INLAND EMPIRE HIV PLANNING COUNCIL

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Riverside/San Bernardino California Transitional Grant Area

Cameron Kaiser, MD
Interim County Health Officer Co-Chair

Henry Nickel
Community Co-Chair

Continuum of Care Committee

Thursday, February 02, 2012
9:30am-11:30am

Meeting Location
San Bernardino County
Department of Public Health
120 Carousel Mall
San Bernardino, CA 92415
(909) 388-0426/PCS Mobile (909) 693-0750

Teleconference Site
Desert AIDS Project
Situation Room, West Wing
1695 North Sunrise Way
Palm Springs, CA 92262-3702
(760) 323-2118

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Agenda

9:30	**1. Call to Order** ▪ Roll Call* ▪ Introductions	L. Ford-Watson
	2. Public Comments[1]	Members of the Public
	3. Members Privilege	PC Members
	4. Approval of Agenda[2]	L. Ford-Watson
	5. Approval of Minutes[2] 5.1 Minutes of January 12, 2012	L. Ford-Watson
	6. Old Business[2] 6.1 Comprehensive HIV Plan • Provide input in the development of the Comprehensive Plan (A-1) • Address Chapter 11 of the 2009-2012 Comprehensive Plan, Monitoring and Evaluation of Plan (A-2)	Subcommittee Members

	7. Public Comments[1]	Members of the Public
	8. Members Privilege	PC Members
	9. Review of Action Items	PC Staff
	10. Agenda Setting for Next Meeting	PC Members/ L. Ford-Watson
	11. Roll Call*	PC Staff
9:30	**12. Adjournment**	L. Ford-Watson

[1] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.

[2] The agenda item may consist of a discussion and a vote. Public comments can be made prior to each Planning Council vote.

* Members must be present at both roll calls to receive credit for meeting attendance.

** Attachment was not available at time of printing, but will be available at the meeting.

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Introduction

A. Overview: ↓ What's New for the 2012 Comprehensive Plan? ↓

1. **Monitoring and Evaluation**
   Grantees are required to evaluate their 2009 Plan successes and challenges…

2. **Early Identification of Individuals with HIV/AIDS (EIIHA)**
   This is a legislative requirement that focuses on individuals who are unaware of their HIV status and how to identify and bring them into care…

3. **The National HIV/AIDS Strategy**
   The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

4. **Healthy People 2020**
   National initiative led by HHS and sets priorities for HRSA. It established new 10-year national objectives for improving the health of Americans The plan should address the 2 major goals (1) increase quality and yrs of a healthy life and (2) eliminate health disparities..

5. **Affordable Care Act (Healthcare Reform)**
   The intent is to expand health insurance coverage and the Plan should outline how efforts are coordinated with and adapt to changes that will occur with its implementation.

B. 2012 Comprehensive Plan Outline ↓

I. Where are we now?

Summary: HAB defines a continuum of care as- "An integrated service network that guides and tracks clients through a comprehensive array of clinical, mental, and social services in order to maximize access and outcomes.: - The purpose of this section is to identify populations in most need of HIV care and services as well as barriers to care, provide an overview of the current state of HIV healthcare and service delivery, as well as identify progress and shortfalls.

II. Where do we need to go?

Summary: The purpose of this section is to provide an opportunity to discuss your jurisdiction's vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system. The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative supports all three National HIV/AIDS Strategy (NHAS) goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

III. How will we get there?

Summary: The purpose of this section is to describe the specific Strategy, Plan, Activities, and Timeline associated with achieving specified goals and meeting identified challenges.

IV. How will we monitor progress?

Summary: The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored.

