Austin Area Comprehensive HIV Planning Council
Evaluations Quality Management Committee Meeting Minutes
January 9, 2017

Charge: Ensures the orderly and integrated and progression of work of the committees of the Ryan White Planning Council. Plans future activities.

MEMBERS PRESENT

Justin Smith
Whitney Bulna
Emma Sinnott

AACHPC STAFF PRESENT

Laura Still, Planner
Scott Lyles, Program Coordinator

ADMINISTRATIVE AGENT STAFF PRESENT

Brenda Mendiola Quality Management Coordinator Administrative Agent

OTHERS PRESENT

I. Call to Order: AACHPC Chair, Justin Smith at 6:05pm

II. Certification of Quorum: Quorum was established and certified by Chair, Justin Smith

III. Introductions/Announcements:

- Emma Sinnott announced a scholarship application for four (4) $7000.00 awards from the HIV Scholarship League is available for students living with HIV, information to be shared with providers and published on HIV PC Facebook page.

IV. Approval of the November 14th, 2017 Minutes: *Chair, Justin Smith motioned the minutes to be Approved as submitted*

V. Review and Discuss Standards of Care Comments:

The Evaluations Quality Management Committee reviewed and discussed preliminary comments on the DSHS draft service standard:

- **Universal Standards**

#	Item	Page#	Comment (include Citation or Justification if applicable)
1	Sections N & O **Overall**	N/A	Highly duplicative between services. The Universal standard is supposed to be "bare bones" and the goal of the universal standard was to reduce duplication, but sections N and O seem to just add more duplication.
2	Sections N & O **Overall**	N/A	Each service category in section N and O that has a similar section, e.g., Discharge or policies and procedures for qualified staff, make sure language is consistent. Even better, possible to take these statements out of each service and just have a single generic statement that covers all service categories.
3	Sections N & O **Overall**	N/A	Sections N and O are generally more specific and beyond the scope of a "Universal "Standard. Some specific information that should be in the service category SOC is instead placed in the Universal Standard. This will make it difficult to track changes and updated them. Unclear what the intention behind sections N and O is. The information that is in the Universal Standards sections N and O is inconsistent between the service categories. For example, discharge information should be in all the service categories for sections N and O or none of them (because it is already in the SOC for each service).
4	**OAHS** Sub-recipient Responsibility	23	5. "Peer review will be conducted and documented for all levels of licensed/credentialed providers." a. This needs to define the specific provider. As it is now, this opens this requirement to LCSW, RDs, RNs, and CNA. Chart review is not a part of the credentialing for these staff. Only prescribing staff. b. The term Peer Review should be changed to chart review, as Peer Review has a negative and stronger connotation. And as it is no organization will conduct a peer review annually for all providers. Chart review is done quarterly for credentialing.

5	Sub-recipient Responsibility	23	6. Can number 6 be combined with number 3 to be clearer? Keeping HR files that depict qualifications for staff would suffice as clear instruction for this standard.
6	Sub-recipient Responsibility	23	7. "All staff lacking experience with HIV must be supervised by an employee with at least 1 year of experience." This can be problematic, especially if the new staff is an MD out of residency. We cannot require supervision by another medical provider. Is this just trying to say that the chain of command must have experience? For instance, the Medical Director may have experience with HIV so that counts as the supervision of medical providers new to HIV?
7	Sub-recipient responsibility	23	Strike bullet 7: doesn't qualify what "lacking" is and it is an unreasonable expectation for service providers.
8	Sub-recipient responsibilities	23	Combine #3 and #6 for clarity: "maintain certification, licensure and education documents"
9	Sub-recipient responsibility	23	#5 needs a more specific term to define "licensed providers". A common one would be "licensed prescribing provider." Need a reference from standard guidance/best practices for the choice of provider term.
10	Sub-recipient responsibility	23	#5 Stipulate what is meant by "peer review"
11	**LPAP** Sub-recipient Responsibility	24	Who is "Recipient" referring to? Is this the AA or DSHS? Can this be stated for clarity?
12	Sub-recipient Responsibility	24	Much of what is listed is duplicative of what is required for pharmacy licensure in the state of Texas. It may be easier to just state that a pharmacy must be licensed. The Texas State board of pharmacy should be listed as a reference.
13	Sub-recipient responsibility	24	#9- #13 can be removed and instead reference the Texas Board of Pharmacy standards (less duplication and any slight variation or updates from the Texas Board of Pharmacy would require an update to this section- too specific for a Universal standard)
14	Sub-recipient responsibility	24	# 14 is duplicative of #7
15	Sub-Recipient Responsibility	24	Add: Maintain documentation that medication was received by client, including client signature and date.
16	**Health Insurance** Sub-recipient responsibility	27	#2: Agency has policy that outlines caps on assistance/payment limits and adheres to DSHS Policy. What does the sub-recipient do when the administrative agent has not set a cap or limits for this category?
17	Performance Measure/ Method	27	"Documentation of client's low income status." Define low income status. What is the required FPL in order for a client to meet eligibility requirements?
18	Overall	27	Standards do not clearly state if assistance can be used to cover services not HIV related.
19	**Mental Health Services** Standard	30	"Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers." Advance Practice Nurses (APNs) should also be listed. APNs frequently provide psychiatric care in community mental health settings.
20	Sub-recipient Responsibility	30	Standards to not clearly state if assistance can be used to cover services not HIV related.
21	Sub-recipient Responsibility	30	#4 "Policies/procedures in place"- remove. Is not specific to Mental Health Services as a service category. Recommend to indicate once that it applies to all service categories and then remove from each individual category in sections N and O
22	Sub-recipient Responsibility	30	#7- Remove- is beyond the scope of Universal standards (too specific and should be incorporated into the MHS standard, not the Universal Standard)
23	Sub-recipient Responsibility	30	#5 clarify- What is meant by "supervision"- manager or technical oversite? Also, may be duplicative of previous bullets and possibly removed.
24	Sub-recipient responsibility	30	"5. Agency has a policy for regular supervision of all licensed staff." Worth noting there is no source citation showing where this requirement is coming from. This is a strange phrase because the mental health professionals listed: psychiatrists, psychologists and licensed clinical social workers all have terminal licensure, meaning that they can practice

