OVERVIEW

Attendance:	Please refer to attendance chart on the last page of this summary		
Location:	Hill Health Center, Room 390, New Haven, CT		
Start Time:	12:00 p.m. – 2:00 P.M.	**End Time:**	1:54 p.m.
Presiding Chair:	Ric Browne	**Recorder:**	Tracy Kulik

Meeting Accomplishments

1. Approval of January 18, 2008 Quality Improvement Meeting Summary
2. Presentation of findings of Primary Medical Care pod (detail in Appendix)
3. Launch of process to update Quality Management Plan

Committee Member Assignments

- Active discussion and input into emerging roles of Quality Improvement
- 'Homework' on status of current Quality Management plan.

Next Meetings

April 18th: Final Overview of Primary Medical Care pod findings at Hill Health Center, Room 390

Meeting Summary/Minutes

Welcome, Overview and Moment of Silence

Ric Browne welcomed meeting participants, asked everyone to introduce themselves, and held a moment of silence to honor individuals affected, infected, or who have died from HIV/AIDS.

Ric Browne reminded people that the meetings are open and members of the public and press may be present. Persons wishing to maintain confidentiality of their HIV status should consider the public nature of the meeting.

Approval of Meeting Summary

Ric asked meeting participants to review the January 18th meeting summary and asked committee members for additions or corrections.

Ric announced that Christine Romanik has asked to step down having served graciously as the Interim Co-Chair for this committee. Charlotte Burch, a dedicated member of the committee, has been invited, and has accepted, the role as new permanent Co-Chair. The committee members gave both individuals a heartfelt round of applause for their service.

Presentation of Findings of Primary Medical Care pod

Tracy Kulik updated the committee on the findings of the Primary Medical Care pod that met from August, 2007 through January 25, 2008. A summary of their findings is attached as an appendix to these minutes. She thanked Mary Walton, who was to have presented this overview, but is overwhelmed with grant activity. In addition the following representatives were thanked for their service.

Dr. Steve Aronin
Dr. Lydia Barakat
Tom Butcher
Dr. Sunil D'Cunha
Clunie Figaro
Tom Kidder
Tracy Kulik
Helen Lansche
Dr. Amit Mahajan
Magalys Perez
Dr. Suba Srinivasan
Dr. Merceditas Villanueva
Mary Walton
Ann Ward
Amy Weinberg

Ryan White Office Quality Management Report

Tom Butcher handed out a presentation and worksheet related to the National Quality Center's suggestions that he received following training on national quality certification. His project to complete as part of this training is updating of the New Haven-Fairfield Counties TGA Quality Management Plan. Tom also handed out that plan, and requested that committee members conduct 'homework' of suggesting updates or refinements to the document to reflect all the work conducted over the past years.

New and Old Business

Ric Browne asked the committee members if there were any additional items they would like to raise. No items were referenced.

Adjournment

The meeting was adjourned at 1:54 p.m.

Next Meeting

The next meeting will be held on April 18th at Hill Health Center, Room 390 to continue discussion on updates to the Quality Management plan.

Meeting Attendance by Month

Date of Meeting		1/18	3/28	4/18	5/	6/	8/	11/	2/
Committee Members									
Charlotte Burch (current co-chair)	PCPM	●	●						
Ric Browne (current co-chair)	PCPM	●	●						
Jose Aquino	PCM	❍	●						
Carlos Barbier	PCM	❍	●						
Henry Bethea	PCM	❍	❍						
Linda Cooney	M	●	●						
Adaline DeMarrais	PCPM	●	●						
Sara Nichols	PCPM	●	●						
James Pitts	PMC	❍	❍						
Christine Romanik		●	●						
Bob Sideleau	PCM	●	●						
Angela Young	M	❍	❍						

	1/19	2/16	4/18	5/	6/	8/	11/	2/
Other Participants								
Part A Office, Thomas Butcher	●	●						
Tracy Kulik, Collaborative Research	●	●						
Planning Council & Primary Committee Member	= PCPM							
Planning Council Member	= PCM							
Committee Member	= M							

Charge: To review the current Standard of Care for Outpatient Primary Medical Care in light of a) Updates to the Department of Health & Human Services (DHHS)/United States Public Health Service guidelines and Centers for Disease Control & Prevention (CDC) guidelines. b) The need for guidance to the Ryan White Part A Grantee for the New Haven-Fairfield Counties TGA in revising the PMC SOC and
c) To inject rigor into the PMC SOC given consistent highest ranking compliance scores to the current SOC .