RYAN WHITE PROGRAM ***PLAN FOR DEVELOPMENT OF THE*** **2012 Comprehensive HIV Services Plan** **SEPTEMBER 14, 2011**

	October 2011	November 2011	December 2011	January 2012	February 2012	March 2012	April 2012	May 2012
Tasks: →	***I. Where are we now?*** A.1. Epi Profile **RWP** A.2. Unmet Nd **RWP** A.3. EIIHA **RWP** B.1. RW Svs **RWP** B.2. NonRW Svs **RWP** B.3. Interface **RWP** B.4. Impact/Cuts **RWP** C.1. Care Nds **R&P** C.2. Capacity Dev **R&P** D.1. Demos **RWP** D.2. Needs **R&P** E. Gaps/Care **R&P** F. Prev/Svc Nds **RWP** G. Barriers to care G.1. Testing **R&P** G.2. Program **R&P** G.3. Providers **RWP** G.4. Client **R&P** H. 09 Eval **R&P** **Develop** strategies, plan, activities and timelines **PC**	***II. Where do we need to go?*** A. Plan Challenges **R&P** B. Care Goals **RWP** C. Unmet Nd Gls **RWP** D. EIIHA Gls **RWP** E. Closing Gaps **R&P** F. Rdcing Overlap **R&P** G. Coordination **RWP** **Determine:** -How proposed plan reflects the CA Statewide Coordinated statement of need **PC** -How plan addresses Healthy People 2020 objectives **PC** -How the plan addresses Affordable Care Act **PC** -How the plan addresses National HIV/AIDS strategy **PC**	***III. How will we get there?*** A. Close gaps **R&P** B. Aware/not in care **R&P** C. Unaware **R&P** D. Special Pops **R&P** E. Coordination **RWP** F. Hlthy People2020 **R&P** G. SCSN **R&P** H. Nat'l HIV Strategy **RWP** I. Unanticipated **RWP** **Set up** draft plan review process (On-line & On-site) **PC**	***IV. How will we monitor?*** A.1. CLD **RWP** A.2. Utilization **RWP** A.3. Outcomes **RWP** **Compile** text, graphics of draft Comp Plan **PC** **Prepare** Executive Summary **R&P**	**Release** draft Comp Plan for review and comment **PC**	**Revise** draft plan to reflect public comment **PC**	**Approve** Plan **PC**	**Submit to HRSA** **RWP**
Tasked to: →	**RWP:** *Ryan Program Staff*	**PC:** *Planning Council & Staff*	**R&P:** *Joint Responsibility*					
Resources Needed: →	ARIES reports PC Input PC Staff Needs Assessment Data RWP Staff	PC Input PC Staff Part C &B input County STD Programs CA State Medicaid Info FQHCs RWP Staff	PC Input PC Staff RWP Staff Part C input Part B input	PC PC Staff RWP Staff ARIES Data EHARS Data	List of locations Media Stakeholder info			

GLOSSARY FOR CONTINUUM OF CARE

ADAP treatments --AIDS Drug Assistance Program is a State-administered program authorized under Part B of the Ryan White Program that provides FDA approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. NOTE: This does not include child care while a client is at work.

Complementary Care

Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. **(EIS)** includes counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting,or under the supervision of a physician, or by other qualified personnel.

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health Education/Risk Reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Health Insurance Premium & Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home and Community-based Health Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are NOT included.

Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Housing and Access Support Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services include the provision of interpretation and translation services.

Medical Care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Medical Case Management Services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Oral Health Care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Pediatric developmental assessment and early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV affected clients, and education/assistance to schools should also be reported in this category.

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Rehabilitation services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Sexual Health Promotion

Substance abuse services–residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

SECTION FOUR

HOW WE WILL MONITOR OUR PROGRESS: EVALUATING OUR PROGRESS IN MEETING OUR SHORT AND LONG-TERM GOALS

Chapter 11: Monitoring and Evaluation of Plan

Monitoring and Evaluation of the Comprehensive HIV Services Plan

The Evaluation Subcommittee of the Clinical Quality Management Committee will assume responsibility for monitoring and updating the Comprehensive HIV Services Plan on an annual basis. Short-term and long-term goals will be reviewed and monitored and changes made in the Plan will be based on changes in the epidemic, service needs, provider capacity, and resources in the TGA. The annual review will also take into account the legislative, regulatory, health service delivery, and treatment changes that will affect the system of care.

Assessment of the compliance of the Planning Council with HRSA requirements is also part of the evaluation responsibilities. The Council support staff, in collaboration with the Evaluation Subcommittee will develop an evaluation template that will be used to monitor the Council's accomplishment of the tasks required to perform, such as timely posting of minutes on the web site, evaluating the Ryan White Program Office, and adequately training new council members on core competencies. Accomplishments of these objectives will be documented and reported to the Evaluation Subcommittee.

