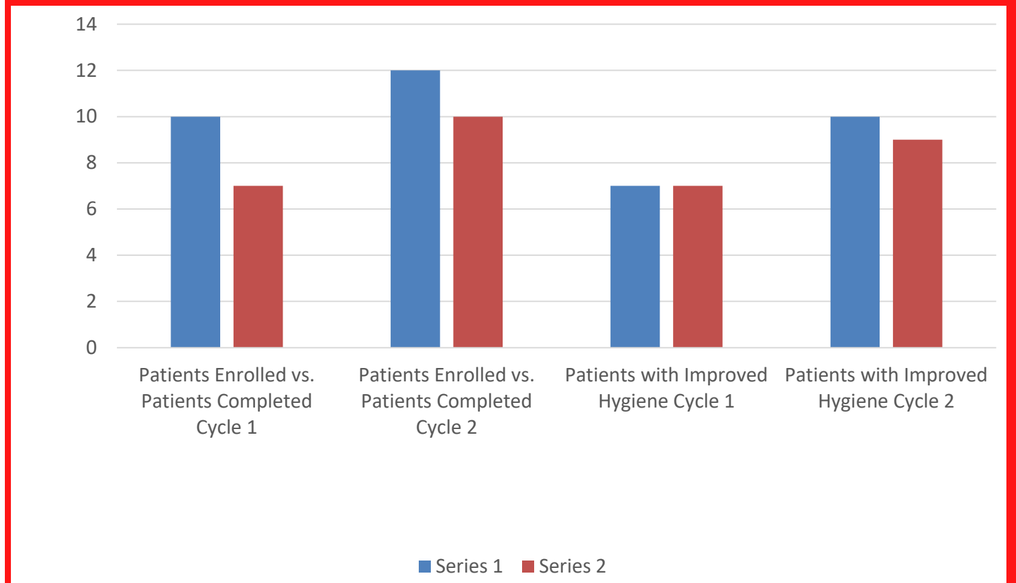
PDSA CYCLES

Cycle 1
Plan: 4-10 patients needing a minimum of 10 fillings will be selected for the C4 Program. Patients will receive longer weekly appts. to expedite their treatment. Once completed, patients will receive a Waterpik/Electric toothbrush combo to maintain good home hygiene.
Do: 10 patients were selected to join the program.
Study: 7/10 patients were able to complete the disease management phase of their treatment within 3 months.
Act: Requirements were lowered from a minimum of 10 fillings to 6 fillings.

Cycle 2
Plan: Requirements lowered to allow more patients to join.
Do: 12 patients were selected and agreed to join program.
Study: 10/12 patients were able to complete the disease management phase of their treatment within a 3-month timeline.
Act: Requirements will be increased back to 10 fillings to ensure we can complete each patient within the timeline.

RESULTS

C4 Program Findings



SUCCESSES, CHALLENGES, & NEXT STEPS

- Most patients that agreed to join the C4 Program completed their treatment within 3 months and have maintained good oral hygiene following their treatment.
- Two patients lost their Ryan White dental benefits, and three patients just stopped coming for treatment.
- We plan to continue with this project into next year.

ACKNOWLEDGEMENTS

Looking Back, Moving Forward Using Data

Agency L

BACKGROUND

- Gap in Medical Care/Lab Work and Pharmacy Pick up Date and Client information update in software systems.
- Document improvement or needs of improvement with data.

AIM STATEMENT

Agency L Staff will update Client information in all Client software systems at the appointment.
By 01/01/24 92%of Clients will be VS/ 95% will be on ARV and 98% will be retained in care.

MEASURES

Process Measures
Weekly quality check on a sample of Client that was billed out.

