2009

Quality Improvement Plan

NASSAU-SUFFOLK

EMA

November 25, 2009

Nassau-Suffolk Eligible Metropolitan Area
2009 Quality Improvement Plan

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PURPOSE

The **Ryan White HIV/AIDS Treatment Modernization Act Part A** mandates that each jurisdiction have a Quality Improvement plan that functions as the vehicle for examining how well the EMA performs in executing program priorities and strategies. The focus is not on the performance of individual agencies/contractors, but rather on how the system is working to improve HIV care.

In addition to an EMA Quality Improvement Plan, there should be individual organizational Quality Improvement plans for every contracted provider that delineates goals and objectives towards attainment of the contracted service goals. HRSA recommends a nine (9)-step model towards achieving Quality Improvement, consisting of:

1. **Commit Leadership & Supportive Organizational Structure**
   - Establish support of program leadership for Quality Improvement
   - Delineate specific Quality Improvement responsibilities of staff
2. **Establish Quality Improvement Plan**
   - Establish Quality Committee to oversee the Quality Improvement program
   - Develop an organizational Quality Improvement plan which delineates goals and objectives for the QI program
3. **Determine Performance Measures & Collect Data**
   - Based on QI priorities, develop/adopt indicators to measure performance
   - Determine method of data collection and collect data
4. **Analyze Data**
   - Analyze data and review the results
   - Identify areas where additional data is required
5. **Develop Project-Specific CQI Plan**
   - Establish project-specific QI team to improve specific aspects of care/services
   - Develop timeline for reporting findings and improvement
6. **Study and Understand the Process**
   - Utilize QI tools and techniques to understand the process
7. **Report progress to senior leadership and staff**
8. **Develop and Implement an Improvement Plan**
   - Identify potential solutions to make improvement to the systems of care.
   - Try a small test of change and analyze results.
9. **Re-measurement**
   - Re-measure indicator after change has been implemented.
   - Determine need for and/or level of re-measurement on an ongoing basis.
10. **Celebrate Success**
    - Communicate results of the project to all levels of the organization
    - Congratulate team in public forum

OVERVIEW OF NASSAU-SUFFOLK EMA

Unique Features of Nassau-Suffolk EMA: The EMA has many unique features that complicate administration of the Ryan White Part A program, some of which are due to the plentiful resources existing in New York State.

1) Nassau-Suffolk EMA funds on a 'services only' basis versus the standard 'client eligibility' basis.

2) A multiplicity of HIV funding streams exist, many of which are more flexible and detailed than Ryan White. New York Medicaid recognizes an HIV specific reimbursement rate, with Designated AIDS Centers (DACs) funded through this mechanism. Three DAC's exist in the Nassau-Suffolk EMA. This funding stream reduces the need for explicit funding of Ambulatory Outpatient Medical Care (AOMC) in the EMA. In addition, ADAP (AIDS Drug Assistance Program) enjoys a broader definition in New York State, with ability to fund primary medical care, laboratory testing and other ancillary services (ADAP Plus) through this funding stream.

3) Quality Management resources. In addition to national resources such as the National Quality Center, New York has long enjoyed the AIDS Institute of New York, an arm of the New York State Department of Health. The AIDS Institute established guidelines for HIV care that are long-standing and in many instances, more rigorous than U.S. Public Health Service guidelines.

Demographics: The Nassau-Suffolk Eligible Metropolitan Area (EMA) contains approximately 2,863,849 residents as of 2008; 37% of the total population within Long Island. The total minority population found within the EMA boundaries include Hispanic populations (13%); Blacks (10%); Asian/Pacific Islanders 5%; Native Americans <1%; and Other 3% or a total of 32%. The disproportionate impact of HIV/AIDS upon the EMA's minority community is evidenced by twice or 62% of new HIV/AIDS cases occurring in this 32% of the population. African Americans comprise 10% of Nassau and Suffolk Counties' general population respectively; yet represent 37% of PLWHA. Latinos comprise 20% of the general population for Nassau and Suffolk Counties; yet represent 25% of PLWHA. Men Who Have Sex with Men (MSM) account for the largest number of cases; while the second largest risk behavior is intravenous drug use.

Geography: The Nassau-Suffolk EMA lies within the boundaries of Long Island, New York. This suburban community is adjacent to the New York metropolitan region. Long Island spans a total of 3,567 square miles and contains a total population of 7,448,618 (U.S. 2000 Census); considered the most populated of any U.S. state or territory, as well as being the 17th most populated island in the world. Nassau and Suffolk Counties comprise the central and eastern portion of the island. Nassau County is the more urban and congested of the two Counties with a population of 1,339,641 for 287 square miles. Suffolk is more rural, with a population of 1,475,488 for 912 square miles. Despite areas of affluence throughout this two-county EMA, pockets of poverty persist. The EMA has an estimated 10,000 homeless, many use illicit substances, as well as housing a sizable immigrant population.

Number of Years Part A and MAI Funding: The Nassau-Suffolk EMA has received Ryan White Part A funds since 1992 and MAI funds since 2000.

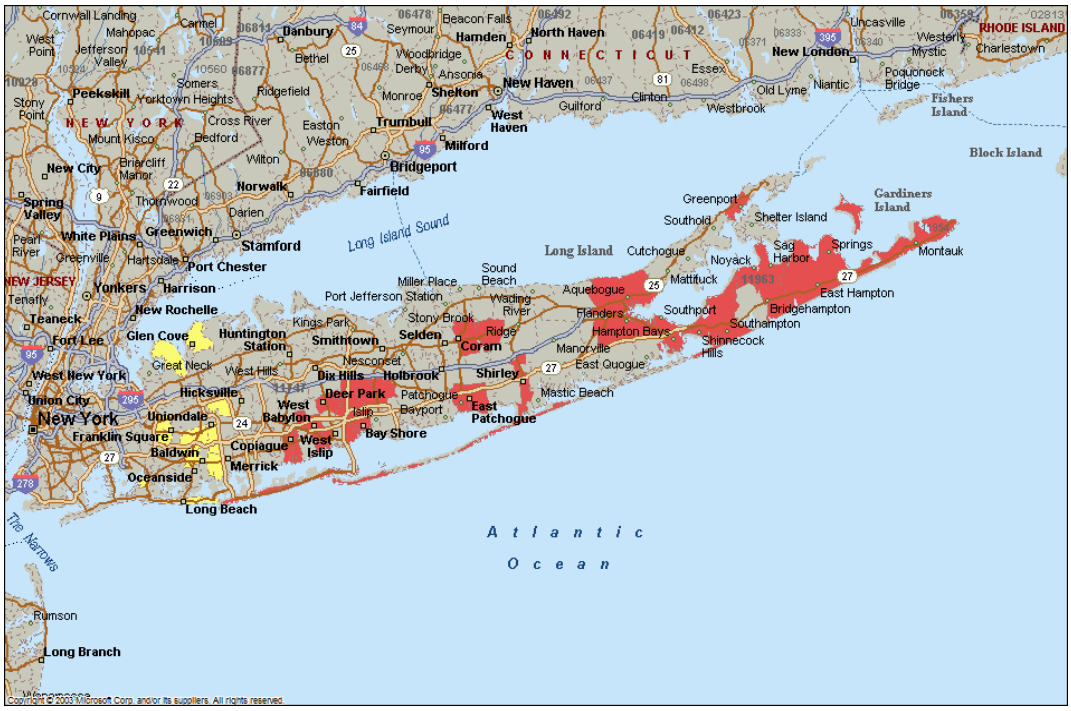
Ryan White Part A Services

Core services offered through Ryan White Part A funding are: Outpatient Ambulatory Medical Care, Medical Case Management, Mental Health, Medical Nutrition, Oral Health and Substance Abuse/Recovery Readiness. Five support services offered are Legal/Health Insurance, Medical Transportation, Outreach, Food Bank and Emergency Financial Assistance. Standards of Care have been developed for the core services and two support services.

