2013-2014
COALITION REGIONAL SERVICES AND STRATEGIC PLAN

OCTOBER 15, 2012

CONTENTS

ACRONYM DEFINITIONS

A

AAO - AIDS Activities Offices of the Lehigh Valley Hospital (AIDSNET Service Provider)
ACA – Patient Protection and Affordable Care Act
ACRN – AIDS Certified Registered Nurses
ACT - Ryan White HIV Treatment Modernization Act
ADAP - AIDS Drug Assistance Program
AETC – PA AIDS Education and Training Center
AIDS - Acquired Immunodeficiency Syndrome
APE - Administrative, Planning and Evaluation
ART – Antiretroviral Therapy
ARV – Antiretrovirals
ASC - AIDS Services Center at St. Luke's Hospital (AIDSNET Service Provider)
ASO – AIDS Services Organizations

B

BOARD – State Board of Pharmacy

C

CAB – Consumer Advisory Board
CAPER - Consolidated Annual Performance and Evaluation Report
CARE Act - Ryan White Comprehensive AIDS Resources Emergency Act
CDC - Centers for Disease Control and Prevention
CD4 - T-Cell test (Test for immune functioning)
CCWS – Co-County Wellness Services (An AIDSNET Service Provider – Berks AIDS Network and Schuylkill Wellness Services are under the umbrella of CCWS)
CHIS – Consumer Holistic Improvement Scale
CM – Case Management
CMs – Case Managers
COLA – Cost of Living Indices
CPG – Community Planning Group
CQI – Continuous Quality Improvement
CRSSP - Coalition Regional Services and Strategic Plan
CW – CAREWare (Department of Health software to collect HIV/AIDS services data)

D

DEBI – Diffusion of Effective Behavioral Interventions

E

EBI – Evidence-Based Interventions
EHARS – Electronic HIV/AIDS Reporting System
EIS – Early Intervention Services
EMA – Eligible Metropolitan Area

EMSA – Emerging Metropolitan Statistical Area

F

FACT – Fighting AIDS Continuously Together
FPL – Federal Poverty Level

G

GPHE – Geriatic Periodic Health Exam

H

HAART – Highly Active AntiRetroviral Therapy
HAB – HIV/AIDS Bureau
HAV – Hepatitis A
HBC – Hepatitis B
HC/PI – Health Communications and Public Information (A prevention/education service)
HCV – Hepatitis C
HIP – Health Insurance Premium and Cost Sharing Assistance
HI-V (Five) - AIDSNET Consumer Advisory Council
HIV - Human Immunodeficiency Virus
HOPWA - Housing Opportunities for Persons with AIDS
HPG – Pennsylvania HIV Planning Group
HPV – Human Papillomavirus
HRH – High-Risk Heterosexuals
HRSA - U.S. Health Resources and Services Administration
HUD - Department of Housing and Urban Development

I

IDG – Interventions Delivered to Groups (A prevention/education service)
IDI - Interventions Delivered to Individuals (A prevention/education service)
IDU - Intravenous Drug Users
IRRC – Pennsylvania Regulatory Review Commission

L

LV – Lehigh Valley

M

MA – Medical Assistance
MAI–TCE - Minority AIDS Initiative Targeted Capacity Expansion
MAWD – Medical Assistance for Workers with Disabilities
MCD – Minor Civil Division
MCO – Managed Care Organizations
MSM - Men who have sex with men
MUA – Medically Underserved Areas
MUP – Medically Underserved Population
MMWR – Morbidity and Mortality Weekly Report

N
NHAS – National HIV/AIDS Strategy
NMAC – National Minority AIDS Council
NQC – National Quality Center

O
OTC – Over the counter

P
PA - Pennsylvania
PA-DOH – Pennsylvania Department of Health
PA-DOC – Pennsylvania Department of Corrections
PA-DPW - Pennsylvania Department of Public Welfare
PA-ETC – Philadelphia PA AIDS Education Training Center
PA-NEDSS – Pennsylvania version of the National Electronic Disease Surveillance System
PCP - Primary Care Physicians
PCRS – Partner Counseling and Referral Services
PHP – Permanent Housing Placement
PHS – Public Health Service
PIC – Prevention is Care (a CDC campaign targeting physicians)
PLWA – Person(s) Living With AIDS
PLWH - Person(s) Living With HIV
PM – Performance Measures
PrEP – Pre-Exposure Prophylaxis
PS – AIDSNET's Program Specialist

Q
QI – Quality Improvement
QM – Quality Management

R
RFI - Request for Information
RFP - Request for Proposals
RW – Ryan White

S
SAM - Self Assessment Module
SCP – Service Coordination Plan
SPBP - Special Pharmaceutical Benefits Program
SSD – Social Security Disability
SSI – Social Security Income
STI – Sexually Transmitted Infections
STRMU - Short-term Rent, Mortgage, and Utility Assistance

T
TasP – Treatment as Prevention
TBRA - Tenant-Based Rental Assistance
TGA – Transitional Grant Area
TOT – Training of Trainers
TPI – Transitional Planning Initiative
TQL – Training of Quality Leaders

U
US – United States

V
VL – Viral Load

Introduction

Mission

AIDSNET is a private, non-profit organization that is one of seven regional HIV Consortia in Pennsylvania responsible for the development of a comprehensive continuum of prevention and care services. Founded in 1991, AIDSNET's mission is to build healthier communities by planning and funding HIV DISEASE care and prevention services. AIDSNET serves Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill counties.

Role of the Consortia

To carry out this mission, AIDSNET examines the needs of the six-county area and develops a plan to meet those needs, given federal and state funding constraints. The organization also functions as the region's fiscal agent, meaning it is responsible for the overall management of the grant from the Pennsylvania Department of Health (PA-DOH), financial and programmatic reporting to the state, as well as financial and programmatic monitoring of Subgrantees. In addition, AIDSNET serves as an advocate for consumers and service providers. It provides technical assistance to a wide range of organizations involved, or wanting to become involved, in the fight against HIV Disease. The organization also supports the development of "best practices" that advance the effectiveness of prevention and care services.

History

AIDSNET tracks its history to the early days of the epidemic. By the mid-1980's, it was evident that the community's response to AIDS would require strong leadership. However, the newness of the epidemic had not allowed for the development of a comprehensive approach by the local agencies. Limited information about the basic nature of AIDS, as well as a lack of resources to help those infected, resulted in an inadequate public health response. This fragmented response may have served to meet immediate needs, but it was clear that a more unified approach was needed.

By 1989, most of the limited state funds being spent on the epidemic were being allocated to the large metropolitan areas. But the epidemic was clearly spreading to the smaller cities in the state, such as those in the AIDSNET region. In August 1990, the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act was signed into law. Title II of the Act (now called Part B) directed that formula-based funding would be awarded to the states, including the Commonwealth of Pennsylvania.

In October 1990, two months after the passage of the Ryan White CARE Act, the PA-DOH announced a new decentralized HIV planning strategy, with the creation of seven regional consortia. The United Way of Northampton and Warren Counties was approached to serve as the fiscal agent for the fledgling coalition serving the six counties in the region, and a request for

additional funding was submitted to the Dorothy Rider Pool Health Care Trust. By January 1992, AIDSNET had begun operation with the support of the state and the foundation.

AIDSNET was incorporated as a non-profit organization on February 16, 1994, and officially began operating on its own on July 1, 1994. AIDSNET decided to incorporate so it could operate as its own fiscal agent. Incorporation provided additional flexibility for the organization and the ability to attract supplemental funding through granting organizations.

Over the years, AIDSNET has earned the respect of service providers, consumers, funding sources and others interested in preventing the spread of HIV Disease. The organization's reputation is based on its desire to partner with other organizations, working toward the goal of providing better services to those who are at risk, as well as those infected with and affected by the disease. AIDSNET has strong administrative procedures, as evidenced by clean audits, as well as strong programmatic and administrative evaluations, which provides comfort to supporters of the organization.

Organizational Structure

The organization is guided by a dedicated Board of Directors, which has led the agency through its difficult times. AIDSNET serves such a diverse region and over the years has been able to recruit Board members representative of the area's diversity. This issue applies as well to its various committees that are dependent upon volunteer membership. It remains a challenge to get representation on the Board and committees from all six counties. One of the roles of the Board of Directors is to monitor the progress of the organization in carrying out its mission. As such, the Board has established an Evaluation and Research Committee, which has as its goal the monitoring of the effectiveness of AIDSNET and it Subgrantees.

Responsibility for carrying out the Board-established goals for the organization rests with a staff of five full-time employees (please see Appendix A for AIDSNET's organizational chart). The Executive Director is hired by the Board of Directors and is responsible for the day-to-day operation of the organization. She/He works with the Board of Directors to develop organizational policies and long-range goals. Based on these activities, the Executive Director leads the staff in establishing annual objectives and working with service providers to develop the programs to accomplish the objectives. She/He promotes AIDSNET and educates groups and organizations about the importance of their support in fulfilling the mission of the organization. In addition, the Executive Director is responsible for raising the funds necessary to carry out the organization's mission.

The Program Manager reports to the Executive Director and oversees the programmatic aspects of the organization. She/He leads the effort to develop a network of service providers to work toward establishing and/or maintaining a continuum of HIV care and prevention services. As such, this person is responsible for providing technical assistance to service providers, as well as monitoring and evaluating Subgrantees. The Program Manager also acts as liaison between the PA-DOH, AIDSNET and the Subgrantees.

The Program Specialist reports to the Program Manager and is responsible for the authorization process and the programmatic reporting function. These responsibilities entail the oversight of the pooled funds administered by the organization, the review of invoices and the development of the data bases necessary to track expenditures and services. The Program Specialist also provides technical assistance to Subgrantees.

The Fiscal Officer reports to the Executive Director and is responsible for the financial record-keeping, fiscal operations and procedures and the human resources function of the organization. She/He prepares AIDSNET's operating budget for review by the Executive Director and the Finance Committee of the Board of Directors. She/He provides technical assistance to service providers, in addition to monitoring the financial records, internal controls and procedures and fiscal policies of Subgrantees. She/He works closely with the auditor and the Finance Committee of the Board of Directors in preparation of the audit and the annual financial reports.

The Administrative Assistant reports to the Executive Director and is responsible for the operation of the office and the maintenance of all records. She/He answers the telephones, does general word-processing and photocopying. The Administrative Assistant purchases the organization's supplies and equipment and is also responsible for the maintenance of the equipment. The Administrative Assistant assists with the financial operation of the organization, as a check and balance against the Fiscal Officer being solely responsible for the financial record-keeping. She/He also maintains the agency's Web site.

Purpose of Planning

The goals of AIDSNET are to develop and implement:

- A coordinated and unified regional HIV prevention program that includes education and risk-reduction strategies;
- A regional HIV care program through which persons living with HIV Disease (PLWH) have access to basic health care and human services regardless of where they live or their ability to pay;
- A regional HIV housing program through which PLWH have access to appropriate housing, based upon their special needs and the stage of their illness; and
- A regional network of community-based service providers through which integrated and comprehensive components of regional programs are delivered to neighborhoods and communities in ways that are cost-effective, responsive to changing needs and meet quality standards.

Description of the Region

AIDSNET seeks to accomplish these goals by providing the necessary funding for prevention services in the areas of Interventions Delivered to Individuals and Interventions Delivered to Groups. Care services provided include case management, housing assistance, patient care, other

support services, treatment adherence and legal services. These services are discussed in detail in the Strategic Plan, including funding information, anticipated outcomes and action steps.

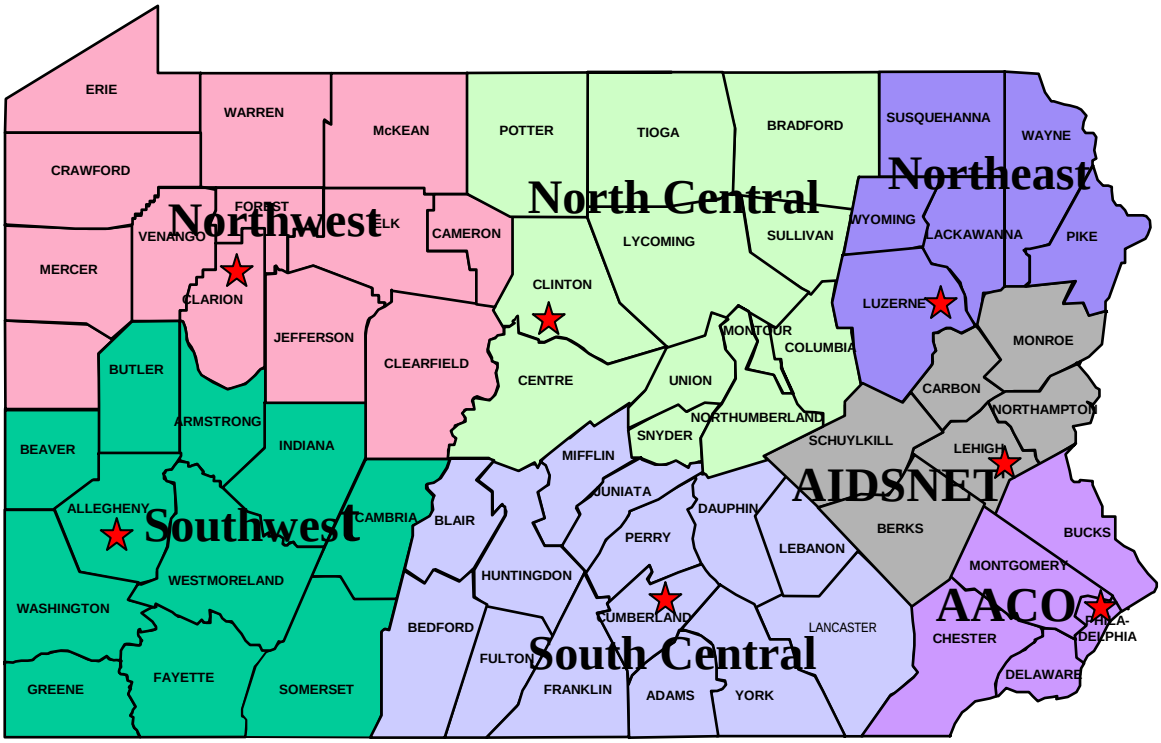
The network of HIV service providers is strong with many dedicated service providers and consumers. But the relatively static funding provided to AIDSNET, based on federal and state allocation formulas, is making it increasingly difficult to meet the needs of the growing infected, affected and at-risk populations.

There is also the challenge of staying current in a field that is constantly changing. AIDSNET does so by devoting a great deal of time to staying current on the latest advances in the care of PLWH and preventing the spread of the disease. Staff works closely with its Subgrantees and other organizations to share information with, and learn from, service providers. It also attempts to stay current by maintaining an active client advisory council.

There is the opportunity for the network to grow in the future. The infrastructure is in place; the network simply needs the additional resources to foster the growth. This calls for a more aggressive fund-raising effort, not just for AIDSNET as an organization, but as the leader of a network of services and a coalition of providers. AIDSNET must be careful to communicate well with its partners in the region, so it does not find itself competing with other members of the network for funding. It also must deal with the stereotypes and stigma for those facing a deadly disease, most often with a great deal of courage, but who are often thought of as drug using and/or sexually irresponsible.

One of the most interesting challenges facing the organization is the geographical diversity of the region. The six-county area includes the full range of possibilities, from the very urban centers of Allentown, Bethlehem and Reading to the very rural areas of Carbon, Monroe and Schuylkill counties. The region's proximity to the border with New Jersey and the New York's metropolitan areas has also created challenges. This is especially true for Monroe County which has experienced rapid growth in overall population and in the number of PLWH, as well as a rapidly escalating housing market, putting PLWH in an increasingly vulnerable position. A map of the region is included on page v of this section.

The purpose of the Coalition Regional Services and Strategic Plan (CRSSP) is to help set the direction for AIDSNET's future. To supplement this effort, AIDSNET is developing a long-range plan to enable the organization to better meet the needs of those infected and affected with HIV, as well as those at risk of becoming infected.


ERIE
WARREN
McKEAN
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TIOGA
BRADFORD
SUSQUEHANNA
WAYNE
CRAWFORD
Northeast
North Central
FOREST
Northwest
VENANGO
ELK
CAMERON
LYCOMING
SULLIVAN
WYOMING
LACKAWANNA
PIKE
MERCER
CLARION
CLINTON
LUZERNE
JEFFERSON
MONTOUR
COLUMBIA
MONROE
BUTLER
CLEARFIELD
CENTRE
UNION
CARBON
ARMSTRONG
NORTHUMBERLAND
NORTHAMPTON
BEAVER
INDIANA
SNYDER
SCHUYLKILL
LEHIGH
MIFFLIN
AIDSNET
ALLEGHENY
Southwest
CAMBRIA
BLAIR
JUNIATA
DAUPHIN
BERKS
BUCKS
PERRY
LEBANON
MONTGOMERY
WESTMORELAND
HUNTINGDON
AACOG
WASHINGTON
CUMBERLAND
PHILA-DELPHIA
BEDFORD
LANCASTER
CHESTER
FULTON
South Central
DELAWARE
GREENE
FAYETTE
SOMERSET
FRANKLIN
ADAMS
YORK

1. Needs Assessment

State and Regional Epi-data

The Centers for Disease Control and Prevention (CDC) has recently made changes to the Human Immunodeficiency Virus (HIV) case definition, taking into account advances in testing and detection. This new case definition recognizes HIV Disease as a spectrum condition with varying degrees of severity; progressing from early stage of infection to full-blown symptomatic infection. Using this new case definition as a guide, the Pennsylvania Department of Health (PA-DOH), Bureau of Epidemiology, has changed how it reports HIV epidemiologic data in its Annual HIV Surveillance Summary Report. Since the inception of the annual summary report, HIV has been reported as two conditions: HIV infection (non-Acquired Immunodeficiency Syndrome (non-AIDS) and AIDS. Tables and figures in the 2011 summary now have HIV and AIDS combined under one identity called HIV Disease. Consequently, any comparison of the tables in this Needs Assessment to previous years' should take into account these differences.

The importance of having regional planning and implementation is demonstrated in Table 1 that shows the differences between the characteristics of Persons Living with HIV Disease (PLWH) in the Commonwealth of Pennsylvania and in the AIDSNET region at the end of 2011. In the AIDSNET region, there is a higher percentage of women (35) with HIV Disease than in Pennsylvania (28). Hispanics represent 40% of cases vs. 15% in the Commonwealth and the predominant mode of transmission in the region is Heterosexual at 30% vs. 31% in Pennsylvania, followed by Intravenous Drug Use (IDU) at 27% vs. 23% in Pennsylvania, then Men who have Sex with Men (MSM) at 22% vs. 35% and, finally, Undetermined/Other at 15% vs. 6% in Pennsylvania.

Table 1: Characteristics of Persons Currently Living With HIV Disease in Pennsylvania and in the AIDSNET Region 2011

Characteristics	**Pennsylvania[1]**		**AIDSNET[2]**	
	Number	**Percent**	**Number**	**Percent**
Total	31,856	100	2,722	100
Gender:				
Male	22,807	72	1,756	65
Female	9,049	28	966	35
Race/Ethnicity:				
White (Non-Hispanic)	10,133	32	942	35
Black (Non-Hispanic)	15,492	47	547	20
Hispanic	4,875	15	1,094	40

[1]Data Provided by PA Department of Health, Bureau of Epidemiology; People Living with HIV Disease in AIDSNET Region and Pennsylvania, Pennsylvania Column; as of December 31, 2011, data reported through March 31, 2012. Percentages may not equal 100 due to rounding.

[2]Data Provided by PA Department of Health, Bureau of Epidemiology; People Living with HIV Disease in AIDSNET Region and Pennsylvania, AIDSNET Region Column; as of December 31, 2011, data reported through March 31, 2012. Percentages may not equal 100 due to rounding.

Asian/Pacific Islander	201	1	6	<1
Native American	33	<1	2	<1
Multiple Race	1,122	4	131	5
Age (years):				
0-12	503	2	51	2
13-19	1,258	4	85	3
20-29	8,315	26	657	24
30-39	10,979	35	955	35
40-49	7,572	24	673	25
Over 49	3,229	10	301	11
Mode of Transmission:				
Men who have sex w/men (MSM)	11,007	35	609	22
Intravenous drug use (IDU)	7,242	23	742	27
MSM & IDU	1,183	4	88	3
Heterosexual contact	9,877	31	803	30
Coagulation disorder	75	<1	15	1
Transfusion/Transplant	38	<1	5	<1
All pediatric[3]	515	2	57	2
Undetermined/Other	1,919	6	403	15

Summary of Regional AIDS Epidemiology

In order to develop appropriate care and prevention services for PLWH, it is necessary to examine what the epidemic looks like in each of the six AIDSNET counties. Table 2 shows that in the counties of Monroe, Northampton and Lehigh there are higher percentages of females living with HIV Disease than in Berks, Carbon and Schuylkill counties. In terms of race/ethnicity, the highest percentage of PLWH for Berks, Lehigh and Northampton counties is among Latinos. In Carbon, Monroe and Schuylkill counties, whites comprise the highest percentage. In Berks and Schuylkill counties, IDU was the predominant mode of transmission for PLWH. For Carbon, Lehigh, Monroe and Northampton counties, heterosexual contact had the highest transmission rate. In Northampton County, IDU transmission is a close second at 28%. Undetermined/Other represent a large gap in data for mode of transmission. It is imperative that the persons doing the pre-test screen gently probe for a likely mode of transmission. HIV infection, other than infants, is limited to sexual or IDU transmission. Since 2003, when those statistics were first gathered, heterosexual transmission has risen in all counties. IDU has decreased in Lehigh and Monroe counties and MSM has risen in Lehigh, Monroe and Schuylkill. It is important to note that all county data listed for PLWH originates in the county where they were diagnosed. People moving from the county of diagnosis are not reflected in any revised data.

[3]Includes adult cases which are assigned pediatric modes of transmission since infection is believed to have occurred before age 13

Table 2: Characteristics of Persons Currently Living With HIV Disease in the Six Counties in the AIDSNET Region as of 2011[4]						
Characteristics	**Berks (n=910)**	**Carbon (n=57)**	**Lehigh (n=931)**	**Monroe (n=248)**	**Northampton (n=439)**	**Schuylkill (n=137)**
	Percent	**Percent**	**Percent**	**Percent**	**Percent**	**Percent**
Gender:						
Male	67	70	64	55	61	81
Female	33	30	36	45	39	19
Race/Ethnicity:						
White (Non-Hispanic)	30	70	32	46	34	45
Black (Non-Hispanic)	19	9	20	25	19	29
Hispanic	46	19	44	21	41	18
Asian/Pacific Islander	<1	0	<1	1	<1	0
Native American	0	0	<1	0	<1	0
Multiple Race	5	2	4	7	5	8
Age (years):						
0-12	2	0	2	3	3	2
13-19	3	0	3	2	3	3
20-29	25	19	24	18	26	27
30-39	39	35	34	30	33	39
40-49	23	28	25	31	25	23
Over 49	9	18	12	16	10	6
Mode of Transmission:						
MSM	21	35	23	23	21	27
IDU	33	11	25	13	28	35
MSM & IDU	4	4	3	2	2	8
Heterosexual contact	26	46	31	40	29	19
Coagulation disorder	0	0	1	0	1	2
Transfusion/Transplant	<1	0	0	1	<1	0
All pediatric	2	0	2	4	3	6
Undetermined/Other	14	5	16	17	16	6

There are an unknown number of residents of Pennsylvania who are diagnosed and treated for HIV outside of Pennsylvania. These people are not represented in any statistics because they were tested elsewhere. They are well enough to continue to work, and they receive their medical treatment where their employers and physicians are located. Until they are treated in Pennsylvania, they will remain unreported in the Commonwealth and AIDSNET data.

The following is a summary of the unique characteristics of PLWH in the AIDSNET region:

[4]Data Provided by PA Department of Health, Bureau of Epidemiology; People Living with HIV Disease in AIDSNET Region and Pennsylvania, County Columns; as of December 31, 2011, data reported through March 31, 2012. Percentages may not equal 100 due to rounding.

- Mode of transmission among PLWH was highest for Heterosexuals (30%) followed by IDU (27%) and MSM (22%).
- Because of IDU transmission, AIDSNET has the highest percentage of women living with HIV Disease (35%) compared to the Commonwealth (28%).
- A markedly higher percentage of PLWH in the AIDSNET region occurred among Latinos, while a significantly lower percentage occurred among blacks, when compared to Pennsylvania. This is due to the racial and ethnic demographics of the region. However, both are disproportionately represented in this epidemic.