Outcome Measures
Broward outcome Report

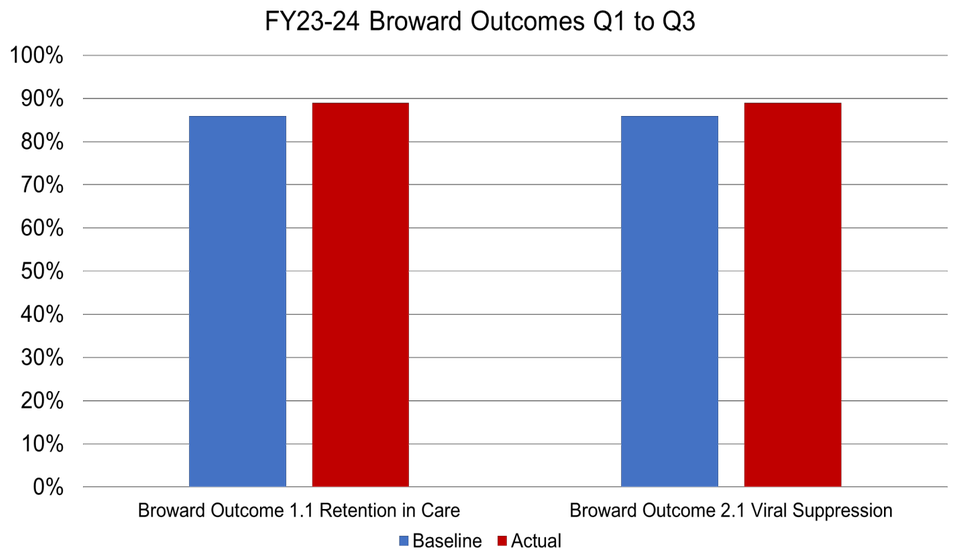
PDSA CYCLES

Cycle 1
Plan: Updating in real time
Do: CR Staff update with Clients in real time
Study: Too long to update
Act: Change

Cycle 2
Plan: Updating by the end of the Day by Software systems
Do: Each staff member will update one Software systems by the end of the day.
Study: Still Slow
Act: Move with this Cycle for the next three months.

Cycle 3
Plan :Back to Cycle 1
Do: updated in real time
Study: decreased in updating is necessary.
Act :Continue in real time

RESULTS



SUCCESSES, CHALLENGES, & NEXT STEPS

- Clients' involvement in QIP was an important part of updating.
- Some barriers are time of updating, not having Lab work and PE.
- Agency L will have ongoing training and updating in real time and if needed setting Client appointments for services

ACKNOWLEDGEMENTS

Handout C3

Quality Improvement Project (QIP) Summary per Agency

FY2023-2024

Agency A

Aim Statement: To increase the number of virally suppressed Black African American (BAA) males and females in our closed cohort from 0 to 28 by March 2024.

Summary: The goal was to increase those not virally suppressed in the subpopulation of BAA males and females by utilizing medical case managers and non-medical case managers to help identify and remove barriers to care for those not virally suppressed. Those who identified to have mental health barriers were contacted to make a referral for mental health services. The results are as follows:

- Overall viral suppression increased by 38% after the QIP intervention.
- Staff identified myriad barriers to care, the most prominent of which are housing, mental health, and substance use.
- Mini-PDSA focused on mental health was unsuccessful.

Overall, there was a 38% increase in viral suppression after the intervention of the QIP. The agency will continue to implement this QIP through the Impact Now Collaborative program and will implement a different PDSA within the larger cohort of not virally suppressed clients.

Agency B

Aim Statement: To increase PrEP patient services from six to fifteen by December 31, 2023, in high-risk patients between the ages of 18 and 64.

Summary: To increase PrEP patient services, there were a few measures put into place such as PrEP provider training, outreach, and prescribing. For PrEP provider training, the agency had the medical providers complete a self-paced virtual training about the agency's internal process for PrEP services and program objectives. To increase PrEP prescribing, providers used the PrEP initiation/assessment tool in EPIC and then referred patients to PrEP. This also included self-referred patients and serodiscordant couples. To improve PrEP outreach, they increased PrEP program visibility online, during outreach events, and around the offices. They started the project with six patients and increased to sixteen by December 2023. Four of their patients are on the Apretude injection, while the other twelve are taking the oral regimen. This QIP allowed the agency to fully assess their take on the Status Neutral Approach to PrEP. The top three social determinants of health (food, housing, and transportation) are considered part of the intake assessment for PrEP.

Agency C:

Aim Statement: To identify and improve Provide Enterprise (PE) process issues, barriers related to client appointments, client and provider compliance with data accuracy, and timely data input into PE.