Map of Nassau-Suffolk EMA with CNI Zip Codes

Nassau and Suffolk Counties uses a 'Community Need Index' or CNI rating for zip codes that display socioeconomic need for human and social services. A map displaying the communities with high CNI scores is displayed below:

Yellow = Nassau, Coral = Suffolk



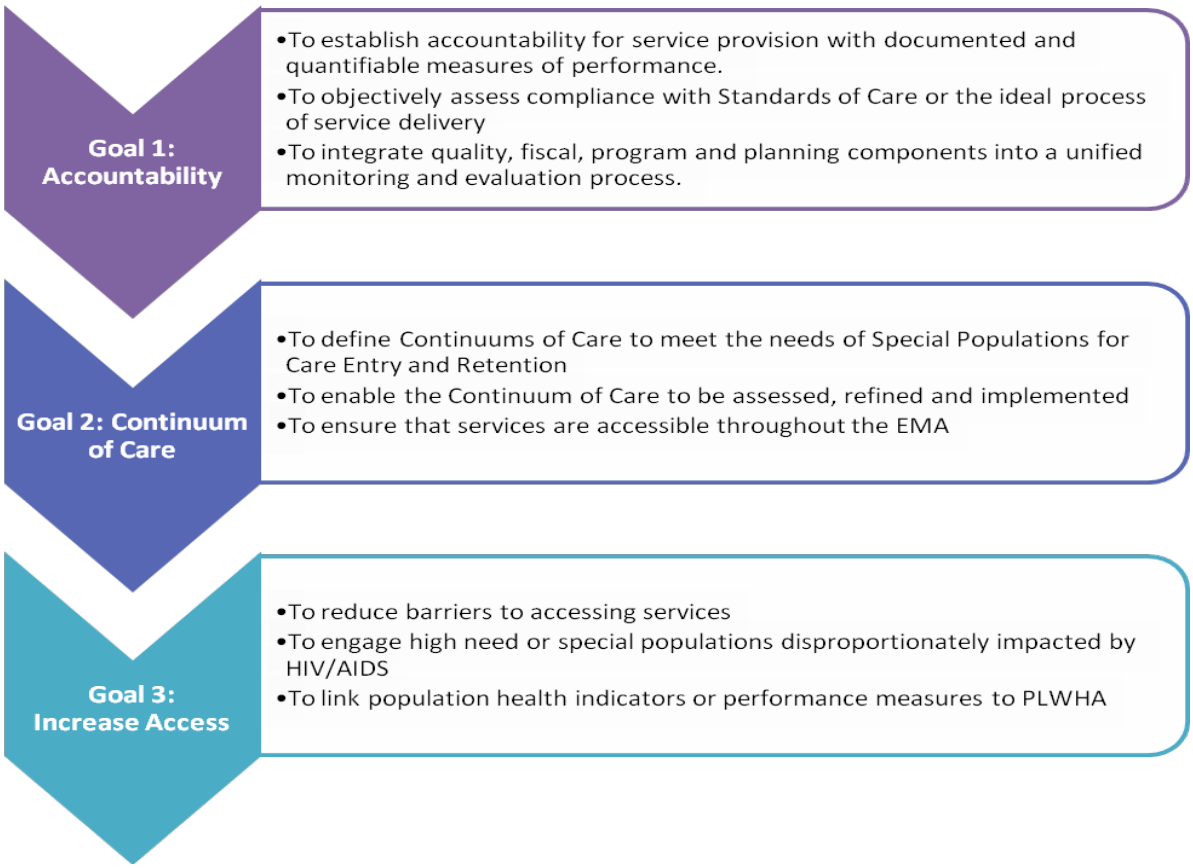
DESCRIPTION OF THE QUALITY IMPROVEMENT PROGRAM

The Part A HIV Quality Improvement (QI) Program measures health and supportive services, provides quality improvement facilitation, and builds capacity in facilities receiving Part A funding in the Nassau-Suffolk EMA. The QI Program has built upon the existing infrastructure for quality improvement in New York State and integrates monitoring of non-clinical indicators (ex: case management, mental health, harm reduction, and treatment adherence services) into the existing system of quality improvement (QI) activities developed for clinical providers. As a result, a comprehensive portfolio of clinical and non-clinical indicators has been developed, allowing all types of providers to monitor and improve their quality of HIV services. Performance indicators measuring the quality of services have been developed for all service categories, including outpatient/ambulatory medical care, medical case management, medical nutrition therapy, mental health, substance abuse/ risk reduction-recovery readiness, oral

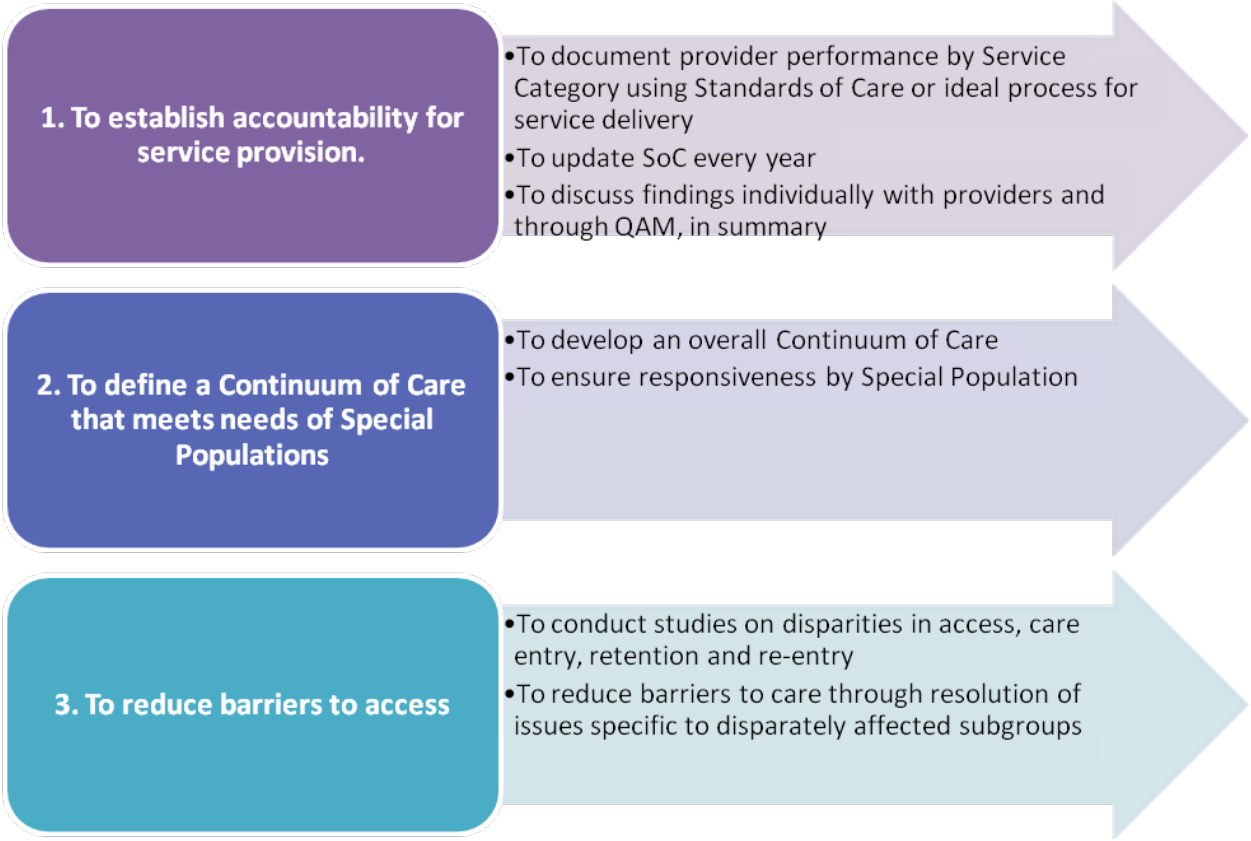
health, medical transportation, food bank (personal hygiene packs), legal services, health insurance, outreach and emergency financial assistance. Performance measurement reviews, an external agency with expertise in Ryan White services, occur annually at each service facility. The resulting performance measurement data from these reviews are presented in aggregate as well as individual reports so that agencies are able to evaluate the systems of care at their institutions. These reviews provide both an assessment of the effectiveness of program services and stimulate quality improvement efforts.

In addition, the QI Program has established several QI learning networks in which providers participate. These learning networks bring together teams of providers of similar services to receive QI guidance using the peer learning model, enabling them to exchange ideas through the learning network's activities. Through these activities, providers focus on improving quality and sustaining improvements at their agencies. Organizational assessments are conducted with each facility to evaluate their quality improvement program and identify areas for development or refinement. During the past year, the QI Program has undertaken the Outcomes Evaluation Initiative, which will evaluate the continuum of care offered to PLWHA in the Part A EMA. The wide scope of the potential data sources will allow analysis of multiple service categories and client variables. The results of the Outcomes Initiative will provide a more thorough understanding of the impact of HIV services on patients and will be useful as a means for deciding future service priorities. The Part A Quality Improvement Program activities are supported by federal funds.

GOALS



OBJECTIVES



QUALITY IMPROVEMENT INFRASTRUCTURE / RYAN WHITE PART A INFRASTRUCTURE

- The QI program is conducted through the combined efforts of the Grantee, its Quality Improvement staff, contracted providers (including clinical and non-clinical staff), and Persons Living with HIV/AIDS. The Key responsibilities for these parties include:
- **Ryan White Office (Grantee) Project Director** has the ultimate responsibility for leadership of process, liaison with Government Project Officer, and issues provider contracts to deliver HIV/AIDS services in alignment with approved Standards of Care (SOC).
- **Contracted providers (clinical and non-clinical)** serve as 'experts' during development/ review/updating/improving of the care standards. They help develop the SOC through service-specific discussion that result in defined SOC based by service category. These standards meet United States Public Health Service guidelines, comply with regulatory mandates, and reflect professional society standards. Contracted providers commit to comply with the SOC.
- **Consumers** are key stakeholders and participate in the strategic planning as part of the Planning Council and committees, and provide first-hand information and experience on how services are received in the field.