The IEHPC 3-year *Comprehensive HIV Services Plan* includes objectives for each of the next three years that support the goals developed through the TGA's community planning process. Evaluating the implementation process and outcomes that result from these objectives is a collaborative process that involves the PC & the RWP Staff.

CLINICAL QUALITY MANAGEMENT

Description of Clinical Quality Management Program (CQM)

CQM Structure, Vision/Mission, and Goals: The TGA is committed to implementing its Clinical Quality Management (CQM) activities with input from PLWHA consumers of RWP Part A/B/ MAI services, HIV service providers, and the Inland Empire HIV Planning Council (IEHPC). The CQM Program ensures *"that all RW eligible PLWHA in the Riverside/San Bernardino, CA TGA receive high quality medical care and support services to maintain them in care."*

- **Overall Purpose and Goals**

The purpose of the TGA's CQM Program is to: (1) Assist medical providers in assuring that services adhere to IEHPC standards of care and established

HIV clinical practice standards of care, the *United States Public Health Service (USPHS) guidelines*, and *Guidelines for Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*; (2) Provide mechanisms to identify opportunities for service improvement; (3) Improve desired patient outcomes; and (4) Use the results of these activities to develop and recommend "best practices." The TGA's CQM Plan provides an overall guide to assist service providers in developing agency-specific CQM plans. The request for proposals process (RFP) informs potential applicants of quality-related expectations for each service category. The RFP requires applicants to respond to how they will meet specific CQM requirements, including data and reporting requirements. The selected and funded service providers are then contractually required to develop and implement CQM Plans with measurable, time-limited goals that capture the various CQM requirements.

- **Roles of Staff and CQM Workgroup Responsible for Overseeing CQM Activities**

The Clinical Quality Management Workgroup, led by the CQM Coordinator, implements all CQM activities for the RWP. The Workgroup is comprised of RWP CQM staff, service providers, service-specific experts, and IEHPC members who are not affiliated with any service provider. The CQM Coordinator convenes meetings of the Workgroup as needed to fulfill the goals and conduct the work of the CQM Program. All Ryan White Part A-funded service providers are contractually required to participate in the Ryan White Program Office's CQM activities. Coupled with the TGA's CQM infrastructure, this has proven an effective approach for accomplishing the mission and goals of the CQM Program, including the periodic assessment of CQM activities.

- **Internal Quality Processes to Assess Progress of the CQM Plan**

The TGA has implemented internal quality processes to monitor and assess the administrative agency (i.e., Ryan White Program Office) on the progress of the CQM plan, including the following:

1. **Intergovernmental Agreement (IGA) -** The TGA includes "quality"-related language within the IGA. It states: "Pursuant to Section 2602(a)(1), San Bernardino County shall serve as Ryan White Program Office and fiscal agent for purposes of receiving and administrating Part A grant funds including: (1) Conducting Quality Assurance Activities for the TGA, (2) Monitoring of Subcontractors, and (3) All aspects of grant management."

   The IGA holds the Ryan White Program Office accountable for quality-related activities. The IGA is developed with input from the IEHPC and negotiated between both Riverside and San Bernardino County. Once finalized, the IGA goes before both counties' Board of Supervisors and is approved by the Chief Elected Official. The annual review of the IGA is a key element of the evaluation of the administrative mechanism (EAM), which is, in turn, an integral component of the TGA's ongoing quality improvement processes.

2. **The Evaluation Of The Administrative Mechanism (EAM) -** As a component of the EAM, the Ryan White Program Office and the IEHPC negotiate an annual agreement that defines an established set of CQM reports that are regularly furnished to the IEHPC to inform their various RWP mandates. This agreement is reviewed and revised annually. The Ryan

White Program Office reports on CQM activities, as outlined in the CQM Plan.

The TGA has also implemented activities to assess the quality of services provided by providers/subcontractors. These activities include, but are not limited to: (1) Client Satisfaction Surveys; (2) Cultural and Linguistic Competency Organizational Assessments; (3) Cultural and Linguistic Competency Client Perception Assessments; and (4) Program Quality Review (including monitoring of program delivery and progress on meeting quality indicator goals).