Populations at Greatest Risk

Using the above characteristics of PLWH in the AIDSNET region, below is a summary of the statistics regarding care, housing and prevention services provided:

HIV/AIDS Among Intravenous Drug Users

In the AIDSNET region, IDU is the second highest mode of transmission, accounting for 27% (742) of all PLWH in the region. Another 88 (3%) identify their mode of transmission as MSM-IDU. The highest percentages of IDU are in Berks, Lehigh**,** Northampton and Schuylkill Counties. However, 2011-2012 demographic data collected in CAREWare (CW) by the three case management (CM) agencies in the AIDSNET region indicates that only 239 (32%) IDU and 23 (26%) MSM-IDU are currently receiving CM services. Additionally, CW data provides further demographics of those receiving CM services:

- Gender – The majority, 66% of IDU are male
- Race/Ethnicity – Hispanics make up the largest percentage of IDU in CM at 52%, while Whites are only 23%, followed closely by Blacks at 21%; for MSM-IDU, Whites account for 65% of those in care, Blacks 26% and Hispanics 17%
- Age – For both IDU and MSM-IDU, 45-64 year olds comprise the highest percentage in CM at 79% and 61% respectively
- Poverty is a number one concern for many of our clients as is evidenced by the high numbers living at or below the Federal Poverty Level (FPL); 79% of IDU fall into this category and 43% of MSM-IDU
- Most are insured with Medicaid and Medicare being the primary insurance source; however, despite the best efforts of case managers (CMs), 29% of IDU and 17% of MSM-IDU remain uninsured
- The overwhelming majority, 89% of IDU and 87% of MSM-IDU, reside in stable/permanent housing; 9% of IDU and less than 1% of MSM-IDU accessed housing assistance through the Housing Opportunities for Persons With AIDS (HOPWA) program to help them secure and/or maintain safe, secure and affordable housing

Co-infection with Hepatitis C (HCV)[5]

It is important to discuss HCV as it is increasingly an issue with PLWH whose mode of transmission is IDU. This is particularly important since IDU transmission accounts for 27% of all PLWH in the AIDSNET region.

People living with HCV are four times more than those living with HIV. Seventy-five percent of those with HCV do not know their status as compared to 25% infected with HIV. A rapid test for HCV is now available and there is a great need for education and prevention, coordinated response, surveillance, psychosocial support and increased funding in order to treat those who are found to be positive through increased testing. HCV is now considered curable.[6]

Natural History[7]

- Spontaneous clearance of the virus after infection: 20-45%
- Of those who do not clear, 55-80% develop chronic infection
    - Infection progresses silently with no symptoms for many years
    - Up to 50% develop cirrhosis
        - Of these, up to 3% develop liver cancer annually

Persons who should be tested are those who:

- Ever used injection drugs
- Received clotting factors before 1987
- Received blood or organs before 1992
- Have evidence of liver disease
- Are HIV infected
- Are children born to HCV infected mothers
- Have received a needle stick injury

Those infected with HCV, should be offered:

- Referral for evaluation for treatment
    - Assessment of degree of fibrosis of the liver
    - Identification of the genotype causing infection
    - Decision regarding medical monitoring and timing of treatment

Hepatitis became reportable in 2003. Data collected in Pennsylvania (PA) from 2003-2010 reported 2,111 cases of HIV/HCV co-infection and 513 cases of HIV/Hepatitis B (HBV) co-infection, although under-reporting, particularly of HCV infection, is known to be widespread.

Women are more responsive than men in seeking HCV testing and following through. There is also a higher probability in the IDU population of having received a HBV vaccination than in the general population. There is a need to increase vaccinations for Hepatitis A (HAV) and HBV;

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[5] Pennsylvania Community HIV Prevention Plan update 2012, 5.9 HIV and Viral Hepatitis, http://stophiv.org

[6] Jill Wolf, LCSW, assistant clinical director Haymarket Center, Chicago (web conference 7/27/12)

[7] http://apps.shareholder.com/slides/view.aspx?mediaid=53544&companyid=OSUR&slideid=28&guid=adbd4bce-545b-4a55-90c5-64f3a1164a0b&width=500&height=375&mediauserid=6324163&unique=1343398463871

they are effective vaccines and give protection. It is important that case managers link those who are hepatitis infected to treatment and critical to help them reduce their alcohol and drug consumption. Hepatic disease has become the leading non-AIDS cause of morbidity and mortality among HIV-infected individuals since the availability of antiretroviral therapy (ART) became widespread in resource-sufficient areas of the world such as the United States. It is estimated that 14% of deaths in HIV-infected persons are liver-related and 66% of those are HCV co-infected. Early detection of chronic hepatitis B and C infection is the key to prevent liver damage and ensure good quality of life for patients. In PA, the number going into treatment was comparable to that of the general population.

Access to Needles and Syringes without a Prescription in Pennsylvania

In July 2009, the regulations for access to needles and syringes changed. The Pennsylvania Independent Regulatory Review Commission (IRRC) approved the final form regulations of the State Board of Pharmacy (Board) removing the prescription requirement for syringe and needle sales.[8]

It will be years before statistics can be gathered and analyzed to quantify the impact of this deregulation on the transmission of HIV and/or HCV. However, it has long been proven that increased access to clean needles does not result in an increase in the amount of drug use.[9]

The HIV prevention providers contracted by AIDSNET reported that most pharmacies are unaware of this ruling and that outreach to educate pharmacists is needed.

HIV among Heterosexuals

The term high-risk heterosexual contact is used to describe persons who report specific heterosexual contact with a person known to have, or to be at high risk for HIV infection (e.g. an injection drug user). High-risk heterosexual contact accounted for 27% (12,900) of estimated new HIV infections in 2009.[10] The historical analysis in the United States (US) suggests that the number of new infections in this population fluctuated somewhat throughout the 1990's and has declined in recent years.

In the AIDSNET region, heterosexual contact is the prominent mode of transmission, accounting for 30% of PLWH. IDU accounts for 27% of PLWH throughout the region. Heterosexual and IDU transmission is closely linked. When someone is tested, the criteria for identifying high risk are very specific and limiting. For reporting transmission statistics, the CDC defines "…a person at high risk for HIV infection shall include a person who, within the past six (6) months, has had unprotected sex with a person who is living with HIV; unprotected sex in exchange for money or drugs; multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners; or has been diagnosed with a sexually transmitted disease." This severely limits the recording of risk.

[8] http://www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2625/AGENCY/documents-12651.pdf

[9] Kerr, T, et al. (2010). Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. *American Journal of Public Health, 100,* 1449-1453.

[10] http://www.cdc.gov/nchhstp/newsroom/docs/HIV-Infections-2006-2009.pdf, August 2011

Many people, especially women, who have tested positive, do not know how they were infected because they state they did not have an IDU risk or an MSM or IDU partner and were in monogamous relationships. Each county shows its own distribution of heterosexuals living with HIV.

Of the 2,722 PLWH in the region, 803 identified their mode of transmission as heterosexual. CW demographic data collected and submitted by the three CM agencies indicates that they provided CM services to 641 (80%) of those identified as living with HIV disease in the region in fiscal year 2011-2012. Additionally, CW data provides further demographics of those receiving CM services:

- Gender – 42% are male and 58% female.
- Race/Ethnicity – Hispanics make up the largest percentage at 48%, while blacks are only 26%, followed closely by whites at 24%.
- Age – 57% are between the ages of 45-64 and 36% are 25-44 years old.
- 66% (426) of heterosexuals that received CM during 2011-2012 live at or below the FPL
- Almost 45% are insured by Medicaid; approximately 25% are on Medicare; approximately 10% have private, or other public insurance; and 18% remain uninsured, which shows a 1% decrease over last fiscal year.
- The overwhelming majority, 93%, resides in stable/permanent housing; 12% accessed housing assistance through the HOPWA program to help them secure and/or maintain safe, secure and affordable housing.

HIV among Gay and Bisexual Men

Gay and bisexual men of all races continue to be the risk group most severely affected by HIV. The term men who have sex with men (MSM) indicate the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality. This is the only risk group in the US in which the annual number of new HIV infections is increasing.

Of the 2,722 PLWH in the region, 609 (22%) identify their mode of transmission as MSM. CW demographic data collected and submitted by the three CM agencies indicates that they only provided CM services to 261 (43%) in fiscal year 2011-2012. CW data also provides the following demographics describing those MSM receiving CM services:

- Race/Ethnicity – The largest percentage of MSM in CM are whites, accounting for more than half at 52%; while Hispanics are only 22%, followed closely by blacks at 20%.
- Age – 25-44 and 45-64 year olds comprise the majority of MSM in CM at 48% and 43% respectively.
- 53% of MSM receiving CM services during fiscal year 2011-2012 live at or below the FPL.
- A little more than 25% of MSM clients are uninsured; the remaining three-quarters are split almost equally among Medicaid (21%), Medicare (23%) and private (26%) insurance.

- 94% reside in stable/permanent housing; 10% received HOPWA housing assistance to help secure and/or maintain housing.

Overrepresentation of Minorities

African Americans

In addition to disparities by risk group, there are also severe racial/ethnic disparities in the US HIV epidemic, with blacks bearing the heaviest burden. While prevention efforts have helped maintain stability in the level of HIV infection among blacks overall since the early 1990's, the ongoing toll in many black communities across the nation is staggering. The disproportionate impact of HIV is true in the AIDSNET region as well.

- While blacks represent only 6% of the population in the AIDSNET region, they account for 20% (547) of PLWH in the region.
- Of these, more than half (299 or 55%) received services at one of the three CM agencies in the region during the 2011-2012 fiscal year.
    - The primary mode of transmission is heterosexual at 56%, followed by 17% each for IDU and MSM.
    - Gender – 58% are male, 41% are female, and 1% is transgender.
    - Age – 45-64 year olds comprise the highest percentage in CM at 57%, followed closely by 25-44 year olds at 32%.
    - 66% (196) live at or below the FPL.
    - Medicaid is the primary insurance for more than a third; 21% are on Medicare and 10% have private insurance; however, 27% remain uninsured despite CMs efforts to link them.
    - 89% reside in stable/permanent housing; and 13% received some form of HOPWA housing assistance.

Latinos

While not as severely impacted as blacks, Hispanics are also disproportionately affected by HIV nationally[11] and in the AIDSNET region. Hispanics represent approximately 13% of the region's population, but account for 40% of PLWH.

- Approximately 49% of this population (533) received services at one of the three CM agencies in the region during the 2011-2012 fiscal year.
- Heterosexual contact was the primary transmission mode for 58%, followed by IDU at 23% and MSM at 13%.
- Gender – 59% are male, 40% are female and <1% are transgender.
- Age – 25-44 and 45-64 year olds comprise the majority of Hispanics in CM at 35% and 57%, respectively.
- A staggering 73% (390) live at or below the FPL.

[11] http://www.cdc.gov/nchhstp/newsroom/docs/HIV-Infections-2006-2009.pdf, August 2011

- Medicaid is the primary insurance provider covering 49% of the clients; 24% are on Medicare; 10% have private insurance; and <1% have other insurance; but 16% remain uninsured.
- 94% reside in stable/permanent housing; and 9% received housing assistance through the HOPWA program.

HIV Over Fifty[12]

It has been estimated that by 2015, 50% of people living with HIV [in the US] will be over 50 years of age.

- There is an increased life expectancy on antiretrovirals (ARV). However, life expectancy is still shorter than for the general population – especially for low CD4 and/or salvage regimens
- Antiretroviral therapy (ART) may produce chronic adverse effects
  - Risk of congestive heart disease increased
  - Metabolic abnormalities more common
  - May not protect from cancers (esophageal, lung, rectal (HPV), renal and liver
  - Conditions seen at earlier age such as – osteoporosis, hypogonadism
- Age Disproportionately Affects Care Resources
  - 80% have at least one chronic disease. Most common conditions are arthritis, hypertension, hearing impairment, heart disease, vision impairment, orthopedic disabilities, diabetes
  - The elderly make up 13% of the population, but utilize 30% of the prescription drugs and 40% of the OTC medications. On average, the elderly take three times more drugs than younger counterparts
  - The elderly suffer two to three times the rate of adverse drug reactions, most likely due to changes in renal and hepatic function and changes in body composition
- Non-AIDS disease is influenced by HIV, treatment, and behaviors and conditions associated with HIV infection.

Geriatric Periodic Health Exam (GPHE)

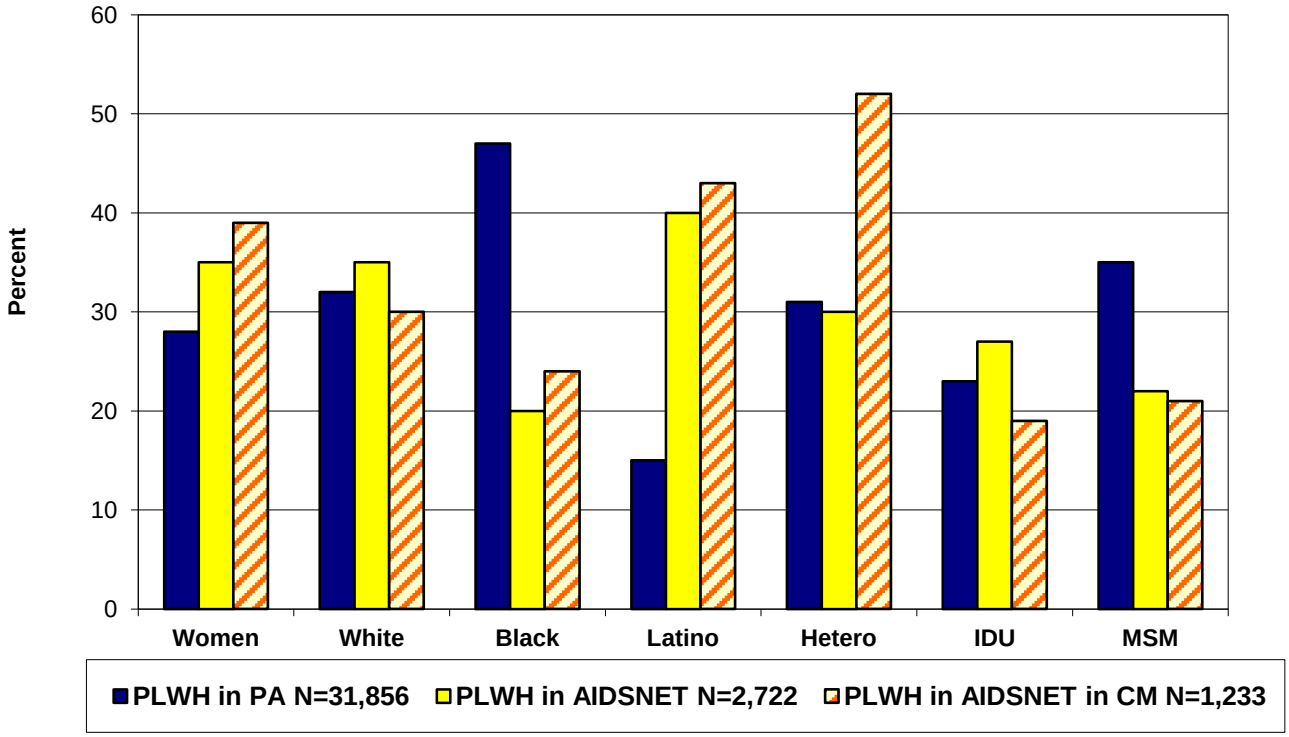
- An assessment aimed at preventing, detecting, and controlling specific conditions or risk factors. It allows detection of the common health issues that require further assessment and/or early intervention. It looks on the person as a whole, not just their HIV. It is self-administered and the initial screen takes less than 30 minutes.
- Targets conditions like frailty, sensory loss, cognitive impairment, depression, polypharmacy among others.
- Opportunity for screening for "risky" behaviors (smoking, obesity, nutrition, medications).

Based on the recent epidemiology data released by the PA-DOH, 301 PLWH in the region are age fifty or older. Aggregated 2011-2012 demographic data collected in CW by the three CM agencies in the region indicates that a total of 285 (95%) PLWH received CM services during the fiscal year. CW data also shows that:

[12] http://www.health.ny.gov/diseases/aids/conferences/plenaries/docs/aging_with_hiv. September 2010

- Heterosexual contact was the primary transmission mode at 54%, followed by IDU at 28% and MSM at 12%.
- Gender – 64% are male and 36% are female.
- Race/Ethnicity – Hispanics account for the largest percentage of PLWH over the age of fifty in CM (45%); whites and blacks each account for 27%.
- 62% have income that is equal to or below the FPL.
- Most are insured, with Medicaid (42%) and Medicare (27%) being the primary insurance source, and 8% have private insurance; however, approximately 11% are uninsured.
- The overwhelming majority (94%) resides in stable/permanent housing; and 18% accessed HOPWA housing assistance.

Chart 1: Demographic/Regional Comparisons between PLWH in PA and AIDSNET and PLWH in AIDSNET who are Receiving Case Management Services[13]

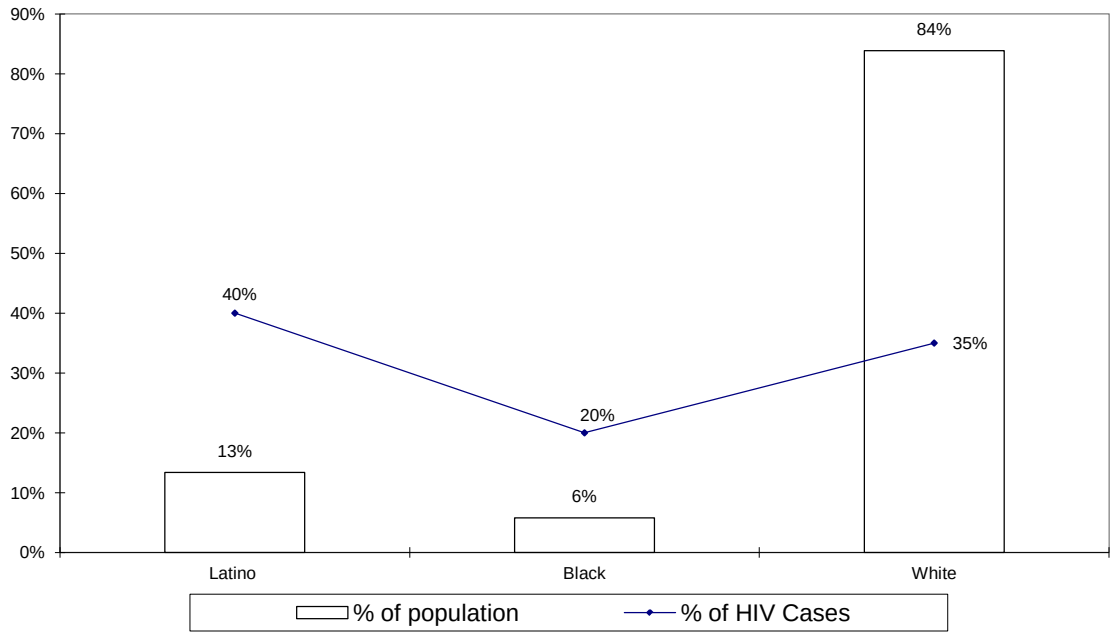


- Racial/Ethnic Distribution of HIV Disease
  Throughout the region, as well as in the rest of Pennsylvania and the nation, blacks and Latinos continue to be disproportionately affected by the epidemic as seen in Tables 1 and 2. The degree of inequity, however, is difficult to realize unless you compare each race's/ethnicity's share of HIV cases to its percentage of the total population. In Chart 2, it is easier to visualize the huge impact this epidemic has made on communities of color.

[13]Data Provided by PA Department of Health, Bureau of Epidemiology; People Living with HIV Disease in AIDSNET Region and Pennsylvania; as of December 31, 2011, data reported through March 31, 2012 and Fiscal Year 2011-2012 CAREWare data

Blacks and Latinos have over 3 times MORE cases of PLWH, as compared to their overall representation in the population, and whites 2.4 times LESS cases of PLWH than their overall representation in the population.

Chart 2: Percent of HIV Disease Cases vs. Percent of Population in the AIDSNET Region[14]



Amendment to Act 148[15]

SB260, the amendment to Pennsylvania's HIV testing law (commonly known as Act 148) passed the Pennsylvania Legislature on June 29, 2011, which took effect 60 days later. All amendments are in §7605, Consent to HIV-Related Test. The other sections of the law were unchanged.

- Informed *written* consent has been replaced by informed *documented* consent of the subject, as a requirement for the performance of an HIV test. The amendments require that a health care provider document the provision of informed consent, including pre-test information, and whether the subject declined the offer of HIV testing.

[14] Based on 2010 Census data and Data Provided by PA Department of Health, Bureau of Epidemiology; People Living with HIV Disease in AIDSNET Region and Pennsylvania, AIDSNET Region Column; as of December 31, 2011, data reported through March 31, 2012.

SB260 -FINAL.pdf

[15]

- The new language states that the health care provider may offer opt-out HIV testing wherein the subject would be informed that he/she will be tested for HIV unless he/she refuses.
- The pretest counseling provision was removed. The requirement remains that any consent be preceded by an explanation of the test, including its purpose, potential uses, limitations and the meaning of its results.
- A negative test result need not be given in person (face-to-face).

Without written evidence of a patient's consent, the concern of opponents[16] of this bill is that patients will be tested without the opportunity to consent or even be aware they've been tested until they get the results. They cite that testing is not the best way to introduce people to HIV care, which takes a lifetime commitment of behavior change and treatment adherence.

While the PA-DOH supported these amendments to better align Pennsylvania's HIV law with the 2006 CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, at this time, the PA-DOH is requiring that all PA-DOH staff and PA-DOH contractors and subcontractors continue to conduct HIV testing activities according to established protocols (obtaining signed written consent and scheduling of face-to-face post-test counseling for both negative and positive test results). The rationale for this recommendation is that while the intent of the amendment to the act is to allow for HIV testing as a routine part of medical care, the focus of the PA-DOH and its contractor's and subcontractor's HIV testing activities is on *targeted testing* of individuals at highest risk for acquiring HIV who seek or receive HIV testing in *nonclinical* settings. For these individuals, the CDC still recommends prevention counseling.

The intent of the amendments to Act 148 is to facilitate routine HIV screening and, therefore, increase HIV testing of patients, including pregnant women, in *health care settings*; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; destigmatize the testing process; and further reduce perinatal transmission.

The HIV Service Delivery System – Provider Capacity, Client Accessibility, and Barriers to Care

AIDSNET is responsible for assuring that there is a comprehensive HIV service delivery system in place in its six-county region to the greatest extent possible. As a Ryan White HIV/AIDS Treatment Modernization Act planning coalition, AIDSNET in mandated to:

- assess the needs of diverse populations infected with HIV;
- develop a plan to meet those needs with a comprehensive continuum of outpatient services and support services aimed at promoting coordination and integration of services;
- assure continuity of services through case management services; and
- evaluate the effectiveness of programs.

[16] Discussed by the AIDS Law Project email 6/29/2011

Availability and Accessibility to Care

AIDSNET currently contracts with three organizations to assure that case management, housing and other supportive services are available to PLWH throughout the region. Case management is the entry point to the care system. It enables clients to access the wide range of supportive services they need to live fuller, more productive lives. Data collected from case management agencies gives AIDSNET additional information to supplement government data, given the lack of current "mature" HIV statistics. AIDSNET's region includes six counties, but the availability and accessibility to care differ among some of the counties. The counties of Carbon, Monroe and Schuylkill are rural and access to physicians in general and HIV specialists in particular is poor. Many physicians in these three counties do not accept Medicaid reimbursement, which is a significant portion of the clients who are in need of services. Many clients are forced to travel to Lehigh or Northampton counties where there is HIV care available in hospitals and in private practice. In the more urban counties of Berks, Lehigh and Northampton, medical care is more accessible. Transportation is also an issue in the rural counties. Clients must have access to their own transportation as transportation services do not cross county lines. AIDSNET provides vouchers for the purchase of gas to facilitate clients remaining in care. In the urban counties, bus passes are provided. However, when the client does access case management services, regardless of the county, they are provided assistance by CMs that meet the PA-DOH standards, including minimum education at a bachelor's level and ongoing required education provided by the PA-DOH Case Management Project. Some of the case managers are bi-lingual and bi-cultural, meeting the needs of the region's large Hispanic population.

CMs have the responsibility of obtaining pre-authorization from AIDSNET for most services. In fiscal year 2011-2012, 1,233[17] PLWH accessed AIDSNET-funded case management services at a cost of $913,526. For the most part, this is an unduplicated count; however, it is possible that clients switched from one case management agency to another during the course of the year. As the data demonstrates in Table 3, the percentage of individuals with HIV that case management agencies are serving is slightly higher than those diagnosed with AIDS. The data for two of the case management agencies have changed very little over the past two fiscal years. However, significant changes for the other two agencies reported is the major contributing factor for the shift.

The following table breaks down HIV status and AIDS diagnosis by percentage for each of the three case management agencies.

- AIDS Activities Office of the Lehigh Valley Hospital (AAO)
- AIDS Services Center at St. Luke's Hospital (ASC)
- Co-County Wellness Services (CCWS)

For fiscal year 2011-2012, there was no change in the total percentage of HIV+, not AIDS cases, or CDC-defined AIDS cases in the AIDSNET region. Two of the three case management agencies, ASC and AAO, reported minimal changes in clients with HIV+, not AIDS and CDC defined AIDS cases; CCWS remained consistent with last years' percentages.

[17] 1,233 represents the number of duplicated clients seen in the AIDSNET region and will be used when discussing county level data or the region as a whole.

Table 3: Status of HIV Clients Seen During Fiscal Year 2011-2012 for Each of the Three Case Management Agencies[18]				
HIV Status	**AAO**	**ASC**	**CCWS**	**TOTAL**
	Percent	**Percent**	**Percent**	**Percent**
HIV (non-AIDS)	48	56	59	52
CDC defined AIDS	52	43	36	47
HIV (progression unknown)	0	<1	5	1

In Pennsylvania, a medically uninsured or underinsured individual who makes less than $37,642.90 annually can apply for assistance in obtaining their medications through the Special Pharmaceuticals Benefits Program (SPBP). For an individual who is actively enrolled in SPBP and successfully completes the recertification process every six months, the maximum income threshold is $55,850.00. Nationally, this program is called the AIDS Drug Assistance Program (ADAP). This program varies widely from state to state, with some states covering few medications, having stricter eligibility guidelines (i.e. low viral or CD4 requirements, 100% of the Federal Poverty Level, etc.) and some having waiting lists. Until recently, in Pennsylvania, this program primarily covered medications specific to HIV or mental health. Since 2003, it has been greatly expanded to include medications for many of the very important additional medications for HCV. In addition to increasing the income eligibility as stated above, SPBP recently expanded its formulary by 39% and has also expanded the lab tests that are covered. An SPBP Advisory Board has also been developed.