REPORTING PROCESS

All contractors are provided with a copy of the Cultural Competency Plan and Standards developed by the Planning Council. Proposals must include the agency's own Cultural Competence Plan and describe

the agency's on-going employee in-service training and new employee orientation. Compliance with these requirements is monitored after contracting by contract management staff.

ROLES & RESPONSIBILITIES OF THE QUALITY IMPROVEMENT PROGRAM:

The roles of staff in quality improvement are to:

1. Jointly develop SOC by service category with the Planning Council's Quality Assurance & Membership Committee and service providers
2. Outline Service Definitions, desired health outcomes and specific indicators that determine progress towards achieving desired outcomes by service category
3. Disseminate the SOC in annual contracts with providers, and then incorporate quality-related expectations into Requests for Proposals and EMA contracts
4. Empower consultants to objectively review compliance with SOC
5. Determine topics and/or providers requiring technical assistance to achieve required compliance levels
6. Assess if providers, following technical assistance, cannot achieve desired health outcomes or achieve compliance with SOC by contracted service. Assessment is conducted using post-Standard of Compliance sampled surveys following technical assistance.

The primary committee involved in the EMA's QI Program is the Quality Assurance/Membership Committee of the Planning Council. This committee develops and implements quality improvement initiatives, and works with the Grantee to revise the Quality Improvement Plan. The QA/Membership Committee receives and reviews data on each service category quarterly. This data is then forwarded to the Executive Committee and then to the Planning Council. Recommendations are then issued to the Grantee.

The remainder of the Planning Council committees are involved as needed to a) integrate deliverables from quality improvement efforts (primarily full population based data) into their work plans, b) serve as links between the HIV/AIDS community and the Council, c) collaborate with the Grantee on issues regarding quality improvement, and d) oversee development of a comprehensive plan for HIV service delivery identifying needs and gaps in service.

The Finance Committee determines allocation of funding categories, and monitors expenditures and service utilization data. QI data are used in the reallocation of funds to ensure service categories not meeting benchmarks (if applicable) will not receive additional funding.

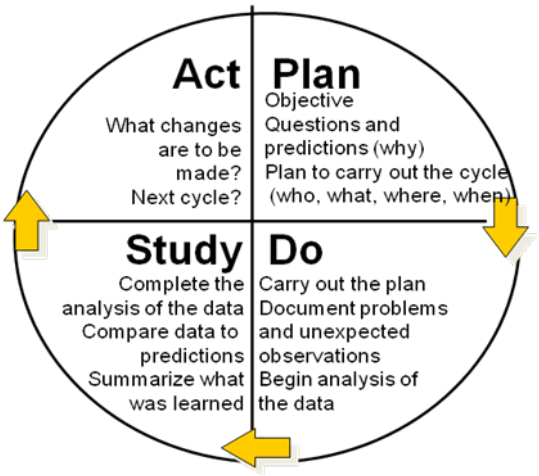
The Executive Committee assesses the data and makes recommendations to the Planning Council. The Finance Committee considers the requests and recommendations for reallocating Ryan White Part A funds that were not expended as planned in the first eight months of the fiscal year, and make recommendations to the Planning Council on reallocating these funds.

Table 1: Committees and their responsibility in the Ryan White Part A Infrastructure

STRATEGIC ASSESSMENT & PLANNING COMMITTEE	This committee establishes and reviews statistical data and discusses ways to collect data on HIV and AIDS. This committee develops estimates of the HIV positive population and the service needs of that population (for example: housing, transportation, medical care, etc.). Using all of the above information, the committee decides on priorities for funding and approves the amount of funding designated for each priority by the Finance Subcommittee.
FINANCE SUBCOMMITTEE	This subcommittee reports to the Strategic Assessment & Planning (SAP) Committee and is responsible for the allocation of funds to the priorities established by the SAP Committee. No member of this subcommittee can work for or be affiliated with any agency that is a recipient of Ryan White Part A funds.
QUALITY ASSURANCE & MEMBERSHIP COMMITTEE	This committee is responsible for evaluating how well services meet community needs, identifying, reviewing, and recommending members to the Council (based upon Ryan White legislatively mandated membership requirements), managing the established Council grievance process, and conducting an annual assessment of the administrative mechanism in the region. This committee works closely with the Consumer Involvement Subcommittee to increase participation and involvement of infected/affected people and communities in Planning Council activities.
CONSUMER INVOLVEMENT SUBCOMMITTEE	This subcommittee reports to the Quality Assurance & Membership Committee and is a joint committee with the Ryan White Part B Care Network. It addresses issues affecting People Living with HIV/AIDS from a consumer point of view and provides feedback to the various PART A and PART B committees. Important issues regarding medical treatment and legislation are presented to the committee. Part of the mission of this group is to encourage outreach, education, empowerment, and advocacy for people infected or affected by HIV/AIDS.
EXECUTIVE COMMITTEE	This committee handles all administrative functions associated with internal management and budget review, grant application, reporting and oversight, coordination with other HIV consortia, planning and coordinating bodies; and procedures for Council record keeping and functions. This Committee also annually reviews the Council's Bylaws and reviews and evaluates the annual grant application and the Minority AIDS Initiative Application grant application.

Joint Part A, B and HIV/AIDS providers and consumers and service-specific representation in EMA.

The Continuous Quality Improvement cycle of Plan-Do-Study-Act (PDSA) outlined in the diagram below is used for CQI Projects:



This cycle consists of first determining which quality improvement projects will be examined. Following subject determination, data is collected; results are examined and then implemented. Results of implementation are monitored with refinement to the plan based on results. Use of PDSA is integral to the development, implementation and refinement of SOC that define how services are delivered in the EMA, and interdisciplinary processes.

STANDARDS OF CARE

The Standards of Care were revised in 2008, with development of a System-Level Standard in 2009. The process of developing Standards of Care included review of the compliance and/or regulatory matrix for each services, review and integration of the United States Public Health Service treatment guideline (if applicable), and review of prior site visit findings. Discussion with provider groups resulted in refined and updated Standards of Care which are updated each year to remain current with revised treatment guidelines or regulations. Current SOCs exist for all contracted services listed below.

- Ambulatory Outpatient Medical Care
- Emergency Financial Assistance
- Health Insurance Premium
- Legal Assistance
- Medical Case Management
- Mental Health
- Medical Nutritional Therapy
- Medical Transportation
- Oral Health
- Outreach
- Substance Abuse/Recovery Readiness

Pods (3 Phases)

Historically, quality improvement projects used 'pods' or small work groups of providers as a discussion vehicle convened by administrative staff to process quality improvement ideas. Initially, these were confined to single service categories. The services that met in pods included Oral Health, Mental Health, Medical Case Management and Outpatient/Ambulatory Medical Care.

Pods typically follow a three-stage process, which may occur within two to three meetings, but can convene more frequently for complex service categories or interdisciplinary issues.

Meeting 1: Pod formation: Objective, Process, Review of Regulatory/Compliance Matrix
Meeting 2: Distillation of findings, outcomes
Meeting 3: Formation of findings into revised Standard of Care, possible pilot in field

The "Pod" meetings present findings of the data collection and analysis to the contracted agencies, as well as facilitate discussions on the current SOC, potential areas of concern with the SOC, and then revisions to the Standards. The goal of the pods is to create SOC that are not process driven, but focus on client clinical outcomes as a result of the care and services provided. For example, pod meetings can compare outcomes by service category to HRSA/HAB Performance Measures to distinguish where the EMA is at median, benchmark (Top 10% or 25%) or above, and implement changes as needed to improve client level outcomes and quality improvement.

Super-Pod vs. Pod

A Super-Pod assembles providers from different service categories and also includes the grantee, consumers and others to review a specific issue that has been determined to *cut across several services* representing a process failure. The QI Storyboard, a methodical approach to quality improvement projects is used to guide participants through resolution of process issues.

(1) TEAM INFORMATION	(2) CURRENT SITUATION	(3) REASONS FOR IMPROVEMENT
▪ List team members, meet brief periods, even over phone, with data. ▪ 8-10 people at maximum	Purpose statement (driving need for improvement) succinctly stated with issue, relevance and time period in which issue presented.	List 3-4 reasons that this issue is critical or important.
(4) ANALYZE ROOT CAUSES	**(5) DEVISE POTENTIAL SOLUTIONS**	**(6) ANALYZE RESULTS**
Use flow diagrams, cause & effect tools, consensus scoring to determine root or underlying causes of symptoms of issue(s).	Summarize possible solutions with field tests and probabilities to determine best solution or set of solutions and sequence.	After field test, analyze results. Look for unintended consequences (good or bad) and behaviors/actions of people vs. what was expected.
(7) FUTURE PLANS	**(8) LESSONS LEARNED**	**(9) FOCUS OF NEXT CYCLE**
Focus on next opportunity specific to this issue (based on findings in 6) or related to this issues.	Summarize what was learned that wasn't known prior to this process and determine applicability to other issues.	Decide what the focus of the next cycle will be and if the team will be maintained or members cycle off.