Specific Indicators that are Monitored by Service Category: The Ryan White Program Office works with the IEHPC and service providers to establish indicators with benchmarks that are monitored for each service category.

To ensure that service providers understand CQM expectations, the Ryan White Program Office provides technical assistance, CQM-specific continuing education, and assistance in the development of agency CQM plans. The Ryan White Program Office assesses the quality of services provided by subcontractors through the annual program quality review process. This process includes the following components:

1. The Ryan White Program Office incorporates quality-related language into its request for proposals processes and Part A contracts. This language requires that all contractors adhere to the TGA's CQM Plan, develop and submit an agency-specific CQM plan, and have representatives participate in quality-centered activities conducted by the CQM Workgroup;

2. The Ryan White Program Office ensures that all RWP Part A-funded providers adhere to USPHS Guidelines and the TGA's Standards of Care (SOC) through its annual contract monitoring and program quality review process. The Ryan White Program Office provides the IEHPC with a year-end monitoring report with aggregated findings. The IEHPC considers these quality efforts as an important component of the priority setting and resource allocation process; and

3. With the CQM Workgroup, the CQM Coordinator monitors service-specific indicators to assess service quality. Through the use of its web-based management information system (known as *AIDS Regional Information and Evaluation System* or ARIES), the Ryan White Program Office is able to monitor most of these indicators on an ongoing basis. If there are any findings, the Ryan White Program Office works with the service provider to jointly develop a corrective action plan. Annually, the IEHPC reviews aggregate findings, including health outcomes, and utilizes this data in their priority setting and resource allocation process.

Data Collection Strategy Including How Data Are Collected: The TGA's data collection strategy includes: (1) collecting fiscal and contract-related data to ensure providers are meeting goals and objectives, (2) collecting outcomes-based data on clinical measures, and (3) inputting this data into ARIES. The system allows the TGA to:

- Reduce, if not eliminate, duplication of intake activities;
- Ensure accurate, reliable eligibility data gathering during intake;

- Efficiently gather service delivery data from service providers;
- Track unduplicated client numbers for reporting and planning;
- Automate the Ryan White HIV/AIDS Program Data Report (RDR); and
- Automate the client-level Ryan White Services Report (RSR).

Through ARIES, the TGA collects, analyzes, and trends client-level data for all Core and Support Services to respond to the client-level data reporting requirement (RSR) and to track unduplicated client-level health outcomes such as:

- CD4 cell counts and HIV viral loads;
- Proportion of clients with an AIDS defining opportunistic condition;
- Proportion of clients with unmet need for support services;
- Proportion of clients who are receiving regular care (utilization data);
- Proportion of PLWH who progressed to AIDS within 12 months of diagnosis; and
- Proportion of PLWH who died within 12 months of an HIV diagnosis.

Monthly, the TGA collects fiscal, contract, and program data through contractually required provider reporting. The Ryan White Program Office then aggregates the data to use for planning, allocation, and reallocation of funds; analysis of unit cost; evaluation of services; and contingency planning.

The Ryan White Program Office requires that service providers enter their unit cost and utilization data into ARIES prior to submission of their monthly invoice. This ensures, on a monthly basis, that service providers have completed data entry in ARIES in a timely manner. At the end of each fiscal year, the Ryan White Program Office prepares various aggregate reports for the IEHPC to review and to inform their priority setting and resource allocation processes, e.g., Health Outcomes Report.

At minimum quarterly, the Ryan White Program Office tracks service providers' progress in meeting stated goals and objectives. As the Ryan White Program Office identifies deficiencies, staff is able to identify early which service provider is not meeting their established targets. The Ryan White Program Office then meets with the service provider to discuss their challenges and identify a course of action for quality improvement.

Use of Data to Show how Part A-funded Services are Improving Clinical Health Outcomes:

The Ryan White Program Office has established several mechanisms to identify whether or not Part A-funded Core Services and Support Services are improving clinical health outcomes. First, the Ryan White Program Office incorporates specific clinical health outcomes, client and service outcomes, and service unit targets into contracts for all services. Second, the Ryan White Program Office quarterly monitors service providers' progress in achieving these targets through ARIES. The Ryan White Program Office also requires service providers to develop a self-monitoring process as part of their CQM plans. For example, providers are able to run a report that lets them see if they have eligibility documentation for clients.