			independently without the requirement of being under clinical supervision by the state of Texas, unlike an LMSW, who would have to practice under the clinical supervision of an LCSW supervisor in order to obtain hours of practice and hours of clinical supervision prior to taking the state LCSW licensing exam. All staff are under the administrative supervision of each program's program manager, as well as under the supervision of Medical Director and/or the Associate Medical Director. In addition, all LCSWs participate in weekly Clinical staffing meetings and can meet with the Program Manager and/or the Clinical Team Lead, who is also an LCSW, in order to staff clinical issues and concerns.
25	**Medical Nutrition Therapy**	31	Sub-recipient Responsibility: Combine #2 and #3
26	Sub-recipient Responsibility	31	#5 should be "distributing," not "administering." Also, wording is unclear around "tracking inventory." Change to "obtaining, storing, and administering…"
27	**Medical Case Management**	32-34	Performance Measure/Method: Items listed under number 5 through 8 aren't measures to assess a contractors work; it seems like directive that, if necessary, should be included in the category standards and not the Universal Standards.
28	Performance Measure/ Method	32-34	#1- #5 &#7 & #10 : are Universal, should be written once, not repeated for each service category Ie. "service providers are trained professionals…" is not specific to MCM Ie. #10- personnel management is not MCM specific
29	Performance Measure/ Method	32-34	#6 too specific for a Universal standard
30	Performance Measure/ Method	32-34	What does "more time than usual" mean?
31	Performance Measure/ Method	32-34	All performance measures in this section are guidance, not actual measures
32	Performance Measure/ Method	32-34	#9 "desired" is not a measure, can remove this bullet
33	Performance Measure/ Method	32-34	"Documentation that service providers are trained professionals, either medically credentialed persons or other health care staff who are part of the clinical team." Could this include licensed social workers? Could this include case managers who have been already doing the activities listed as non-medical for over 5 years? Our agency has many non-medical case managers who do above and beyond, including some tasks listed as medical case management. All of these case managers have been in this field for 5 years or more and have extensive case management training.
34	Sub-recipient Responsibility	32-34	Aside from hiring criteria (which is more appropriately included in the service category SOC and is too specific to be in the Universal), there is nothing specific to MCM in this section. Consider consolidating and removing generic information.
35	Sub-recipient Responsibility	32-34	#3: P&P are in place for the following: Viral Suppression/Treatment Adherence—can you elaborate on what is expected in this P&P
36	Sub-recipient Responsibility	32-34	Almost all case managers do medical case management and not all agencies can hire medically credentialed staff or health care professionals because the medical case manager does more than just medical. The credentials for medical case management should be fixed.
37	**Substance Abuse Outpatient**	35-36	Performance Measure/Method: Should item number 6 be listed as a measure and a sub-recipient responsibility? If it were listed as a sub-recipient responsibility, the amount listed under sub-recipient could be reduced.
38	Performance Measure/ Method	35-36	"7. Supervisors' files reflect notes of weekly supervisory conferences." Does this refer to weekly clinical staffing meetings, or to notes for staff who are receiving clinical supervision toward LCDC licensure?
39	Sub-recipient Responsibility	35-36	"7. Each staff member will have documentation of minimum experience to include: • Two years of experience in HIV or other catastrophic illness and continuing education in HIV • One year of experience in family counseling as pertaining to substance use • Non-violent crisis intervention training