DATA COLLECTION

The grantee, the contract administrators and the fiscal staff at UWLI are responsible for monitoring the quality of services that receive Part A and MAI funding. Each agency, as a contracting requirement, submits a program work plan based on the stipulations of award for Part A and MAI funds. The program work plan describes how services in the region will be delivered and how PLWHA will engage in these services. Two methods of data collection exist for quality improvement measures:

1. Monthly and quarterly submission of data reports containing quality indicators that contribute to performance measures
2. Annual site visits of chart audits that objectively quantify compliance with Standards of Care by service category in addition to fiscal, program and planning audits.

The process for data collection at the annual site visits has been standardized to allow for year-to-year comparisons and includes demographic data on the unduplicated number of clients served and the monthly units of service provided for each program. Demographics collected include gender, age, race and ethnicity, county and zip code of residence, mode of transmission, HIV status, household income, housing arrangements, and medical insurance enrollment status. The data utilized by the region assists in evaluating the effectiveness of the priorities in reaching the communities disproportionately impacted by HIV/AIDS by ensuring that the goals of the priorities are accomplished and outcomes achieved. The quality and thoroughness of the data that is collected has enabled the EMA to evaluate the neighborhoods and communities being targeted and the amount and kind of services being utilized by PLWH/A.

ANNUAL SITE VISIT PROCESS

Site Visit Procedure

Quality Management site visits are assessed on an annual basis. An external consulting group, Collaborative Research, LLC, with Ryan White expertise conducts the chart audits/site visits. Providers are sent letters with the information below detailing the site visit process:

Prior to the Monitoring Visit:

- The Ryan White Part A Office will make available the most up-to-date monitoring tool along with a written description of what to expect at the program compliance site visit
- The program receiving the site visit is expected to become completely familiar with the program monitoring tool
- The program will assemble materials necessary to extract information for compliance with the monitoring tool

Entrance Interview:

The purpose of the visit will be reviewed, which involves:

1. Reviewing the goals and objectives for the program for the contract year
2. Determining compliance with the EMA's Standards of Care using the monitoring tool
3. Reviewing client files for eligibility, completeness, and quality of services received by the agency

The program will be asked to describe any major accomplishments and barriers that may stand in the way of successfully providing the contracted service.

Monitoring:

- All necessary information in the monitoring tool will be reviewed

- The agency is expected to have all necessary materials on site for the completion of the monitoring and knowledgeable staff available to answer any questions that may arise

Exit Interview:

- The auditor will review any findings or deficiencies and give the agency direction on interim action steps if necessary and if technical assistance will be provided
- If warranted, a date will be set for submission of corrective action items and/or a date will be set for a return visit.

Assessment Tools

Several tools are used for site visits. These are found in the Appendices:

1) A chart assessment tool to ascertain compliance to the Standards of Care for each service category audited (paper version in Appendices; data collection during site audits will be electronic)

2) Client level data variables to be extracted prepared for the site visit used to compile demographic and service care data. Initial data elements mandated for 2009 include the following fields for Outpatient Ambulatory Medical Care and Medical Case Management. Unique identifiers as required by HRSA include:

Outpatient Ambulatory Medical Care		**Medical Case Management**
YEAR OF BIRTH		*All fields in OAMC*
ETHNICITY		Risk Reduction screening/counseling
RACE		# OAMC visits in current year
GENDER		CD4 counts and dates
TRANSGENDER SUBGROUP		PCP prophylaxis (if indicated)
HEALTH INSURANCE		Prescribed HAART (type & date)
HOUSING STATUS		Screened for TB in current year
ZIP CODE OF RESIDENCE		Screened for TB since HIV Diagnosis
FEDERAL POVERTY LEVEL		Screened for STD in current year
FIRST OAMC VISIT		Screened for Hepatitis B
DETAIL OF FIRST OAMC VISIT		Screened for Hepatitis B since HIV Diagnosis
HIV STATUS (HIV/AIDS)		Completed Hepatitis B Vaccination series
YEAR OF AIDS DIAGNOSIS		Screened for Hepatitis C
CLIENT RISK FACTOR		Screened for Hepatitis C since HIV Diagnosis
VITAL ENROLLMENT STATUS		Screened for Substance Abuse/ Mental Health
DEATH		PAP smear (annual)
		Pregnant? If so, ART? If So, Prenatal?

3) Demographic extraction tool to obtain further demographic information not extracted from CAREWare. Items that can't be extracted from electronically filed reports include linked data fields (time from client intake to care plan, time from initial assessment to six-month reassessment, etc.)

4) Provider Data Collection Flow Sheets containing service category data on each client at the front of client charts to make data extraction quicker for the auditor.

Reporting Process

Several reports are issued once site visits are conducted and the data has been analyzed. The reports are issued to the following:

- Ryan White Grantee Office
- Contracted providers
- Planning Council
- Quality Assurance/Membership Committee (a consumer driven committee)
- Strategic Planning & Assessment Committee

Final Report

A final report will be issued by the auditor. The report includes:

1. A raw data spreadsheet containing client-level (by CAREWare, AIRS or other unduplicated client-level numbers) data elements obtained at the sites
2. Compliance findings and comments reviewed during the exit interview along with any additional findings or recommendations for improvement
3. A compliance to the SOC report for the agency
4. Analysis of the demographics for the site

DATA ANALYSIS

Data analysis consists of mining the individual data by provider agency and ranking the providers' compliance with SOC overall and by Service Category. Current performance by the EMA providers is measured as an aggregate and analyzed. In addition, the Strategic Planning Region's performance is calculated annually with detailed client demographics provided. Client chart audits in conjunction with fiscal and program monitoring and integration of the quality efforts allows the Grantee to conduct a comprehensive review of performance of contracted providers.

QUALITY IMPROVEMENT TOOLS & TECHNIQUES

Additional quality improvement tools and techniques include the following:

1. Process Flow Diagrams, which tracks changes over time. A specific type of process flow diagram is Statistical Process Control Analysis, which is a 'run' chart or chart tracking process change over time.

2. Cause and Effect / Fishbone Diagrams analyze process dispersion in a simple, visual tool. The resulting diagram illustrates the main causes and sub-causes leading to an effect (symptom).

3. Support & Barriers Brainstorming is a brainstorming exercise in which support to a solution is contrasted to factors that could prevent it from being solved.

4. Data Mapping is the ability to map data into causal diagrams that lead to determining root cause versus underlying system.

PERFORMANCE MEASURES

Performance Measures are extrapolated from data collected on individual client charts during annual provider site visits. These Performance Measures are then compared annually to national standards for clinical outcomes using HRSA's HIV/AIDS Bureau (HAB) proposed Office of Performance Review (OPR) clinical outcome indicators and the National Institutes of Health's clinical indicators. A matrix is developed and populated comparing the Nassau-Suffolk EMA results to those found nationally. Below is a table comparing the Nassau-Suffolk EMA percent of compliance to the HAB performance measures and to the national best practice compliance.

HRSA/HAB (HIV/AIDS Bureau) Performance Measures:

LEGEND: **GREEN** – Exceed benchmark (at or higher than 10%) **BLUE** – Benchmark (at or higher than 25%)

BOLD BLACK – Meet benchmark BLACK (UNBOLDED) – At median **BOLD RED** – Below median

AIDS Institute of New York Performance Indicators	HAB HIV Clinical Performance Measures	National Best Practice	2007	2008	2009
	Tier 1. HIV Morbidity				
	1.1 Medical visit every 6 months		94%	92%	98%
CD4 Count & Viral Load	1.2 CD4 test every 6 months	Top 10%: 2003 = 87.2% 2004 = 87.7% 2005 = 90.3%	**99%**	**99%**	**99%**
	1.3 PCP for CD4<200	Top 10%: 03-05=100% Top 25% = same Median 2003=93.3% 2004=90.9% 2005=92.3%	**100%**	**100%**	**100%**
	1.4 Clients prescribed ARVs	Top 10 & 25%: 2003-05=100% Median: 2003=100% 2004=88.9% 2005=95.7%	**90%**	**97%**	**98%**
HIV Specialist Care			91%	94%	97%
Treatment Adherence	2.5 Adherence counseling every 6 months for patients on ARVs	IHI goal=90% Top 10%: 2003=95.8% 2004=94.7% 2005=97.5%	**99%**	**100%**	**100%**

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AIDS Institute of New York Performance Indicators (measured every 4 months)	HAB HIV Clinical Performance Measures	National Best Practice	2007	2008	2009
Antiretroviral (ARV) Therapy (appropriate management & treatment adherence)			66%	88%	98%
Patients receiving ARVs, received in past, or eligible for ARVs based on NY State guidelines.			89%	92%	98%
Patients appropriately managed & stable on ARVs			89%	92%	98%
Patients appropriately managed & unstable on ARVs			100%	100%	100%
Appropriate management for end-stage patients or patients with no other therapeutic options			100%	100%	100%