Tenure: The pod met every two (2) weeks by teleconference over a four-month period with supportive materials and minutes of the prior meeting issued prior to each teleconference. The group determined that every other Wednesday, from 12 noon to 1 p.m. was the optimal time for involvement.

Context: The Outpatient Primary Medical Care service category historically leads the New Haven-Fairfield Counties TGA in compliance with the Standard of Care and detailed data that contributes to the grant cycle. Provider input during the site visits indicated that there was desire for more rigor and validation of benchmark status. Specific discussion topics relate to updates of DHHS and CDC treatment guidelines, the need to focus on the dominant exposure group, Injection Drug Use and related issues—HIV: Hepatitis C co-infection, cost & complexity of care (1.7 times the cost of any other exposure group), correlation to advanced disease states upon presentation to care and treatment adherence concerns.

Historic compliance scores for Outpatient Primary Medical Care:

YEAR	AUDIT BASE	SCORE	# Providers
2005	Mock-sample	88%	13
2006	Full-100%	95%	12
2007	20% sample	100%	11

The PMC pod was stratified into three (3) components:

(1) Care Entry
(2) Care Guidelines
(3) Care Re-entry

Three components and detail of Agenda Items:

1) Care Entry/Access to Care
Objective: Means to move CDC-defined 'Late to Care' into Care faster
- HIV Testing/Referrals to Care/Early Intervention Services (EIS)
- CDC guidelines for routine testing
- Referral issue (uninsured or uninsurable often referred to Ryan White)
- Resistance testing upon diagnosis and ART initiation?
- Disparities to Access

2) Care Guidelines (once in care)
Objective: Compliance with treatment guidelines that reflect the unique nature of the epidemic in the TGA and reduce or eliminate disparities in care
- Start ART
* Type of ART, disparity by race/ethnicity, exposure, age
- Hep C/HIV co-infection protocol
- Extent and nature of co-morbidities
* Track prior to HIV infection, related to ART, coincident to ART/HIV
- Referral issue
* Referrals to: Mental Health, Dental Health
* Referrals to: Specialty Medical (GYN, Endocrine, Cardiovascular, Oncology, etc.)
- Conversion of SOC from Structure/Process and some Outcomes to e Outcomes focused (QI)
- Co-location of services
- Treatment adherence
- Updates from four (4) pilot sites on HIV Counseling & Testing

3) Care re-entry
Objective: Understanding of medical issues faced by PLWHA who exit and re-enter care and means to prevent this pattern.
- Signs of erratic in care/means to reinforce care maintenance
- Outreach for 'fallen out of care'
- Self Managed Protocol

Conclusions of Group

1) *HIV Counseling & Testing* – issues adhering to dysfunctional CDC counseling protocol with extensive unfunded mandates—four (4) pilots underway in New Haven-Fairfield Counties TGA;
2) *Resistance Testing* – decision to fund genotype testing upon initial entry into care and decision to start antiretroviral therapy (HIV medicine)
3) *Co-location of services*
    a. *Substance Abuse Rehabilitation* – not perceived as needed due to good communication, 'stand-alone' service and desire for PLWHA anonymity
    b. *Mental Health Counseling* – perceived as desirable due to interaction of HIV drugs and psychotropic medications, issues with lack of communication about psychotropic medications (types of meds, dosage, change in meds) and correlation to treatment adherence.
4) *HIV: Hepatitis C co-infection protocol* – need to formulate as guideline NOT mandate
5) *Self-managed protocol to encourage care re-entry for 'selective service' users* – high 'selective service' users of services other than PMC are Anglo MSM, Black MSM, IDU, Foreign Born and 'Aged' (over 45 years of age) – (1) Substance Abuse Rehab (2) Mental Health (3) Dental Health.