Summary: The agency developed a QIP that focused on the issues surrounding data accuracy and validity. Their goal was to increase its Broward Outcomes and Indicators measure from 81.2% to 85% by December 2023. They wanted to achieve their goals by improving client communication and engagement, provider communication and engagement, and client and provider compliance with medical care appointment(s), and data input into PE. By December 2023, the agency increased its Broward Outcomes and Indicators 1.1 to 84.85%. Although they did not reach their goal, they identified many issues that will continue to impede progress if accurate and timely data and PE alerts are not addressed and/or inputted into PE by all Ryan White contracted providers. Client retention efforts improved with consistent engagements and reminders about the importance of compliance and responsibility to remain in care. The agency will continue to adopt and implement their QIP "Data Accuracy Matters in Time (DAMIT)."

Agency D

Aim Statement: To increase the successful completion of action plan goals by 5% by November 2023.

Summary: The agency wanted to increase the completion of action plan goals by the agreed date. The disease case managers were responsible for reviewing action plan goals during each patient office visit and documenting their interaction in a timely manner. Overall, 85.42% of clients achieved one or more action plan goals by the target resolution date from March 2023 to November 2023. The agency faced some barriers that impacted compliance with needed services and goal completion such as patients falling out of care and social determinants of health (unstable housing and behavioral health issues). For the next fiscal year, they will continue to adopt this QIP and conduct a more granular assessment between goal completion and viral suppression.

Agency E

Aim Statement: To increase the percentage of individuals virally suppressed by 3% for clients served within the selected sample size and the accuracy of data reporting and collection.

Summary: The agency wanted to increase viral suppression by improving their data entry into Provide Enterprise (PE) to ensure that data drives case management decisions. Many of the reports run with inaccuracy because of both human and programming errors. Inaccurate data prevents the agency from identifying individuals at high risk of falling out of care or who have already dropped out of care and assessing the effectiveness of interventions. A few measures were implemented to increase viral suppression through improving data entry, such as the number of PHQ-9 screenings completed, the number of clients not virally suppressed or at-risk, the frequency of contacts/attempts with clients, frequency of case consultations, and the implementation of creative interventions to increase viral suppression through improving data entry. The results are as follows:

- 53 of the 65 individuals have a VL of 20 or below.
- 5 of the 65 have VL 20-40
- 4 of the 65 have VL 50-100

- 3 of the 65 have VL 100+
- 2 of the 65 were not seen since baseline.

Although they did not meet the goal of 85% being virally suppressed, they successfully increased the viral suppression from 35 to 53 individuals. Some barriers they faced included clients who were lost to care and the increased burden on case managers to track the data by hand and compare it to the data in PE. Homelessness and substance use were the top detractors of medication adherence. The agency will continue to work with PE to ensure accurate reporting. Their next QIP will be based on case manager feedback and focus more on the client care and effectiveness of the newly implemented interventions.

Agency F

Aim Statement: To increase compliance improvement by 1%, from 92% to 93% compliance, within the Ryan White caseload seen at the agency, focusing on retaining in-care patients who have not had a medical visit and/or do not have current viral load and CD4 values within six months from their last visit, by 1/31/24 through implementing interventions.

Summary: A few measures were implemented to help increase the compliance rate, such as home visits to re-engage clients, ensuring all patients are given follow-up appointments three months out at check-in, and viral load suppression. During their PDSA cycle, they implemented home visits to help re-engage clients, assessed the change in the level of care, and provided medication reconciliation. With the utilization of behavioral health peers, they identified that some patients had emotional barriers and the best way to overcome them was to re-engage the patient with a provider and behavioral health peer. Out of twelve home visits, they have seen six patients. Of those six patients that received home visits, two patients were brought back to care and the other four were retained in care. Their results showed that their compliance rate increased by 0.5% from 92% to 92.5%. They experienced some barriers such as patients not answering the door, patients not being comfortable with the agency representatives being at their house, and a delay in the approval of home visits which delayed the overall PDSA cycle process. The agency will attempt another cycle intervention to determine if they should adopt or abandon the QIP. They will implement a team approach where they include a medical social worker with the behavioral peer in hopes it improves the outcome.

Agency G

Aim Statement: To increase the percentage of Black Non-Hispanic and Haitian women populations attending their doctor's appointments as scheduled from 65% to 75% for the next six months.

Summary: The agency wanted to increase the percentage of Black Non-Hispanic and Haitian women populations that are attending their doctor's appointments through providing effective HIV education and transportation assistance. They also collected feedback from the clients about challenges they encountered. The results are as follow:

- Quarter 1 84% of scheduled appointments were attended.
- Quarter 2 88% of scheduled appointments were attended.
- Quarter 3 60% of scheduled appointments were attended.