GREEN – Exceed benchmark (at or higher than 10%) **BLUE** – Benchmark (at or higher than 25%)
BOLD BLACK – Meet benchmark BLACK (UNBOLDED) – At median **BOLD RED** – Below median

AIDS Institute of New York Performance Indicators (measured every 4 months)	HAB HIV Clinical Performance Measures	National Best Practice	2007	2008	2009
	Tier 2. Co-morbidities				
Pelvic Exam and Pap Smear Eligibility = All female patients 18 years or > AND sexually active patients 13- 18 years old.	2.1 (% of women who) have PAP every 12 months	Top 10%: 2003=100% 2004=99.1% 2005=100% Top 25%: 2003=84.3% 2004=86.7% 2005=87.0%	**99%**	**99%**	**95%**
PPD (TB) Screening	2.2 TB screening since HIV diagnosis	Top 10%: 2003=88.9% 2004=91.9% 2005=88.8% Top 25%: 2003=77.4% 2004=73.5% 2005=74.8%	**88%**	**91%**	**95%**
STD screening on patients 18 years and > and sexually active patients 13-18 years.	2.3 Syphilis test yearly	Top 10%: 2003=99.0% 2004=100% 2005=100% Top 25%: 2003=90.4% 2004=92.2% 2005=95.7% Median: 2003=77.7% 2004=83.6% 2005=86.3%	**81%**	**99%**	**99%**

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BOLD BLACK – Meet benchmark BLACK (UNBOLDED) – At median **BOLD RED** – Below median

AIDS Institute of New York Performance Indicators (measured every 4 months)	**HAB HIV Clinical Performance Measures**	**National Best Practice**	**2007**	**2008**	**2009**
Hepatitis C Screening The number of HCV+ patients for whom alcohol counseling and HCV education was provided The number of patients for whom hepatitis A status was documented	2.4 Hepatitis C screen	IHI goal=95% Top 10%: 2003, 04, & 05=100% Top 25%: 2003=99.4% 2004=95.6% 2005=96.7% Median: 2003=93.0% 2004=95.6% 2005=96.7%	**30%** **100%** **95%**	**30%** **100%** **97%**	**65%** **100%** **98%**
Lipid Screening on patients receiving ARVs	2.6 Lipid screen every 12 months for patients on ARVs	Top 10%: '03-'05= 100% Top 25%: 2003 = 98.5% 2004=100% 2005=97.9%	**82%**	**85%**	**95%**
	2.7 Completed Hepatitis B vaccination program	2004=100% (CDC)	**48%**	**52%**	**65%**
Dental Exam	2.9 Oral exam every year	IHI goal=75% Top 10%: 2003=66.7% 2004=77.8% 2005=66.7% Top 25%: 2003=46.7% 2004=62.2% 2005=53.6% Median: 2003=30.0% 2004=35.8% 2005=36.0%	**30%**	52%	64%

LEGEND:
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BOLD BLACK – Meet benchmark BLACK (UNBOLDED) – At median **BOLD RED** – Below median

HAB HIV Clinical Performance Measures	National Best Practice	2007	2008	2009
Tier 3. Prophylaxis				
3.1 Patients with CD4<50 received MAC prophylaxis	Top 10%: 2003-05=100% Top 25%: same	**100%**	**100%**	**100%**
3.2 Patients with CD4<50 received ophthalmology screen every 12 months	Top 10% & 25%: 2003-05=100%	**100%**	**100%**	**100%**
3.4 Substance abuse screen every 12 months	Top 10%: 2003-05=100% Top 25%: 2003=92.3% '04-'05 =100% [Median: 2003=74.4% 2004=86.4% 2005=92.7%	**50%**	**50%**	**50%**
3.5 New clients receive mental health screen	Top 10%: 2003-05= 100% Top 25%: 2003=93.0% 2004=89.5% 2005=35.1%	**100%**	**96%**	97%
3.10 Pneumococcal vaccine received every 5 years	Top 10%: 2003=97.7% 2004=95.8% 2005=97.5% Top 25%: 2003=92.4% 2004=90.1% 2005=93.0%	**94%**	**98%**	
3.11 Influenza vaccination every 12 months		94%	98%	98%
3.12 HIV/HCV co-infected clients receive alcohol counseling every 12 months		92%	94%	94%
3.13 Smoking cessation counseling provided every 12 months	Top 10%: 2003-05=100% Top 25%: 2003=93.3% 2004=97.8% 2005=98.4% Median: 2003=75.8% 2004=90.0% 2005=88.2%	**100%**	**98%**	**98%**
3.14 HIV prevention & self-care education provided every 12 months		95%	96%	95%
		60%	68%	75%
		100%	98%	98%

COMPLIANCE WITH STANDARDS OF CARE/CAPACITY BUILDING

Providers with statistically significant failure to meet SOC compliance and with systematic issues are provided technical assistance to implement changes to improve client level outcomes and quality improvement. Along with this, resolution of system-wide quality improvement issues is conducted in areas that meet or are deficient in performance as outlined in the HAB performance measures. In addition, improvement opportunities will be discussed in the system-wide work group of providers or 'Super Pod'.

CONTINUOUS QUALITY IMPROVEMENT PROJECTS

The process used to determine focal areas for possible quality improvement projects includes annual review at the start of the Fiscal Year by the Quality Assurance/Membership Committee of trended results of quality measures. Included among the quality measures are three sources of data.
(1) HRSA/HIV-AIDS Bureau and AIDS Institute of New York Performance Measures
(2) Quality Indicators and Outcomes from Implementation Plans (Formula/Supplemental and Minority AIDS Initiative (MAI))
(3) Quality Outcomes from Scope of Service reviews.

Based on those indicators and outcomes in which providers are experiencing difficulty in achieving defined thresholds or meeting national medians, one to two specific areas are distilled for review by the committee. Increasingly, the QA/Membership Committee has involved consumers in study of these issues in addition to the historic provider involvement by the grantee. If the issue is service category specific, a focused review of the problem is placed in context. This context includes development of a regulatory/compliance matrix to U.S. Public Health Service guidelines and professional society recommendations; a literature search of national issues within the HIV/AIDS and other arenas with these specific barriers to compliance and comparison to national medians of performance. Following this review, discussion of possible resolution occurs, whether that be documentation assistance (simplified or streamlined referral forms, flow or face sheets); technical assistance (education in treatment protocols) or data assistance (aid in recording quantitative information through spreadsheets, CAREWare and/or AIRS). If the issue persists, and cuts across multiple services presenting as a process issue, a 'Super-Pod' or involved process using a Quality Improvement Storyboard may be required.

Several projects occurred to improve the quality of the monitoring tools and the work plans.
Included among the Quality Improvement projects in 2009 are:
1) Development of standardized referral forms for Oral Health and Mental Health from other clinical services to ensure capture of biological markers, client's medical history and medications;
2) Review of Outreach services;
3) Clarification of objective and process for Maintenance in Care; and
4) Development of a 'Super-Pod' or consumer, provider, staff work group to study transportation.

QUALITY IMPROVEMENT PLAN IMPLEMENTATION

All facets of Quality Improvement have been implemented over the prior three-year period (2007 to 2009). Initial efforts in 2007 were to develop and refine Standards of Care. Working Groups of service-specific providers met to review and refine these Standards in 'pods' or small, representative. provider groups. Site visits provided baseline data (2007) with refinement and distillation of Standards in 2008. In 2009, expansion and sophistication of the Standards occurred with development of Chart Abstract tools, trended comparison to HRSA/HIV-AIDS Bureau and AIDS Institute of New York performance

measures and empowerment of the first 'Super-Pod' or review group of an issue transcending service categories. This inaugural Super-Pod is focusing on transportation as it affects all services.

The QI Plan entails 4 distinct components—(1) Standards of Care (2) Working Groups or Pods (3) Site Visits typically monitoring SoC compliance using a 20% sampling method and (4) Annual Report of Findings (Summary and Provider Specific).

1) Standard of Care refinement	1. Update SoC to incorporate new or revised regulatory components 2. Update SoC to include treatment guideline changes
2) Pod: > Focus in 2009: Transportation	1. Select Issue that cuts across service category lines – October 2009 2. Review QI Storyboard/Process – October 2009 3. Convene group to initiate process – November 2009
3) Annual Quality Management Site Visits	1. Conducted in June and July of 2009 2. Reports distributed in August of 2009 a. Data Collection b. Data Entry c. Data Analysis d. Data Presentation e. Technical Assistance
4) Final Report	Summarize findings of 2009 Annual Quality Management Site Visits into Final Report and trend over 3-year timeframe: 2007 to 2009

COMMUNICATION

The Grantee Office reports to the Nassau County Executive through an administrator. On a quarterly basis, health outcome information is reported to the Ryan White Office from all providers. An information loop exists between the Administrative Agency (the Grantee) and the Planning Council regarding clinical quality improvement findings. Data is presented to Planning Council Committees by an external consulting firm with Ryan White expertise. The Strategic Assessment & Planning and Finance Committees work with the Grantee to refine processes for monitoring expenditures and service utilization, and present data by service categories to the Planning Council.

