Ryan White EMA Planning Council

New Haven and Fairfield Counties

Brian Kuerze & Ken Teel, Co-Chairs

Quality Improvement
Meeting Minutes

Meeting Date: Friday, October 5, 2012
Start Time: 12:11 p.m.
End Time: 1:40 p.m.
Location: Burroughs Community Center, Bridgeport, CT
Presiding Chair: Brian Kuerze
Recorder: Virginia Thomas

Summary of Committee Business Votes

A motion to approve the September 7, 2012 Quality Improvement Committee minutes was made by Ric Browne and seconded by Tom Kidder. This passed with 4 for, 0 against and 4 abstentions - detail in Minutes. A motion to approve Technical Assistance Needs Recommendations was made by Ric Browne and seconded by Ken Teel. The recommendations passed with 8 for, 0 against, and 1 abstention.

Attendance Record – 2012

	Planning Council Member	1/6	2/3	3/2	4/12	5/4	7/13	8/3	9/7	10/5	11/2
1.	Ric Browne	Y	Y	Y		Y	Y	Y	Y	Y	
2.	Kenneth Cousar										
3.	Brian Datcher	Y	Y	Y							
4.	Heidi Jenkins				Y						
5.	Tom Kidder	Y	Y	Y	Y	Y	Y	Y	Y	Y	
6.	Brian Kuerze **Co-Chair**		Y		Y	Y		Y		Y	
7.	*Beverly Leach PC Co-Chair*	Y	Y	Y	Y	Y					
8.	Ronald Lee				Y					Y	
9.	Andrew Lyons				Y				Y	Y	
10.	*Leif Mitchell PC Co-Chair*	Y	Y	Y					Y		
11.	Caesar Moffett, Jr.										
12.	Joanne Montgomery	Y		Y							
13.	Alex Ortiz										
14.	Christine Romanik		Exc	Y	Y	Y	Y	Y		Y	
15.	Ray Ruiz, Jr.										
16.	Robert Sideleau					Y		Y	Y	Y	
17.	John Sousa								Y	Y	
18.	Roberta Stewart					Y					
19.	Ken Teel **Co-Chair**	Y	Y	Y	Y	Y	Y		Y	Y	
20.	Dennis Torres					Y					
	Ryan White Office	Y	Y		Y	Y	Y	Y	Y	Y	
	Planning Council Staff	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	% of Council present:	35%	40%	40%	35%	38%	24%	29%	35%		
	Guests: Lauren Tierney, Adaline DeMarrais.										

(1.0) Moment of Silence
Brian Kuerze called the meeting to order at 12:11 p.m. A moment of silence was observed in recognition of all who have been affected by HIV/AIDS.

(2.0) Welcome and Introduction
All participants introduced themselves.

(3.0) Co-Chair Announcements
Given the new bylaw regarding length of Quality Improvement Co-chair, which has been shifted to a 2 year term versus 3 year term, Brian Kuerze will be nearing the end of his term in the next month. Please notify him if you have interest in this position, he would love to speak with you about it. The requirements for eligibility are Planning Council membership for, preferably, more than 6 months. This is an important and valuable way to participate in Quality Improvement and Planning Council, and all interested parties are encouraged to speak with Brian more about the possibility of serving as Co-Chair.

(4.0) Approval of September 7, 2012 QI Meeting Minutes
MOTION 1: A motion to approve the minutes of the September 7, 2012 QI Committee was made by Robert Sideleau and Seconded by Ric Browne.

Edits:

- There was discussion about the overall quality of the minutes and a need for them to better reflect the discussion as it occurred. Some members were concerned that the last meeting minutes, especially in the section about Early Intervention Services, served more as a snapshot of facts instead of communicating how the discussion went. Rob Sideleau mentioned concern over the minutes stating wha he felt to be ungrounded facts about Hep C co-infections, which did not adequately capture how the committee spoke about Early Intervention Services.
- Action items: to better distill the meeting minutes of September 7, 2012 and bullet point main issues discussed. Ex: Issues related to the newly diagnosed, salient facts, peer discussions on what the virus is, health literacy, etc.
- Correction: Ken Teel called the meeting into order.

For: 4 (Tom Kidder, Bob Sideleau, Andrew Lyons and John Sousa)
Against: 0
Abstain: 4 (Christine Romanik, Ric Browne, Ronald Lee, Brian Kuerze)
Ken Teel was not there to vote.