Table 4: Percent of Active SPBP Cardholders by Gender, Race and Ethnicity in Each of the Six AIDSNET Counties (as of 7/1/2012)[19]						
Demographics	**Berks (n=217)**	**Carbon (n=18)**	**Lehigh (n=267)**	**Monroe (n=69)**	**Northampton (n=160)**	**Schuylkill (n=20)**
Gender:						
Male	71	78	65	67	71	65
Female	29	22	34	33	29	35
Transgender	0	0	1	0	0	0
Race/Ethnicity:						
White	35	78	34	54	40	75
Black	28	17	32	26	26	25
Hispanic	23	0	27	13	26	0
Other/Unknown	14	5	7	7	8	0

In the following table, characteristics are given for PLWH seen by the three case management agencies during fiscal year 2011-2012. Heterosexual contact continues to be the overwhelming mode of transmission in all three agencies, followed by IDU and then closely by MSM. This reinforces the sub-epidemic that was mentioned earlier, which involves male IDU who are heterosexually transmitting HIV to their female partners. When comparing the last two fiscal

[18]Fiscal Year 2011-2012 CAREWare data exports Note: Duplication of clients is possible if a client moved from one county to another (or one CM agency to another). Percentages may not equal 100 due to rounding.

[19] Department of Public Welfare data report 9/12/2012

years, the modes of transmission have remained relatively stable with small, noticeable changes in the heterosexual and IDU populations.

Table 5: Percent of Clients Seen by Characteristics during Fiscal Year 2011-2012 for Each of the Three Case Management Agencies[20]

	AAO (n=645)	ASC (n=351)	CCWS (n=237)	Totals (n=1233)
Gender:				
Male	61	55	67	60
Female	39	45	33	39
Transgender	<1	<1	0	<1
Race:[21]				
White	49	67	74	59
Black	25	28	26	26
Asian	<1	<1	0	<1
Native Hawaiian/Pacific Islander	<1	<1	0	<1
American Indian/Alaskan Native	<1	<1	<1	<1
More than one race	25	3	0	14
Unknown	0	0	0	0
Ethnicity:				
Hispanic	44	40	45	43
Non-Hispanic	56	60	55	57
Current Age:				
<2	0	0	0	0
2-12	0	0	0	0
13-24	5	4	2	4
25-44	37	33	32	35
45-64	54	57	65	57
65+	4	6	2	4
Mode of Transmission:				
MSM	22	22	19	21
IDU	17	17	28	19
MSM & IDU	1	1	4	2
Heterosexual contact	54	52	46	52
Perinatal transmission	3	3	2	3
Hemophilia/Coagulation disorder	1	0	0	1
Transfusion	1	2	0	1
Unknown/Not reported	0	3	0	1
Other	<1	1	<1	<1

[20]Fiscal Year 2011-2012 CAREWare data exports and custom reports from providers. Note: Duplication of clients is possible if a client moved from one county to another (or one CM agency to another). Percentages may not equal 100 due to rounding.

[21]Fiscal Year 2011-2012 data exports and custom reports from providers; the CW data combines both race and ethnicity thus race does not equal 100%. If the percentage of Hispanics listed under ethnicity is added to the percentages listed under race, the total will equal 100%.

An alternate way of looking at the distribution of case managed clients is by county rather than by case management agency, as seen in the following table.

Table 6: Numbers of Clients per County Accessing Services Through Case Management 2011-2012[22]

County	Number of People
Berks	230
Carbon	30
Lehigh	561
Monroe	96
Northampton	287
Schuylkill	29
Other	0
Total	1,233

The following table shows the percentage of PLWH by types of health insurance. Almost half of the PLWH in case management in the AIDSNET region continue to be on Medicaid, with a slight decrease in Medicaid-insured clients and a slight increase in Medicare-insured clients from 2010-2011 Individuals from Berks, Lehigh and Northampton counties that are on Medicaid are enrolled in Health Choices (managed care). The enrollment of Medicaid recipients in managed care in the other three counties of Carbon, Monroe and Schuylkill was implemented in 2005 on a voluntary basis due to the very limited network capability of the managed care organizations (MCO) in these counties, which severely limits clients' access to services. There was a significant drop in the medically uninsured from 2010-2011; however, 19% of clients continued to be medically uninsured despite CMs' attempts to locate medical assistance for them.

Table 7: Percent of Case-Managed Clients by Health Insurance Status[23]

Type of Insurance	HIV (n=1,233)
Medicaid	42
Medicare	25
None (uninsured)	19
Other	2
Private	12
Unspecified	0
Other Public	<1

It is important to note that the accuracy of the above figures depends solely on each agency updating its data. Initially, a client who has no medical coverage is entered into CW as uninsured. However, after entering into case management, all efforts are made to obtain medical insurance. When this occurs, CW should then be updated to reflect the change in the client's

[22]Fiscal Year 2011-2012 CAREWare data exports and custom reports from providers. Duplication of clients is possible if a client moved from one county to another (or one CM agency to another).

[23]Fiscal Year 2011-2012 CAREWare data exports and custom reports from providers. Duplication of clients is possible if a client moved from one county to another (or one CM agency to another). Note: Percentages may not equal 100 due to rounding.

insured status. AIDSNET reinforces the importance of timely and accurate updates in CW, barriers to securing and entering required data, and strategies for overcoming these barriers. The conversion to CW version 5 in December of 2010 provided efficiency in Annual RSR and RDR reporting, but it continues to reveal new flaws and barriers to collecting and extracting accurate data for all the Pennsylvania care providers.

Implementation of U.S. Health Resources and Services Administration's (HRSA) Eligibility Criteria to receive Ryan White (RW) Services

The seven consortia were informed by the PA-DOH in December of 2011 that all clients, including all clients currently in case management and all new clients, had to go through a certification process every six months to determine eligibility to receive services funded by Ryan White funds.

The semi-annual criteria consisted of the following:

- Proof of HIV Diagnosis
- Verification:
    - of insurance and/or any other third party resource
    - identity (w/photo)
    - residency
    - income

The annual criteria consisted of the following tests:

- Viral Load
- CD4 count
- Proof of receiving ART

Those clients already in care were seen by all three CM agencies. The following table shows the result of certifying all clients already in care at the end of March 2012 and the projection of how many more clients would be eligible for Medicaid if the expansion included in the Affordable Care Act was implemented in PA.

Table 8. Percentage of Clients Certified in the Three CM Agencies

CM Agency	% Recertified	Number of clients who were not recertified due to not coming in or having incomplete documentation	% Income Ineligible	% eligible for MA if/when income eligibility is increased to 133%
AIDS Activities Office of the Lehigh Valley Hospital	343/400 = 86%	50/400 = 13%	7/350 = 2%	75/343 = 22%
AIDS Services Center at St. Luke's Hospital	237/287 = 82%	50/287 = 17%	4/237 = 2%	4/233 = 2%
Co-County Wellness Services	166/185 = 89%	14/185 = 8%	5/171 = 3%	26/166 = 16%

Those clients who enroll in CM or who return after being discharged from CM services cannot receive any RW services until their eligibility is confirmed. The cost of the time the CMs go through for the certification process with the client, including any help the CMs may provide in getting documentation, is not billable unless the client is certified within that billing period. Also, if a client comes in with an immediate need, the client can receive that service, but the agency will incur the cost if the client is found ineligible. The ability of a CM agency to incur those expenses will determine if a client receives those services or if services are delayed until eligibility confirmed.

AIDSNET's Authorization of Services

As mentioned earlier in this document, most care services are preauthorized by AIDSNET. This is accomplished through a review process by the AIDSNET Program Specialist (PS) to ensure that the services requested are HIV related and that other resources have been sought first, adhering to the mandate that Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) funding be the payer of last resort. In support of this, the AIDSNET region shows very little assistance funded for direct medical care services as 81% of the AIDSNET region clients are medically insured or are eligible for charity care. As Table 9 reflects, the most heavily used/authorized services during the 2011-2012 fiscal years were Transportation, Oral Health Care, Legal, and Health Insurance Premium and Cost Sharing Assistance (HIP). There were significant increases in Oral Health Care, 72%, and HIP, 80%, services over the prior year. Certain changes in some categories are worth noting. Home and Community-Based-Health Care and Substance Abuse-outpatient services were added to meet the AIDSNET region's client needs. The decrease in direct emergency assistance, which includes medications, is in part due to the continued expansion of the SPBP formulary and an increase of the income eligibility cap, as well as the fact that co-pays, deductibles, and premiums are captured under the HIP category. Benefits, such as Supplemental Security Income (SSI) or Social Security Disability (SSD), that were almost automatically given at the onset of the epidemic, are now becoming increasingly difficult to receive. CMs advise their clients to expect a denial the first time they apply and that an appeal can take up to a year for a decision; therefore, requests for legal assistance remain primarily for appeal of denial for SSI and SSD.

Table 9: Care Services Provided Fiscal Years 2008-2012[24]

AIDSNET Authorized Service	**Number of Services Provided to Clients**			
	2008-2009	**2009-2010**	**2010-2011**	**2011-2012**
HIP: Deductibles, Co-Pays, Premiums and COBRA	51	41	40	72
Day/Respite Care	0	0	0	0
Dental Care	18	31	55	95
Direct Emergency Assistance	61	31	29	22
Eye Care	0	1	1	
Homemaker Services	0	0	0	
Hospice Services	0	0	0	0

[24] AIDSNET Authorization Database as of August 2012

Legal Services	124	149	111	80
Medical Services (over $25)	20	13	8	5
Medical Supplies	0	2	0	
Mental Health Services	14	14	42	40
Nutritional Counseling	0	0	0	0
Home and Community Based Health Care				5
Rehabilitation – Home	0	0	0	0
RW Housing Support	7	4	18	17
Skilled Nursing	0	0	0	0
Substance Abuse-Outpatient				2
Transportation	88	92	80	114
Total	381	378	384	452

Barriers to Care

As more individuals become infected and poverty and medication toxicity drain their financial and physical abilities, the use of authorizations may increase, especially for Medical Services, Legal Services, Dental Care Services, Mental Health Services and Transportation Services. The AIDSNET region has seen a significant increased need for Dental Care services. Infection is the primary risk concern for PLWH, and very few dental care providers in the AIDSNET region accept Medicaid. This limits the availability and access to necessary dental care for PLWH. As managed care, back-to-work issues, high unemployment rates, disability issues and hepatitis co-infections impact the clients in the AIDSNET region, it is anticipated that authorizations will reflect these needs as well. Despite the many issues facing individuals infected or affected by HIV disease, AIDSNET will continue to provide as many services as possible within financial limitations and governmental regulations.

Since 1995, the death rate from AIDS has been steadily decreasing. Table 10 notes a gradual decrease over the past three years, with 2011-2012 having the same number of total deaths as 2010-2011. The percentage of people still alive in each year of diagnosis after 1994 is greater than 50% and observed survival time after diagnosis with AIDS is improving consistently with each successive year of diagnosis. For fiscal year 2011-2012, Table 10 shows no change from fiscal year 2010-2011 in the death rate, and HIV/AIDS- related deaths remain at 15% of the 2011-2012 deaths reported to AIDSNET. Deaths not related to AIDS continue to be at 85%, and can primarily be attributed to various cancers, cardiac arrest/event, liver failure, cerebral hemorrhage, cirrhosis of the liver, and various illnesses.

Table 10: Number of AIDSNET Case Managed Clients That Have Passed Away Fiscal Years 2007-2012[25]					
Gender	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
Male	5	13	16	15	13
Female	7	4	10	5	6
Transgender	1	1	0	0	1
Total	13	18	26	20	20

The following table demonstrates the disproportionate number of clients in case management that have incomes equal to or below the FPL as compared to the general population. The federal poverty level is defined as the set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the US, this level is determined by the Department of Health and Human Services. FPL varies according to family size and the number is adjusted each year for inflation, based on the activity of the Consumer Price Index, and reported annually in the form of poverty guidelines. Families are officially poor in the US if they earn income at or below the federal poverty level[26] (in 2012, $23,050 for a family of four). In the AIDSNET, region 69% of the case managed clients live at or below 100% of the FPL. It is important to note that the statistics only represent those PLWH who are in case management and are not representative of the entire population of PLWH in the AIDSNET region.

Table 11: Percent of Federal Poverty Levels by County Comparing Differences Between PLWH in CM During Fiscal Year 2011-2012 to the General Population[27]						
Equal to or less than the FPL	**Berks**	**Carbon**	**Lehigh**	**Monroe**	**Northampton**	**Schuylkill**
PLWH in CM	63	63	66	66	66	59
General Population	12	11	12	10	9	12

As ARV has delayed the progression to AIDS, PLWH are living longer. AIDS is now considered a chronic illness, not an immediate expectation of death as it was before medications. Despite the side effects and the fatigue that usually accompanies disease progression or side effects of ARV, more and more PLWH desire to enter or reenter the work force. This desire, however, is accompanied with the fear of losing precious medical benefits after going back to work and then getting sick again, which is cyclical in some chronic illnesses. Medical Assistance for Workers with Disabilities (MAWD), the Pennsylvania Department of Public Welfare's (PA-DPW) program, provides medical coverage even if earnings increase above the usual limits for Medicaid. This program gives an opportunity for clients to maintain medical coverage if they enter the work force making low wages or are either uninsured or underinsured.

"Unmet need" is a very specific term adopted by the HRSA that describes PLWH who are aware of their status, but are not actively in medical care. This is described and quantified in more detail in section three of this document. The most critical need for these clients is to have them start or reconnect with medical care. The case manager is charged with finding out what barriers caused them to either not begin or to stop medical visits and treatment. These barriers could be

[25] Fiscal Year 2011-2012 CAREWare data exports and custom reports from providers
[26] Current Fiscal Year 2012 figures from http://aspe.hhs.gov/poverty/12poverty.shtml
[27] http://www.dsf.health.state.ps.us/health/countyprofiles/2012 Numbers are rounded for easier comparison.

denial of HIV status, fear of disclosure to family, partners, friends; lack of medical insurance; substance abuse issues; not wanting their employer to find out; poverty issues, etc. A very large component of this effort is to retain the client in care and to address any barriers that might lead the client to drop out of care.

Housing Needs

AIDSNET recognizes that decent, safe and affordable housing play a critical role in the health and well-being of PLWH. The greatest barriers over the years have been HIV-related illness, inability to pay rent, domestic violence, separation or divorce from a partner and mental health and/or substance abuse issues. With the very slow recovery of the economy and the shift in the housing market, risk of foreclosure has also become a concern for clients in the AIDSNET region. Safety is always an important concern because poverty forces clients to live in high crime areas where the rent is affordable. Housing opportunities for those who have been involved with the criminal justice system are virtually nonexistent. This is especially true in the case of drug-related arrests, even in the absence of a conviction. Given that a significant proportion of the HIV population has past or current involvement with substance abuse, this constraint in the system has had a significant impact on the population. Public housing assistance requires an onerous application process and then a long waiting list. By the time clients become eligible, many have lost touch with the local housing authority.

AIDSNET has the following programs for meeting housing needs:

- Short-Term Rent, Mortgage and/or Utility Assistance (STRMU), which pays for rent, mortgage payments and utilities. Eligibility of mortgage payment assistance is a new component of the program;
- Tenant-Based Rental Assistance Program (TBRA) for people who need ongoing rental assistance;
- Transitional Housing Program, which offers short-term shelter and supportive services. AIDSNET funds transitional housing for 4 homeless men at the YMCA of Reading and Berks County; and
- Permanent Housing Placement (PHP), which provides assistance with first month's rent and security deposit.

The local housing authorities are the primary source of subsidized housing in the region. Each of the six counties has a housing authority, as do five of the largest municipalities within the region. Housing authorities receive funding from the federal government. Communication between the housing authorities is minimal, and applications must be made to each housing authority separately. Some of the rules, regulations, preferences and priorities are mandated at the federal level; others are local preference, thereby adding to the confusion.

Housing authority assistance comes primarily in two forms. The first is public housing units that are owned by the housing authority. The second is Section 8 vouchers, which are administered by the housing authority, although the housing units are privately owned. These vouchers are good for a specific amount of rent and utilities towards any unit owned by a landlord willing to accept the Section 8 voucher if the unit meets inspection guidelines.

The process for application varies slightly from one housing authority to the next. Once an application has been submitted, each housing authority has a policy of conducting a credit and criminal background check. The credit check is done with an understanding that those applying for housing assistance are doing so out of financial need. Like many people with low incomes, the applicants have had difficulty making timely payments on their bills. Accordingly, a high credit rating is not expected. If applicants owe any money to a public-housing program, the bill must be paid before the application will be accepted. The criminal background check does not allow for the same leeway as the credit check. Any drug-related or violent criminal conviction within the past three years is grounds for automatic denial. Applicants cannot have been on probation within the past year. Patterns of alcohol abuse, indicating the applicant would not make a good tenant, are also grounds for denial.

Once the application process is completed, the client is then put on a waiting list.

Barriers

Waiting time for public housing is approximately two to five years. Waiting lists vary dramatically from one county or municipality to the next. Some of the waiting lists periodically close, meaning applications are not accepted during that time.

Housing Services Provided During Fiscal Year 2011-2012

The following table demonstrates housing arrangements of clients who received case management services during fiscal year 2011-2012. The large majority (92%) of people reported being permanently housed, which exceeds the Housing and Urban Development's goal to have 80% of PLWH in safe and stable housing. Approximately 4% reported not being in permanent, stable housing arrangements, which represents a 2% decrease over the prior years' data. The AIDSNET region has experienced a decrease in the number of non-permanently housed clients and has seen a moderate increase in those clients that are permanently housed, which continues to represent diligent efforts by case management agencies to assist PLWH with locating permanent/stable housing.

Table 12: Housing Arrangements of Clients who Received Case Management Services During Fiscal Year 2011-2012[28]

Housing Status	Number	Percent
Permanently housed	1135	92
Non-permanently housed	55	4
Institution	41	3
Other	2	<1
Unknown/unreported	0	0
Total	1233	100

[28] 2011-2012 fiscal year CAREWare exports. Duplication of clients is possible if a client moved from one county to another (or one CM agency to another). Note: Percentages may not equal 100 due to rounding.

During fiscal year 2011-2012, a total of 138 unduplicated individuals/households living with HIV accessed $408,583 of AIDSNET-funded direct housing services for themselves, their families, or persons living with them. Of the total individuals/households, 118, or 86%, reside in the Emerging Metropolitan Statistical Area (EMSA) using $325,797, or 80%, of the direct-service HOPWA funds. The EMSA is made up of Carbon, Lehigh, and Northampton counties, with Berks, Monroe, and Schuylkill counties making up the remaining three of the six counties within the AIDSNET region. AIDSNET anticipates, based on trending, that it will continue to service a majority of its HIV population with housing needs within the EMSA counties, which is primarily due to access to public services types. The following two tables (13 and 14) provide a breakdown between clients and clients and their family members and for characteristics of those assisted between 2007 and 2012.

Table 13: Clients Assisted with Housing Between 2007 and 2012[29]

Description	**2007-08**[30]	**2008-09**[31]	**2009-10**[32]	**2010-11**[33]	**2011-2012**
PLWH who received housing assistance	126	125	132	138	138
Number of other persons in family units who received housing assistance	150	159	150	164	135
Total persons who received housing assistance	276	284	282	302	273
Total family units assisted with housing	N/A[34]	N/A[35]	N/A[36]	N/A[37]	N/A

Table 14: Characteristics of Clients and their Family Members Assisted with Housing Between 2007and 2012[38]

	2007-08[39]	**2008-09**[40]	**2009-10**[41]	**2010-11**[42]	**2011-12**
Demographics	**Number (%)**	**Number (%)**	**Number (%)**	**Number (%)**	**Number (%)**
Total	276 (100)	284 (100)	282 (100)	302 (100)	273 (100)
Gender:					

[29] AIDSNET's Housing Opportunities for Persons with AIDS (HOPWA) Annual Progress Reports fiscal year 2006-2010 & Consolidated Annual Performance and Evaluation Report for fiscal year 2011

[30] Excludes PLWH and other family members that received Permanent Housing Placement only.

[31] Excludes PLWH and other family members that received Permanent Housing Placement only.

[32] Excludes PLWH and other family members that received Permanent Housing Placement only.

[33] Excludes PLWH and other family members that received Permanent Housing Placement only.

[34] Total Family Units Assisted was not a reporting category on the HOPWA Annual Progress Report for fiscal year 2007-2008 so this data is not available.

[35] Total Family Units Assisted was not a reporting category on the HOPWA Annual Progress Report for fiscal year 2008-2009 so this data is not available.

[36] Total Family Units Assisted was not a reporting category on the HOPWA Annual Progress Report for fiscal year 2009-2010 so this data is not available.

[37] Total Family Units Assisted was not a reporting category on the HOPWA Annual Progress Report for fiscal year 2010-2011 so this data is not available.

[38] AIDSNET's HOPWA Annual Progress Reports fiscal years 2006-2010 & Consolidated Annual Performance and Evaluation Report fiscal year 2011-2012

[39] Excludes PLWH and other family members that received Permanent Housing Placement only.

[40] Excludes PLWH and other family members that received Permanent Housing Placement only.

[41] Excludes PLWH and other family members that received Permanent Housing Placement only

[42] Excludes PLWH and other family members that received Permanent Housing Placement only

Male	129 (47)	145 (51)	137 (49)	148 (49)	131 (48)
Female	147 (53)	139 (49)	145 (51)	154 (51)	142 (52)
Race:[43]					
White	116 (42)	114 (40)	130 (46)	152 (50)	101 (37)
Black	85 (31)	78 (27)	80 (28)	75 (25)	75 (27)
Asian/Pacific Islander	1 (<1)	7 (2)	2(<1)	3 (<1)	1 <1
Multiple races	74 (27)	85 (30)	70 (25)	72 (24)	96 (35)
Ethnicity:					
Hispanic	144 (52)	129 (45)	148 (52)	163 (54)	119 (44)
Non-Hispanic	132 (48)	155 (55)	134 (48)	139 (46)	154 (56)
Age (years):[44]					
17 years and under	84 (30)	93 (33)	86 (30)	84 (28)	80 (29)
18-30	37 (13)	43 (15)	41 (15)	51 (17)	34 (12)
31-50	97 (35)	100 (35)	106 (38)	105 (35)	97 (36)
51 and over	58 (21)	47 (17)	49 (17)	62 (20)	62 (23)

HIV Prevention Services

Trying to measure what does not occur, the number of infections prevented, is a difficult challenge in HIV prevention. Three key indicators can be used to measure the impact of HIV prevention efforts:

- Examining increases or decreases in estimated HIV infections over time is an important indicator, but may mask important signs of success. With more people living with HIV than ever before, thanks to effective HIV medications, there are more opportunities for transmission. Yet the number of infections has not increased, indicating that HIV testing, prevention and treatment programs are effectively reducing the rate of transmission.
- A useful measure of prevention success is the estimated rate of HIV transmission, which indicates the likelihood that an HIV-infected individual will transmit the virus to others. There has been an 89% decline in the estimated rate of HIV transmission since the mid-1980's.
- Scientists have developed models to estimate the number of HIV infections that have been averted because of HIV prevention efforts. These models suggest that hundreds of thousands of HIV infections have been prevented because of the nation's HIV prevention efforts.

Proven HIV Prevention Intervention

Research has led to a growing number of proven, cost-effective approaches to reduce the risk of HIV infection. In the US, proven strategies include:

- Learning one's HIV status has been shown to result in substantial reductions in risk behaviors.

[43] Percentage for Race may not total 100 due to rounding.
[44] Percentage for Age may not total 100 percent due to rounding.

- Prevention programs for people living with HIV.
- Prevention programs for people at risk of HIV infection.
- Partner services that reduce the spread of HIV by facilitating the confidential identification and notification of partners who may have been unknowingly exposed to HIV.
- Antiretroviral medications significantly reduce the risk of HIV transmission from HIV-infected pregnant women to their infants.
- Effective substance abuse treatment that helps drug users stop injecting eliminates the risk of HIV transmission through injection drug use.
- Increasing the availability of condoms and sterile syringes is associated with significant reductions in HIV risk.
- Sexually transmitted infections (STI) increase an individual's risk of acquiring and transmitting HIV and STI treatment may reduce HIV viral load.

The following table reflects PA-DOH HIV Prevention Project Performance Indicators measuring results from Counseling & Testing efforts, as well as Partner Notification that can assist those newly diagnosed with contacting a sexual partner(s) and recommend testing.