The Executive Committee assesses the data and makes recommendations to the Planning Council. The Strategic Assessment & Planning and Finance committees consider requests and recommendations for reallocating Ryan White Part A funds that were not expended as planned in the first eight months of the fiscal year, and make recommendations to the Planning Council on reallocating these funds.

Based on reports and results of the Needs Assessment (the 'voice of the consumer'), sampled and self-reported data are used to further investigate potential quality issues. Issues with disparities in care, access to services or other concerns are reflected in the triennial Comprehensive Strategic Plans as goals.

APPENDICES

A. LIST OF PROVIDERS AND SERVICE CATEGORIES – FY 2009

B. ASSESSMENT TOOLS / STANDARDS OF CARE

Appendix A. List of Contracted Providers in Nassau-Suffolk EMA, 2009

#	NAME	CONTRACTED SERVICES (2009)
1	Catholic Charities	Oral Health
2	Circulo de la Hispanidad	Medical Transportation
3	David E. Rogers Center for HIV/AIDS Care Southampton Hospital	Mental Health, Medical Case Management (subcontract Stony Brook Research Foundation)
4	Economic Opportunity Council (EOC)	Medical Transportation
5	FEGS	Mental Health, Substance Abuse-Recovery Readiness, Maintenance in Care
6	Hispanic Counseling Center	Mental Health
7	LIAAC (Long Island Association for AIDS Care)	Outreach
8	Nassau University Medical Center	Medical Case Management
9	Nassau-Suffolk Law Services	Legal Services, Health Insurance Premiums
10	North Shore University Hospital	Outpatient Ambulatory Medical Care, Medical Case Management
11	Stony Brook Medical Center	Maintenance in Care, Medical Nutrition Therapy, Mental Health
12	Suffolk County Department of Health	Oral Health
13	Suffolk County Department of Human Services	Pre-Release Medical Case Management

APPENDIX B. Quality Improvement/Standard of Care Chart Abstract Tools

CORE SERVICES:

1. **Outpatient/Ambulatory Medical Care**
2. **Medical Case Management**
3. **Medical Nutrition Therapy**
4. **Mental Health**
5. **Oral Health**
6. **Substance Abuse/Recovery Readiness**

SUPPORT SERVICES:

7. **Emergency Financial Assistance (EFA)**
8. **Legal/Health Insurance**
9. **Outreach**
10. **Transportation**

Outpatient/Ambulatory Medical Care:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status** Current documentation of program eligibility & client enrollment		
5	**Client Treatment Consent, Rights and Responsibilities** Documentation signed & dated by client		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**HIV Flow Sheet** Present in chart; complete & up to date; Primary Care Provider clearly noted		
9	**Medical Problem List** Problem List utilized; present in chart, complete & up to date		
10	**Medication List** Present in chart, organized, complete & up to date		
11	**Allergies** Properly documented on Problem List; drug allergies noted		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
12	**Client Demographics** Age, ethnicity, appropriate gender identity indicated		
13	**Initial Comprehensive Medical History and Physical Exam** Completed and signed/dated by provider		
14	**LABS**	**CBC**	
15		**Chemistries**	
16		**CD4 Eval:** Nadir CD4 count identified	
17		**Viral Load:** Baseline VL indicated in chart	
18		**Toxo Titer**	
19		**HAV screen:** Hepatitis A status indicated in chart	
20		**HBV screen:** Hepatitis B status indicated in chart	
21		**HCV screen:** Baseline Hepatitis C serology indicated	
22		**GC screen**	
23		**Chlamydia screen**	
24		**PAP**	
25		**RPR / VRDL**	
26	**Opportunistic Infection History** OI Hx and current prophylaxis recorded in chart		
27	**TB Screen** PPD read and documented		
28	**Oral Exam** Documentation of oral exam at time of Initial Hx & referral if indicated		
29	**Mental Health Status / Psychosocial Assessment** Mental health status indicated; documentation of psychosocial/family hX		
30	**Recently Incarcerated** Jail/ Prison within past 24 months		
31	**Baseline HIV/STD Assessment & Screening** Risk behavior assessment completed; risk factors identified		
ONGOING EVALUATION & HEALTH CARE MAINTENANCE			**COMPLIANCE WITH SOC**
32	**Follow-up Evaluation** Monitor visits q3-4 mos. or 3 visits within the last year		
33	**PCP prophylaxis** If CD4<200, PCP prophylaxis recommended / initiated		
34	**MAC prophylaxis** If CD4<50, MAC prophylaxis recommended / initiated		
35	**Toxo prophylaxis** If CD4<100 and toxo titer positive, toxo prophylaxis recommended / initiated		
36	**TB Screening** Documented PPD within last year; CXR referral if indicated (PPD+)		
37	**Ongoing HIV/STD Risk Assessment & Screening** Risk behavior assessment annually and at time of STD Dx		

Outpatient/Ambulatory Medical Care (continued):

Immunizations		COMPLIANCE WITH SOC
38	**HAV / HBV** vaccination administration indicated in chart	
39	**Influenza** vaccination annually; indicated in chart	
40	**Pneumovax** administration: at least once; revaccination as indicated	
41	**Tetanus** vaccine documented within last 10 years	
Perinatal Care		
42	**PAP Smear & Pelvic Exam** Documented within 6 mos. of initial Hx	
43	**Pregnancy** Indication of pregnancy status and pregnancy counseling	
44	**HIV Prophylaxis** Protocol in chart for ZDV in labor or documentation of ZDV received	
ANTIRETROVIRAL THERAPY		**COMPLIANCE WITH SOC**
	Laboratory	
45	CD4 cell count and viral load test upon initiation of anti-HIV therapy	
46	CD4 cell count and viral load test q3 months indicated in chart	
47	CBC q3 months	
48	Chemistries q3 months	
49	LFTs (as appropriate) – Liver Function Test	
50	Lipid profile (as appropriate)	
51	Resistance test ordered appropriately (acutely infected / failing ARV therapy)	
ARV Therapy Strategy		**COMPLIANCE WITH SOC**
52	ARV therapy regimen consistent with current guidelines	
53	ARV therapy regimen appropriate for patient's CD4/VL	
54	ARV medications correctly combined and dosed	
55	Adverse drug reactions indicated / addressed	
56	Medications adjusted appropriately for side effects & toxicity	
57	Adherence assessment completed	
58	Other (as appropriate):	
CONSULTATION / REFERRAL FOR SPECIALTY CARE		**COMPLIANCE WITH SOC**
59	**Dental** Documentation of oral health exam and referral if indicated	
60	**Ophthalmology** If CD4<100, ophthalmology visit within last 12 months	
61	**Mental Health** Assessment / Hx / Request for treatment / referral as indicated	
62	**Substance Abuse** Assessment / Hx / Request for treatment / referral as indicated	

Medical Case Management:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status (annual update)**Current documentation of CARE program eligibility & client enrollment		
5	**Client Treatment Consent, Rights and Responsibilities** Documentation signed & dated by client		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**Case management acuity sheet** Present in chart; complete & up to date; Primary Care Provider clearly noted		
9	**Medication List** Present in chart, organized, complete & up to date		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
10	**Client Demographics** Age, ethnicity, appropriate gender identity clearly and properly indicated		
11	**Initial Assessment** Completed and signed/dated by client and case manager		
12	BASELINE: ASSESSMENT & CARE PLAN	**In Primary Medical Care? Where? Since When?**	
13		**CD4:** lowest CD4 count identified (if available)	
14		**Viral Load:** lowest VL indicated in chart (if available)	
15		**Comorbidities/Other medical conditions**	
16		**Sexually Transmitted Infection history.** Risk behavior assessment & STD screen completed; risk factors identified	
17		**Opportunistic Infection history**	
18		**Mental Illness/Psychosocial assessment history** Health status indicated; documentation of psychosocial/family history	
19		**Substance abuse history**	
20		**Housing status**	
21		**Subsistence needs status:** a) food b) transportation c) employment	
22		**Oral Health Status**	
23		**Recently Incarcerated** Jail/ Prison within past 24 months	
24		**Other** (as appropriate):	
CARE PLAN DEVELOPMENT			**COMPLIANCE WITH SOC**
25	**Clinical** Documentation of clinical status, needs with referral as indicated		
26	**Support** Documentation of socio-economic status, needs with referral as indicated		
27	**Other** Assessment/Hx/Request for treatment/ referral as indicated		
CARE PLAN REASSESSMENT (Annual Update mandated, 6 month preferred)			**COMPLIANCE WITH SOC**
28	**Clinical** Update on clinical status, needs with referral if indicated		
29	**Support** Documentation of socio-economic status, needs with referral as indicated (see next section)		