As a TGA-wide database, the data entered into ARIES (including clinical health outcome indicators) are shared between service providers, allowing providers of Core and Support Services to assess the health of their clients. As an example, an

agency that provides only Food Services can monitor the clinical outcomes of their clients by accessing up-to-date medical data (such as CD4 and viral load test results) that have been entered by medical clinics.

Description of Data Collection and Results

Client Level Data Preparation and Use of Data: The TGA's management information system (ARIES) is currently capable of collecting virtually all of the required client-level data (CLD) elements contained in the Ryan White Services Report (RSR). The original partners responsible for creating ARIES (the State of California, the State of Texas, San Bernardino County, and San Diego County) have thoroughly assessed the system and determined the changes that need to be made to ensure that all of the RSR elements can be collected in ARIES. The next ARIES software upgrade, scheduled for November 2008, will include all of the RSR-required elements.

The TGA will then participate in a data submission trial-run being conducted by the HRSA contractor charged with assessing the effectiveness and accuracy of the extraction program used to pull the RSR-required elements from ARIES. The extraction program will then be edited according to the findings from the trial-run to ensure that the system is able to produce accurate reports for HRSA. Reporting programs are currently being written by the California State Office of AIDS ARIES systems analysts to ensure completeness of the CLD required for the RSR.

The Ryan White Program Office, service providers, and IEHPC have utilized CLD collected in ARIES for the last two years to assess and improve Clinical Quality Management. Service providers use ARIES' client-level reports to assess the clients' health status and progress (e.g. testing results, referral follow-up, and needs assessments). The Ryan White Program Office monitors CLD elements to ensure service providers are meeting targets and to identify service providers that may need technical assistance. The IEHPC reviews aggregated reports (e.g. health outcomes, utilization, and client demographic reports) prepared by the Ryan White Program Office to assess the overall quality of RW-funded services and factors these data into improving the TGA's Standards of Care. The Ryan White Program Office has developed and contractually mandated specific requirements ensuring data is complete and accurate, which will, in turn, improve the TGA's CQM program's ability to assess and improve client health outcomes.

Client Level Data (CLD) Collection and Reporting Process: All RW-funded outpatient/ambulatory health services and medical case management providers are contractually required to collect CLD, as delineated in Section II.C.8 of current contracts: *The Contractor shall be required to collect Client Level Data (CLD) and report such data in the required format to the County within the required timeframes. The County will communicate the specific data elements to be collected and the reporting formats and timeframes within the contract year.*

The Ryan White Program Office is currently drafting a policy to ensure that outpatient/ambulatory medical care and case management service providers clearly understand which CLD elements are to be reported beginning January 1, 2009. As stated earlier, State ARIES systems analysts are developing data reports that the Ryan White Program Office and service providers will run on a regular basis to

ensure completeness of the required CLD in ARIES. If deficiencies are discovered, the Ryan White Program Office will work with the respective service provider(s) to identify compliance barriers and provide technical assistance to ensure that required CLD are complete in ARIES by the time the reports are due to HRSA.

CQM Data Collected to Date and Results: The TGA collects and monitors a wide range of CQM data. Contracted providers enter, track, and analyze viral load and CD4 test results to determine the number of clients with improved and maintained health outcomes. The Ryan White Program Office trends these test data over time to evaluate the effectiveness of Part A funded services in slowing the disease progression. Through ARIES, service providers are also able to track client referral outcomes data. Providers' compare the number of referrals made with the number of referrals kept to demonstrate successful linkages to care. The reporting function in ARIES further enhances this process by generating useful reports to inform client follow-up (e.g., Referral/Linkages Report).