			• Training in mental health issues and knowing when to refer a client to a mental health program/counselor." What is the reason for this requirement? There is nothing comparable for Mental Health Services? No citation given. How is Interdisciplinary Case Conferences defined? It's important to staff clients and challenging client situation, but why make an arbitrary requirement to staff all clients? It also seems strange that this documentation would be attached to the client's electronic health record.
40	Sub-recipient Responsibility	35-36	"9. Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months. Case Conference documentation, signed by the supervisor, in client record will include: • Date, name of participants and name of client • Issues and concerns • Follow-up plan • Clinical guidance provided" What is the reason for this requirement? There is nothing comparable for Mental Health Services? No citation given. How is Interdisciplinary Case Conferences defined? It's important to staff clients and challenging client situation, but why make an arbitrary requirement to staff all clients? It also seems strange that this documentation would be attached to the client's electronic health record.
41	**Non-Medical Case Management** Performance Measure/ Method	37	4. Supervisor signature and date, signifying review and approval of initial comprehensive assessment, for case managers during their probationary period. This requirement increases administrative work for supervisor since each agency has various lengths and times to define probationary period. At our agency probationary period is defined as first 6 months of work, whereas case managers probably do not need every comprehensive assessment checked off past the first 60 days of employment.
42	Sub-recipient Responsibility	37	#2: What all does assuring this entail? Not clear.
43	**Food Bank** Sub-recipient Responsibility	39	Applications for large groups coming in: this would be a major determent for getting large, one time groups to volunteer. Applications are done for all individual volunteers. Overall job description for volunteers and different programs; there is not a job description for individual volunteer duties within the Food Bank. There are policies and procedures around individual duties regarding the safety factor of these tasks. No file on hand for one time volunteers in large groups.
44	**Substance Abuse Services (residential)** Sub-recipient Responsibility	48-49	"11. Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active patient at least once every six (6) months." Why is this requirement not as specific as the one listed above for Substance Abuse Outpatient Care in item #9? There is no requirement for proof of said staffing to be included in the client's record.
45	Sub-recipient Responsibility	48-49	"7. Documentation of supervision during patient interaction with Counselors In Training (CIT) or Interns as required by DSHS." "11. Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active patient at least once every six (6) months." 13. Agency will have a policy and procedure for patients to follow if they need after-hours assistance. Why the language change from "client" to "patient"? It seems arbitrary. Like we've been using client throughout the majority of this document, but just to change it up, let's say patient now instead. Or, since this section refers to a residential treatment setting, they're patients now, not clients. It seems strange and random and pointless.

- **OAHS**

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	General		General: Need to reference clinical guidelines, instead of define clinical guidelines in the text- reference a clinical practice. This would reduce need for repeat edits and would reference best practice without fear of clinical guidelines in the SOC being different from other best practice/guidelines.

	General		General: If you reference clinical practice, then they shouldn't have to include explicit content about clinical practice in the Universal standard i.e. clinical cancer screen (had to include details of cancer screen that are too complex for this level of document) and CD4 count (incorrect- do not need to test everyone every 3 months for CD4), i.e., Pap during initial… (just reference the guidance/best practice from, for example, US Preventative Services Taskforce)
			Remove "and screening" from oral health assessment. Screening implies that you are evaluating for a specific condition
1.	Physical Examination	3	"Examination of oral cavity should be included in both the initial and interim physical examination of all HIV patients". The measure to assess this is related to seeing a dentist which is not the same as a medical oral exam. Providers will exam the oral cavity; however they cannot conduct a dental visit. What is really being measured here? Are you looking for documentation that a provider talked with a patient about dental care? I know it's a HAB measure, but it doesn't fit with this standard. Physical Examination Section: Oral cavity screening- performance measure- duplicated and requires oral exam by a dentist (should not be a criteria of a physician's examination)
2.	Initial Screening/Assessments	5	There is an extra * listed after housing status. Is this supposed to reference something or is it a mistake?
3.	Initial screening/assessment	5	"Screenings should include at a minimum: • Oral health and screening" An oral health screening is listed as a requirement for initial screening and assessment. Is this in reference to an examination of the oral cavity or a dental assessment? If it is a dental assessment, it is difficult to have that built into an OAHS visit. Maybe rewording to standard to require documentation of oral health discuss with patient. Remove "and screening" from oral health assessment. Screening implies that you are evaluating for a specific condition
4.	Initial Screening/Assessment	5	"Cervical Cancer Screen" – this may be difficult to fit into an initial appointment. Also, these may be completed as a referral and not onsite. How is this accounted
5.	Initial screening/assessment	5	"Cervical Cancer Screen" – it may be worth noting the standard is to comply with current clinical recommendations rather than spelling everything out – this would minimize the need for updating when changes are made.
6.	Follow up visits	13	'Every 3-6 months" – CD4 count. This is not in line with clinical recommendation for virally suppressed stable patients. Requiring this frequency may be problematic for patients who routinely move on and off the RW program – issuance companies may not pay for high frequency testing.

Final vote for adoption by Planning Council

- **APA (LPAP) -**Tabled
- **Emergency Financial Assistance-**Tabled
- **Outreach –**Tabled
- **Substance Abuse Outpatient-**Tabled
- **Substance Abuse Residential-**Tabled

VI. Meeting Adjourned at 9:23 pm

NEXT SCHEDULED MEETING

TBD