Table 15: PA- DOH 2009 HIV Prevention Project Progress Report[45]

Performance Indicators	**Results**
A.1: The number of newly diagnosed HIV infections	285
A.2: The number of newly diagnosed HIV infections, 13-24 years of age	81
B.1: Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites	0.5 % (285/51,953
B.2: Percent of newly identified, confirmed HIV-positive tests returned to clients	94% (267/285)
B.3: Percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's actual 2009 measure reported in B1	20% (76/375)
C.1: Percent of contacts with unknown or negative serostatus receiving an HIV test after Partner Counseling and Referral Services (PCRS) notification	45% (171/378)
C.2: Percent of contacts with a newly identified, confirmed HIV positive test among contacts who are tested	11% (18/71)
C.3: Percent of contacts with a known, confirmed HIV-positive test among all contacts	14% (52/378)
D.1/D.4: Proportion of women who receive an HIV test during pregnancy	87.5% (interim) (130,375/149,000
D.2**:** Proportion of HIV-infected pregnant women who receive three-part antiretroviral therapy (during the antepartum,	Not Applicable

[45] 2009 CDC HIV Prevention Project Annual Progress Report for Pennsylvania (2UPS323509-06)

intrapartum and neonatal periods) to prevent Perinatal transmission[46]	
D.3**:** Proportion of HIV-infected pregnant women whose infants are perinatally infected	Not Applicable
E.1: Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one Community Planning Group (CPG) member that reflects the perspective of each population	83% (10/12)

The HIV Prevention Delivery System

All coalitions throughout the state collect a core set of prevention data based on the CDC interventions and report them on a quarterly basis.

The definitions of interventions are as follows:[47]

- Interventions Delivered to Individuals (IDI) – Health education and risk-reduction counseling provided to one individual at a time. IDI assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. It contains screening and recruitment protocols, consists of multiple sessions and the development of a documented Individual Prevention Plan (IPP) including planned client objectives. It excludes Outreach, Comprehensive Risk Counseling Services and HIV counseling and testing, which are reported in separate categories.

- Interventions Delivered to Groups (IDG) – Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. IDG uses peer and non-peer models involving a wide range of skills, information, education, and support. IDGs are structured interventions with screening procedures, curricula, documented learning objectives, the use of evaluation tools and referrals. It excludes any group education that lacks a skills component (e.g., information only education such as "one-shot" presentations).

The implementation of these definitions has been a significant step in the further development of prevention services. More so than previously utilized definitions, the CDC terminology for prevention services focuses the attention of prevention staff on a participant's specific high-risk behaviors and skills building needs for risk reduction. The ability to assess these areas, in a

[46] Applicable only to those jurisdictions with supplemental funding for Perinatal transmission prevention through the Health Department Cooperative Agreement
[47] CDC website last updated 5/10/02

variety of settings, requires a more sophisticated understanding of prevention and continually improving skill levels on the part of service providers.

Since adoption of these guidelines, prevention providers have made progress in shifting from very high levels of outreach to contacts that include risk assessment, the evaluation of barriers that inhibit the adoption of risk-reduction behaviors and risk-reduction skill building. The divide between accurate risk-reduction knowledge and practice is a large one that must be broached over repeated interventions during prolonged periods of time.

A few of the current challenges faced by prevention agencies are: (1) the tracking of prevention activities to facilitate accurate collection of data; (2) finding appropriate Effective Behavioral Evidence-Based Interventions (EBI), facilitation and skills-based trainings to ensure that prevention staff are equipped to provide quality IDI or IDG interventions; (3) keeping current with the changing landscape of prevention; and (4) staff retention.

CDC's HIV Prevention Strategy [48]

To maximize its effectiveness, the CDC is pursuing an approach it refers to as High-Impact Prevention. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to greatly increase the impact of HIV prevention efforts. Five primary considerations drive High-Impact Prevention:

- High-Impact Prevention prioritizes proven interventions that are most cost-effective at reducing overall HIV infections.
- Priority is placed on proven interventions that are practical to implement on a large scale at reasonable cost.
- Selection of proven interventions is based in part on how many people can be reached once the intervention is fully implemented.
- Attention is given to how different proven interventions interact and how they most effectively can be combined to reach the most-affected populations in a given area.
- Identify proven interventions that will have the greatest overall potential to reduce infections.

CDC's High-Impact Prevention approach guides the broad allocation of prevention resources, as well as the development of specific prevention strategies for all populations at risk, including gay and bisexual men, communities of color, women, injection drug users, transgender women and men, youth and others. Prevention is evolving with the epidemic by using biomedical and behavioral strategies to reduce new HIV infections.

Implementing CDC's Prevention Strategy

CDC's high-impact strategy is focused on large scale interventions in large cities, such as Philadelphia that represents the largest proportion of HIV cases in the Commonwealth of Pennsylvania. The CDC's focus on universal testing and getting clients into medical care and

[48] http://www.cdcnpin.org/scripts/hiv/prevent.asp

treatment has been mirrored by the CARE Act's increasing focus on providing core medical services. Both are very important in prevention and key objectives of the *National HIV/AIDS Strategy*. However, how does this strategy translate into the smaller cities and communities that are found in the AIDSNET consortia? That is the biggest challenge AIDSNET and prevention providers are facing. For many years, AIDSNET has had PLWH as its highest prevention priority. However, in trying to identify new positives by testing, which is a universal goal of all interventions, the barriers are having a much smaller population to recruit for intervention, the specificity of populations and the number of sessions per intervention. It has been difficult to recruit high risk populations that are hard to access, such as MSM and IDU. The Strategic Plan, Section 6 of this document, further discusses this issue

Prevention Services Provided During Fiscal Year 2011-2012

Prevention services changed dramatically for the fiscal year 2011-2012 as the AIDSNET region transitioned into funding services based on the PA-DOH's mandate that all State-funded prevention interventions must be Tier I or Tier II DEBI/EBI IDI and IDG as listed on the CDC Compendium of Evidenced-based Interventions. The AIDSNET region funded providers in the amount of $422,704 for CLEAR, Personalized Cognitive Risk Counseling and RESPECT IDI and AIM, Cuidate!, Decisions for Life, Healthy Relationships, and VOICES/VOCES IDG. Because a unit cost could not be determined at the onset of the new prevention intervention program, all six AIDSNET region prevention providers were funded on a monthly Program Cost determination basis.

There was a significant drop in the number of clients served over prior year 2010-2011 due to several factors: elimination of Outreach and Health Communications and Public Information (HC/PI) services, limited number of prevention types, limited availability of required DEBI/EBI trainings, limited number of trained personnel to provide the interventions, and challenges with clients willing to attend multiple-session interventions. The data in Table 15 represents the number of IDI and IDG intervention contacts by mode of transmission, the total number, and percentage of prevention contacts by mode of transmission and the total and percentage of contacts by type of intervention.

Prevention services reached a total of 6,757 individuals during fiscal year 2011-2012 at a cost of $363,538. This represents a 10% decrease in dollars expended from the previous fiscal year. It is essential to note the continued shift in emphasis from very large numbers of prevention contacts from prior years to evidenced-based IDI and IDG interventions that focus on behavior change. This is an important positive change and a trend that will continue as mandated by PA-DOH. Of the prevention contacts provided during fiscal year 2011-2012, IDG comprised 68% of the contacts.

Table 16: Number and Percent of Duplicated Contacts in IDI and IDG Intervention Types of Each Transmission Category during Fiscal Year 2011-2012.				
Transmission N=6,757	**Interventions Delivered to Individuals (IDI)**	**Interventions Delivered to Groups (IDG)**	**TOTAL NUMBERS**	**Percentage reached per/Transmission**
MSM	97	439	536	8
MSM/IDU	0	0	0	0
IDU	88	2266	2354	35
Heterosexual	1972	1888	3860	57
Pregnant Women	5	0	5	<1
General Public	2	0	2	<1
Total Interventions	2164	4593	6757	100
% reached per Intervention type	32	68	100	

Table 17: Demographics of PLWH in the AIDSNET Region and 2011-2012 Prevention Contacts		
Characteristics N=6,757	Percent of PLWH in the AIDSNET Region	Percent Reached Through Prevention Activities
GENDER:		
Male	65	61
Female	35	39
Transgender	0	<1
RACE:		
White	35	79
Black	20	18
Asian/Pacific Islander	<1	<1
American Indian/Alaskan Native	<1	<1
More than one race	5	2
Race not targeted	n/a	<1
ETHNICITY:		
Hispanic	40	34
Non-Hispanic	60	66
Age:		
<14	2	<1
14-19	3	20
20-29	24	34
30-39	35	21
40-49	25	16

Over 49	11	9
Mode of Transmission:		
Men Who have sex w/men (MSM)	22	8
Intravenous drug use (IDU)	27	35
MSM & IDU	3	0
Heterosexual contact	30	57
Coagulation disorder	1	0
Pregnant women with/at risk for HIV	n/a	<1
Transfusion/Transplant	<1	0
All pediatric	2	0
Undetermined/Other	15	<1

Conclusions of the Needs Assessment

- Sixty-five percent of PLWH are men and thirty-five percent are women in the AIDSNET region. PLWH receiving case management in the region were 60% men, 39% women and <1% transgender. The region continues to have the largest representation of women living with HIV Disease in the Commonwealth. This is due to the growing number of heterosexual transmissions and is thought to be a result of the region having the highest percentage of PLWA due to IDU.
- A markedly higher percentage of PLWH in the region was Latino (40%) compared to their representation in the six counties (13%). Similarly, blacks were 20% of PLWH compared to their representation in the region (6%).
- PLWH are disproportionately found in communities of color. Blacks and Latinos have over three times more HIV Disease cases as compared to their representation in the population; and whites approximately two and a half times fewer HIV/AIDS cases than their representation in the population.
- Mode of transmission was 30% for heterosexual contact, followed closely by IDU at 27% and 22% from MSM. When comparing these numbers to the statewide figures, which are 31%, 23% and 35% respectively, the differences in planning for prevention and care services become evident.
- Co-infection with HCV is thought to be up to 90% of clients who have IDU as their mode of transmission. Clients are dying as a result of advanced HCV, despite the advances in treatment for HIV which are prolonging survival time.
- Currently, there are a total of 2,722 reported PLWH living in the AIDSNET region.
- Case management services reached 1,233 individuals in fiscal year 2011-2012.
- Nineteen percent of clients (234) receiving case management in fiscal year 2011-2012 were uninsured.
- In the AIDSNET region, approximately 69% of individuals receiving case management services were below the FPL.
- The most heavily-used authorized services during the fiscal year were for Transportation, Oral Health Care, Legal Services and HIP.
- Barriers in fulfilling clients' housing-related needs included safety, domestic abuse, public housing application processes/waiting list, housing amenities and the limited

availability of housing funds for those who have been involved with the criminal justice system.

- There is an increasing need for establishing standards for effective assessment of risk behaviors and counseling of PLWH in medical clinics and other health practices.
- There continues to be a growing emphasis on prevention interventions that focus on the risk-reduction behavior change and skill building, such as IDI and IDG. With this goal in mind, the PA-DOH has instructed consortia to provide IDI and IDG that are Tier I and Tier II EBI.
- MSM individuals are underrepresented in the prevention activities, and efforts to reach them will be an emphasis in the future.
- The challenges in providing prevention services are the need for training in EBI interventions, counseling skills for the prevention workers to provide high-quality interventions, staff retention, the collection of more accurate data, and the downward trend in prevention funding. A new challenge in providing prevention activities is implementing the CDC's movement toward high impact prevention services within AIDSNET's six suburban and rural counties.

2. Gap Analysis

The Gap Analysis builds on the work of the Needs Assessment by going into greater detail, especially regarding the differences between counties within the region. The results identify the area of adequate service delivery and gaps in the care and prevention system in each county.

Determining service gaps and looking for duplication of services is an important part of planning.

Methodology

In the AIDSNET region, this work takes place through various meetings with the HI-V group (HIV Information for Victory) comprised of clients receiving case management (CM) care in one of the our agencies providing that service, the Planning Committee, the Allocations Committee, the Service Coordination and Prevention Education Advisory Councils and ongoing communications with providers. AIDSNET has designed a gaps inventory matrix for the six counties where services that are funded by the U. S. Health Resources and Services Administration (HRSA), Housing Opportunities for Persons with AIDS (HOPWA) and State 656 are provided.

AIDSNET uses other tools to identify possible gaps in services. Throughout the year, spending among AIDSNET's Subgrantees is monitored and trends are reviewed for planning and funding decisions to meet the needs of clients. This is done to reassure that gaps are identified within our service delivery system and specific actions taken to address them whenever possible while adhering to the guidelines of the above mentioned funding streams.

Consumer Involvement

AIDSNET also conducts a client survey or focus group annually that not only evaluates the client's satisfaction with services provided by their case management agencies, but also addresses their ability to access services within their community and to identify emerging needs not being met.

Client Satisfaction Survey 2012

The following questions were asked statewide by all Part-B CM agencies about the quality of services clients receive. Clients were reminded that their responses would not identify them and informed that all responses would be used to improve the quality of services.

The following scale was used: 1 = Strongly Agree, 2 = Agree, 3 = Disagree and 4 = Strongly Disagree

1. I am able to get an appointment with my case manager when needed.

    1 - Strongly Agree 122 (67%)

2 - Agree	51 (28%)
3 - Disagree	5 (3%)
4 - Strongly Disagree	4 (2%)

2. My case manager makes referrals to agencies/individuals that meet my needs.

1 - Strongly Agree	109 (60%)
2 - Agree	67 (40%)
3 - Disagree	3 (2%)
4 - Strongly Disagree	3 (2%)

2a. When those referrals cannot assist me, my case manager is able to help me.

1 - Strongly Agree	103 (57%)
2 - Agree	72 (40%)
3 - Disagree	4 (2%)
4 - Strongly Disagree	3 (2%)

3. My case manager allows me to be more independent in addressing my problems.

1 - Strongly Agree	112 (62%)
2 - Agree	66 (36%)
3 - Disagree	1 (<1%)
4 - Strongly Disagree	2 (1%)
No Response	1 (<1%)

4. I am comfortable sharing my feelings and problems with my case manager.

1 - Strongly Agree	130 (71%)
2 - Agree	43 (24%)
3 - Disagree	5 (3%)
4 - Strongly Disagree	2 (1%)
No Response	1 (<1%)

5. My case manager works with my HIV medical care providers to help me understand my medical care/options.

1 - Strongly Agree	117 (64%)
2 - Agree	60 (33%)
3 - Disagree	2 (1%)
4 - Strongly Disagree	2 (1%)
No Response	1 (<1%)

6. My case manager and I work together in making decisions about my goals, needs and options.

1 - Strongly Agree	113 (62%)

2 - Agree 62 (34%)
3 - Disagree 5 (3%)
4 - Strongly Disagree 2 (1%)

7. Overall, I am satisfied with the case management services I received over the past 12 months.

1 - Strongly Agree 131 (72%)
2 - Agree 45 (25%)
3 - Disagree 3 (2%)
4 - Strongly Disagree 3 (2%)

Clients play a large role in AIDSNET's priority setting process. During this process, members of the HI-V group are provided with a draft of the priority tables, encouraging them to critique the prioritizations for both care and prevention activities. They also review the gaps inventory seen below. This information is then used during final priority setting to reassure that gaps identified are prioritized and addressed as funding permits.

County Level Resource Inventory

The numbers in the boxes in Table 1 define the levels of availability, adequacy, accessibility and utility. It goes without saying that if an individual is uninsured, barriers to care are unavailability, insufficiency and inaccessibility.

- Unmarked boxes indicate that the service is available, adequate and accessible
- "1" shows that services are not available
- "2" indicates that the services are insufficient
- "3" indicates that they are inaccessible for people living with HIV/AIDS
- "4" indicates that these services were not utilized

Table 1– Gaps Inventory Matrix for AIDSNET Region 2011-2012

Services	**Berks**	**Carbon**	**Lehigh**	**Monroe**	**Northampton**	**Schuylkill**
Case Management						
Outpatient/Ambulatory Medical		2, 3		2, 3		
Housing Assistance		2		2		
Treatment Adherence		1		1		
Health Education/Risk Reduction/Prevention		2		2		
Emergency Financial Assistance	2	2	2	2	2	2
Health Insurance						
Medical Transportation		2		2	2	
Oral Health		2, 3	2	2, 3	2	

Behavioral: Mental Health/Substance Abuse		2	2	2	2	
Legal Services		2	2	2	2	
Medical Nutrition Therapy		2		2		
Food Bank/Home Delivered Meals						
Psychosocial Support (Groups)		1, 2	2	1, 2	2	
Home Health Care						2
Hospice Services						
Rehabilitation				2		4
Child Care		2		2		
Day/Respite Care	4	2	2	2	2	4
HIV Primary Care		2		2		1
Assisted Living				2		4

The following services and delivery systems were confirmed by email from each funded agency.

Table 2 – Updates of Service Capacity within the Region	
Service	**Remarks**
Outpatient/Ambulatory	Berks County now has the Reading Hospital Part C clinic and Dr. Arias' practice. However, across the region the need is still overwhelming compared to the availability of HIV medical care providers available.
Housing Assistance	Public Housing/Section 8 lists in ALL regions remain closed. When they do occasionally open, they usually close within the hour. Public Housing options in Schuylkill County consist of substandard housing stock.
Treatment Adherence	Schuylkill County has an AIDS certified registered nurse providing this service. This service is not available in Carbon and Monroe Counties because there are no infectious disease doctors. Clients in these counties must travel to Lehigh, Northampton, Scranton, and Philadelphia to receive treatment adherence and other HIV medical care.
Emergency Financial Assistance	Across the regions, other sources for funding are becoming limited.
Oral Health	Care Group Dental, which used to care for the uninsured in Berks County, is temporarily closed with no word of reopening. The Apple Dental Clinic, which opened in Mt. Pocono, is not providing adequate services to meet the need. Northampton

	County dental services, although present, are either insufficient to meet the need and/or inaccessible. The cost of dental care and limited availability of providers willing to serve PLWH are barriers.
Behavioral Health	All counties have some service providers, but it is difficult for clients to schedule appointments due to long waiting lists. Bet-El Counseling Services provides services to the Latino population in Bethlehem, which covers parts of Lehigh and Northampton Counties.
Legal Services	Are insufficient and inaccessible in Schuylkill County.
Psychosocial Support Groups	Lehigh and Northampton Counties have insufficient groups for the density of the area.
Home Health Care	Although minimally utilized, this service is insufficient/inaccessible in Schuylkill County. Medical Assistance (MA) or private insurance usually pays for this service and case managers link clients to this service when the need arises.

The list below highlights the changes in the Gaps Inventory Matrix from last fiscal year and shows the Medically Underserved Areas (MUA)/Populations (MUP) or a County Subdivision (also known as minor civil division, or MCD) within the six counties.

In Berks County

- Oral Health Care and Behavioral: Mental Health/Substance Abuse services changed from insufficient to unmarked (available, adequate and accessible), and Childcare services changed from insufficient/not utilized to unmarked (available, adequate and accessible).
- (MUA or MUP)[1]12 census tracks in Reading

In Carbon County

- Health Education/Risk Reduction and Medical Transportation services are no longer inaccessible for PLWH.
- Emergency Financial Assistance HIV Primary Care services changed from not available to insufficient.
- Oral Health Care services changed from not available to insufficient/inaccessible for PLWH.
- Legal and Medical Nutrition Therapy services changed from unmarked (available, adequate and accessible) to insufficient.
- Psychosocial Support in the form of support groups insufficient.

[1]Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. http://muafind.hrsa.gov/index.aspx

- Home Health care services changed from insufficient to unmarked (available, adequate and accessible).
- Hospice and Rehabilitation Services changed from not utilized to unmarked (available, adequate and accessible).
- Child Care and Day/Respite Care services changed from not utilized to insufficient.
- Assisted Living services changed from insufficient/inaccessible for PLWH to unmarked (available, adequate and accessible).
- Coaldale (MUA), Lansford borough (MCD), Nesquehoning borough(MCD) and Summit Hill borough (MCD)

In Lehigh and Northampton Counties

- Emergency Financial Assistance and Legal Services changed from unmarked (available, adequate and accessible) to insufficient.
- Oral Health Care is no longer inaccessible to PLWH.
- Assisted Living services changed from insufficient/inaccessible for PLWH to unmarked (available, adequate and accessible).
- In Lehigh County, Hospice, Rehabilitation and Childcare services changed from not utilized to unmarked (available, adequate and accessible) and Day/Respite Care services changed from not utilized to insufficient.
- In Northampton County, Medical Transportation and Behavioral: Mental Health/Substance Abuse services changed from unmarked (available, adequate and accessible) to insufficient.
- MUA - 2 sites in Allentown service area
- MUP - 5 Low Income in Easton service areas
- MUA - 5 in South Bethlehem service area

In Monroe County

- Outpatient/Ambulatory and Oral Health Care services are insufficient and inaccessible for PLWH.
- Health Education and Assisted Living services are no longer inaccessible for PLWH. Oral Health Care has been vastly improved with the opening of a dental clinic, but at the current time is insufficient to meet client demands.
- Legal services changed from unmarked (available, adequate and accessible) to insufficient.
- Psychosocial Support in the form of support groups is insufficient.
- Hospice services changed from not utilized to unmarked (available, adequate and accessible).
- Rehabilitation and Day/Respite Care services changed from not utilized to unmarked (available, adequate and accessible).
- Child Care services changed from inaccessible for PLWH to insufficient.
- HIV Primary Care changed from not available to insufficient.
- Stroudsburg Low Income (MUP) and Stroudsburg borough (MCD)

In Schuylkill County

- Outpatient/Ambulatory, Housing Assistance, Medical Transportation, Oral Health Care, Behavioral: Mental Health/Substance Abuse and Legal services changed from insufficient/inaccessible for PLWH to unmarked (available, adequate and accessible).
- Emergency Financial Assistance services changed from inaccessible to insufficient.
- Psychosocial Support services in the form of support groups changed from insufficient to unmarked (available, adequate and accessible).
- Home Health Care services changed from not utilized to insufficient.
- Hospice services changed from inaccessible for PLWH to unmarked (available, adequate and accessible).
- Child Care services changed from not utilized to unmarked (available, adequate and accessible).
- Assisted Living services changed from insufficient/inaccessible for PLWH to not utilized.
- Shenandoah Service Area (MUA), Ashland borough (MCD), Butler township (MCD), East Union township (MCD), Frackville borough (MCD), Gilberton borough (MCD), Girardville borough (MCD), Gordon borough (MCD), Mahanoy City borough (MCD), North Union township (MCD), Ringtown borough (MCD), Shenandoah borough (MCD), Union township (MCD), West Mahanoy township (MCD)
- Shamokin Service Area (MUA), Eldred township (MCD), Hubley township (MCD), Upper Mahantongo township (MCD)
- Coaldale (MUA), Coaldale borough (MCD), Delano township (MCD), Kline township (MCD), McAdoo borough (MCD), Rush township (MCD), Schuylkill township (MCD), Tamaqua borough (MCD)

Stakeholder Involvement

Our Subgrantees play a significant role in the identification of gaps in services. They actively participate in our priority setting and have input into what services are needed due to gaps in community resources. AIDSNET's Board of Directors also plays a role by identifying areas that they have recognized as gaps in services in the community.

Other medical and social service agencies within our region also provide valuable information by identifying services that are not available, not accessible or are not adequately addressing their clients' needs. After all the information is gathered by various sources and discussed, the data are reviewed and gaps in services are identified, prioritized and addressed as funding allows.

The 2012 AIDSNET HI-V annual summit was attended by 19 individuals representing four of the six counties in the AIDSNET region. The focus of this year's summit was on what is new in HIV care, treatment and prevention; and meditation and relaxation for healing and improved health outcomes. The success of antiretrovirals has extended the life expectancy and slowed the progression to CDC defined AIDS. However, living longer has brought about a new list of concerns from co-morbidities and concerns about long-term care/financial stability to increased isolation and depression, bringing questions about quality of life for PLWH to the forefront. Many participants expressed ongoing concerns that medical, mental health and social service

providers are not equipped to address their long-term needs. Discussions throughout the weekend also revolved around limited access to support groups and strategies to overcome the isolation. The summit is also used to increase consumer involvement in the AIDSNET HI-V Consumer Advisory Group, Board and various committees.

Assessment of Service Gaps

Regionally, there are gaps in medical transportation services and an insufficient number of accessible HIV Primary Care specialists. Despite the law against discriminating against PLWH, clients report some dentists unwilling to perform dental work on HIV positive individuals adding to the difficulty of inadequate dental services available and accessible to clients. Clients and case managers often point out that there are very few dentists within our region, particularly in Monroe and Carbon counties, that accept Medicaid as a source of payment for services. This is a serious gap given that Medicaid is responsible for more than half of our clients' medical coverage. However, over the last several years there has been a marked increase in providing funds for dental care to clients.

While analyzing the gaps in the AIDSNET region, it is evident that a significant reason for the gaps is the rural nature of some of our counties (Monroe, Carbon and Schuylkill). According to the American Medical Association and HRSA, Monroe County is suffering from an extreme provider shortage, requiring an additional 108 physicians to meet existing needs.[2] Additionally, the borough of Stroudsburg is designated by the federal government as a Medically Underserved Population (MUP).

The shortage of physicians is especially acute for individuals on Medical Assistance. Currently, there is no infectious disease physician treating HIV clients. Citing Monroe's rates of uninsured/under-insured, health disparities and poverty, the PA-DOH identified Monroe County as a priority area for increased access to health care in its most recent State Health Improvement Plan.

Transportation for medical or dental appointments is available for most HIV-positive individuals, although this transportation may require hours in a vehicle or being dropped off at the provider early in the morning by arranged transportation (such as Shared Ride, hospital shuttle or courtesy van) and waiting until late afternoon for pick up and limited days of availability. These types of transportation services usually do not cross county lines, thus becoming inaccessible for those clients who travel out of their county (Carbon, Monroe and Schuylkill) to obtain HIV medical care.

Subgrantees' staff occasionally provides transportation when no other alternative exists so that clients can access their appointments. This service is especially important for clients who must travel long distances to access essential services. In the more urban areas, the Subgrantees supply bus tickets or, under certain conditions, pay for taxis to get clients to medical services.

