.Nassau-Suffolk HIV Health Services Planning Council
Clinical Quality Management Committee
October 28, 2021
Virtual Zoom Meeting

MINUTES

MEMBERS PRESENT:	MEMBERS ABSENT:	GUESTS
Darlene Rosch, Esq	Joseph Pirone, Co-Chair	Kristy Cordero
Janice Davidson	Kevin McHugh	Felix Ruiz
William Doepper	Erik Rios	David Modello
Ana Huezo	Traci Shelton	
Juli Grey-Owens	Edward Soto	
Teresa Maestre		
Johnny Mora		
Hope Sender		
Claire Simon		
Crissy Witzke		
Kerry Thomas		

STAFF:	STAFF Absent:
Georgette Beal	
Nancy O'Keefe	
JoAnn Henn	
Myra Alston	
Katie Ramirez	

I. Welcome & Introduction

Ms. Rosch, Co-chair, opened the meeting at 10:06 am. She welcomed everyone, then requested a moment of silence to remember everyone who has come before us and the purpose of why we are here today.

II. Approval of August 26, 2021 Minutes

Mr. Doepper made a motion and Ms. Grey-Owens seconded the motion to accept the August 26, 2021 meeting minutes as amended.
3 Abstentions 0 Opposed 7 Approved. Motion carried.

III. Congratulations to the CQM Co-chairs for the new committee term.

The results of the new Co-Chairs for the upcoming term were announced. Ms. Darlene Rosch and Mr. Doepper were voted as the Co-Chairs. Congratulations were extended.

IV. Administrative Mechanism Report

The Administrative Mechanism, a HRSA grant requirement, is an annual assessment which evaluates the efficiency of the process used by Nassau County and UWLI to rapidly allocate funds to priority areas in terms of timeliness and effectiveness and in carrying out or overseeing the contracting process.

Surveys were sent to Planning Council members and funded Part A providers. Questions for Council members were specific to the Council, its mission, trainings, and the PSRA process. Provider questions focused on distribution of funds in FY 20-21, contract monitoring, and knowledge of PSRA process. These surveys review the previous year planning process and the priorities that are funded in the current fiscal year. The Planning Council is responsible for making formal recommendations to the CEO of the EMA in order to continue the timeliness and effectiveness of the contracting process.

The findings of the FY20-21 Administrative Mechanism illustrated how the Planning Council, PSRA Process, the administration of funds, and technical assistance all work together to ensure that needs are being met. Survey results confirm that the EMA is effective at both allocating and reallocating funds to priorities that mirror the needs of the region and are supported through needs assessments and data collection.

Council members indicated a clear understanding of the PSRA process, a key component of the administrative mechanism. All (100%) council members replied that they were familiar with the process and 90.91% reported participating in the process through Planning Council and committee meetings. Members agreed that the process was data driven and an overwhelming majority reported that the needs of special populations were addressed.

More than 93% of providers (an increase over the previous year) were familiar with the PSRA process. An overwhelming majority also agreed the process was data driven and addressed the needs of special populations. A small percentage of both PC members and providers, (less than 8%), replied that the needs of IDU were not considered; 4.55% of members did not think that the needs of MSM were considered in the planning process.

The COVID-19 pandemic forced the EMA to re-examine how it approached its planning processes, contracting and vouchering systems in FY20. Specifically, the Planning Council had to adjust the manner in which meetings and the PSRA process were conducted. Consequently, all meetings were moved to a virtual platform. United Way also had to amend its contracting process, the process for submitting and approving vouchers and how programs would be monitored when many providers were operating remotely.

A significant number of survey respondents recommended keeping many of the changes that were implemented; 85.71% of providers replied that contracting changes made it easier for agencies to get contracted; 78.57% responded that vouchering changes simplified the vouchering process. All respondents agreed that contract managers and fiscal staff were accessible, and that technical assistance, when requested was reported as both timely and helpful.

A deficiency that was identified is the need for the EMA to continue working to shorten the length of time for processing vouchers. While 85.71% of providers responded that vouchers were paid in a timely manner, approximately half also indicated that the average time for UWLI to reimburse an agency once a complete contract had been submitted was over 30 days. However, further examination revealed that some of the delays were due to missing documentation, voucher error or late submission. Once contracted, 93% of vouchers were paid within one month. While not mentioned by survey respondents, it was deemed that contracting delays had an impact on the perception of late payments. From the time CFAs were sent to the date of signature

took up to 4 months in 2020. In general, payments were timely. ACH deposits implemented in 2021 will continue to have a greater impact on timeliness and ways to improve the contracting process will continue to be examined. New multi-year funding should greatly reduce the contracting time moving forward.

Despite challenges, all agencies were monitored and received a comprehensive site visit in FY 20-21 and provider requirements were minimized to reduce burden as much as possible. While in-person site visits were preferable and viewed as easier by some providers, given the current health crisis, visits will continue virtually in FY21. Provider survey respondents suggested the addition of mid-year or quarterly check-ins and meetings between contract administrators and providers in addition to site visits.

Ms. Huezo made a motion to approve the Administrative Mechanism report, which was seconded by Mr. Thomas. The report will be presented to the full council in November 2021.

V. Review of PCN #21-02:Eligibility Recertification

There have been changes to the Policy Clarification Notice (PCN) 21-12 determining client eligibility & payor of last resort in the Ryan White HIV/AIDS Program. Although eligibility is still a requirement, the purpose of this policy change is to reduce administrative and client burden while enhancing continuity of care to ensure that clients have access to medical and support services in order to achieve viral suppression.

