RYAN WHITE CARE COUNCIL
CHILDREN'S BOARD, TAMPA
WEDNESDAY, JULY 7, 2010
1:30 P.M. - 3:30 P.M.

MINUTES

CALL TO ORDER

The meeting of the Ryan White Care Council was called to order by Dave Konnerth, Chair at 1:40 p.m.

ATTENDANCE

See attached attendance list.

CHANGES TO AGENDA

There were no changes to the agenda.

ADOPTION OF MINUTES

The minutes for June 2 were approved with 18 yes votes and 0 no votes.

CHAIR/VICE CHAIR'S REPORT

Dave Konnerth shared that three members have recently resigned.

Janet asked anyone willing to serve as a mentor to new members let Nicole know so that mentoring assignments can be made. Staff reminded everyone that the meeting space is reserved for an additional 90 minutes before each meeting to allow time for individuals to meet and discuss items.

GRANTEE'S REPORT

Aubrey Arnold shared that Hillsborough County government has consolidated some departments. Family and Aging Services will now be the department that has oversight for the Ryan White Program.

The Quality Management workgroup will hold their next meeting on July 9th. The Assessment of the Administrative Mechanism is underway with surveys released for providers and coming soon for Care Council members. A provider meeting is scheduled for August 13th.

Aubrey stated that our local area has been working diligently to address the waiting list created on July 1st when ADAP (AIDS Drug Assistance Program) capped enrollment. As of July 2nd there were 2090 waitlisted clients and 523 in Florida. There were 80 in our four county EMA (Eligible Metropolitan Area). ADAP will implement formulary restrictions beginning August 1st and only include Antiretrovirals (ARVs) and medications for opportunistic infections (OIs). The Department of Health has funded temporary positions in both Hillsborough and Pinellas counties to assist eligible clients with accessing the Patient Assistance Programs (PAPs) to get medications directly from the pharmaceutical companies.

Health Services Advisory Committee (HSAC) held a summit meeting on July 17 to discuss how to fill the gap at the local level and help clients to continue getting necessary medications with limited funding. At this time, our local formulary remains open as a wrap around to ADAP. Utilization will be monitored while encouraging the use of other resources. HSAC will consider other strategies and their impact with additional recommendations forthcoming.

The State is considering adjusting the state Eligibility Rule 64D to restrict income. This is being carefully considered as there would also be an impact to other patient care programs. Members reminded the group that there is a difference between eligibility requirements and qualifications for individual programs and services. Individual program/service qualifications may be more restrictive than the state eligibility requirements.

ADAP clients are considered out of compliance with program requirements if they do not pick up their medications by the 60th day. Their case is closed out that day at the end of business by the state's database. It is imperative that clients communicate with their case manager or the local ADAP office if they have circumstances (hospitalization, jail, etc) that would keep them from their scheduled pickup.

COMMITTEE REPORTS

A. Client Services – Randy Masters, Co-Chair

The committee discussed the exclusion of asymptomatic clients from AICP (AIDS Insurance Continuation Program) and presented a motion for the Care Council to review the issue. Since all work is done at the committee level and Planning and Evaluation has reviewed this topic, it was decided that the Care Council Chair would create a letter to the HIV Bureau Chief indicating the local position that asymptomatic individuals be included in AICP.

The committee also presented a motion that the Care Council defines 'wait list'. Again, since all Care Council work is done in committees, this item was deferred to the Planning and Evaluation Committee and will be on their August agenda.

The committee presented a third motion about the urgency of meeting client needs, but felt this item needed further discussion at the next Client Services meeting and may be resolved with the definition of 'wait list'.

B. Health Services Advisory Committee (HSAC) – John Melartin, Co-Chair

The summit information was shared during the Grantee's report. The committee did not hold a regular business meeting.

C. Membership – John Melartin, member

The committee presented the slate of new care Council members. The following motion passed with 15 yes votes, 0 no votes and 1 abstention (Freeman):

THAT THE SLATE* OF MEMBERS FOR THE 2010-2013 TERM BE ADOPTED BY THE CARE COUNCIL.

*As per the bylaws, members must vote on the entire slate, not on individual candidates.

NEW VOTING MEMBER SLATE
September 1, 2010 – August 31, 2013

Applicant Name	County
Martin Clemmons	Pinellas
Nolan Finn	Pinellas
Tonicia Freeman	Pinellas
Pam Gatches-Fort	Hillsborough
David Hasiba	Pinellas
John Melartin	Pinellas
Ricardo Mendiola	Pinellas
Jerry Nealy	Hillsborough
Rachel Pennington	Hillsborough
Christopher Spall	Pinellas
Brian Sprague	Pinellas

The slate of new members will be presented to the Hillsborough County board of County Commissioners for final appointment.