[2]Monroe County Assessment of Needs and Assets Update 2008, Ann M. Adams, RN, MSN and Elizabeth A. Bresinger, MPH, Red Road Enterprises, February 25, 2008

There is also a gap in treatment adherence services in our region. Currently, there are three providers located in Berks, Lehigh, Northampton and Schuylkill counties contracted to provide adherence counseling by AIDS certified RNs or Physician Assistants that focus on clients keeping their medical appointments and maintaining their medication regimen.

There are food banks in Berks, Lehigh, Northampton and Schuylkill counties that provide food to clients to help supplement their limited incomes and maintain their weight. Although it is important for food banks to continue their services, there is a gap in the availability of fresh, nutritionally-sound food. The WIC program and food stamps had begun to give vouchers for fresh fruits and vegetables. However, funding was cut in an attempt to balance the state budget. The limit to how often each food bank can be used during a specified time frame (once a month) is also a barrier. An increase in job loss and homelessness, combined with a decrease in available social services and donations caused by the continued economic downturn, have placed an overwhelming burden on food banks in the region. This has led many food banks to implement additional restrictions on how much food a household receives.

There are also gaps in services for support groups. Since AIDSNET raised the guidelines for support groups, there has been only one proposal submitted for support groups from non-profit agencies. The longevity and consistency in qualified group leaders and client participation have continued to be a barrier to the provision of long-standing support groups.

In addition to common emerging trends, AIDSNET has also identified with several of the critical gaps in care and treatment found in the 2009 Statewide Coordinated Statement of Need.[3] Those common gaps are:

Dental Care

- In most counties of Pennsylvania (44/67), there is a lack of dental providers who participate with Medical Assistance (MA) and Medical Assistance HMO's.
- A high number of PLWH in Pennsylvania receive their medical care through the MA program, which accounts for the limited access to dental care in the Commonwealth because many dentists do not accept Medicaid reimbursement.

HIV/AIDS Medical Services

- The number of uninsured State residents rose by 32% from 2000 to 2005 and employer-based health insurance premiums increased 75% from 2000 to 2006. Pennsylvania (PA) has the 10th largest number (1.2) million of uninsured individuals in the United States (US) with 13.4% of the non-elderly population uninsured.
- In rural counties, factors such as lack of health insurance coverage, inadequate sources of ongoing and specialized care, health literacy and a diverse, culturally competent workforce are some of the barriers that many rural residents must navigate in order to receive care.
- Private insurance carriers have created new barriers to care for members with HIV Disease. Increase in co-payments for medications, physician visits and procedures for those with private insurance have made it more difficult to pay for medical care, especially for those with families who have limited income. These expenses can force

[3]Statewide Coordinated Statement of Need for the State of Pennsylvania, January 2009

clients to choose between lifesaving care and payment of rent, mortgages, utility bills and food.

- The limited number of providers, especially medical specialists, in rural regions is problematic. Clients must often travel significant distances for care and public transportation options are extremely limited. Language barriers are not readily addressed by small, rural agencies. Concerns about confidentiality sometimes influence PLWH to seek medical care outside of their own communities.
- There is also a shortage of Primary Care Physicians (PCP) in all regions of the state. Large patient caseloads and low state compensation for Medicaid services have caused many PCP's to decide to see no new Medicaid clients. The result is hospital emergency rooms serve as the PCP for many PLWH.
- The majority of HIV specialists are located in urban centers such as Philadelphia, Pittsburgh and Harrisburg. Pennsylvania continues to have a shortage of HIV specialists in rural areas. This forces many Pennsylvanians to travel great distances to receive their HIV medical care.

Mental Health and Substance Abuse Services

- Many mental health providers will not see individuals with Medicare, including clients who are dually eligible (individuals with both Medicare and Medicaid). Those providers who do treat dually eligible clients can have waiting lists over a year long. There is also a lack of mental health practitioners who specialize in HIV Disease throughout the state and even fewer available that can provide culturally appropriate care to clients.
- Individuals accessing both inpatient and outpatient drug and alcohol treatment with health care benefits have the same issues as those accessing mental health services in Pennsylvania. There is only one inpatient drug and alcohol facility in the eastern part of Pennsylvania that specializes in individuals who have both drug and alcohol and mental health issues.

Case Management (CM)

- CM services function as a gateway for PLWH to access social services and other core services; however, there has been little or no increase in funding. With new HIV infections and life expectancy of PLWH increasing, the HIV service delivery system suffers. Case Manager (CMs) in PA urban areas are handling 30-60 cases each, which is two to three times more than appropriate according to the strength-based model used by the state. High caseloads and low salary leads to burnout and high turnover rate of CMs.
- HRSA limits Ryan White funding to medical CM, other forms of service such as peer CM, specialized CM, assistant CM and even support groups have less funding. Since these services are now more difficult to access, this creates additional stressors on medical CMs. This is particularly true for CM services related to housing, peer counseling, women and children.
- Clients report that additional CMs are needed to meet the demands in the rural areas due to the great distances between clients and services.
- The inability of clients to access services directly, fosters situations in which PLWH remain dependent on CMs, driving up caseloads. Increased case loads limit CMs' abilities to service all their clients adequately.

Aging Services

- In Pennsylvania, there are 3,229 persons over the age of 49 with HIV Disease, or 10% of all PLWH statewide.
- The number of older adults infected with HIV Disease may be even greater since physicians do not perceive older adults to be at risk for HIV infection and are less likely to test them for HIV. That leads to later detection of HIV and delayed treatment.
- Ryan White funding is limiting how providers can treat the co-morbidities associated with HIV Disease and aging. For instance, eye glasses are no longer an eligible expense under Ryan White funding. Unfortunately, Medicare and Medicaid do not pay for vision care so many consumers who were once able to receive glasses under Ryan White are no long able to obtain glasses under any funding stream. Adding to the difficulties for older PLWH is that an HIV diagnosis often results in isolation from social support networks, stigma, along with all the other problems associated with ageism.

Limitations to a Gap Analysis

There are limitations that may prevent AIDSNET from completing a full assessment of all the gaps in services. They may include, but are not limited to, lack of participation and understanding by communities and organizations that are hesitant to address the transmission aspects of sexual activity and substance abuse that are the primary behaviors fueling the HIV epidemic.

Participation on every level is necessary in confirming a reliable gap analysis. If only a limited number of clients, community organizations or other medical/social service providers in our region participate in identifying gaps, the resulting analysis may not provide a comprehensive picture of what is missing or what is available. For instance, clients need to understand what each service is and what it entails prior to participating in this process. Both Subgrantees and other service providers, while participating in a gap analysis, require openness and honesty. It is important to understand, that given current resources, there always will be gaps. A gap will not be identified if an agency has difficulty in stating they are not able to provide a particular service or is having difficulty in meeting requests for that service but reports this service is being done. All participants must provide accurate information in order to have an accurate gap analysis.

AIDSNET, like all systems in the state, strives to address these and other emerging trends, as well as fund services that will fill the gaps. Some areas have been more successful than others. Those that can be addressed through funding are more successful. Those gaps that conflict with perceived community values, as in the case of harm reduction and prevention, are more difficult to address. AIDSNET will continue to analyze gaps in services within the region. When identified and prioritized, AIDSNET will implement policy and/or fund services to close the gaps using the most efficient and effective methods possible with available funds.

3. Unmet Needs

Unmet Need

According to Centers for Disease Control and Prevention (CDC) estimates, there are 1.2 million people infected with HIV in the US.[1] Of them, about 75% (900,000) know their HIV status. Of these, approximately 33% (297,000) are not receiving HIV-related primary health care. Therefore, approximately 67% of persons living with HIV Disease (PLWH) who know their status are receiving medical treatment. Health Resources and Service Administration (HRSA), guiding the HIV/AIDS Bureau (HAB) and its research partners' review of research findings, suggests that access to quality HIV-related primary care has improved as a result of the Ryan White CARE Act (ACT), but that some sub-populations of PLWH are disproportionately less likely than others to be receiving such care. Therefore, HRSA guidelines call for getting more PLWH into primary care, particularly those who are disproportionately affected. In addition, their review of the ACT's intent suggests that the ACT's resources are to be kept "focused on early intervention and care delivery rather than expansion into prevention areas such as outreach to persons who do not know their HIV status." However, targeting the needs of the "disproportionately affected and historically underserved populations"[2] requires assessment of unmet need. Ideally, unmet need will be assessed by geographic location, race/ethnicity, gender, mode of transmission and other service gaps, so programs can better understand who is not in care and why.

HRSA defines unmet need as, "the need for HIV-related health services by individuals with HIV who know their status (PLWH aware) and people living with AIDS (PLWA aware), but are not receiving regular primary health care." More specifically, HRSA has defined unmet need for HIV-related primary medical care as not having evidence of at least one of the following three components that are the minimal indicators for HIV primary medical care: viral load (VL) testing, CD4 count, or provision of antiretroviral (ARV) therapy during a 12-month period. In the HRSA definition of assessment of unmet need, the focus is therefore on the need for HIV primary health care. Other primary health care recognized by HRSA, but not included in the definition of HIV primary medical care ("in care"), is oral health care, outpatient mental health and/or substance abuse treatment, nutritional services and specialty medical care referrals.[3] Service Gap analysis is defined as all service needs not currently being met for all PLWH except HIV primary medical care. This definition includes additional need for primary health care for those already receiving HIV primary medical care ("in care") and includes the need for supportive services for individuals not receiving HIV primary medical care ("not in care"). Service gaps may occur because no services are currently available or because available services are either not appropriate for or not accessible to the target population. The needs of individuals

[1] http://kff.org/hivaids/upload/3029-071.pdf

[2] *Implementation of HRSA Guidance on Estimating Unmet Need for HIV-related Basic/Primary Medical Care among Persons Living with HIV/AIDS in Pennsylvania: A Conceptual Framework of Studies and Care among Persons Living with HIV/AIDS in 2003 in Pennsylvania*, PA-DOH, Department of Epidemiology, October 12, 2004

[3] *Introduction to Epidemiologic Methods for Assessment of Unmet Needs for HIV-related Primary Medical Care,* Pennsylvania Spring Public Health Institute 2005, Benjamin Richard H. Muthambi, DRPH, MPH, State HIV AIDS Epidemiologist

for these other HIV-related services, such as counseling and testing or case management, is recognized as non-medical supportive services. These services facilitate PLWH accessing and remaining in primary medical services as assessment of service gaps. These service gaps will be covered to a limited extent in this section and in greater detail in the larger context of a comprehensive unmet needs assessment in future phases conducted by the Pennsylvania Department of Health (PA-DOH), HIV/AIDS Epidemiology Section and in separate supplemental statewide and regional studies, in collaboration with the PA-DOH and other HIV service areas/coalitions and their consultants.

The Framework[4]

HRSA/HAB supports ongoing efforts to develop methods to assist states in assessing unmet need. This framework is the result of one of those initiatives. It is to be used to estimate how many PLWH who know their status in a region are "in" and "out" of HIV primary medical care. Those who are "out of care" constitute an estimate of unmet need.

The framework requires that ACT grantees and planning bodies obtain data on the total number of people in their area who have been diagnosed with HIV or AIDS and the number of people who are in care. By subtracting those in care from the total number of people who are aware of their HIV/AIDS diagnosis, an estimate will be obtained of the number of people who know they are HIV/AIDS and are not in care, constituting those with an unmet need for HIV primary medical care. In other words, those individuals that cannot be identified as "in care" are assumed to be "out of care."

The unmet need framework uses data on the number of people who are HIV/AIDS aware and not the total number of people with HIV or AIDS (true HIV prevalence). In addition, an individual must have an HIV diagnosis before receiving HIV primary medical care. The framework distinguishes between individuals who have been diagnosed with AIDS (PLWA) and those who have not been diagnosed with AIDS (PLWH aware), because care needs and patterns are generally quite different depending on disease progression. The PLWA term does not require an additional "aware" or "unaware" designation, since all people diagnosed with AIDS are presumed to be aware of their status.

The development of HIV reporting systems in various states with limited resources has generally taken three to four years or more to generate reasonably reliable data, including achieving optimum completeness of electronic laboratory reporting, which is the ideal data collection method for data used for these needs assessment studies. HIV reporting (by name) began in October 2002 in Pennsylvania, excluding the Philadelphia area that began names-based HIV reporting in 2006. Therefore, in the absence of mature HIV reporting data, the DOH's interim alternative strategy is to implement the assessment of unmet need in an incremental manner, using alternative data sources. HIV case reporting will be used when the system reaches acceptable levels of timeliness, completeness and accuracy.

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[4] *A Practical Guide to Measuring Unmet Need for HIV-Related Primary Medical Care: Using the Unmet Need Framework*, Institute for Health Policy Studies, University of California, San Francisco, James G. Kahn, M.D., M.P.H, Jennifer Janney, M.P.H. and Patricia E. Franks, B.A.

Estimation of Unmet Need for HIV-Related Primary Medical Care in Pennsylvania and AIDSNET Region Using the HRSA/HAB Unmet Need Framework [5]

- Objectives**:** To estimate the extent of Unmet Need for HIV-related Primary Medical Care in Pennsylvania using the HRSA/HAB Unmet Need Framework.
- Study Population Size Estimation: The population of persons living with HIV or AIDS (PLWH/A) in PA was estimated based on analyses of the database of the electronic HIV/AIDS Reporting System (eHARS) for case reporting of HIV/AIDS in PA.
- Primary Outcome Measure: The primary outcome measure is the proportion (%) of PLWH or PLWA with a past history of receiving HIV-related services who had unmet need for primary medical care (i.e. no evidence of receiving any one of the three indicators of HIV-related primary medical care: viral load [VL] testing or CD4 count or provision of ART during a 12-month time frame).
- Analyses Methods: The data from eHARS was analyzed to determine the size of the population of persons living with HIV or AIDS (PLWH/A) in Pennsylvania as of 12/31/2008. To estimate the proportion of PLWH/A with unmet needs for HIV-related primary medical care (HRPMC), care pattern data on the proportion of persons with unmet needs was derived from Medicaid and Special Pharmaceutical Benefits Program (SPBP) data for publicly-insured patients, and from Part C HRSA-funded sentinel sites for privately-funded patients, and a composite measure of the proportion of PLWH/A with unmet needs in the jurisdiction. A modified version of Option 2 of the HRSA Unmet Need Framework was used to calculate the number of PLWH/A with unmet needs.
- Rationale for Selection of the above-referenced Methods: Pennsylvania promulgated regulations for reporting of HIV in 2002, and this has enabled the jurisdiction to use eHARS equivalent data collected through the Pennsylvania version of the National Electronic Disease Surveillance System (PA-NEDSS) to determine the sizes of populations of PLWH/A as described above. However, current HIV reporting regulations do not include undetectable viral loads and CD4 T-lymphocytes greater than 200 cells/ul or 14%, hence it is still not possible to use eHARS/reporting data to estimate care patterns in the absence of laboratory test results of all viral load and CD4 T-lymphocytes counts. Amendment of HIV reporting regulations in Pennsylvania is still in progress in order to include undetectable viral loads and CD4 T-lymphocytes greater than 200 cells/ul or 14%. In the meantime, the jurisdiction continues to use Medicaid, SPBP and Part C data to estimate care patterns.
- Results of the estimation of unmet needs using a modified version of Option 2 of the HRSA Unmet Need Framework: Of the 35,914 people estimated to be living with HIV/AIDS in the jurisdiction, we estimate that 25,563 (or 71%) received HIV primary medical care during the specified time period, while 10,351 (or 29%) demonstrated unmet need for HIV primary medical care. Among the 21,793 people with AIDS, 6,538 (or 30%) had unmet need; and among the 14,121 people with HIV (non-AIDS), 3813 (or 27%) had unmet need.
- Limitations: The estimates of unmet needs rely on a multitude of data sources as opposed to the most ideal source (which is the eHARS for case reporting of HIV/AIDS).

[5] http://www.health.state.pa.us/pdf/epi/Integrated_HIV_AIDS_Epidemiological_Profile_PADOH_2010.pdf

- Cross-Program Collaboration: The collaborating programs which contributed data to the estimation of unmet needs include eHARS-equivalent data on case reporting of HIV/AIDS (for estimation of population size of PLWH/A in PA), Medicaid & ADAP (for care patterns among publicly-insured patients), and selected sentinel Part C (for care patterns among privately-insured patients).
- Conclusions and Public Health Recommendations**:** Based on cross-validation using HRSA framework methods described above, we estimate that 29%-33% of persons living with HIV in PA, who are aware of their HIV status, have unmet needs for HIV-related primary medical care. This estimate indicates that a substantial number of persons living with HIV who are aware of their HIV status can potentially remain out of care for sustained periods of up to one year or longer. Further studies to refine these findings, including demonstration projects to assess and address unmet needs, are continuing in 2010-11.

Table 1: Estimated Numbers of Persons with Unmet Need for Primary Medical Care among Persons Living with HIV-non-AIDS (PLWH) and AIDS (PLWA) Statewide and in the AIDSNET Region [6] [7]

Calculation of Indicators of Unmet Need	**Statewide**	**2008**	**AIDSNET[8]**
Input	**Value**	**Data Source**	**Value**
Population Sizes			
A. Number of PLWA, recent time period	21,793	2008 eHARS Data on PLWH/A	1,092
B. Number of PLWH[9], recent time period	14,121	2008 eHARS Data on PLWH/A	1,329
A+B=Total number of persons living with HIV[10]	35,914		2,421
Care Patterns			
C. Number/percent of PLWA who received the specified HIV primary medical care services in the 12-month period	70%	PA Medicaid+ADAP & Part C Sentinel Site Data]	64%
D. Number/percent of PLWH who received the specified HIV primary medical care services in the 12-month period.	73%	PA Medicaid+ADAP & Part C Sentinel Site Data]	74%
Calculated Results	**Number (%)**	**Calculations**	**Number (%)**
E. Number of PLWA who did not receive HIV primary medical services	6,538 (30%)	E=A-(AxC) (E/A)	393 (36%)
F. Number of PLWH who did not receive HIV primary medical services	3,813 (27%)	F=B-(BxD) (F/B)	346 (26%)
G. Total HIV aware (PLWA+PLWH) not receiving HIV specified primary medical care services (quantified estimate of unmet need	10,351 (29%)	G=E+F (G/A+B)	739 (31%)

[6] Based on Estimates among Publicly insured (75% of the total) and Privately Insured HIV+/aware populations (25% of the total)

[7] http://www.health.state.pa.us/pdf/epi/Integrated_HIV_AIDS_Epidemiological_Profile_PADOH_2010.pdf

[8] AIDSNET/regional samples estimates of PLWH/A (rows C & D) are based on independent distributions for the particular region

[9] PLWH: People living with non-AIDS and are aware of their status

[10] PLWH: People living with AIDS and PLWH and are aware of their status

Summary of AIDSNET Unmet Need

The following summarizes the estimates of unmet need in the AIDSNET region from the PA-DOH Department of Epidemiology

- Of the 2,421 PLWH/A in the AIDSNET HIV/AIDS service coalition area, it was estimated that 1,682 (or 69%) received HIV primary medical care during the specified time period, while 739 (or 31%) were estimated to have unmet need for HIV primary medical care;
- The greatest number of people living with unmet need (both with AIDS and without AIDS diagnosis) appears to be in Berks and Lehigh counties;
- There do not appear to be statistically significant differences in met need between racial/ethnic groups, genders and age groups among those living with HIV (non-AIDS). Hispanics with an AIDS diagnosis appear to have a higher likelihood of unmet need relative to the white reference group; and
- Residents of urban counties appear to be more likely to have unmet need than those living in rural counties, but this finding may be a result of people living in urban counties being more likely to receive services through the managed care component of MA.

Strategies to Address Unmet Need

Following are issues experienced by providers across the state regarding retaining PLWH in care.

What are the activities undertaken to reconnect clients/patients who are lost to medical care?

- Up to 3 reminder calls prior to the scheduled visits.
- Monthly medication refill reminder calls
- Case management (CM) providers mentioned utilizing every interaction to inquire about health, labs, adherence, stressing the importance of staying in care.
- Many Part B and C Ryan White medical providers and CM providers had a tracking system alerting them to patients who have not had a medical visit for the last 4 to 6 months.
- Once identified, these patients were contacted with graduated intensity, starting with phone call and letters.
- Some providers would call all allowable contacts in the patient's chart (emergency, etc.) if they did not get a response.
- Others actually went to the last known address.
- Many providers offered to accompany the patient to their medical visit.
- Some providers were able to know when patients were admitted to the hospital, would visit them during their hospital stay and would follow-up after discharge.

Once the patient was reconnected, many providers had discussions with the patient to identify why they left care, how that barrier could be eliminated and then worked with the patient toward that goal. Most frequent reasons for leaving care were:

- Lack of insurance
- Lack of transportation

- Mental health & drug use issues
- Incarceration
- Hospitalization/illness
- Non-permanent housing

Providers describe these activities as an ongoing process, as many of these patients have multiple co-morbidities (mental health, drug use, poverty) and will likely fall in and out of medical care.

Of the activities listed above, what are the most successful?

- Many providers describe the importance of maintaining a relationship with the patients, helping them with a variety of needs (housing, mental health, etc.), thus reducing their barriers to receiving regular medical care.
- Providers felt it was very important to ensure a safe, confidential and non-judgmental space for patients. The ability to be flexible and have available "all the tools in the toolbox" was often mentioned, as every person has different reasons for not being consistent with care.
- The closer the CM agency is tied to medical care, the better able staff providing linkage services were able to function.
- Many providers indicated that "one-stop shop" (providing medical, case management, mental health, dental, etc.) was their goal or ideal.

What are the barriers/challenges when addressing unmet need?

- Locating the client
  - Address change
    - Transient population (frequently moving)
    - Migrants
  - Disconnected phone
  - Homelessness

- Psychosocial Factors
  - Mental Health
    - Substance Abuse
    - Homelessness
  - Poverty
    - Medical care not as important as immediate shelter and food
  - Stigma
    - Not wanting to be seen by others going to an HIV agency

- Access to Care
  - Transportation
    - Traveling to different providers located in different parts of the city/area
    - Especially difficult in rural areas

- Resources
  - Long waits to schedule or reschedule to see physicians
  - When reconnected, can lose them again due to a long wait for visit
  - Lack of specialists
  - Lack of providers
  - Lack of community resources
- No insurance
  - Borderline healthcare eligibility or undocumented

- Client
  - Difficulty following through on referrals
  - Client does not want to be in treatment
  - Denial
  - Mistrust of medical profession

- Agency barriers
  - Once case closed cannot bill to continue search
  - Understaffed
  - Time consuming
  - No staff dedicated to locating client, i.e. outreach worker
  - Physicians calling in multiple renewals for prescriptions without seeing client

With regard to barriers, it is important to note that Pennsylvania is primarily a rural state. Many of the above responses contain references to travel distances and lack of "local" resources. With the exception of Philadelphia, all other counties have areas designated as rural, and 48 of the 67 counties, or 72%, are rural based on population density. Specialized medical services, infectious disease in the case of HIV, will distribute based on demand. So patients living outside of population centers have long treks to care, and providers and CMs have a long way to travel to clients. While Part C providers have made a huge difference in the availability of HIV medical care, the north-central region of Pennsylvania has no Part C providers. The only Part A recipient in the State is the Philadelphia region.

What activities would be implemented to connect individuals to care if resources were not limited?

Responses reflected need for more resources and more flexibility with those resources. This included medical care and support services, including easing/eliminating many state-imposed case management standards and restrictions. In rough order of popularity, responses were as follows:

- Outreach workers to locate and assist individual's return to care: provide transportation, accompany to appointments and do home case management and medical visits. Peer navigators to assist patients through the "system of care."
- Outreach to medical providers who are not part of the Ryan White system to offer case management and outreach to their HIV patient populations, particularly to

those who may have fallen out of care. Educate these providers about the availability of Part B and Part C services.

- Adequate case management staffing to comprehensively address all barriers to care and monitor client progress.
- Reliable transportation options, including the ability to provide transportation to specialty-care visits.
- Provide on-site, accessible and timely mental health services.
- Provide incentives for patients to return to care.
- Additional resources to address homelessness and cost of medical care.

Is there anything else about efforts to retain individuals in medical care?

> Here again there was testament to the commitment of provider staff to do anything in their power to link and retain people into medical care. Many providers again indicated that outreach and retention, "constant follow-up" is an ongoing process with many patients with mental health and drug use histories. The importance of relationships with patients was paramount.
>
> Many expressed concern over lack of resources for outreach and follow-up with individuals who have not initiated care. Providers, already overwhelmed, are concerned that HIV-positive individuals with multiple co-morbidities are "out there" and the system has very limited resources to bring them into care and retain them in care.

What does this suggest for regional and state-wide efforts to address unmet needs? The above efforts reflect that retention of clients at Part C clinics is about 85%. PA-DOH analysis of Medicaid and SPBP recipients reflect a retention rate of 66%. The next step is to identify strategies to address residual unmet need. These strategies will be facilitated by the PA-DOH but cannot be standardized to all regions. The strategies adopted by the Coalitions must be applicable to their regional differences.