Table 11-1. Comparison of Select 2004 and 2008 Program Monitoring Quality Indicator Results

Service	Quality Service Indicator	TGA Compliance		Change
		2004	2008	
Outpatient/ Ambulatory Health Services	Clients in care will be screened for TB annually	61%	72%	+11%
Mental Health Services	Clients will have an individualized Treatment Plan signed by client and clinician/therapist.	83%	93%	+10%
Oral Health Services	Clients will have a follow-up prophylactic visit within 6 months of initial visit.	99%	100.0 %	+1%

During program monitoring, the Ryan White Program Office reviews indicators for medical care and other RW-funded services from individual client records and from ARIES. Table 22 shows a sample of indicators gathered during the March 2004 and March 2008 Part A program monitoring cycles. This example documents improvement in the quality of services delivered to PLWHA.

In 2007, the Ryan White Program Office added new compliance components specific for mental health and substance abuse services. The monitoring team looked for evidence of health outcomes tracking for clients that received individual and group counseling. From 2007 to 2008, mental health and substance abuse service providers demonstrated an average improvement of 5% in the collection of outcomes for these services. Thus, service providers are making concerted efforts to collect, analyze, and report mental health and substance abuse service outcomes for program clients.

Because the collection of clinical health outcomes data is relatively recent, the TGA is beginning to establish its own quality benchmarks (e.g., 85% of clients will demonstrate maintained and/or improved health outcomes). An examination of CD4 counts and viral loads among 819 clients from March 2007 through March 2008 revealed that an average of 69% of PLWHA receiving RWP-funded medical care

services had "good" (i.e., maintained or improved) counts. This represents a significant improvement from the 58% of clients with "good" counts in FY 04/05, the first year the TGA collected these types of results. Although the TGA has not reached its target goal, significant progress has been made in achieving improved health outcomes.

How CQM Data Has Been Used to Improve/Change Service Delivery:

- ***Quality Efforts Used by IEHPC in Priority Setting & Resource Allocation Process***

Annually, the TGA analyzes, synthesizes, and presents aggregate data to the IEHPC to inform their decision-making process in setting priorities and allocations. For the *PSRA 2008,* the Ryan White Program Office and Planning Council Support Staff updated, refined, and submitted to the IEHPC several quality specific reports including: the *Program Monitoring Aggregate Data*; *Program Client Profile – Basic Demographics*; *Program Client Profile – Gender by Race*; and *Program Client Profile by Service Area*. These reports facilitated the IEHPC's understanding of who is being served by RW funds (race, gender, age, insurance status, etc) and where current clients reside. A comparison of RWP utilization and HIV/AIDS prevalence data further showed where there are potential disparities in RW service provision (mostly among Latino/a and African American PLWHA). The Ryan White Program Office provided the summit participants with health outcome results by race/ethnicity for CD4 Count and Viral load data collected from RWP-funded providers. This report was provided along with service-level health outcomes data that demonstrated the positive impact on health outcomes for PLWHA receiving RWP services. For example, the data indicated that, while African American clients experienced the greatest improvement in average viral load test results, they also had a much higher "early" viral load count, suggesting they entered the TGA's system of care further along in the disease progression than White and Latino/a clients.

This information gave strengthened the IEHPC's understanding of the accomplishments as well as the deficiencies of RW-funded services in the TGA. The IEHPC utilized this information to make decisions regarding priorities and allocations. In response to the above example, the IEHPC prioritized *Outreach Services* and recommended a 24% increase in funding in order to improve case finding to identify African American and Latino/a PLWHA earlier in the disease progression and link them to care. The IEHPC further directed the Ryan White Program Office to ensure culturally appropriate marketing methods to better reach minority PLWHA. The IEHPC agreed that 100% of MAI funds would remain in Health Education/Risk Reduction to ensure focused services are provided to minority PLWHA to increase their retention in care. The TGA utilizes MAI funds to enhance the self-management skills of minority PLWHA as part of the *Chronic Care Model,* to promote retention in care and treatment adherence, thereby improving their health outcomes. The IEHPC drafted several directives to address the quality of services to minority PLWHA, including directives related to the following:

- Develop systems to assess and increase minority PLWHA satisfaction with all services.
- Develop systems to assess and increase the availability of culturally competent and linguistically appropriate services, specifically medical & non-medical case management.

- Ensure that outreach marketing campaigns are culturally and linguistically appropriate.

In response to quality data showing the positive health impact of access to outpatient medical care, the IEHPC increased the recommended funding allocation for outpatient/ambulatory health services by 38% over the current FY 08/09 allocation.