D. Minority Advocacy Committee (MAC) –

The committee did not meet in June.

E. Planning and Evaluation (P&E) – Marty Clemmons, Chair

The committee discussed the exclusion of asymptomatic individuals from AICP (AIDS Insurance Continuation Program) and the impact to our local Insurance Services Program (ISP). Members asked the ISP provider to supply all client enrollment eligibility criteria, specific services provided, waitlist and other policies so that the committee could better understand the program.

F. Resource Prioritization and Allocation Recommendations Committee (RPARC) – Marty Clemmons, Chair

The committee reviewed the survey questions and letters to providers and Care Council members for the Assessment of the Administrative Mechanism (AAM). The committee also reviewed expenditure data for all services and funding streams. Members were pleased to see that out of

our $9M grant for part A, we spent out 99.3%. Carry-over has been requested.

The Grantee's office is presenting the Care Council members an abbreviated version of those final expenditures for review. For clarity, the Care Council is presented with expenditures by service category and county, but not broken down to the individual contract level.

The committee presented the MAI allocations for the FY 10-11. Part A MAI funds are being synchronized with the Part A cycle effective this year (FY 10-11) and in order to accomplish that the allocations need to be realigned to reflect the actual grant award, which was a *decrease* for MAI.

The FY 09-10 award totaled $558,209, but the FY 10-11 MAI award is $532,414. Actual service dollars must decrease $23,216. The recommendation to decrease the Substance Abuse/Hispanic allocation is based on the fact that this is the only service category that is not being completely utilized in the current funding cycle.

Since MAI has adjusted their fiscal year, contracts that are awarded in August will only have seven months to spend their funds because the grant year will end with Part A fiscal year end in February. Beginning March 1, MAI and Part A will again operate on the same fiscal year. The following motion passed with 16 yes votes and 0 no votes:

THAT THE CARE COUNCIL ADOPTS THE FY 10-11 MAI ALLOCATIONS AS FOLLOWS:

MAI ALLOCATION RECOMMENDATIONS FY 2010-11				
Service	**County**	**Allocations FY 09-10**	**Allocations FY 10-11**	**Difference +/-**
Substance Abuse Treatment/Black	Hillsborough/ Pinellas	$58,765	$58,765	**0**
Substance Abuse Treatment/Hispanic	Hillsborough/ Pinellas	$39,177	$15,961	**$23,216**
Treatment Adherence/Black	Pinellas	$74,940	$74,940	**0**
Treatment Adherence/Hispanic	Pinellas	$64,550	$64,550	**0**
Treatment Adherence/Black	Hillsborough	$83,542	$83,542	**0**
Treatment Adherence/Hispanic	Hillsborough	$84,824	$84,824	**0**
Treatment Adherence/Black	Pasco/Hernando	$48,097	$48,097	**0**
Treatment	Pasco/Hernando			

Adherence/Hispanic		$47,909	$47,909	**0**
	Total Contracted	$501,804	$478,588	**$23,216**

G. Rural Issues – Randy Masters, Chair

The committee planned their August meeting in Pasco County – Dade City. They are hoping to offer incentives and provide some education to clients. Lunch will be provided by Pharmacy One Pro.

H. Standards, Issues and Operations (SIOC) – Janet Kitchen, Chair

The committee did not meet.

I. Women, Infants, Children, Youth and Families (WICY&F) – JaDawn Wright - Chair

The committee is having a 'Sizzling Summer' event for youth on July 13th from 6-8 pm at the Hospice in St. Petersburg. The event will focus on positive decision making in a round-table discussion and testing will be offered. They will have dinner and gift card giveaways.

The committee also discussed the ADAP situation and its effects on case management. They would like to work on some information about the Patient Assistance Programs and come up with some recommendations for case managers and their role in this process.

PUBLIC POLICY REPORT &

COMMUNITY CONCERNS

David Hasiba shared that mental health services are no longer offered at the Pinellas Care Clinic due to a cutback by St. Joseph's Hospital.

PREVENTION ACTIVITIES/ QUALITY MANAGEMENT

Cheryl Owens from the Health Council of East Central Florida, the contracted Quality Management provider, presented an introduction and overview of the QM program to the Care Council. The slides are attached.

ANNOUNCE-MENTS

Members announced upcoming community events and shared flyers of local programs.