Another strategy that is being investigated by AIDSNET and other coalitions is gaining access to names of physicians that are treating HIV patients in their practice. Strategies are being explored to be able to achieve this with the least effort on the part of the physicians to facilitate contact in order to educate them about the benefits that their patients may be able to access through Ryan White funding. Contact with these physicians would reinforce the positive nature of CM services such as medication and medical adherence. This request was sent to the Epidemiology section of the PA-DOH, but coalitions were not granted this information based on issues of confidentiality. Alternative ways to access this information are being investigated. The PA Comprehensive Plan submitted to HRSA in February 2009 contained a goal addressing Unmet Need. Specifically, it addresses the improvement of case finding and facilitates linking individuals to care and treatment. The objective is to collaborate with the PA AIDS Education and Training Center (AETC) to identify methods for reaching out to physicians who treat HIV/AIDS clients.

The state committee has also been working with the Pennsylvania Department of Public Welfare (PA-DPW) to form a collaboration to inform PA-DPW offices, specifically the County

Assistance offices (Intake Case Workers and the Confidential Case Workers) and phone representatives that work on the Welfare Hotline, about the seven HIV-Regional Coalition offices describing them as a support network offering assistance with medical services, housing, utilities, transportation, food and dental care for individuals that are HIV/AIDS consumers. It is the intent of this collaboration for the PA-DPW staff to inform any person who is HIV positive who applies for county assistance and is identified as HIV positive.

AIDSNET has adopted the performance measures from the PA-DOH Part B Quality Management Committee. Of these, several will pinpoint clients who are not receiving the recommended medical visits or tests and/or have not met the basic definition of being in care. They are as follows (see the Quality Management (QM) section of this document for full description of all performance measures):

- Minimum number of medical visits
- Adequate tracking of CD4 T-cell count
- Viral load testing
- Retention in care

All case management agencies are aware of these performance measures. The two Part C providers have been collecting these for some time. The other case management agency is now collecting this data as well. AIDSNET has worked with providers to overcome some of the barriers to receiving and analyzing this data, such as inconsistency of location in CAREWare where data was being entered. However, some barriers still remain:

- Staff's level of expertise in entering and extracting CAREWare data.
- Physicians or hospitals lack of, or slow response to, requesting lab values or dates of clients' visits.

Again, Part C providers have the advantage of their own clinics to retrieve the necessary indicators. However, community-based providers must request this data and often meet with resistance or no response at all.

AIDSNET has traditionally requested from the SPBP a count of clients by county that have received this benefit in order to compare it with the number of individuals who are currently in care (see Table 4 in Needs Assessment).

A contributing factor to unmet need is the fact that patients have six times the rate of dropout from medical services during the first year of enrollment in Pennsylvania medical assistance, regardless of gender, resulting in six times the chance of having unmet need. Since obtaining medical benefits are one of the most important goals for newly enrolled case management clients, it could be assumed that they might have a very high drop-out rate from these services. In an effort to identify client retention rate, AIDSNET met with the four case management agencies who stated they do not see this pattern among their clients. Rather they see some clients being consistent with quarterly assessments, some are sporadic and some come to obtain housing assistance and then drop out. Recognizing that the primary purpose of case management services is linking clients to medical care and adherence, a standardized form of providing supporting documentation for outcomes will, besides collecting accurate data, provide a client

retention rate and possibly reveal patterns that can be addressed to reduce the incidence of clients lost to care.

Implementation of the revised CM standards in January 2010 extended the length of time to discharge clients from CM services from six months to one year following no face-to-face contact. This has removed one of the barriers listed above by allowing CM providers to continue billing while searching for a client to link them back to care. To ensure that adequate steps are being taken by Case Managers (CMs) to re-connect clients to care, the new standards require that each Subgrantee have a policy and procedure in place that details this process. If a client has not maintained face-face contact with his/her case manager, there must be a mechanism in place to re-engage the client per the standards:

> Indicator A1-8.1: A policy and procedure is maintained by agencies to retain clients in case management and HIV medical care.
>
> *Example of evidence:*
> - Agency has a documented policy and procedure in place to re-engage clients that defines specific times frames and actions to follow
> - The policy and procedure describes specific methodologies for entire process
> - Documentation that the procedure was followed is noted in the client's case file

All CM agencies have been monitored and been found to have such a policy and procedure in place.

A new committee has been formed to update the CM standards. One of its goals is to recognize the advances in medical treatment of HIV and using a multi-tier approach that is connected to the client's medical status. This will help reduce unnecessary visits to the CMs based on medical and social need.

Transitional Planning Initiative (TPI)

Through collaboration between the Pennsylvania Department of Corrections (PA-DOC) and the PA-DOH Discharge Planning Committee, the TPI program was implemented with protocols and procedures during the early part of 2006. All case management (CM) agencies throughout the Commonwealth may potentially serve clients being referred from the PA-DOC system. Each of the seven regional coalitions is the contact point for infectious disease nurses at every state penitentiary to call when a client is nearing release. Then that information is communicated to the appropriate CM agency within the coalition's region. A Case Manager in turn contacts the PA-DOC nurse and begins to help the client make the transition to the community. S/he makes every attempt to talk to the client to begin the engagement process so that the client will keep the CM appointment. This is very important regarding unmet need when addressing residents of the state penal system. Individuals residing in a state institution often are imprisoned for several years and are very disconnected from the community. Some prisoners are known not to disclose their HIV status while in prison and, therefore, meet the definition of unmet need. It is imperative to have them reconnect to medical care. Both those that have been receiving medical care and those that have not been in treatment while incarcerated are at very high risk of

dropping out of care due to the issues that brought them into the system. A significant percentage of individuals in prison have a substance abuse and/or a mental health diagnosis. This initiative attempts to address these issues. The PA-DOH has recently made TPI training a mandatory core requirement for case management training through the Pennsylvania CM Project. This will insure that new CMs are aware of this initiative. This last fiscal year, calls from the PA-DOC nurses to the AIDSNET region have been focused on inmates being relocated to the city of Reading in Berks County. In total, AIDSNET has received 23 requests during fiscal year 2011-2012. One was referred to AIDS Activities Office at the Lehigh Valley Hospital in the city of Allentown in Lehigh County, and one was referred to AIDS Services Center at St. Luke's Hospital in the city of Bethlehem in Northampton County. The remaining requests (21) were referred to Co-County Wellness Services in the city of Reading in Berks County.

4. Priority Setting/Resource Allocation

Definition: Within a given locale, the process of applying the Needs Assessment and Gap Analysis to determine:

- The relative order of importance of services, programs, and populations the Coalition will financially support in the forthcoming fiscal years(s); and
- The percentage and/or amount of funds to be directed to prioritized services, programs, sub-populations, and/or initiatives.

The priority setting and resource allocation exercises should be based on the conclusions of the previously presented Needs Assessment and Gap Analysis, including data from CAREWare (CW) and prevention programs. This is to insure that those care and prevention services identified to be the most needed reach the statistically appropriate populations within AIDSNET's six-county region of Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill. Persons Living with HIV Disease (PLWH) are the first priority to address by retaining them in Case Management (CM) and medical care. Prevention services, especially testing and identifying a positive individual, follows the Centers for Disease Control (CDC) treatment as prevention model consisting of immediate referral to medical care at notification. All known PLWH must be retained in care in order to be assisted in adhering to necessary medical treatment, to address behavior that will reduce transmission, with the goal of a reduction in the community viral load. The statistically prioritized populations in this region are intravenous drug users (IDU), high risk heterosexuals (HRH) and men who have sex with men (MSM). Although MSM is statistically third in percentage, there has been a trend upward in infections among the youth. This population, as well as IDU, is difficult to find and engage in prevention services, therefore, the degree of difficulty in reaching and engaging in prevention services may suggest an inverse proportion of funding.

Priority Setting

AIDSNET's staff used the data from current regional epidemiology to draft the Prioritization of Risk Behaviors for Prevention Services (Table 1), and clients' use of services to prepare a Prioritization of Care Services (Table 2). In essence, these tables summarize the conclusions of the Needs Assessment and Gap Analysis. The tables will be used as a guide to the allocation of resources for the 2013-14 fiscal years. These tables appear below.

Historically, the CRSSP was written for two years and contracts from the Pennsylvania Department of Health (PA-DOH) followed the same time table. However, following the HRSA Monitoring of the PA-DOH Part B funding, many changes were recommended. It is unknown at this time what changes will be instituted. The PA-DOH is engaged in technical assistance from a consultant firm hired by HRSA. The time frame for identification and implementation of changes is unknown at this time. However, as of this writing, the PA-DOH has just informed the Pennsylvania (PA) Consortiums that contracts will be for 2013-2014 with the option to renew for the next four years. This will also affect the contracts for providers, and Executive Directors of the provider agencies were informed via a conference call.

The care prioritizations address three issues: Increasing Life/Health and Reducing Transmission; Access to Care/Poverty; and Supportive. The Planning Committee which updates prioritizations is comprised of clients, contracted agencies, Board, and staff members. Both care and prevention agencies are members. This committee meets monthly to review significant changes, such as services no longer funded under Ryan White, changes in U.S. Health Resources and Services Administration (HRSA) requirements recommendations from the CDC, the PA-DOH and any other issues affecting client care. Because the committee consists of funded providers and clients, AIDSNET's oversight assures that no one agency benefits at the cost of another.

Table 1: Prioritization of Risk Behaviors for Prevention Services
People with HIV
Intravenous drug users (IDUs)
High Risk Heterosexuals
Men who have sex with men (MSM)

Table2: Prioritization of Care Services		
Public Health Issues: Increasing Life/Health and Reducing Transmission	**Access to Care/Poverty**	**Supportive**
Case Management (focusing on linking to primary/specialty medical care)	Health insurance/ Premium Cost Sharing Assistance	Behavioral Health Services (Mental Health, Substance Abuse)
Ambulatory/Outpatient Medical Care	Housing Assistance	Psychosocial Support
Medical CM/Treatment Adherence (focused on reducing viral load)	Emergency Financial Assistance	Legal
Health Education/Risk Reduction (prevention with positives)	Medical Transportation	
Oral Health		

The HI-V committee, comprised of clients, met on August 2, 2012. The prevention and care advisory committees, which is comprised of staff and supervisors from all contracted agencies reviews and votes on the priorities. They met on September 11, 2012. The Board met on October 3, 2012, and voted to approve the priority setting and resource allocation to be incorporated into the Coalition Regional Services and Strategic Plan (CRSSP).

The Planning Committee also reviewed the draft resource allocation plans for the 2013-2015 fiscal years (now limited to the 2013-2014 fiscal year), which were prepared by AIDSNET's staff based on trends in client needs.

The resource allocation plans distribute available funds among the various care and prevention services by funding source. They serve as a guide to the Allocations Committee and the full Board of Directors in making the allocations for each fiscal year.

Although both the Committee and the Board have a strong track record of respecting the resource allocation plans, they also have an obligation to fund the proposals that best meet the needs of the region. Sometimes, this means putting more funding in some service areas and less

funding in other categories than was recommended by the resource allocation plan. One of their recommendations was to increase oral health care funds due to increased client need. Obtaining information from providers and clients is important in the resource allocations process. But the final allocation of funds is decided by the AIDSNET board. This is to prevent any conflicts of interest that may naturally be in place at the provider and client level. However, because of AIDSNET's authorization process, whereby all care services go through an approval process, we have an ongoing awareness of changes in client needs, which inform us of any need to change the current year's budget and the prioritization process.

In each of the prioritization tables, the behaviors and services are prioritized within the different categories. Prioritization of risk behaviors is based on the data in the Needs Assessment. Therefore, people living with HIV are the highest priority for prevention interventions. However, the amount of funding may be based on the degree of difficulty in reaching a particular population, i.e. IDU and MSM.

The resource allocation plan is based on the prior two tables, anticipated funding levels for the fiscal year and funding restrictions. The plan is included as Table 3.

As indicated in Table 3, the allocation process started with determining AIDSNET's needs and allocating the necessary funds between programmatic and administrative costs, and among the four funding sources. The state funds were then distributed, since that is the only resource for prevention services. Initially, all of the state dollars that could be allocated to services were used for prevention. Next, the Housing Opportunities for Persons with AIDS (HOPWA) funds that were available for distribution were allocated for housing services (housing and transitional housing). Finally, the Ryan White CARE Act nine-month and three-month resources were allocated to services, starting with case management. When there were insufficient funds to meet the priority care services, small amounts of state and HOPWA funds were moved to care services to balance the budget.

Table 3. Allocations by Service and Funding Source

	AMOUNT BUDGETED 13-14	STATE 656	RYAN WHITE JULY - MARCH	RYAN WHITE APRIL - JUNE	HOPWA	% OF TOTAL BUDGET
INTERVENTIONS DELIVERED TO INDIVIDUALS	**200,000**	200,000				8.5%
INTERVENTIONS DELIVERED TO GROUPS	**200,000**	200,000				8.5%
SUBTOTAL PREVENTION	**400,000**	400,000	-	-	-	17.0%
HOUSING	**386,000**				386,000	16.4%
CASE MANAGEMENT	**920,000**		675,000	225,000	20,000	39.0%
PATIENT CARE	**160,000**	10,000	112,500	37,500		6.8%
TREATMENT ADHERENCE	**70,000**		52,500	17,500		3.0%
AIDSNET ADMINISTRATIVE	**192,298**	55,702	73,907	24,636	38,053	8.2%
AIDSNET PROGRAM	**229,357**	65,234	87,236	30,161	46,726	9.7%
TOTAL	**2,357655**	530,936	1,001,143	334,797	490,779	100.0%

The draft CRSSP was made available on the AIDSNET website for review by the general public for a one-week period from September 25, 2012, through October 3, 2012. Those wishing to comment could respond in writing during that time period or in person at the Annual Meeting held September 25, 2012. Notices were sent to service providers, as well as clients, informing them that the draft document was available for review. The notice was also posted on AIDSNET's Web site and a press release was sent to area newspapers. Final changes were made to the document and the finished product was presented to AIDSNET's Board of Directors at its regularly scheduled meeting on October 3, 2012, and approved.

Should the resource allocation plan need further modification due to either an increase or decrease in funding, or because of an amendment to its contract with PA-DOH, AIDSNET will

follow the recommendations of the Allocations Committee and various groups that were consulted in this process to the greatest extent possible. Since such decisions usually must be made on relatively short notice, staff will consult the members of the Allocations Committee by email and obtain authorization for the submission at the next regularly scheduled meeting of the Board of Directors. In the event that a client is in need of a service that is not eligible under RW funding, our case managers look for other alternatives, such as Fighting AIDS Continuously Together (FACT), a non-profit agency fully staffed by volunteers that rely solely on numerous fund raisers throughout the year. Our Program Specialist also helps the case manager to find other resources.

5. Service Procurement

The Coalition Regional Services and Strategic Plan (CRSSP), a two-year document that has been accepted by the Pennsylvania Department of Health (PA-DOH), is the compass from which AIDSNET funds organizations, monitors objectives and reports deliverables to the state. As of Fiscal Year 2007-2009, AIDSNET began entering into two-year contracts with its providers following the PA-DOH lifting a limit of a one year contract with providers. The requirements for procurement of services are well documented in our contract with the PA-DOH. The deliverables to be met by Subgrantees mirror the deliverables to be met by AIDSNET to the PA-DOH, with a focus on the direct services they will provide. However, as a result of HRSA auditing PA Part B grant, the PA-DOH will be contracting with the Consortia for one year with an option to renew for four years. This is explained in more detail in the Strategic Plan section of this document. In turn, AIDSNET will be changing its Request for Proposals (RFP) to the same time frame.

After the CRSSP is submitted to the PA-DOH on October 15, 2012, AIDSNET's staff prepares a Request for Proposals (RFP) for the 2013-2014 fiscal year. The RFP follows the guidelines of the PA-DOH. To insure that those applying have all the information they need, AIDSNET further details the process, such as all documentation needed and a description of the fiscal process to follow to determine a unit cost. Applicants are encouraged to contact AIDSNET with any questions they may have in preparing the proposal, but are not provided actual assistance in the writing of the proposal.

The Allocations Committee reviews the proposed RFP before it is distributed to potential service providers in November 2012. The Committee draws its membership from Board members, community resource people and clients. AIDSNET tries to assure that the Committee represents the diversity of the community and has representatives from all parts of the region. Staff reviews this CRSSP with the Committee members when they meet to review the RFP, so they understand how this document impacts the review of grant applications. Staff meets with new Committee members individually to orient them and help them to feel comfortable with the process.

The goal of the procurement process is to find the most effective programs and the most cost-effective method of providing services to persons living with HIV Disease (PLWH) and targeted prevention populations. AIDSNET's procurement process enables potential applicants to understand clearly what is expected in the proposal, how the application will be evaluated and when they can expect to receive a response to their submission. It is important that potential applicants have confidence that their proposals will be treated fairly. However, it is equally important that the process has the flexibility necessary to allow AIDSNET to adjust its technical assistance to meet the specific needs of the applicant agencies. By doing so, AIDSNET lessens the gap between larger organizations with experienced grant writers and smaller, grassroots organizations that have little experience in preparing a proposal. The RFP includes the priority and funding information described in other sections of the CRSSP.

The following is a summary of the timeline for the RFP process:

MONTH	PROCESS
November 2012	Mailing sent announcing the availability of the RFP; press release sent to local newspapers; RFP mailed or emailed to interested applicants
December 2012	Pre-proposal meeting held for all interested applicants
January 2013	Deadline for submission of proposals set
February and March 2013	Allocations Committee members read and score proposals; Committee meets and reviews proposals
March 2013	Allocations Committee selects proposals for funding and finalizes allocations table
April 2013	Board of Directors approve Allocations Committee decisions
April 2013	Agencies notified of decisions
April and early May 2013	Providers are contacted by AIDSNET's Fiscal Officer to adjust its unit cost and calculating the number of units to be completed based on the award.
Mid May 2013	Mail contracts to the PA-DOH for review and approval

A mailing to announce the availability of the RFP and detailing the timeline for submission and review of the RFP is sent in early November 2012 to organizations on a list of potential service providers maintained by AIDSNET. As in the past, staff updates the mailing list beforehand, paying particular attention to include community-based organizations. A press release is sent to local newspapers announcing the availability of the RFP and the information posted on the organization's web site. The RFPs are mailed or emailed to potential applicants in late November. The information requested from applicants in their response to the RFP includes, but is not limited to, an organizational profile, description of prior program experience, needs assessment, description of target populations, goals, outcome-based objectives, action steps, evaluation process, quality management plan, and completed financial forms. The RFP references the sections of the CRSSP that are most relevant to completing an application for funding. AIDSNET seeks proposals that address the needs, targeted populations and desired outcomes identified in the CRSSP. Copies of the CRSSP are made available to potential applicants and the CRSSP is available as a download from our website.

A pre-proposal meeting is held in early December for all interested applicants. The RFP includes a complete timeline for the submission and review of applications, as well as the selection of proposals for funding and the negotiation of a contract. The timeline is also reviewed during the pre-proposal meeting. The RFP is reviewed with potential applicants and questions are fielded. The scoring tool and its use by the Allocations Committee is included in the RFP and reviewed with applicants during the pre-proposal meeting.

Our Fiscal Officer meets with applicants that request assistance regarding the fiscal documents. Accurate financial forms are especially important in that they are used to determine an appropriate unit cost for each activity to be funded.

The federal and PA-DOH goals of ensuring greater access and fewer disparities with regard to minority and underserved populations are emphasized in the RFP and the pre-proposal meetings.

The same is true for care services to women, infants, children, and youth. A summary of any changes made to the RFP or the process, or significant clarifications made at the meetings are sent to organizations on the RFP mailing list. Potential applicants are encouraged to take advantage of AIDSNET's offer of technical assistance in preparing their responses to the RFP. A late January date and time deadline for submission of the responses to the RFP is specified in the packet.

After the deadline, the proposals are reviewed by staff for completeness. If there is anything missing, the applicant is notified. The proposals are then sent to the members of the Allocations Committee. During the review period, staff is in contact with applicants seeking clarification of the proposals and budgets as needed.

Prior to the beginning of the procurement/allocation process, AIDSNET's Executive Director meets with any new members of the Allocations Committee to orient them regarding the scoring system, procedures and set up meeting times. The meetings are traditionally held during weekends to accommodate members' schedules. A very important part of this process is to insure there is no conflict of interest among the members prior to their reading the proposals. To that end, all committee members sign a "Disclosure of Conflict of Interest" form confirming that they have no conflicts that are real or could be construed as having a bias toward any of the agencies who submitted proposals. They also sign a confidentiality form insuring that the content of the meetings are not to be discussed outside of the committee membership.

Prior to meeting as a group for voting and deciding on allocations, each member of the committee reads and scores all the proposals. The members are given a draft allocations table based on the current budget and historical need for services and prior spending trends. This table is finalized by the committee during the decision-making process. Then the Allocations Committee meets in February and March to review the proposals**.** This involves an in-depth discussion of each proposal by type of service and agency. During the Committee's review of the applications, the staff provided technical assistance and guidance when requested from Committee members. However, the actual funding decisions are made solely by the Committee members. The proposals are reviewed based on the quality of the application, including the applicant's organizational structure, agency and personnel experience, organization's programmatic and administrative track record, understanding of the complexities related to providing these services to targeted populations, expected outcomes, strategies and action steps, cost and consistency with this document.

The Committee specifically reviews proposals for:

- the relative priority of the activity and the population served as measured on the Prioritization of Risk Behaviors for Prevention services presented in the Priority Setting/ Resource Allocation section of this document (Table 1);
- the soundness of the approach- the degree to which there is a logical connection between the proposed program and the need it is addressing (This includes the federal and PA-DOH goal of ensuring greater access and fewer disparities with regard to minority and underserved populations. The same is true for care services to women, infants, children, and youth);

- the programmatic capacity of the organization-the extent and quality of experience the applicant has in this area (partially based on the results of prior programmatic monitoring), including the organization's ability to describe clearly the desired outcomes in terms of outcome-based objectives;
- the administrative capacity of the agency- the extent and quality of experience the applicant has in administering federal and/or state funds, including the agency's ability to maintain appropriate fiscal and programmatic records and its ability to monitor its programs (partially based on the results of prior programmatic and fiscal monitoring, as well as review of the agency's audit);
- the other resources the potential provider is bringing to the program-the extent of other resources the applicant is able to provide to support the program, including direct and in-kind contributions;
- the organization's documented need for AIDSNET's support- the extent to which the applicant can document that AIDSNET's support is truly needed and without that support, the service could not be provided;
- the agency's record in coordination and cooperation with other service providers- the extent to which the applicant coordinates its activities with other providers in an attempt to develop the most comprehensive network of services possible, and the extent to which this service is not duplicative of services being provided by other organizations; and
- the appropriateness of the funding requested- the degree to which there is a logical connection between the service described in the narrative and the budget for that service, as well as the appropriateness of the program costs and the unit costs associated with the service.
- Allocations are made consistent with the resource allocation tables discussed previously. In addition, the Prioritization for Risk Behaviors for Prevention Services (Table 1 in the Prioritization/Resource Allocation section of this document) is used in determining the distribution of prevention funds. Care funding is allocated based on the Prioritization of Care Services (Table 2) found in the same section in determining the distribution of care funds.

Some care service providers are funded from a pool for the specific service. In other words, rather than making an allocation to each service provider, the funds are pooled for use by all of the approved providers for that particular service. Referring to Table 3 in the same section, other support services are examples of pooled services. The appropriate case management agency obtains pre-approval of specific expenditures from AIDSNET's Program Specialist before the service is provided. Please see Appendix B for AIDSNET's policy on authorizing access to pooled dollars. AIDSNET's staff monitors expenditures by approved providers to assure that funding is fairly distributed among the six counties based on need.

Usually, funding is based on a unit cost not to exceed the amount allocated to a specific provider for that particular service. However, program funding may be made available to providers for the first year of a service or for significant changes to a currently-funded program.

The Allocations Committee members have the option of using other techniques to learn more about applicants, including, but not limited to:

- Reviewing monitoring/evaluation reports;
- Requesting written clarification of specific proposal information;
- Requesting a face-to-face interview with an organization; and
- Conducting on-site visits.

AIDSNET reserves the right to reject any and all proposals received as a result of the RFP or to negotiate separately with competing applicants for all or any part of the services described in the proposals. Should the evaluation of the applications demonstrate that there are not sufficient proposals of quality to meet the needs of the region; AIDSNET reserves the right to contact other applicants to determine their level of interest in providing the applicable services. In such cases, the applicants contacted will be given an opportunity to submit an application or an addendum to their proposal for these services. These applications/addendums will be evaluated using the same criteria described above. Should these proposals be of sufficient quality, the applicant will be recommended for funding. If this additional step fails to produce a quality proposal, a separate RFP will be issued for the applicable services. The Allocations Committee also makes recommendations for funding if there are any additional funds awarded to AIDSNET.

The Allocations Committee's recommendations are submitted for approval to AIDSNET's Board of Directors at its April meeting. As per AIDSNET's Grievances and Appeals Policy, the decisions of the Board of Directors are final.

Agencies are notified of the decisions of the Board of Directors, verbally and in writing. Within a week of the Board meeting, the Executive Director contacts the applicants by phone to inform them if they have been awarded a contract, the amount of the award, and confirm that said agency will be able to deliver the services within the award given. Further contract negotiations by the Fiscal Officer is done by contacting each agency, reviewing the unit cost and calculating the number of units to be completed based on the award. This must be done in order to submit completed contracts for review and approval by the PA-DOH. Within two weeks, letters are sent confirming the verbal information already given; and they are reminded that no funds are available until contracts are approved by the PA-DOH and that contracts do not go into effect until July 1.