Two major changes have been incorporated in PCN 21-02: The elimination of the six month eligibility recertification requirement, which was replaced with allowing RWHAP recipients and sub-recipients the flexibility to conduct timely eligibility confirmation in accordance with their policies and procedures in order to assess if there are changes in client's income and/or residency status. Although each agency has their own set of policies and procedures, guidance will be offered to providers to help maintain continuity. The PCN also affirmatively stated that immigration status is irrelevant for the purpose of eligibility for RWHAP services. Since the EMA has not included immigration status in eligibility determinations in the past, there will be no changes regarding this.

A letter will be sent to providers before this change in eligibility recertification takes effect on January 1, 2022. The Service Standards will also reflect these changes. To clarify, only the recertification process is changing. The eligibility recertification differs from the 6 month client reassessment. Recertification refers to confirming client's eligibility for Ryan White Part A service. Reassessment refers to reassessing clients service needs and updating care and treatment plans that were agreed on by the client and provider for any changes in need. The timing of these reassessments have not changed.

The N-S EMA recognizes the challenges that programs experience when checking eligibility with clients who are seen sporadically throughout the contract year. For example, a client seen ten months after their initial eligibility determination will now have their recertification done the ten month visit/service. This change will also be useful with clients who request services infrequently and will also reduce the burden on both clients and staff to collect documents that may not be relevant. Moreover, clients who have a change in eligibility requirements, such as a

change in address, will have their recertification done at that time. The guidance continues to allow for client self-attestation, but sparingly.

The EMA expects agencies/institutions with more than one funded program to create processes for sharing client eligibility across priorities so that each priority will have the ability to access eligibility documents, this will reduce clients continually be asked the same eligibility questions within the same agency. Providers are also strongly encouraged to do more on their end to determine client eligibility.

VI. Regional CQM Update

In a PowerPoint presentation, Ms. O'Keefe shared the FY20-21 Clinical Quality Management Results. For this contract year, each program was provided a tool that contained criteria from the EMA's Service Standards and HIV/AIDS Bureau performance measures and was asked to audit ten client records for each funded priority. A total of 236 records were reviewed by 14 agencies funded to provide services under 25 priorities. Two EIS programs served less than 10 clients, which accounts for the number of client records not ending in zero. It should be noted that restrictions placed on UWLI RW Part A/MAI and program staff due to the COVID -19 pandemic influenced how this review was conducted and necessitated the agency self-audit.

There was a breakdown of the number of funded providers for the priorities reviewed for Core and Support Services. Reported outcomes illustrated how compliant programs were for the elements on which they were reviewed. Elements reviewed differed as they were specific to the funded priority. Only elements that were scored at below 90%, required follow up. An agency was considered to be compliant if it scored 90%, a recognized standard to ensure clients receive quality care, or above.

Outcomes:

- Emergency Financial Assistance (EFA) was compliant on the eight elements on which it was reviewed.
- Early Intervention Services (EIS) was compliant on all fourteen elements.
- Medical Case Management (MCM) the seven programs funded to provide MCM services were compliant on 24 of 26 elements.
- Mental Health (MH) were compliant on 9 of 12 elements. The 3 elements that scored below 90%, were asked in other programs but were not necessarily documented under the Mental Health service.
- Medical Nutrition Therapy (MNT) were compliant on 16 of the 17 elements. The one element, *budgeting and shopping* may have been asked by not documented under that priority.
- Medical transportation (MT) was compliant on the seven elements on which it was reviewed.
- Oral Health (OH) were compliant on 12 of the 20 elements. As a follow up, technical assistance will be provided to the agencies to assist and improve percentages.
- Outpatient Ambulatory Health Services (OAHS)- scored 90% on seven of nine elements. Follow up is planned.
- Other professional Services-Legal OPS-legal) was compliant on all five elements on which it was reviewed.

Retention in Care Data and Next Steps.

The CDC HIV Surveillance Data as of 12/31/2020 (which covers years 2017-2019), across the Care Continuum was shared with the committee. Data for the four stages: Diagnosed, Receipt of Care, Retained in Care, and Viral Load Suppression for the three year period was shown. Overall the numbers look better than other TGAs and EMAs. Stage 3, Retention in Care for the three year period, hovered at 65%. Committee members were asked if this number seemed accurate and what may be some of the reasons for the relatively low percentage. The actual definition for Retained in Care is, *any person 13 years or older, diagnosed with HIV who had (2) care visits documented by test results for CD4 or viral load at least 90 days apart in a calendar year.* Timing is not necessarily taken into account. An individual diagnosed at the end of the year, would have only one visit in a calendar year. A provider may only require one annual visit. The client is still retained in care, but not reflected in the CDC data. Some individuals, like snowbirds, may not live in the state year round. Although they have had two care visits in a calendar year, the visits may have been in separate states. Consequently, the data may not accurately depict what is happening in the EMA and is not best practice. The definition of retained in care may need to be changed or be addressed in the Integrated Plan. Funded providers should be asked about clients retained care to better assess the accuracy of the reported 65%.

VII. Announcements/Adjournment

World AIDS Day is December first and there are a number of events are planned.

- The Planning Council's World AIDS Day committee is planning a virtual event for Friday, December 3rd from 7pm-8:30pm. There will be a panel discussion in addition to awards, invocation, and candlelight ceremony. A Save the Date flyer will be sent out.
- Northwell CART will be having a virtual event on December 1, 2022. Flyer to be sent.
- Ms. Simon informed the committee that the state is planning World AIDS Day events from 12/1/2021-12/3/2-021. Details to follow.

Ms. Huezo made a motion to adjourn the October 28, 2021 CQM meeting. The motion was seconded by Mr. Doepper.

Membership sub-committee

There was a Membership Sub-committee meeting to review two Planning Council applications. Planning Council membership demographics were also part of the discussion. It was decided that both candidates would be balloted after the November Planning Council meeting. A Survey Monkey link would be sent to Planning Council members after which the required documentation will be sent to the county.