- February 2024 77% of scheduled appointments were attended.

The agency identified a need for more education on HIV, the importance of attending medical appointments, and the importance of understanding CD4 and viral load suppression. They will utilize the QIP as a tool to keep improving the program and will strengthen the case manager's work through the addition of a peer educator.

Agency H

Aim Statement: To increase retention rate of clients from 88% to 90% by conducting a client call-back protocol for Hispanic/Latinx Ryan White clients utilizing the agency's services by December 2022.

Summary: To increase the retention rate of clients, this agency followed up with client appointments. The agency linked clients with linkage specialists to help schedule initial appointments with HIV care and treatment plans with other agencies. They also followed up with clients checking specific goals within three to six months. They contacted clients twice a month to ensure they remained in medical care and compliant with their medications. The retention in care did increase from quarter one to quarter three. Some issues they faced were the time it took for providers to update appointments and labs in the PE system which affected the overall data quality. The agency will adopt this QIP and work with testing counselors and linkage specialists to increase access to care for clients.

Agency I

Aim Statement: To increase client satisfaction and utilization of legal services from fiscal year 2022-23 quarters two and three by 5% by end of fiscal year 2023-24 quarter three in clients that use Ryan White-funded legal services.

Summary: To increase client satisfaction and utilization of legal services, measures such as service accessibility and identifying of barriers for new and current clients to legal services were implemented. To increase accessibility to services, the agency provided options for remote and in-office appointments by providing a survey that helped determine a client's preference. New clients received a survey to help identify potential barriers to care. Some barriers impacting survey completion included survey fatigue and paperwork burden. There were limitations to data reporting as the retention rate appeared lower in PE than what was internally tracked. Moving forward, they will look at more unique ways to directly improve client utilization of legal services and system-wide retention in care.

Agency J

Aim Statement: To improve the overall viral load suppression in patients who have had a positive depression screening (PHQ2/9) questionnaire.

Summary: The four measures used to help reach this goal were tracking appointment no-show rates, linkage to case management and peer specialist, linkage to in-house licensed clinical therapist, and addressing any barriers that prevent patients from maintaining compliance. During

the QIP cycle, the agency referred and provided mental health services to clients with a positive PHQ 2/9. Their results showed that they exceeded their goal of 85% and ended up with 87% of their clients, with a positive PHQ 2/9, virally suppressed. The main barriers that the agency faced with this specific patient population were the co-morbidities that come along with it such as substance misuse and homelessness. Another issue was engaging the clients in mental health services. They plan to adopt the QIP cycle.

Agency K

Aim Statement: To increase our retention rate by improving our patient processes. Patients needing at least ten restorations (fillings) will be offered to join our "C4 Program" that will allow them to expedite their treatment, making maintaining their oral health manageable.

Summary: To reach this goal, patients who fit the criteria were provided treatment in the C4 program, monitored at each visit, and tracked for retention rates. During the first PDSA cycle, ten patients were selected and agreed to join the C4 Program. Seven of those patients were able to complete the “disease management” phase of their treatment within the 3-month timeline. For the second PDSA cycle, they decreased the number of fillings required to allow more patients to join the C4 program. Twelve patients were selected, and ten of those patients were able to complete the “disease management” phase of their treatment within the 3-month timeline. Patients were given an electric toothbrush/Waterpik combo to maintain their oral health at home. Seventeen of the twenty-two patients enrolled in the C4 program completed their treatment. The first group of patients have all had their 3-month check-ups at least once and have improved their hygiene since starting the program. Of the second group of patients, nine have had their 3-month check-ups, and all of them have improved their hygiene since starting the program. The barriers that this agency encountered were two of the patients who had expired out of Ryan White, three patients who no longer remained in contact, and some patients who had conflicted appointments or schedules, which made it challenging to remain on treatment. The agency plans to adopt this QIP for next year and increase the number of patients enrolled from ten to twenty patients per quarter.

Agency L

Aim Statement: To close the date gaps within PE for Medical Care/ Lab Work and Pharmacy Pickups. The staff will update clients at the time of appointment.