Medical Nutritional Therapy:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status (annual update)** Current documentation of CARE program eligibility & client enrollment		
5	**Client Treatment Consent, Rights and Responsibilities** Documentation signed & dated by client		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**Case management acuity sheet** Present in chart; complete & up to date; Primary Care Provider clearly noted		
10	**Medication List** Present in chart, organized, complete & up to date		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
11	**Client Demographics** Age, ethnicity, appropriate gender identity clearly and properly indicated		
12	**Initial Assessment** Completed and signed/dated by client and case manager		
13	BASELINE: ASSESSMENT & CARE PLAN	**In Primary Medical Care? Where? Since When?**	
14		**CD4:** lowest CD4 count identified (if available)	
15		**Viral Load:** lowest VL indicated in chart (if available)	
16		**Comorbidities/Other medical conditions**	
17		**Sexually Transmitted Infection history.**	
18		**Opportunistic Infection history**	
19		**Mental Illness/Psychosocial assessment history**	
20		**Substance abuse history**	
21		**Housing status**	
22		**Subsistence needs status (a) food b) transportation c) employment**	
23		**Recently Incarcerated** Jail/ Prison within past 24 months	
24		**Oral Health status**	

Medical Nutritional Therapy (continued);

	NUTRITION HISTORY	COMPLIANCE WITH SOC
25	**Clinical** Documentation of clinical status, needs with referral as indicated (see next section)	
26	**Baseline nutrition screen** 1) Weight (usual body weight, weight when diagnosed, recent weight hx, record weight loss/ gain)	
27	**Severe weight loss (cachexia)** 2) Severe weight loss (more than 5% of UBW unintentionally) over 2-3 months	
28	3) Level of appetite/ nutritional intake	
29	4) History of diabetes or lipid disorders	
30	5) GI-related issues (e.g. nausea, diarrhea, swallowing issues)	
31	**2.2 A list of HIV medications prescribed to patient**	
32	**2.3 Baseline screening for food security**	
33	1) Regular access to food (food bank/pantry, congregate meals)	
34	2) Housing status	
35	3) Access to cooking facility	
36	4) Financial status	
37	**2.4 Nutritional education provided, topics covered**	
38	1) Dietary habits for people living with HIV	
39	2) Diet & adherence to HIV medications	
40	3) Diet and special concerns (diabetes, lipodystrophy)	
41	4) Budgeting & shopping	
42	5) Nutritional related symptom management	
43	6) Food preparation and cooking	
44	**2.5 Client satisfaction survey conducted**	
45	1) Overall quality of nutritional therapy services	
46	2) Quality of food provided	
47	3) Quality of nutrition education	
48	4) Selection of food meeting dietary needs	
49	5) Selection of food meeting cultural needs	
50	**2.6 Resource list of community food/nutrition**	

Mental Health:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status (annual update)**Current documentation of program eligibility & client enrollment		
5	**Client Consent, Rights and Responsibilities** Documentation signed & dated by client		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**HIV Medication List** Present in chart; complete & up to date; Primary Care Provider clearly noted		
9	**Mental Health/Substance Abuse Medication List** Present in chart, organized, complete & up to date		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
10	**Client Demographics** Age, ethnicity, appropriate gender, RISK/EXPOSURE - identity clearly and properly indicated		
11	**Site of Primary Medical Care**		
12	**Initial Assessment** Completed and signed/dated by client and case manager		
13	BASELINE: ASSESSMENT	**In Primary Medical Care? Where? Since When?**	
14		**Mental Health Assessment** GAF Score or other mental health baseline	
15		**History of Substance Use** Substances used, Age at first use	
16		**Screening** Cognitive impairment, depression, anxiety, PTSD, suicidal / homicidal ideation, psychosocial status, sleep and appetite assessments	
17		**Psychiatric history** Mental health history, prior treatment including psychotropic medications	
18		**Barriers to Treatment** Legal, Employment or other barriers to Treatment	
19		**Motivation for Treatment** Reasons to enter Treatment at this time	
20		**Possible underlying Medical or Medical treatment reasons** Consideration of dementia, organic reasons or drug reactions	
21		**Recently Incarcerated** Jail/ Prison within past 24 months	
22		**Other** (as appropriate):	
TREATMENT PLAN DEVELOPMENT			**COMPLIANCE WITH SOC**
23	**Clinical** Documentation of clinical status, connect to HIV medical care		
24	**Mental Health/Substance Abuse** Refer to mental health and/or substance abuse services, document location of services, type of service (Individual therapy, Group Therapy) and expected tenure (amount of time)		
25	**Psychiatrist Referral (if indicated)** Document psychiatrist referral, if needed, reasons why, expected outcome and duration		

Oral Health:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status; Referral Form** Current documentation of program eligibility, client enrollment from referral source with referral source clearly documented		
5	**Client Treatment Consent, Rights and Responsibilities** Documentation signed & dated by client		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**HIV Flow Sheet** Present in chart; complete & up to date; Primary Care Provider clearly noted		
9	**Oral Health Problem List** Problem List utilized; present in chart, complete & up to date		
10	**Medication List** Present in chart, organized, complete & up to date		
11	**Allergies** Documented on Problem List; drug allergies clearly noted		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
12	**Client Demographics** Age, ethnicity, appropriate gender identity clearly and properly indicated		
13	**Prior Oral Exam** Documentation of prior oral exam & referral made if indicated		
14	**Initial Oral History and Physical Exam** Comprehensive Head & Neck and intraoral exam completed and signed/dated by provider at initial visit		
15	ORAL BASELINE	**Teeth screening:** determine current endentulism	
16		**Teeth screening:** determine extent of caries	
17		**Mouth screening:** determine gum health and extent of gingivitis	
18		**Mouth screening:** check for periodontal disease	
19		**Mouth screening:** check for any lesions or suspicious oral or pharyngeal	
20		**Other** (as appropriate):	
21	**Opportunistic Infection History** OI Hx and current prophylaxis recorded in chart		
22	**Baseline Risk Assessment & Screening** Risk behavior assessment; risk factors identified		
23	**Recently Incarcerated** Jail/ Prison within past 24 months		

Y = Yes
N = No
NC=Non-Compliant (cannot be determined from information in chart)
NA=Not Applicable (to patient or program/facility

Oral Health (continued):

	ONGOING EVALUATION & HEALTH CARE MAINTENANCE	COMPLIANCE WITH SOC
24	**Regular dental screenings** Monitor visits 2 visits within the last year	
25	**Emergency dental visits** Determine reason for emergency dental visits (if any) – pain and/or bleeding and that patient was seen within 24 hours of request (and location of care)	
26	**Ongoing Risk Assessment & Screening** Risk behavior assessment annually and at time of Oral Health Care visit	
27	**Other:** As appropriate	
	CONSULTATION / REFERRAL FOR SPECIALTY CARE	**COMPLIANCE WITH SOC**
28	**Periodontal** Documentation of need for periodontist and ability to secure timely referral	
29	**Oral Surgery** Documentation of oral surgery referral and ability to secure timely referral	
30	**Medical** Documentation of referral for medical care	
31	**Other** Assessment / Hx / Request for treatment / referral as indicated	

Substance Abuse/Recovery Readiness:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status (annual update)** Current documentation of program eligibility & client enrollment		
5	**Client Consent, Rights and Responsibilities** Documentation signed & dated by cli**ent**		
6	**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client		
7	**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis		
8	**HIV Medication List** Present in chart; complete & up to date; Primary Care Provider clearly noted		
9	**Mental Health/Substance Abuse Medication List** Present in chart, organized, complete & up to date		
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
10	**Client Demographics** Age, ethnicity, appropriate gender, RISK/EXPOSURE - identity clearly and properly indicated		
11	**Site of Primary Medical Care**		
12	**Initial Assessment** Completed and signed/dated by client and case manager		
13	**BASELINE: ASSESSMENT**	**In Primary Medical Care? Where? Since When?**	
14		**Mental Health Assessment** GAF Score or other mental health baseline	
15		**History of Substance Use** Substances used, Age at first use	
16		**Alcohol/Drug Assessment** Current volume of use and method of administration	
17		**Prior Treatment Received** Mental health and/or Substance Abuse rehabilitation	
18		**Barriers to Treatment** Legal, Employment or other barriers to Treatment	
19		**Motivation for Treatment** Reasons to enter Treatment at this time	
20		**Recently Incarcerated** Jail/ Prison within past 24 months	
21		**Other** (as appropriate):	
READINESS PLAN DEVELOPMENT			**COMPLIANCE WITH SOC**
22	**Clinical** Documentation of clinical status, connect to primary medical care, oral health)		
23	**Mental Health/Substance Abuse** Refer to mental health and/or substance abuse services, document location of services, type of service (IP, OP, Residential, Individual, Group) and expected tenure (amount of time)		
24	**Client decision to consider referral** Based on above, Client Request for treatment / referral as indicated		
CONSULTATION/ REFEERRAL FOR CARE			**COMPLIANCE WITH SOC**
25	**HIV Medical Care** Ensure that client is either attached to Medical Care or link them		
26	**Dental** Documentation of oral health exam and referral if indicated		
27	**Mental Health** Assessment / Hx / Request for treatment / referral as indicated		
28	**Substance Abuse** Assessment / Hx / Request for treatment / referral as indicated		