Profiles of activity related to HIV testing from PMC Providers (4):

Agency: FQHC #1	**Agency: FQHC #2**
Developing protocol to integrate HIV testing into normal panel of screening on annual basis. Population to be tested includes all clients ages 13-64 years of age using rapid test. Issues: build in 20 minute increment to determine results of rapid test with confirmation of all positives using Western blot. Also ensure that counseling is available given initial positive finding. Other issue: cost of rapid tests Question: if too costly or time-intensive, possibility of determining high-risk candidates (+ RPR, STD, IDU, Prenatal)	Discussing with State Department of Public Health adding two (2) rapid HIV Counseling & Testing staff. Issues: (1) Training staff to do phlebotomy 2) Additional 15-20 minutes increment over current 15-minute visit time to determine results of rapid test
Agency: Hospital	**Agency: FQHC #3**
Conducting separate study to determine feasibility of HIV Testing & Counseling at Primary Care clinic at Waterbury Hospital with secondary site at Yale Primary Care clinic. Using funds from restricted grant for rapid testing. Starting in Oct and running until end of academic year (June, 2008). Issues: 1) unenforceable CDC guidelines 2) funding for rapid tests 3) legal restrictions including pre-post counseling, separate consent forms	Used grant funding from Foundation to procure 100 rapid testing kits. Experience: successful in use in primary care clinic integrating into panel of testing. Issues: 1) cost of rapid HIV testing kits 2) Concern about risk stratification given recent experience in diagnosing HIV infection among older women of Eastern European origin presenting with respiratory issues which turned out to be toxoplasmosis with no other risk factors

Conclusions:

(1) Investigate possible sources of funding for rapid HIV tests
(2) Investigate literature on baseline seropositivity in different settings (health departments, STD clinics, blood banks, hospitals, emergency departments)

OUTPATIENT AMBULATORY MEDICAL CARE
A. Accreditation or Licensure
0 – no HIV-specific training documentation found
1 – documentation of adherence to HIV-specific training, not 10 hours per year per staff
2 - documentation of adherence to HIV-specific training, at least 10 hours per year per staff
0 – no documentation of agency accreditation or licensure
1 – documentation of agency accreditation or licensure
B. Quality Improvement activities focus on HIV care process measures
0 – no Quality Improvement activities documented
1 – no Quality Improvement activities focused on HIV care processes
2 - Quality Improvement activities focused on HIV care processes documented
C. HIV Counseling & Testing will occur
0 – no HIV Counseling & Testing was documented
1 – documentation of HIV counseling & testing, no detail of client a) demographics b) exposure
2 - documentation of HIV counseling & testing, detail of client a) demographics b) exposure
D. Resistance testing will occur for newly diagnosed patients, new to care or return to care
0 – no documentation of resistance testing for newly diagnosed, new to care or return to care
1 – documentation of resistance testing for newly diagnosed, new to care or return to care
E. Client Visit to Primary Medical Provider. Has it occurred? How often
0 – no documentation of primary medical visits found
1 – documentation of primary medical visits found but less than every 4 months
2 – documentation of primary medical visits found at least every 4 months
F. Ongoing laboratory monitoring of immune function
0 – no CD4 or Viral Load lab tests documented
1 - CD4 or Viral Load lab tests documented, but more than every 4 months
2 - CD4 or Viral Load lab tests documented, within or more often than every 4 months
G. Clients with CD4<350 evaluated by HIV specialist once a year
0 – no assessment documented of clients with CD4 less than 350
1 - assessment documented of clients with CD4 less than 350, less frequently than once/year
2 - assessment documented of clients with CD4 less than 350, more frequently than once/year
H. Disease progression slowed for clients in primary medical care (CD4)
0 – not assessed or documented if clients with stable CD4 count (CD4 count with 50 cells or 30%)
1 - assessed or documented if clients with stable CD4 count, but less frequently than once/year
2 - assessed or documented if clients with stable CD4 count, but more frequently than once/year
I. Prophylaxis protocol followed for prevention of opportunistic and chronic diseases
0 – no documentation of adherence to, or existence of, prophylaxis protocol
1 – documentation of adherence to prophylaxis protocol
J. Co-infection protocol followed for HIV: Hepatitis C patients
0 – no documentation of adherence to, or existence of, HIV: Hepatitis C protocol
1 – documentation of adherence to HIV: Hepatitis C protocol
K. Screening protocol (new and existing patients) followed for mental health issues
0 – no documentation of adherence to, or existence of, Mental Health screening protocol
1 – documentation of adherence to Mental Health screening protocol

yellow font indicates new indicators