Summary: To increase viral suppression (92%), prescribed ARV (95%), and retention in care (98%), this QIP plans to address the quality of data and the time in which it is entered into the system. The goal was to update the client data in all four database systems (Smart Choice, Athena, Quest, and PE) at the time of service. The results are as follows:

- PE: Broward Outcome Report 1.1 (Retained in care) 86% to 89%/98% of Clients Retained in care
- PE: Broward Outcome Report 2.1 (V.S) 86% to 89% / 92% of Client will be Viral Suppression
- Smart Choice: 90% -99% of Home delivered to the correct address.
- Athena: 79% to 95% of Clients are in Athena.

- Quest: 5% to 15% Clients VL out of Quest into PE.

The challenges that the agency faced included technical issues, potential discrepancies between databases, and the need for a robust system to manage updates effectively. The next QIP will be focused on maintaining positive interactions and resolving issues effectively.

Priority Setting & Resource Allocation Committee (PSRA) & Community Empowerment Committee (CEC)

Present:

Handout D

Moderator: Elizabeth "Coach Kitty" Davis

THE 2024 HIVPC RYAN WHITE PART A LISTENING TOUR

SAVE THE DATE

We want to HEAR from YOU!

Your ISSUES
Your RECOMMENDATIONS!

Topic:

The Challenges of Living Healthy with HIV in Broward County

Wednesday
24 April

AIDS HEALTHCARE FOUNDATION COMMUNITY ROOM (AHF)

700 SE 3rd Ave
1st Floor
Fort Lauderdale, FL 33316

3 PM- 5 PM

Broward HIV Planning Council

BrowardHIVPC

Door Prizes Available

REFRESHMENTS WILL BE SERVED

REGISTER HERE:
HTTPS://US02WEB.ZOOM.US/J/84221674634

LIVE

THIS IS AN AUDIO RECORDED PUBLIC EVENT

HIV HEALTH SERVICES PLANNING COUNCIL
MEETING GROUND RULES

1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.

2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.

3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.

4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.

5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.

6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.

7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.

8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.

9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.

10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.

11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

Revised 7/24/14

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH REGLAS BÁSICAS DE LA REUNIÓN

1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.

2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.

3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.

4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.

5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.

6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.

7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.

8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.

9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.

10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.

11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV
RÈGLEMAN RANKONT-YO

1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.

2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.

3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.

4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priyorite sou lòt manm-yo.

5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.

6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.

7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respektè menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.

8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.

9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.

10. Vye langaj, menas vyolans, oswa posesyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.

11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.

Acronym List

ACA: The Patient Protection and Affordable Care Act 2010

ADAP: AIDS Drugs Assistance Program

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BISS: Benefit Insurance Support Service

BMSM: Black Men Who Have Sex with Men

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CM: Case Management

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

DCM: Disease Case Management

DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
HAB: HIV/AIDS Bureau
HHS: U.S. Department of Health and Human Services
HICP: Health Insurance Continuation Program
HIV: Human Immunodeficiency Virus
HIVPC: Broward County HIV Planning Council
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development
IW: Integrated Workgroup
IDU: Intravenous Drug User
JLP: Jail Linkage Program
LPAP: Local AIDS Pharmaceutical Assistance Program
MAI: Minority AIDS Initiative
MCDC: Membership/Council Development Committee
MCM: Medical Case Management
MH: Mental Health
MNT: Medical Nutrition Therapy
MOU: Memorandum of Understanding
MSM: Men Who Have Sex with Men
NBHD: North Broward Hospital District (Broward Health)
NGA: Notice of Grant Award
NHAS: National HIV/AIDS Strategy
NOFO: Notice of Funding Opportunity
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University
OAHS: Outpatient Ambulatory Health Services
OHC: Oral Health Care
PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

PROACT: *Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward's treatment adherence program.*

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SA: Substance Abuse

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

Recipient: Government department designated to administer Ryan White Part A funds and monitor contracts.

Planning Council Support (PCS) Staff/'Staff': Provides professional staff support, meeting coordination, and information to the HIVPC, its standing and ad-Hoc Committees, Chair, and Recipient.

Clinical Quality Management (CQM) Support Staff: Provides professional support, meeting coordination, and technical assistance to assist the Recipient through analysis of performance measures and other data with the implementation of activities designed to improve patient care, health outcomes, and patient satisfaction throughout the system of care.

Provider/Sub-Recipient: Agencies contracted to provide HIV Core and Support services to consumers.

Consumer/Client/Patient: A person who is an eligible recipient of services under the Ryan White Act.