ADJOURNMENT

There being no further business to come before the Care Council, the meeting was adjourned at 3:20 p.m.

Note: A tape recording of the meeting is available for review at The Health Councils.

ATTENDANCE LIST **July 7, 2010**

Care Council Members	Present
Michael Amidei	
Martin Clemmons	X
Vincent D'Agostino	X
Linnwood Davis	X
Laura Dunn	
Wayne Fernald	Ex
Edward Ford	X
Tonicia Freeman	X
John Geeslin	X
Lois Hall	X
David Hasiba	X
Denis Hayes	
Natalie Jackson	X
James King	X
Janet Kitchen	X
David Konnerth	X
Andrew Maldonado	X
Randy Masters	X
John Melartin	X
Crisaida Mendez	
Anil Pandya	
Guttenberg Pierre, Jr.	X
Bill Quercia	X
Tyrone Stamps	
Donnette Waul	
JaDawn Wright	X

Associate Members	
Bill Thomas	
Tom Wood	

Grantee Staff	
Aubrey Arnold	X

Health Councils Staff	
Nicole Brown	X
Collette Tomberlin	X

Error! Objects cannot be created from editing field codes.

Background: Health Council of ECF

- Affiliated with the Health Councils (Health Council of West Central Florida and Suncoast Health Council)
- Orlando EMA/Area 7 – Data, Research, Evaluation, Quality Management contractor
- Quality Management experience with large grants (SAMHSA, Robert Wood Johnson)

Quality Management Purpose

- Ultimately to improve the quality of care and services and the quality of life of PLWHA
- ***How?*** By assessing the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections…..

Quality Management Purpose (continued)

…and by developing supportive strategies that increase access to and quality of HIV service…

….and by ensuring that available demographic, clinical and healthcare utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

It is important to have….

- A quality management (QM) program responsive to consumer needs with priorities supported by leadership, by the providers in the service system, and by the planning bodies.
- The priorities and the variety of quality activities should be routinely communicated to all program and provider staff.

Critical Elements…

- Quality management program development should include the formation of a sustainable quality infrastructure which includes quality committee structures with stakeholders, providers and consumers as well as a written quality management plan to guide and direct the overall program.

Critical Elements continued…

- Development/utilization of performance measurement systems to collect clinical and non-clinical data
- Initiation of quality improvement activities to improve key service areas as prioritized by internal and external stakeholders

Critical Elements continued…

- Routine involvement of consumers to ensure that the delivery of services is responsive to their changing needs, as defined by these communities.

HRSA/HAB expects QM programs to be patient-focused and have the following characteristics…

- Be a systematic process with identified leadership, accountability, and dedicated resources available to the program
- Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks

Important Characteristics…

- Focus on linkages, efficiencies and provider and client expectations in addressing outcome improvement
- Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities (i.e., JCAHO, Medicaid, and other HRSA Programs)
- Ensure that data collected are fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

What makes a good quality indicator?

- Relevance: Does the indicator relate to a condition that occurs frequently or does it have a great impact on patients?
- Measurability: Can the indicator realistically and efficiently be measured given the Grantee's finite resources?
- Accuracy: Is the indicator based on accepted guidelines or developed through formal group-decision making methods?
- Improvability: Can the performance rate associated with the indicator realistically be improved given the limitations of the clinical services and patient population?

How is all this accomplished?

- Development of a comprehensive clinical quality management infrastructure, including routine QM meetings with cross-functional representation
- Description of QM program in a written quality plan, with a clear indication of responsibilities and responsible parties
- Designated leaders for quality improvement and accountability

How is all this accomplished (continued)?

- Development and/or adaptation of quality indicators for key clinical and service categories and routine performance measurement of key care aspects
- Use of data to improve the organization's performance on key services and link of performance data results to quality improvement activities
- Inclusion and involvement of key stakeholders in your quality program, including consumers, and sharing of performance data with program staff

The Steps We Will Take (as recommended in the HRSA TA Manual):

- Step 1: Confirm Commitment of Leadership & Establish Supportive Organizational Structure
- Step 2: Establish Quality Management Plan
- Step 3: Determine Performance Measures & Collect (and in this case review!) Baseline Data (Year 1 focus on Medical Care, Oral Health and Medical Case Management)
- Step 4: Analyze Data
- Step 5: Develop Project-Specific CQI Plan
- Step 6: Study and Understand the Process
- Step 7: Develop and Implement an Improvement Plan
- Step 8: Re-measurement
- Step 9: Celebrate Success

Error! Objects cannot be created from editing field codes.