Following verbal notification to agencies that did not receive an award, they are given the opportunity to attend a debriefing session where AIDSNET staff and/or Allocations Committee members will provide feedback to the applicant. Accommodating schedules, AIDSNET arranges the time and location of the debriefing and decides who will represent AIDSNET at the meeting. This usually occurs within two weeks of the verbal notification, if the agency decides they want to meet.

Subgrants are submitted for review and the final approval received from the PA-DOH. Subgrants are then sent to the agencies for signature and a copy of executed signature pages are sent to the PA-DOH within 15 calendar days of execution.

6. Strategic Plan

AIDSNET continues to operate under its existing goals. As stated in the organization's bylaws, the goals of AIDSNET are to develop and implement:

- a coordinated and unified regional HIV prevention program that includes education and risk-reduction strategies;
- a regional HIV care program through which persons living with HIV (PLWH) and their families have access to basic health care and human services regardless of where they live or their ability to pay;
- a regional HIV housing program through which persons living with HIV have access to appropriate housing, based upon their special needs and the state of their illness; and
- a regional network of community-based service providers through which integrated and comprehensive components of regional programs are delivered to neighborhood and communities in ways that are cost effective, responsive to changing needs and meet quality standards.

The process AIDSNET uses to develop the strategic plan is an ongoing one in which providers, various committee members, and clients keep up to date with any change that must be addressed whether it is further restrictions in eligible services, emerging populations, changes in trends of clients' need for specific services, diminishing funds, etc. This is done through board and committee activities, advisory councils, sitting on state committees and ongoing communication with the Pennsylvania Department of Health (PA-DOH).

National HIV/AIDS Strategy (NHAS) released in 2010 establishes the nation's priorities for HIV prevention and care and the progress toward those goals has just been released[1]

Goal 1: Reducing new HIV infections

There are approximately 50,000 new HIV infections in the United States each year, with most infections concentrated among gay men and in communities of color.

Goal 2: Increasing Access to Care and Improving Health Outcomes for PLWH

Recent estimates suggest that only 41 percent of persons living with HIV are receiving care and only 36 percent are prescribed retroviral therapy. Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration of the United States Department of Health and Human Services (HRSA) are continuing to support a five-year research project conducted in six HIV clinics with the goal of increasing access to HIV care and treatment by providing services to retain patients in care.

Goal 3: Reduce HIV-related Disparities and Health Inequities in the United States

HIV remains concentrated among communities of color and gay men. Rates of HIV infection among blacks and Latinos are approximately eight- and three-folds higher,

[1] http://aids.gov/federal-resources/national-hiv-aids-strategy/implementation-update-2012.pdf

respectively, compared to whites, and gay men are over 40 times more likely to acquire HIV than heterosexual men or women.

Goal 4: Achieving a more coordinated response to the epidemic in the United States
The goals of the Strategy can only be met through an ongoing and coordinated response across all levels of society.

Interventions Delivered to Individuals and Groups (IDI and IDG)

The CDC defines such interventions as "health education and risk reduction counseling with a risk reduction skills component." To qualify as an IDI or IDG, the participant(s) must identify his/her own risk(s) and ways of reducing those risks. Risks might include having sex without the use of a latex barrier, such as a condom or dental dam, sharing a needle to inject legal or illegal drugs, having sex with an intravenous drug user, or regularly using drugs or alcohol to the point that it clouds one's judgment as to what is risky behavior. Because this activity is intended to result in the actual reduction of risk (which is usually best accomplished one-on-one) and is available throughout the region, IDI are considered to be the most valuable prevention intervention. The standards define IDG as planned, structured interventions with screening procedures, curricula, and documentation of learning objectives using evaluation tools and making referrals.

As part of the Early Intervention Services (EIS) process, referral relationships are maintained among all funded Subgrantees and points of entry to help identify people with HIV and refer them into the health-care system. Specifically, in the AIDSNET region, the local health departments, the Part C grantees, prevention providers and the counseling and testing sites have working relationships with the care service providers. For example, CM agencies have an on-site presence at all Part C locations within the region. To bridge the gap between prevention and care services, AIDSNET convenes joint meetings with prevention and care service organizations to provide education and facilitate the process of getting recently diagnosed people with HIV into care. By organizing these meetings, AIDSNET continues to assess and enhance the EIS process.

Prevention Services

It is anticipated that the overwhelming majority of the prevention contacts will be targeted toward the individuals identified in the Prioritization of Risk Behaviors for Prevention Services (Table 1) located in the Priority Setting/Resource Allocation Section of this document. Similarly, the HRSA and the PA-DOH goal of ensuring greater access and fewer disparities with regard to minority and underserved populations will also be taken into consideration in the allocation of these funds.

Greater emphasis is being placed on providing effective prevention services to PLWH. In 2010, an estimated 47,129 people were diagnosed with HIV in the 46 states with confidential name-

based HIV[2]. The following table lists new HIV infections by County within the AIDSNET consortia for 2011.[3]

Table 1. New HIV Infections in the AIDSNET Consortia in 2011

County	Number of new HIV infections in 2011
Berks	22
Carbon	3
Lehigh	45
Monroe	11
Northampton	18
Schuylkill	5
TOTAL	104

It is estimated that sexual transmission accounts for almost 80% of new HIV infections each year. Conservative estimates based on the changes in behavior observed once people find out they are infected with HIV indicate that the 20% of people who are unaware that they are infected account for at least 54%, and potentially as much as 70%, of the new sexually transmitted infections each year. The transmission rate among those who don't know they are infected is 3.5 times higher than for people who know about their HIV status.[4] The importance of getting these individuals tested and into care that includes both treatment and prevention interventions is critical and is part of the NHAS goals.

A planning committee has been meeting for the last year to specifically focus on trends in new infections and to improve collaboration among prevention agencies, including local hospitals. Given the limitation of funding, historically there has been a natural tendency for agencies to be competitive with each other. The planning done in selecting specific populations to be reached through EBI, without duplication, has reduced that tendency and has opened up the opportunity for better collaboration. The committee currently has just begun a partnership with the Philadelphia - PA/MidAtlantic AIDS Education and Training Center (AETC) on planning a training to educate physicians on the importance of HIV testing, focusing on goal one and two of the NHAS.

Status of Prevention Services

The PA-DOH funds prevention services to AIDSNET with State 656 funds. Prevention interventions must be either an IDI or an IDG. Any prevention activity must be an evidenced-based intervention (EBI), which means they have been found to be effective. All interventions are based on prevention priorities described earlier in this document, namely persons with HIV remaining the number-one population to be reached. The remaining priorities are then based on regional statistics of PLWH in the six counties, but the percentage of funding for each high-risk

[2] http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV_at_a_glance.pdf 2012
[3] Page 12 Annual HIV Surveillance Summary HIV Surveillance and Epidemiology Section - Bureau of Epidemiology Pennsylvania Department of Health December 31, 2011
[4] PA 2nd Annual Ryan White Summit, Dr. Deborah McMahon, University of Pittsburgh, October 26, 2010

population is based on the degree of difficulty in reaching them. For instance, AIDSNET is funded for Ryan White Part B services, Medical Case Management (CM), a core service that addresses PLWH. Clients are relatively accessible when they come in to see their CM or receive medical services in the HIV clinics. Part of the CM interaction is the assessment of the client for the need for an intervention to decrease the chance of transmission. This assessment is paid by RW. Recruitment, which is a large part of a successful intervention, is less onerous for prevention with positives. When referred for an intervention, the cost then shifts to 656 funds. However, MSM, IDU, and high-risk heterosexuals in the region are difficult to find, recruit, and retain in prevention interventions; and, therefore, may require a higher unit cost. It remains the priority of any intervention to test those whose status is unknown.

Providing Evidenced-Based Interventions (EBI)

Clients, prevention providers and board members are part of the Planning Committee and met monthly with AIDSNET staff to plan what intervention(s) and what targeted behavior(s) they would seek funding for while avoiding duplication in those counties where there was more than one prevention provider. Funding and staffing limits the number of interventions and populations each provider can reach. The committee currently is assessing the implementation of last year's interventions to evaluate the cost and effectiveness of continuing these interventions.

The CDC has instituted 'High Impact Interventions' as a result of the NHAS. In most states, large cities are primarily the source of the majority of infections. The following table demonstrates the barrier faced by those regions that either do not have large cities, or are in rural areas covering a large number of counties.

Table 2. Percentage and Number of PLWH in the Seven PA Consortia

Consortia	**Percentage of PLWH**	**Number of PLWH**
AIDS Activities Coordinating Office (Philadelphia)	64	20,289
Family Health Council of South Central (Harrisburg)	11	3,408
The Jewish Healthcare Foundation (Pittsburgh)	10	3,204
AIDSNET	9	2,722
NE Regional HIV Coalition	2	781
NC District AIDS Coalition	2	737
NW PA Rural AIDS Alliance	2	715

As a result of this new focus on High Impact Interventions, the available trainings by the CDC have been limited. Although some of the providers had already implemented EBI in the past, they cannot continue if they experience a loss in staff who had been implementing the intervention. They need to hire a new staff person and cannot continue any interventions until that person is trained. Because the loss of a staff person is not anticipated, does the agency have funds to cover the cost of training, travel and lodging? While waiting for training to become available, no interventions are being implemented. To be successful in providing these interventions, agencies with small staff may not be appropriate to continue funding. The Allocations Committee will have to consider this when reading proposals and allocating

prevention funds. AIDSNET will be requesting technical assistance from the PA-DOH to receive EBI trainings from individuals within the state who are CDC qualified to provide these trainings.

During the 2013-2014 fiscal year, it is expected that all agencies funded for prevention services will meet the minimum outcomes as described in the EBI they are contracted to provide. To accomplish these outcomes, AIDSNET has budgeted $200,000 for IDI and $200,000 for IDG during the 2013-2014 fiscal year. The distribution of these funds for IDI and IDG will depend on the proposals chosen for funding by the AIDSNET Allocations Committee and Board.

Care Services

Case Management (CM)

CM is the entry point for all care services in the six-county area. The CM standards revised several years ago set a minimum service level for programs providing Ryan White Part B HIV CM regardless of setting, size, or target population.

CM standards were developed to:

- Clearly define CM and describe models of CM service;
- Clarify service expectations and required documentation across HIV programs providing CM;
- Simplify and streamline the CM process;
- Encourage more efficient use of resources; and
- Promote quality of CM services.

Medical CM

Medical CM services (including treatment adherence) are a range of client-centered services that link clients with medical care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical CM, and requires collaboration and coordination between the medical provider and case manager. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical CM includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments, which goes beyond a medication assessment.

Medical CM includes client-specific advocacy and/or review of utilization of services. This includes all types of CM, including face-to-face, phone contact, and any other forms of communication. It also includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Medical CM is a proactive model intended to serve persons living with HIV, including their families and support systems, who have multiple complex psychosocial and/or health related needs,. The model is designed to serve individuals who may require and who agree to an intensive level of CM service provision.

Goals and Key Activities

The goals of medical CM include the following:

- Early access to and maintenance of comprehensive medical care and social services.
- Prevention of disease transmission and delay of HIV progression.
- Promotion and support of client independence and self sufficiency using a strength-based service approach.

Key activities include the following:

- Assessment of the client's needs and personal support systems;
- Development of a comprehensive, individualized service plan in coordination with the client;
- Coordination of services required to implement the plan;
- Client monitoring and follow-up to assess the efficacy of the plan; and
- Periodic re-evaluation and adaptation of the plan as necessary. It includes client-specific advocacy and/or review of utilization of services for all types of CM, including face-to-face, phone contact, and any other forms of communication.

The key to CM is the development of an effective service plan, At the completion of a bio-psychosocial assessment, each client and respective case manager develop an individual Service Coordination Plan (SCP) which:

- Includes realistic, measurable and mutually acceptable goals which are based on information from the bio-psychosocial assessment;
- Identifies the action step(s) needed to achieve each goal, including target date(s) for accomplishment of stated goals;
- Specifies action steps for which the client and/or the designated representative and case manager are responsible;
- Indicates the anticipated result of each action step;
- Indicates referrals made to other providers/services in connection with the action steps; and
- Includes a space for signatures by the client and case manager.

Each case file, including the service plan, will be reviewed at least once a year by the supervisor of each agency. The reviewer will monitor the SCP, risk reduction and medication assessment plans for completion and linkage. The client's progress will be assessed at least once every 90 to 180 days depending on the acuity of the client's need for services and follow-up.

The goal is to continue to provide CM services throughout the six-county area, and to provide the same quality of services throughout the region. Subgrantees will make every effort to link clients into the service system who are about to be released, or who have been released recently, from county jails and state or federal prisons.

Another CM standards committee has been formed to update the standards to reflect the recertification of clients. It also is looking at the continuum of HIV and fitting the standards to reflect such changes. Not everyone needs to be seen every ninety days. The committee is

looking at models from other states that have made such changes. AIDSNET staff sits on this committee.

During the 2011-2012 fiscal year, 1,233 (duplicated) clients received CM services in the six-county region. As of July 1, 2011, previous outcomes were replaced by the newly implemented performance measures described below.

Performance Measures [5]

Performance measures (PM) are indicators used in monitoring quality of care and are a central component of a clinical QM program. They allow providers to track data and identify trends in their ability to provide a specific service, treatment, or level of care. Data from PM help providers set targets and then compare the actual services, treatments, or care against those targets. Performance measures may, for example, calculate the percentage of patients who are eligible for and receive a specific service or test, such as T-cell count or medical visit, over a specific period of time. Performance measures can help providers identify blips in care when targets are not met. Providers can evaluate the factors that might have led to the underperformance and make necessary corrections. Conversely, sustained high results on measures may help providers determine the factors that lead to success and set the stage for establishing even higher standards in areas in which they consistently exceed their targets. Performance measures can be applied to a single department or agency or to an entire network of care, Eligible Metropolitan Area (EMA) or Transitional Grant Area (TGA), or State.

Specific PMs are not mandated in the legislation or by the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV Bureau (HAB), but they are a central component of the Quality Management (QM) program requirements. Programs should choose a balanced set of measures for the QM program, one that ensures that services are accessible and that care is delivered according to established HIV treatment guidelines.

Sources of Performance Measures

Several sources provide PM. At the request of and in partnership with its providers, HAB developed the HIV PM, which can be used by providers in their QM programs. The measures were released in 2008 and 2009 and will be reviewed and revised on an annual basis. Four sets of measures are available for use: clinical care, oral health, medical case management, and AIDS Drug Assistance Program (ADAP).[6] PMs are continually being expanded and updated, but primarily focusing on the medical treatment of HIV.

Selecting Performance Measures

Providers have the flexibility to select PM and should choose measures that are most important to their agencies and the populations they serve. Measures should reflect the variety of services provided, the patient population, the number of patients and clients served, any State or external agency requirements, and availability of resources to collect performance data.

[5] HRSA CARE ACTION, August 2010
[6] ADAP In PA is known as the Special Benefits Pharmaceutical Program (SPBP)

HAB's PM have consistent elements. They identify what is being measured, which patients should be included in the analysis, and the data elements and sources. They also identify goals, targets, and benchmarks for comparison and describe how each measure relates to the U.S. Public Health Service HIV treatment guidelines. The use of PM also helps highlight areas for further evaluation.

The PA-DOH Part B Quality Management (QM) Committee adopted the HRSA Performance Measures (PM) designed and implemented for HRSA by the National Quality Center. Most of these measures are medically focused following the medical model of caring for PLWH. However, the Part B Committee adopted measures that are in line with the services they fund. These performance measures for CM agencies are:[7]

1. Documentation of Retention in Care defined as the percentage of clients with HIV infection whose records indicate retention in care. This goal has not been established by HRSA. The total for FY 2011-2012 was 86%.
2. Mental Health History and Treatment Status defined as the percentage of clients with HIV infection who have their mental health history and treatment status documented. This goal has not been established by HRSA. For FY 2011-2012 the total was 65%. The low percentage is due to the fact that one of the criteria CAREWare uses for calculating this measure is Medical Visits, which are not provided and collected by the case management agencies in the AIDSNET region.
3. Substance Abuse History and Treatment defined as the percentage of clients with HIV infection who have their substance abuse history and treatment status documented. This goal has not been established by HRSA. For FY 2011-2012, the total was 57%. The low percentage is due to the fact that one of the criteria CAREWare uses for calculating this measure is Medical Visits, which are not provided and collected by the case management agencies in the AIDSNET region.
4. Secondary risk assessment defined as the percentages of active CM clients that do a risk reduction plan at least one time annually with the goal being set by the Part B QM Committee as 100%. For FY 2011-2012 the total was 96%.
5. Medication Assessment and Counseling defined as the percentage of clients with HIV infection on antiretrovirals (ARV) who were assessed and counseled for adherence two or more times in the measurement year with the HRSA goal set at 90%. AIDSNET's criterion for this PM is only counting those clients who were referred to AIDS Certified Registered Nurses (ACRN) for specific adherence issues; it does not include the initial assessment as included in the HRSA standard. Therefore, AIDSNET percentages will always fall below the HRSA standard. For FY 2011-2012 the total was 36%.
6. CM Training is defined as the percentage of case managers and supervisors meeting their *prorated* mandatory hours of CM project approved training in a measurement year with the goal of 100% of CMs working the full year receiving 20 hours. During FY 2011-2012 100% of the CMs received the minimum training.

For those CM agencies that also provide and collect data on medical services, they must measure the following clinical PM as well. Currently, this data is only being captured and uploaded to the Web Portal by our one Part B/C provider.

[7]The full description of these measures is in Appendix C

7. PCP Prophylaxis defined as the percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis with the HRSA goal of 95%. For 2011-2012 the total was 91%.
8. HAART Monitoring defined as the percentage of clients with AIDS who are prescribed HAART with the HRSA goal of 90%. For 2011-2012 the total was 99%.
9. ARV Therapy for Pregnant Women defined as percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy. This goal has not been established by HRSA. For 2011-2012 the total was 100%.
10. Viral Load Testing defined as the percentage of clients with HIV-infection who had a viral load test administered within 3 to 4 months of most recent medical visit. This goal has not been established by HRSA. For 2011-2012 the total was 99%.

All agencies, regardless of whether they are providing care and/or prevention services, must conduct an annual Organizational Assessment to confirm that its structure meets the National Quality Center (NQC) guidelines and that they are able to conduct ongoing Quality Improvement activities to insure the quality and efficiency of the services provided.

All of these measures require the collection of data and define the numerator and denominator of the data to be measured, exclusions, possible data sources, rationale and benchmarks (if established).

Limitation of the Data

Before the development and implementation of these PM, AIDSNET had been collecting many of these measures using the Consumer Holistic Improvement Scale (CHIS). These measures were used as AIDSNET's CM outcomes. The AIDSNET Planning Committee decided to forgo using the CHIS instrument and solely use the PM as outcomes. This was done to prevent duplicative collecting and reporting efforts.

In preparing for the transition, AIDSNET's Program Manager met with representatives from all four CM agencies. They reported using different fields if and/or when entering this data into CAREWare, which is HRSA's reporting program. In order to get accuracy and consistency in the data, AIDSNET's Program Specialist developed a standardized methodology of entering, reporting and collecting the data in CAREWare, and then went to each CM agency to implement it. Since the implementation of the standardized method of data entry, these difficulties have been overcome.

The frequency of reporting is specified in the PM, with many of them being calculated for the measurement year. However, HRSA reporting requirements splits the year into quarters. The Program Manager consulted with the CM agencies in order to meet the reporting requirements and timelines.

These PM will be under review by the Part B QM Committee and that committee is waiting the hiring of the PA HIV Care Unit's QM position.

During the 2013-2014 fiscal year, it is expected that all agencies will meet the minimum benchmarks as described in the Performance Measures or its revision adopted by the Part B QM Committee of the PA-DOH Division of HIV. To accomplish these outcomes, AIDSNET has budgeted $920,000 for medical CM for the 2013-2014 fiscal year.

As the entry point for all care services in the six-county area, equitable CM is the key to meeting the HRSA and PA-DOH goal of ensuring greater access and fewer disparities with regard to minority and underserved populations and increasing services to women, infants, children and youth. It is understood that, during fiscal year 2013-2014, approximately 28% of AIDSNET's Ryan White allocation must be spent on women, infants, children, and youth with HIV. This requirement may be changed depending on whether the calculation is to be determined regionally or on a state-wide basis. Because AIDSNET is a Part B provider, it does not provide services to infants and children. Historically, AIDSNET has either met or exceeded its percentage of expenditures on women, reflecting the large numbers of women enrolled in CM (481 or 39%).

The Part B QM Committee also implemented PM for the Fiscal Agents across the Commonwealth. They are as follows:[8]

1. Staff Development as defined as the percentage of Coalition and Fiscal agent staff members who complete eight hours or more of training per year. AIDSNET's staff exceeded this standard
2. Inclusion of a Minimum Set of Elements in a Needs Assessment defined as the percentage of HRSA-defined elements of Needs Assessment contained in the document. AIDSNET included 9/10 elements or 90%
3. Secondary Risk Assessment (Clients in CM receiving prevention messages) defined as the percentages of active CM clients that do a risk reduction plan at least one time annually. The score was 92%
4. Customer satisfaction regarding service delivery defined as the percent of consumers who agreed or strongly agreed for each of the seven standardized core questions asked. Please see the Evaluation Section of this document for a report on the survey conducted this year.
5. Addressing priority populations and services through funding defined as the .percentage of priority populations or services identified in the needs assessment that were addressed in the funding plan. AIDSNET included 5/5 or 100% in the funding plan.

It is anticipated that these also will be reviewed and revised after the Quality Management position at the PA-DOH is filled and there is an assessment for possible indicators for Part B services.

Institution of the HRSA Mandated Certification Process

As detailed in the Needs Assessment section of this document, the semi-annual requirement for CM clients to prove eligibility to receive RW services may prove a barrier for some clients to access needed services. For instance, if a client is just moving into the area, getting proof of

[8] The full descriptions of these measures are in Appendix C.

residency might be difficult if s/he does not have any accepted documentation with current address, such as two months' of utility bills, SPBP card, or signed lease that is used to verify residency.

Another issue that might prove a barrier is the inability to provide assistance until the client is certified. A CM agency can provide services while awaiting documentation; but if it turns out that the client is ineligible, the CM billable hours it takes to go through the certification process with a client must come from alternative funding. Also, the CM agency must also use other funding to cover the costs of providing any emergency client needs, such as the immediate need for prescriptions, which could cost hundreds to thousands of dollars. Applying to the pharmaceutical company may take more than a month to receive a response. Interrupting antiretroviral therapy (ART) is a life-threatening occurrence.

AIDSNET and the CM agencies are aware of these barriers and will look to viable alternatives to funding, but there are really no options other than paying with alternative funding (if the agencies have it) or not providing services to the client until certified. Those clients who have been in CM are now aware of the certification; therefore, we think the barriers discussed will apply predominately to new clients. Most of the clients are aware of the need to document eligibility if they are on SSI, Medicaid, Medicare, etc., and are adjusting to the fact that they now have to prove eligibility to receive RW services. AIDSNET will start tracking how many clients are denied crucial services due to the barriers inherent in this process to assess the actual extent of these barriers.

Housing

Of all of the services provided through the CM system, one of the most important is housing assistance. During the 2013-2014 fiscal year, housing assistance will total $386,000.

Currently, housing assistance is distributed through several programs in the AIDSNET region: Tenant-based Rental Assistance (TBRA), Short-term Rent, Mortgage and Utility Payments (STRMU) and Permanent Housing Placement (PHP). The funds are pooled for use by the CM agencies, rather than making specific allocations to each organization. All requests for assistance are approved on a case-by-case basis. Statistics on who received these services are included in the Needs Assessment of this document.

TBRA is used in cases where the households' incomes are limited to the point where they are likely to need long-term assistance to prevent homelessness while they are on the waiting lists for other affordable housing programs (e.g., public housing and Section 8). Because of strict rules about criminal record and drug history, it is possible that the households will not be eligible for subsidized housing and will be receiving TBRA indefinitely. AIDSNET has had to develop and implement a waiting list policy for clients requesting TBRA assistance (see Appendix D). To do this, considerable research was done on waiting list policies across the nation before one was drafted and finalized. It was decided that the policy would follow a first-come, first-served basis. Exceptions to this policy based on homelessness and domestic violence could be made on a case-by-case basis. Records show that during Fiscal Year 11-12, individuals on the TBRA waiting list eventually received TBRA assistance, moved into Section 8 or Public Housing, or

their financial situation changed and they were no longer in need or wanted TBRA assistance. These clients were then removed from the waiting list. As of this writing, there are seven individuals on the waiting list.

Each year, we have seen the increased need for TBRA assistance and accordingly increased the funds designated for TBRA. To insure that TBRA assistance is given to people in need and meet the eligibility under HOPWA guidelines, AIDSNET updated its housing form, requiring clients to initial each section of the housing agreement. This was done in order to insure there was proof that the client was informed of the TBRA requirements. Occasionally in the past, clients would state that they did not know the requirements of receiving TBRA. Since the form has been changed, there has been a reduction in the amount of appeals received by clients when they are denied TBRA. Some of the reasons for being denied are not meeting the income guidelines, not providing requested information, not adhering to the TBRA requirements, and not proving need for this assistance.

STRMU is available to households needing immediate aid to prevent homelessness. By federal regulation, the assistance is limited to 21 weeks per fiscal year, although AIDSNET tries to limit assistance to 17 weeks whenever possible to allow more families to be assisted. CM services are now a separate category. Hotel/motel vouchers may be available through Ryan White funding in the presence of extreme emergencies and on a limited basis due to the high cost of this type of temporary housing.