- ***Quality Improvement (QI) Projects to Improve Service Delivery***

Over the past four years the TGA has taken major steps to improve service delivery through the implementation of quality improvement projects. The TGA's first project in FY 04 was to complete a CQM Plan that would establish a formalized CQM program in the TGA, including initial steps to develop specific health outcomes indicators. In September 2007, a review of the CQM accomplishments revealed that the TGA had met 100% of its original CQM Plan goals (e.g., Established a Clinical Quality Management committee on the IEHPC; Established outcome indicators for all service categories; Established a CQM Workgroup through the Ryan White Program Office's Office to facilitate CQM; Designated key CQM Staff in the Ryan White Program Office's CQM Office; etc.)

More recently, in response to HRSA's new service definitions and new developments in Clinical Quality Management (CQM), the IEHPC's Clinical Quality Management Committee decided to revise the TGA's standards of care (SOC) for all RW-funded service categories. A consultant was secured in January 2008 to provide expertise and draft a complete set of service standards (19 in total). These standards were then reviewed by RW service providers, non-RW service providers, and others with expertise related to the various services. 14 individuals participated in the "expert reviews" and provided invaluable feedback and advice to the CQM Committee. The Committee is currently reviewing the drafts and feedback from experts and expects to have a complete set of newly revised SOC by the end of 2008.

INLAND EMPIRE HIV PLANNING COUNCIL

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Riverside/San Bernardino California Transitional Grant Area

Cameron Kaiser, MD
Interim County Health Officer Co-Chair

Henry Nickel
Community Co-Chair

Continuum of Care Committee

Thursday, January 12, 2012
10:00am-12:00pm

Meeting Location*
Riverside County
Beaumont Civic Center
550 E. 6th St.
Beaumont, CA 92223
(909) 388-0426/PCS Mobile (909) 693-0750
*Teleconferencing is not available at this location

These facilities are in full compliance with the Americans with Disabilities Act of 1992.

Minutes

Attendees: G. French, B. Contreras, C. Harris, L. Ford-Watson
Guest: K. Fillippelli, D. Karr, A. Gomez
PCS: A. Soria

10:00	**1. Call to Order** ▪ Roll Call* ▪ Introductions	L. Ford-Watson
	2. Public Comments[1] None	Members of the Public
	3. Members Privilege L. Ford welcomed back old and new committee members to the Continuum of Care Committee.	PC Members
	4. Approval of Agenda[2] Motion to approve: C. Harris/B. Contreras Motion carried	L. Ford-Watson
	5. Approval of Minutes[2] 5.1 Minutes of December 15, 2011 Motion to approve: B. Contreras/G. French G. French/L. Ford- Watson abstained. Motion carried.	L. Ford-Watson

	6. Old Business[2] 6.1 Comprehensive HIV Plan • Provide input in the development of the Comprehensive Plan (A-1) Motion to incorporate the glossary to the Continuum of Care and Prevention Chart. B. Contreras/G. French Motion carried. • Address Chapter 11 of the 2009-2012 Comprehensive Plan, Monitoring and Evaluation of Plan (A-2)	Subcommittee Members
	7. New Business[2] 7.1 Roles and Responsibilities (A-3) Committee members read and reviewed the Roles and Responsibilities of the committee.	
	8. New Business	
	9. Public Comments[1]	Members of the Public
	10. Members Privilege	PC Members
	11. Review of Action Items PCS will make incorporate the Glossary into the Stages of Life. The Committee requests the attendance of the Ryan White Program at the next meeting. The committee request… Guidance and information on Chapter 11. What's changed? Data collection? ARIES Development? Strategies? Where are you with Provider request? What needs to be updated?	PC Staff
	12. Agenda Setting for Next Meeting	PC Members/ L. Ford-Watson
	13. Roll Call*	PC Staff
12:00	**14. Adjournment**	L. Ford-Watson

[1] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.

[2] The agenda item may consist of a discussion and a vote. Public comments can be made prior to each Planning Council vote.
* Members must be present at both roll calls to receive credit for meeting attendance.
** Attachment was not available at time of printing, but will be available at the meeting.

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