(5.0) New Business/Old Business

a. Review PCAT
The only item on the PCAT for October is that the results from the 2012 Site Visits will go out this afternoon. The QI Committee is on track with the PCAT.

b. Review Technical Assistance needs resulting from 2012 QI Site Visits
Rhonda Stewart from Collaborative Research conferenced in to review the Technical Assistance needs and recommendations. She began by stating that the site review process was amazing overall and a great several weeks.

- First recommendation: While EIS programs are currently working, EIS program development with regard to Standards of Care will help reflect quality improvement indicators and better show the initiatives of the Early Identification of Individuals with

HIV/AIDS. This is also a big part of bringing back those who are unaware of their status.

- Second: revise the Medical Case Management quality indicators to be specific to clinical indicators. This will help free up medical case managers to focus on linking and referring clients; they should not have to be asked to track things that will not keep a client in care and/or is out of their scope of work. Ric Browne agreed and pointed out that often times clinician's recommendations from a first visit are often not followed-up on. Tom Butcher supported this notion by suggesting that the EMA let clinicians make the call on labs, etc. Rhonda finished up this recommendation by stating that as long as clients stay on board with their treatment, the clinical indicators set out by HAB are best to follow.
- Third: review and revise the Substance Abuse Standards of Care for frequency indicators that may not be applicable to certain therapies/treatments. Ex: methadone treatments do not necessarily have an end date. Brian mentioned that it can be difficult to keep up with different measures and that they have always tried to make them more centralized.
- Fourth: Documentation. Rhonda mentioned the quote, "If we don't document, we didn't really do it". There should be a review of mental health services documentation especially including frequency of sessions, start/end times to each session, and session type. There should also be better documentation of follow-up with initial plan or attempts to follow up with initial plan. Discussion of differences to mental health support group documentation vs mental health individual counseling sessions with regards to frequency of sessions was reviewed with the committee in general. Rhonda confirmed that including start and end dates for group therapy would be inapplicable since group therapy sessions are designed to have an open-ended format.
- Fifth: Pods to review documentation with regard to acuity, assessments and reassessments, and prioritizing needs and documentation of care plan with co-constructed goals with client. Rhonda and Tom specified with this recommendation that a co-constructed and well-documented goal with a client would be long term such as, "I want to make it to all my appointments". The tasks are the steps that it takes to complete that goal like, "Arrange medical transportation and child care services for client". Both tasks and goals need to be documented to create a bigger picture for those reviewing the documents.
- Sixth: Monitoring Tools. Every attached recommendation is specific to Ambulatory Outpatient Medical Care. Rhonda stated that overall, clinics are already doing much of what is recommended, but that there should be credit for doing those things by adding them into the monitoring tools and QI plan. HAB= division of HRSA that oversees HIV programs. *See attached recommendations and justifications for further detail.*
- Ken Teel asked for further explanation of the challenge the EMA is facing in not following up with risk reduction counseling twice a year. Tom Butcher explained that there can be cultural barriers with clinicians who have misgivings or discomfort with discussing sexual behaviors and topics, yet in order to approach risk and testing, broaching sexual behaviors is necessary and most effective when mandated.
- Discussion regarding the system level recommendations for EIS indicators was reviewed with committee members to provide examples of quality indicators Tom and the QI staff are considering for the EIS Standard of Care. System level recommendations were reviewed as part of the EIS program and Tom discussed these as an "overview" to present to the committee at a later time for approval.
- The request for approval of the recommendations for Technical Assistance and the addition of the 5 HAB measures to the monitoring tool for AOMC was submitted.

Motion to approve recommendations: Ric Browne
Second: Ken Teel
In favor: 8-For, 0-Against, 1-Abstain
Tom Kidder, Andrew Lyons, Christine Romanik, Robert Sideleau, John Sousa, Ronald Lee, Ric Browne, and Ken Teel.
Abstentions: Brian Kuerze.

(6.0) Announcements

Please speak with Brian Kuerze if you are interested in serving as Co-Chair for the Quality Improvement Committee. His term is almost up and everyone who is interested is encouraged to speak with him about the position.

- The NH AIDS Walk is October 20, 2012. Registration is at 9:30 a.m. and the walk begins at 10:30 a.m.
- The AIDS Project NH now has a crystal meth anonymous meeting once a month.
- The AIDS Project NH is also having an Oktoberfest fundraiser on October 6, 2012. The next meeting is on Friday, November 2, 2012 at the Greek Olive from Noon to 2 p.m.

(7.0) Adjournment

The meeting adjourned at 1:40 p.m.