Substance Abuse/Recovery Readiness (continued):

	REASSESSMENT		COMPLIANCE WITH SOC
	Re-assessment **Completed and signed/dated by client and case manager**		
29	**PROGRESS: RE-ASSESSMENT**	**In Primary Medical Care? Where? Since When?**	
30		**Risk/Exposure:** update risk within past 6 months, re-examine initial risk/exposure	
31		**In Primary Medical Care? Where? Since When?**	
32		**Mental Health Assessment** GAF Score or other mental health baseline	
33		**Current Substance Use** Substances currently used: types, volume, methods. If not active use, time 'clean' since recovery readiness entry	
34		**Barriers to Treatment (and reduction given service)** Legal, Employment or other barriers to Treatment	
35		**Motivation for Treatment (and enhancement given service)** Reasons to enter Treatment at this time	
36		**Other** (as appropriate):	
DISCHARGE/ TERMINATION			**COMPLIANCE WITH SOC**
37	**Discharge from Recovery Readiness** Documentation of case closure		
38	**Involuntary Termination from Recovery Readiness** Documentation of involuntary termination, reason, correspondence to client		

Y = Yes
N = No
NC=Non-Compliant (cannot be determined from information in chart)
NA=Not Applicable (to patient or program/facility

Emergency Financial Assistance (EFA)

	STRUCTURE	COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible	
4	**Staff Follows Eligibility Guidelines** Staff follows eligibility guidelines for client	
5	**Services are Available** Services are available to those who meet guidelines	
	PROCESS	**COMPLIANCE WITH SOC**
6	**Client Demographics** Age, ethnicity, gender, *risk/exposure* documented	
7	**Collaboration with Other EFA providers** Letter of collaboration between providers and CM agencies	
8	**Alternate Funding Sources** Provider assists in seeking at least 3 alternate funding sources	
9	**EFA Cap** Provider stays within EFA cap or informs MCM when the cap will be exceeded	
	OUTCOME	**COMPLIANCE WITH SOC**
10	**Payments** Routine requests for payment are made within 7 days	
11	**Emergency Requests** Emergency requests for payment are made within 48 hours	

Y = Yes
N = No
NC=Non-Compliant (cannot be determined from information in chart)
NA=Not Applicable (to patient or program/facility

Legal/Health Insurance:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3		**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible	
4		**Program Eligibility & Enrollment Status (annual update)** Current documentation of program eligibility & client enrollment	
5		**Client Consent, Rights and Responsibilities, Confidentiality** Documentation signed & dated by client	
6		**Medical Record Release Forms** Release forms (as necessary) present, current, & signed by client	
7		**Confirmation of HIV Diagnosis** HIV antibody test record, confirmatory lab data, or letter of diagnosis	
8		**Legal Problem List** Present in chart; List of Legal Problems and Category; Health Insurance	
9		**Health Insurance Status Summary** Present in chart, organized, complete & up to date	
INITIAL EVALUATION			**COMPLIANCE WITH SOC**
11		**Client Demographics** Age, ethnicity, appropriate gender, RISK/EXPOSURE - identity clearly and properly indicated	
12		**Initial Assessment** Completed and signed/dated by client and legal aid case worker	
13	**BASELINE: ASSESSMENT**	**In Primary Medical Care? Where? Since When?**	
14		**Legal Issue(s):** *Categorize by the following*:	
A		**Citizenship:** if Immigration or Naturalization issue, refer	
B		**Consumer Finance**	
C		**Family.**	
D		**Education**	
E		**Health**	
F		**Housing**	
G		**Income**	
H		**Individual Rights**	
I		**Job**	
J		**Other** (as appropriate):	
13	**Possible Legal Issues**	**DETERMINATION OF LEGAL ISSUE**: (1) Citizenship (2) Consumer Finance (3) Family (4) Education (5) Health (6) Housing (7) Income (8) Individual Rights (9) Job (10) Other (11) Citizenship (12) Consumer Finance (13) Family (14) Education (15) Health (16) Housing (17) Income (18) Individual Rights (19) Job (20) Other ***(21) Health Insurance***	
14	**Possible Legal Redress**	(22) Counsel & advice (23) Brief Service, (24) Negotiate settlement without litigation, (25) Negotiate settlement with litigation (26) Represent client in non-litigation manner (27) Administrative Agency decision (28) Court decision (29) Referral for other legal assistance	
K		**HEALTH INSURANCE (*see section below*)**	
15	**Possible Actions for Health Insurance Relief**	**ACTIONS**: (30) Global Assessment (31) Application (32) Instruction (33) Obtain Entitlement (34) Hearing (35) Representation of Client	

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Outreach:

CHARTING & MONITORING			COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible		
4	**Program Eligibility & Enrollment Status (annual update)** Current documentation of program eligibility & client enrollment		
5	**Client Consent, Rights and Responsibilities, Confidentiality** Documentation signed & dated by client		
6	**Confirmation of HIV Diagnosis** Letter from Doctor and/or Provider confirming diagnosis and active client		
OUTREACH INTAKE			**COMPLIANCE WITH SOC**
7	**Referral to Outreach** Document when request is made for Outreach (agency/ provider or client requesting, reason for request, date/time and nature of barriers to access necessitating outreach efforts).		
8	**Client Demographics** Age, ethnicity, appropriate gender, address recorded, handicaps		
OUTREACH ASSESSMENT			**COMPLIANCE WITH SOC**
9	**Initial Assessment** Completed and signed/dated by client and Outreach provider		
10	**BASELINE: ASSESSMENT**	**In Primary Medical Care? Where? Since When?**	
11		**Barrier to Care Entry or Re-Entry:** *Categorize by the following*:	
A		**Citizenship:** if Immigration or Naturalization issue, refer	
B		**Consumer Finance**	
C		**Family.**	
D		**Education**	
E		**Health**	
F		**Housing**	
G		**Income**	
H		**Individual Rights**	
I		**Job**	
J		**Other** (List as appropriate):	
K		**HEALTH INSURANCE**	
OUTREACH PROVISION			**COMPLIANCE WITH SOC**
12	**Client Demographics** Age, ethnicity, appropriate gender, address recorded, handicaps (if any)		
13	**Referral to Outreach** Document when request is made for Outreach (agency/ provider or client requesting, reason for request, date/time and nature of barriers to access necessitating outreach efforts).		
14	**Outreach Efforts.** Document response to provider or client, # of attempts to link to services leading to entry or re-entry into HIV medical care, types of services, contact with client and communication to referring provider/agency.		
15	**Provision of disabled access.** Document if any provisions were made to accommodate disability of client, what kind, when.		
16	**Document all no-shows.** Document all failures of client to keep appointments, whether to services or on return, date and time.		
OUTREACH DISCHARGE/ TRANSFER			**COMPLIANCE WITH SOC**
17	**Discharge from Outreach** Documentation of case closure (entered or re-entered in HIV Medical Care)		
18	**Involuntary Termination from Outreach.** Documentation of involuntary termination, reason, correspondence to client and initial referring agency.		
FOLLOW-UP			**COMPLIANCE WITH SOC**
19	**Documentation of Active Engagement in HIV Medical Care.** Documentation of active engagement at 3, 6, 9 and 12 month's post-Outreach service provision.		

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Transportation:

CHARTING & MONITORING		COMPLIANCE WITH SOC
3	**Recordkeeping Requirements** Chart is properly stored & secure; chart is clearly organized; entries legible	
4	**Program Eligibility & Enrollment Status (annual update)**Current documentation of program eligibility & client enrollment -- not eligible for Medicaid or transportation from other funder	
5	**Client Consent, Rights and Responsibilities, Confidentiality** Documentation signed & dated by client	
6	**Confirmation of HIV Diagnosis** Letter from Doctor and/or Provider confirming diagnosis and active client	
MEDICAL TRANSPORT		**COMPLIANCE WITH SOC**
7	**Client Demographics** Age, ethnicity, appropriate gender, address recorded, handicaps (if any)	
8	**Request for Medical Transportation** Document when request is made for medical transportation (date/time), service requested for transport, estimated time of pick-up and drop-off, and address of provider and client.	
9	**Service transported to and from** Document reason for medical transportation, service transported from and to, time of pick-up and drop-off, address of provider and client.	
10	**Provision of disabled access.** Document if any provisions were made to accommodate disability of client, what kind, when.	
11	**Document all no-shows.** Document all failures of client to keep appointments, whether to services or on return, date and time.	
12	**Provide monthly listing of transports by service.** Provide monthly list of medical transports by service to Ryan White Office	
13	**Other**	
DISCHARGE/TERMINATION		**COMPLIANCE WITH SOC**
14	**Discharge from Medical Transportation** Documentation of case closure (secured other transport, no longer eligible, eligible for transport by other payer)	
15	**Involuntary Termination from Medical Transportation** Documentation of involuntary termination, reason, correspondence to client	

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