HAB Measures recommended for addition into current monitoring tool for EMA providers:

HAB Measure	Justification For Recommendation
Percentage of clients with HIV infection on ARVs who are assessed and counseled for adherence two or more times in the measurement year	This measure reflects the importance of adherence to treatment and medications that can impact HIV-related morbidity. HAB based their selection of this measure on studies that showed non-adherence among patients on ARV was the "strongest predictor for failure to achieve viral suppression below the level of detection."
Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of infection	Recommendation for HCV screening annually for those not already positive. HCV/HIV co-infection can predispose HIV-infected patients to liver toxicity from HAART. *Per CDC as reported in the STD Treatment Guidelines, 2010: "All persons with HIV infection should undergo serologic testing for HCV at initial evaluation (130,131). HIV-infected MSM can also acquire HCV after initial screening. Liver function tests should be serially monitored for abnormalities that could be caused by acute viral hepatitis or medication toxicity. HIV-infected persons with new and unexplained increases in ALT should be tested for acute HCV infection. To ensure the detection of acute HCV infection among HIV-infected MSM with high-risk sexual behaviors or concomitant ulcerative STDs, routine HCV testing of HIV-infected MSM should be considered."*
Percentage of clients with HIV infection who have been screened for Hepatitis B virus infection status	Recommend annual screen for HBV for those not immune or positive. 1. "About 20% of all new HBV infections and 10% of all new HAV infections in the US are among MSM. For MSM not infected with HBV or HAV, any sexual activity with an infected person increases their risk. In particular, unprotected anal sex increases the risk for both HBV and HIV among MSM, and direct anal-oral contact increases the risk for HAV." (CDC Fact Sheet, HIV and Viral Hepatitis, Nov. 2011) **2. Ways people can be infected with Hepatitis B per CDC**: Contact with infectious blood, semen, and other body fluids, primarily through birth to a mother who has hepatitis B; sexual contact with an infected person; sharing of contaminated needles, syringes, or other injection drug equipment; and needlesticks or other sharp instrument injuries. (IBID)

HAB Measure	Justification For Recommendation
Percentage of clients with HIV infection at risk for sexually transmitted infections (STI) who had a test for chlamydia within the measurement year	Recommend annual screening for Chlamydia. 1. Dr. Gail Bolen, Director of the Division of Sexually Transmitted Disease (STD) Prevention at CDC reported the following recommendation in her commentary on January 9, 2012: "Annual screening for HIV (in uninfected patients) and for bacterial STDs, such as syphilis, gonorrhea, and chlamydia, is recommended for all sexually active MSM. More frequent screening is indicated for MSM who are at higher risk, such as those who have multiple or anonymous partners, those who have sex in conjunction with illicit drug use (such as methamphetamine), and those who have drug-using partners; these higher-risk MSM should be screened every 3-6 months." 2. CDC recommends yearly chlamydia testing of all sexually active women age 25 or younger, older women with risk factors for chlamydial infections (those who have a new sex partner or multiple sex partners), and all pregnant women. (CDC Chlamydia Fact Sheet, Feb. 2012)
Percentage of clients with HIV infection at risk for sexually transmitted infections (STI) who had a test for gonorrhea within the measurement year	Recommend annual screening for Gonorrhea. 1. Dr. Gail Bolen, Director of the Division of Sexually Transmitted Disease (STD) Prevention at CDC reported the following recommendation in her commentary on January 9, 2012: "Annual screening for HIV (in uninfected patients) and for bacterial STDs, such as syphilis, gonorrhea, and chlamydia, is recommended for all sexually active MSM. More frequent screening is indicated for MSM who are at higher risk, such as those who have multiple or anonymous partners, those who have sex in conjunction with illicit drug use (such as methamphetamine), and those who have drug-using partners; these higher-risk MSM should be screened every 3-6 months." 2. CDC recommends annually screening for sexually active MSM, bi-sexual men, and high-risk sexually active women at least once a year. (CDC Fact Sheet, Gonorrhea Treatment Guidelines, August 2012)

System Level Indicators:

Indicator	Justification for Recommendation
Percentage of clients who, upon testing,	This is representative of EIS system levels of care

received HIV+ disease stage diagnosis that remain stable in CDC HIV-disease stage at 6 months with medical care	ensuring clients are engaging in medical care and treatment adherence with the goal of remaining with CDC defined HIV disease stage diagnosis within the first 6 months of their entry into medical care. EIIHA strategy presenting outcomes to represent "referral and linkage" to care progress.
Percentage of clients who receive confirmatory testing within two weeks of HIV+ rapid test	EIS system of care indicator ensuring clients are linked to medical care for confirmatory testing and engage in medical care as soon as confirmed. EIIHA strategy and would present outcomes to represent "informing, referring and linking" progress for engaging clients in care; also follows NHAS goal to reduce unaware