PHP is available to help clients move into a permanent residence and can be used only to provide a security deposit and/or first month's rent. Clients currently residing in a unit are not eligible for this type of assistance. PHP is no longer defined as a HOPWA supportive service and is defined as a direct housing service.

The Ryan White HIV Modernization Act

The Ryan White HIV Treatment Modernization Act of 2006 (ACT) provided the Federal HIV programs flexibility to respond effectively to the changing epidemic. The principles used to guide the changes were to serve the neediest first, focus on life-saving and life-extending services, increase prevention efforts, increase accountability and increase flexibility. The new law changes how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV-AIDS across the country. This ACT, that was due for renewal or repeal in October 2009, was carried over unchanged for the next three years. This was done due to the Health Insurance Reform bill being debated at the time that was later passed in 2010. The ACT is up for renewal in 2013 and is expected to remain unchanged until the results of the presidential election and its impact on the further implementation of the Patient Protection and Affordable Care Act (ACA) is determined. It may be several years before the impact of this bill is quantified by Congress in order to determine that this reform is sufficient to cover the medical and supportive care of PLWH in and of itself or if the ACT will need to be continued to supplement those costs. The ramification of the ACA is discussed below.

The ACT recognizes that HIV has had a devastating impact on racial/ethnic minorities in the U.S. In 2009, Blacks accounted for 44% of new infections [9] and Latinos 20%[10]. Funding under this ACT is divided into five distinct sections: Parts A, B, C, D and F. The ACT limits the maximum amount that a grant may decrease from the preceding year and limits the amount of increase in grant funds for a state using code-based rather than names-base HIV reporting.

The AIDS Drug Assistance Program (ADAP) is the largest single ACT program and is included in Part B. The new law takes steps to ensure that more low-income individuals have access to approved life-saving medications. The Secretary of Health and Human Services will develop and maintain a list of core ADAP medications needed to manage symptoms associated with HIV infection. This formulary, which will include all classes of antiretroviral drugs, will be the minimum requirement for all ADAP programs to provide in order to ensure that people living with HIV get the essential medications they need on a consistent basis. To do this, funding for the ADAP supplemental program was increased from three to five percent. In Pennsylvania, this program is known as the Special Pharmaceutical Benefits Program (SPBP) and has the largest share of Part B funding.

The most significant changes were made to Parts A, B and C. AIDSNET is funded under Part B of the ACT. All three funding streams must spend 75% of their award on essential medical care, otherwise called core services. Support Services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV, can expend the remaining funds.[11]

It is evident, however, that the medical model is clearly defined in the ACT as the most important part of treating people with HIV. With the medical advances, it is a rational stance. However, it has been made abundantly clear in the literature that social services, such as CM, are a critical component in accessing required care and services. This is done by assessing the client's care and service needs and facilitating coordination of these services received by each client with HIV. These goals are achieved by providing education, creating connections between care seekers and care givers and providing support.

The regional system is designed to meet the needs of the various populations across the State, whether they are living in rural or urban settings and whether their needs are distinguished by risk behaviors, race, gender, age and/or socioeconomic status. Hopefully, Pennsylvania will remain in compliance. A one-tier system would suggest that one size fits all. Accountability is important to insure that limited funds reach the ever increasing HIV population. However, quality is imperative and should not be compromised. At this time, the PA-DOH, as currently structured, reports it would not be able to replace the functions of the regions.

[9] http://www.cdc.gov/hiv/topics/aa/index.htm, last modified February 2012
[10] http://www.cdc.gov/hiv/latinos/index.htm, last modified, November 2011
[11] See Appendix E for definition of care and supportive services

The Patient Protection and Affordable Care Act (ACA) [12]

This act was passed in 2010. Some aspects of the act have already been implemented. In 2014, the most significant changes, including creating state insurance health exchanges and Medicaid expansion, will go into effect. As the ACA is implemented, many more PLWH will have health care coverage. However, the coverage may not be affordable or support the range of services critical to effective HIV Care.

Medicaid Expansion to 133% of the Federal Poverty Level (FPL)

- In states that choose not to comply and expand their Medicaid programs, these clients are unlikely to be able to afford health coverage. The Ryan White Program will provide medical services, access to medication, and supportive services for this population.
- Of those states that will expand Medicaid coverage, they will need to meet basic coverage requirements. States may offer limited or no coverage for some types of medical services; implement restrictive prescription drug limits; and offer limited case management, adult dental, mental health and substance abuse coverage. Expanded Medicaid programs also may not cover non-emergency transportation and/or peer support services. The Ryan White Program will need to fill these gaps in Medicaid coverage to ensure comprehensive care for PLWH.

Private Insurance

- Ryan White Program clients who range from 100 to 400 percent FPL will be eligible for subsidies to purchase private insurance through the health insurance exchanges.
- Private plans designed for healthier populations are likely to limit services and drug coverage through formularies. Successful management of HIV disease requires regular access to a range of services and uninterrupted access to HIV treatment. To help people with HIV stay healthy – it will be important for Ryan White to continue to provide services that may fall outside of private insurance coverage.
- The Ryan White Program allows states to use ADAP funds to purchase health insurance and pay insurance premiums, co-payments, and deductibles for individuals who are eligible for ADAP. As the ACA is implemented, the Ryan White Program must continue to assist PLWH with insurance affordability.
- The National HIV/AIDS Strategy (NHAS) calls for an increase of patients linked to care from 65 percent to 85 percent. The Ryan White Program has been proven to be highly successful at retaining clients in care. According to the Centers for Disease Control and Prevention (CDC), only 41 percent of all PLWH are retained in care and only 28% have their viral load suppressed. [13]
- The study, HPTN 052, found that an undectable viral load reduces the risk of transmission by 96 percent. In a convenience sample of eight Ryan White-funded Part C programs ranging from the rural South to the Bronx, retention in care rates ranged from 87 to 97 percent compared to an estimated national retention rate of 51 percent. Once in

[12] Draft factsheet from National Alliance of State & Territorial AIDS Directors September 2012
[13] Vital Signs: HIV Prevention Through Care and Treatment — United States, December 2011
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6047a4.htm?s_cid=mm6047a4

care, patients served at Ryan White-funded clinics do well, with 75 to 90 percent having undetectable levels of the virus in their blood.

Eligibility

- Not all PLWHA will be eligible for the Medicaid expansion or the health insurance exchange subsidies, so the Ryan White Program must continue to provide these individuals with comprehensive care and supportive services to ensure the best health outcomes.

HRSA Monitoring PA-DOH Part B Funding

On March 14-16, 2012, HRSA met with PA-DOH leadership and staff, Consortia staff, representation of providers and clients from the regions, except Philadelphia whose Part A funding was being monitored, to assess the services provided by the grant. HRSA then presented its findings and recommendations, asking the PA-DOH to respond. Below are some of the recommended changes that directly impact the Consortia.

- Eliminate or consolidate Consortia model to improve efficiency and insure compliance with the ACT's 75/25 requirement
- Change to RW fiscal year to decrease administrative burden and to decrease time needed to pay providers
- Move from Cash Needs Request to Invoicing
- Interim contracts with Consortia for one year with ability to renew up to four additional years to allow for implementation of any changes
- Contract language should hold Consortia liable for any fine, recoup, or repayment due to HRSA, and in turn will be put in providers' contracts
- If the regions are funding providers' administrative costs, the regions must understand that this must be included in their own administrative cap
- SPBP moved to PA-DOH and will eventually take over recertification of all clients and may pay premiums, co-pays & deductibles
- Method for allocations to Consortia needs to be updated. Each region should request specific amount of funds
- Providers of Patient Care services should have contracts with budgets. They should receive administrative oversight, which includes monitoring for quality of services and to insure they are adhering to HRSA guidelines

AIDSNET will be assisting the Part B HIV Care unit in meeting HRSA requirements and/or suggestions. During this process, the impact on the client will be the major consideration. Providers are well aware of the potential changes as it is part of the agenda of the Planning Committee meetings.

Patient Care

AIDSNET's Patient Care includes payment assistance for medical services and medications, dental care, health insurance payments, home health care, mental health services, legal services, and medical eye care**.** It also includes assistance with obtaining food through pantries.

The annual budget for the 2013-2014 fiscal year is $160,000 for Patient Care services. The money will be pooled for the use by Subgrantees, rather than specific allocations to each organization. All requests for assistance are approved on a case-by-case basis, except for medical services under $25 and assistance with food through pantries. The amount needed for patient care has seen significant annual fluctuations depending on the needs of the clients. For instance, when SPBP expanded its formulary, the need to use Patient Care funds for prescription coverage dropped dramatically. There is the possibility that SPBP will eventually take over Health Insurance Premium & Cost Sharing Assistance. This accounts for approximately $25,000 in patient care funds. If this happens, the Planning Committee would have to assess the distribution of patient care funds.

Medical CM Treatment Adherence

Medical and medication adherence counseling services are intended to educate and empower clients to maximize participation in their own care. Treatment adherence, as defined by AIDSNET, does not include an assessment as defined by HRSA, but follows the assessment for need. Services are provided by ACRN or physician assistants.. AIDSNET provides this vital service through the funding of three organizations. The annual budget for medication adherence for 2013-2014 fiscal year will be $70,000.

Psychosocial Support Services

This service includes individual and/or group counseling, other than mental-health counseling, provided to clients, family, and/or friends by non-licenses counselors. It may also include psychosocial providers, peer counseling, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling or education.

One component of this service is support groups. Support groups are not intended to be a substitute for mental health counseling and the sponsoring organization must assure that persons in need of therapy are referred to the appropriate organization. AIDSNET's Allocations Committee asked staff to develop new guidelines for the funding of support groups.

Staff developed a guidance policy for support groups that was approved by the Allocations Committee after significant input from clients, providers and Board members. It included requirements that groups must be closed; meaning that for the fixed duration of the group, new members will not be admitted. In addition, it was stipulated that group leaders must be trained facilitators.

The guidance also included recommendations that groups should be co-facilitated. Case managers and/or peers can be used as support group co-facilitators in the presence of a trained co-facilitator and only when appropriate (for emotional and educational groups, not therapeutic groups) and should involve close supervision. Outcomes should be developed based on the specific structure and content of the group. Finally, it requested applicants for support group funding to include a complete description of the proposed groups, including the type of group (e.g., therapeutic, educational or emotional) and a description of the target populations (e.g.,

gender, race/ethnicity, infected/affected, age and geographic area served). This service has not been funded for the last five years due to the lack of proposals from non-profit agencies. AIDSNET continues to look for solutions to this gap. During the last Request for Proposal (RFP) process, there were no requests for funding of support groups.

Goals:

1. Involve providers in any fiscal, contractual, or administrative changes as they are implemented by the PA-DOH
    - The following years will be full of changes that are unknown at this time. However, we will be working closely with providers to inform them of any changes and ask for their experience in making any necessary changes.

2. Adapt to changes as they occur regarding the results of the HRSA Monitoring, the Affordable Care Act and the RW 2013 Reauthorization
    - What will the consortia structure, look like? Will it be eliminated or consolidated?
    - How will the ACA look as a result of November's election? It will take time for any changes to occur. However, one of the items in the act that will not change is the requirement that most individuals have some type of health insurance. Most of the clients we serve have Medical Assistance (MA) or private insurance. Undocumented individuals with HIV will not be able to get insurance; but, hopefully, they will continue to be treated
    - PA is one of the states suing to stop the ACA's requirement to raise the MA income eligibility to 133%.

3. Continue improving Care services to follow changes in best practices
    - Implement changes while maintaining or improving capacity of the delivery system and client access to needed services
    - AIDSNET's primary concern is that clients have access to the latest treatment regimens and that they are being treated by experienced HIV Physicians

4. Adapt to the changing focus of prevention. The CDC's focus of prevention (i.e. treatment as prevention, high impact interventions) is focusing on reaching high-risk individuals (with the primary population being PLWH) and getting them into treatment or retaining them into treatment in order to reduce the individual's viral load, thus decreasing the community viral load, further reducing new infections.
    - Therefore, prevention interventions for high-risk populations must focus on testing to find positives and enroll them in care
    - Those interventions for PLWH must be focused on:
        - Retention in care
        - ART adherence
        - Maintaining undetectable viral load, thereby reducing the community viral load

5. Assess the ability to quantify the "treatment cascade" in the region. This is a construct that is relatively new. Reiterating national statistics given earlier in the sections, only 41

percent of all PLWH are retained in care and only 28% have their viral load suppressed. This will be a long-term project with the first step of finding out how much accurate data we can gather. We will be able to obtain the last three percentages on those currently in care, and work on improving retention in care and maintaining suppressed viral load.

- % of HIV infected
- % of HIV diagnosed
- % linked to HIV care
- % retained in HIV care
- % on ART
- % with suppressed viral load (≤200 copies/ml)

6. Participate in the revision of CM Standards
    - AIDSNET will be active in the revision of the CM standards to reflect changes in the current treatment to slow the progression of HIV. It is imperative to reduce barriers for clients in order to for them to get the medical treatment they need and any supportive services that will keep them in care.
    - Given the advances in treatment, does every client need to be seen every 90 days? How can the newly instituted semi-annual recertification process affect the frequency of visits? Just like HIV is seen on the continuum, CM needs to make that change. One size does not fit all, especially in light of the upcoming, as yet unknown, implementation of further parts of the ACA.

7. Budget Process

The budget was prepared by the Fiscal Officer and Executive Director with assistance in the development process by the staff. The Program Specialist provides trends in client spending as it relates to the taxonomy, which is a list of services that can be paid with U.S. Health Resources and Services Administration (HRSA) funds. The Program Manager discusses the expenses involved with monitoring the agencies, holding committee meetings and state travel to attend Pennsylvania Department of Health (PA-DOH) committee meetings. The Administrative Assistant provides information regarding supplies or equipment needs. All staff estimates planned travel and staff development. Out of state travel, which must be approved by the PA-DOH, has been all but eliminated. A significant amount of staff development trainings are done on-line.

The budget for care, prevention, and housing was completed in September 2012, after the priority setting and resource allocation sections of this document were finished. The allocations for each service were based on these priorities. If any additional funds become available after the initial award by the PA-DOH, a budget modification is prepared. The funds are allocated based on the decisions made by the Allocations Committee in case any additional funds are awarded. Any variance from the priorities set and the amount of money allocated for a service was due to the availability of funding from other sources

The development of the administrative budget began in July 2012 when the Fiscal Officer researched criteria to establish and propose a percentage increase for staff salaries for the next two fiscal years. Various resources including, but not limited to, cost of living indices (COLA) were used to determine this percentage. The Fiscal Officer worked with the Executive Director to establish the percentage of program vs. administrative time each staff person worked. The percentage increase and allocation of staff time by funding source were then approved by the Executive Director. The Fiscal Officer prepared the administrative budget by mid-August. Resources used to compile this budget included staff input, contractual obligations, the prior year's spending patterns and the administrative caps defined by HRSA, Housing Opportunities for Persons with AIDS (HOPWA) and the PA-DOH. Staff and Board development plans detailed in this document were also used to prepare the budget. The AIDSNET cost portion of the budget was then reviewed by the Executive Director for completeness and accuracy.

Once the entire budget was completed, it was presented to the Finance Committee of the Board of Directors for review and to the full Board of Directors for approval in October 2012.

The Resource Allocation Plan for 2013-2014 was developed by staff in September 2012. The plan was approved at the Annual Meeting on September 25, 2012, and by AIDSNET's Planning Committee on September 27, 2012. Final approval by AIDSNET's Board of Directors was given at the October 3, 2012, meeting.

AIDSNET
July 1, 2013 - June 30, 2014

CATEGORIES	ORIGINAL BUDGET
I. PERSONNEL SERVICES	**361,903.36**
II. CONSULTANT SERVICES	**0**
III. SUBCONTRACT SERVICES	**1,776,000.00**
IV. PATIENT SERVICES	**160,000.00**
V. EQUIPMENT	**0**
VI. SUPPLIES	**5,075.00**
VII. TRAVEL	**6,000.00**
VIII. OTHER COSTS	**48,676.00**
TOTAL	**2,357,654.36**

8. Staff Development Plan

AIDSNET believes in fostering personal growth by providing a positive work environment, one in which all staff members are able to reach their maximum potential. One way to accomplish this goal is to involve staff members in different projects which enable them to develop new skills. Additionally, this is accomplished through staff meetings held twice a month, as well as regular communication with all employees. Staff meetings are also important in building and maintaining a cohesive staff with a shared sense of vision and priorities. The purposes of staff meetings include, but are not limited to, identification of priorities for the organization, provision of updates to state and federal guidelines, discussion and resolution of Subgrantee related issues and progress reports on projects. Staff will also continue making progress toward cultural competency awareness to improve meeting the needs of a diverse region.

An important part of maintaining a positive work environment is providing a consistent work atmosphere, which gives employees the sense of security they need to be successful. AIDSNET provides this consistency through its personnel policies, as well as regular discussion of policies and procedures. AIDSNET's policies include guidance on such issues as the chain of command, compensation, fringe benefits, evaluations and grievances.

Due to AIDSNET's small staff size, each staff member has a great deal of responsibility. The size of the staff and workload assigned to each employee emphasizes the need for cross-training. This is essential so the organization can continue to be successful in accomplishing its goals even when a staff person leaves the organization or must take a leave of absence. AIDSNET's staff has created and implemented a procedure manual that contains job responsibilities and the processes used to accomplish those tasks for most of its staff. The manual is updated as changes in policy and procedures occur.

AIDSNET understands the importance of having a diverse staff that is reflective of the community. When there are staff vacancies, diversity is one of the criteria for selecting the successful candidate.

All staff may require specialized training when changes occur to regulations, data collection processes, reporting processes, or program development. Staff may attend training or conferences that assist them in maintaining and improving skills required to serve the Subgrantees, facilitate coalition planning and contract management, enhance the performance of duties or prepare for additional responsibilities.

Of course, it is essential that staff remains current on the latest developments in the field of HIV/AIDS. Much of this effort can be accomplished with on-line publications. However, it is still important that staff periodically attend conferences, both in-state and out-of-state, when approved. The cost of the actual conference is included in the annual budget under the line item "Staff Development." All other costs associated with the conference, including travel, lodging and meals, are included in the annual budget under the line item "Travel." The details of the approximate expenses of possible conferences that staff may attend follows. AIDSNET prides itself in benefiting from applying for scholarships to ease the budgetary burden, while receiving

quality training. These conferences are in addition to the regularly scheduled meetings and the periodic trainings offered by the PA-DOH. Assuming no registration fees are involved, the costs of these meetings and trainings are included in the annual budget under the line item "Travel."

With the increasing difficulty of maintaining a 10% administrative cap, staff has been encouraged to participate in on-line training and/or webinars whenever possible and appropriate.

AIDSNET
Staff Development
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Pennsylvania Ryan White All Parts Summit	
Sponsored by The Pennsylvania/Mid-Atlantic AIDS Education Training Center	
Three staff people attending	
1 night's lodging @ $130 per person	$ 390
Meals (one day @ $28 per person)	84
Mileage (168 miles @ $.555/mile)	93
Total	$ 567
National HIV/AIDS Social Work Conference	
Conference dates and location to be determined	
One staff person attending	
Registration	$ 250
3 night's lodging @ $139 per person	417
Mileage Reimbursement (400 miles @ .555/mile)	222
Meals (four days @ $28/day)	112
Total	$ 1,001
Microsoft Excel 2010 - Introduction	
Northampton Community College on-line instruction	
Date of class to be determined	
Registration	99
Total	$ 99
Homes Within Reach Conference December 3-5, 2012	
Harrisburg Hilton	
Registration Fee	$ 400
Hotel 2 nights @ $125	250
Travel mileage (176 miles @ .555/mile)	98
Meals: 1 lunch @ $11 and 1 dinner @$22	33
Total	$ 781
PA Chamber Human Resource Updates 2 times	
Dates and exact location of events to be determined	
Harrisburg Area	
Registration Fee @ 35.00 each	$ 70
Travel rental car and gas (67.00 each)	134
Total	$ 204

9. Board/Membership Development Plan

Structure

The role of the Board of Directors is to set, direct, implement and monitor policy. Although the Board has the ultimate responsibility for policy, there is a clear need for staff input. Staff is encouraged to contribute according to what they perceive to be AIDSNET's needs.

The Board and Officers' responsibilities are:

- the overall management of AIDSNET;
- providing guidance, direction and monitoring for the completion of regional goals;
- review and approve the budget and fiscal management;
- the selection, support and evaluation of the Executive Director;
- ensuring the effective organizational planning;
- determining and monitoring of AIDSNET's programs and services;
- enhancing AIDSNET's public image; and
- serving as a Court of Appeal in disputes not otherwise manageable with the Executive Director's prerogatives.

Procedures

Highlights of the organization's bylaws are described below:

- The mission of AIDSNET is to build healthier communities by planning and funding HIV/AIDS care and prevention services.
- The Board of Directors shall have full power to conduct, manage and direct the business and affairs of the corporation and all powers of the corporation are hereby granted to and vested by the Board.
- The Board of Directors shall employ an Executive Director to oversee the day-to-day operations of AIDSNET.
- *Robert's Rules of Order*, the most recent revised edition, shall constitute the ruling authority in all cases wherein such rules do not conflict with the rules of this organization or any statute of the Commonwealth of Pennsylvania.
- Bylaws may be amended by the affirmative vote of two-thirds (2/3) of the Board of Directors present at any regular meeting of the Board or at any meeting of the Board called for the express purpose of amending these bylaws, providing that those present constitute a quorum, and provided that the general purpose of the amendment(s) shall have been stated in the notice of the meeting and that such notice shall have been sent to all members of the Board at least fourteen (14) days prior to the meeting.
- In the event of the liquidation of dissolution of the corporation, whether voluntary or involuntary, no members shall be entitled to any distribution or division of its remaining property, assets or the proceeds of the same. In the event of liquidation payment of all liabilities of the Corporation, dispose of all remaining properties or assets or properties solely to an organization(s) or entity (ies) which organized exclusively for charitable,

educational or scientific purposes and which is set at that time fully and duly qualified as an exempt organization(s).

- The organization shall indemnify each person who is or was a Board member, officer, or employee of the organization, against any liability and reasonable expense that may be incurred by her/him in connection with or resulting from any claim, action, suit, or proceeding (whether brought by or in the right of the organization or otherwise), civil or criminal, or in connection with an appeal relating thereto, in which she/he may become involved, as a party or otherwise, by reason of his/her being or having been a Board member, officer, or employee, whether or not she/he continues to be such at the time of the liability or expense is incurred, provide such person acted, in good faith, in what she/he reasonably believed to be the best interests of the organization and, in addition, in any criminal action or proceeding, had no reasonable cause to believe that his/her conduct was unlawful.
- The books of the organization shall be audited annually by an independent certified public accountant appointed by the Board. The Auditor's Report shall be filed with the records of the organization. A summary of this report shall be presented to the Board of Directors.

AIDSNET's bylaws are attached in their entirety as Appendix F.

The Board of Directors is structured to consist of no less than 15 nor more than 25 voting members, and one ex-officio voting member, the Executive Director. Currently, there are 13 members on the Board. The recruiting of new members is an ongoing practice. The officers are Chair, Vice Chair, and Secretary/Treasurer. Standing committees have been established per the bylaws of the organization. Regular meetings of the Board are held the first Wednesday of every other month. Special meetings of the Board are held whenever called by the Chair or by a majority of the Board members. The Board of Directors in conjunction with the standing committees and AIDSNET staff are involved in the decision-making process. A description of the role of each standing committee in the decision making process follows:

- Allocations Committee
  - Consists of Board members and community representation; staffed by the Program Manager, Fiscal Officer and Executive Director
  - Oversees preparation of Request for Proposals
  - Reads and scores proposals
  - Develops a proposed budget for the provision of services
  - Meets as needed

- Evaluation and Research Committee
  - Consists of Board members and community representation; staffed by the Executive Director
  - Reviews the programmatic monitoring process
  - Evaluates the organization's overall performance
  - Monitors the need for local research projects and reviews proposals for same
  - Meets as needed

- Executive Committee
  - Consists of Officers and Committee Chairs – staffed by the Executive Director
  - Oversee the Executive Director and operation of the corporation
  - Develops a Board and/or committee member recruitment strategy
  - Meets alternative months of Board Meetings

- Finance Committee
  - Consists of Board members and community representation; staffed by the Executive Director and Fiscal Officer
  - Reviews operating budget, financial statements and annual audit
  - Provides technical assistance to staff on an as-needed basis
  - Meets prior to every Board Meeting

- Marketing and Development Committee
  - Consists of Board members and community representation; staffed by the Executive Director
  - Prepares, implements and updates the organization's marketing plan
  - Develops and coordinates the organization's local fundraising efforts
  - Oversees the preparation of the Annual Meeting, Annual Report and marketing materials
  - Meets as needed

- Planning Committee
  - Consists of Board members and community representation; staffed by the Program Manager, Fiscal Agent and Executive Director
  - Oversees the preparation of the Coalition Regional Services and Strategic Plan
  - Oversees the development of needs assessments and gap analyses
  - Meets as needed

- Quality Management Committee
  - Consists of Board members and community representation; staffed by the Program Manager, Fiscal Agent and Executive Director
  - Responsible for overseeing the planning, directing, coordinating and improving services provided in the region
  - Track trends, decide next steps for the QM Plan and monitor performance of the entire system of care
  - Meets quarterly to review HIV care and prevention services and to facilitate coordination between these systems.

In addition to the standing committees, the Board of Directors may create and disband ad hoc committees from time to time. An ad hoc committee may be established by the Executive Committee upon the recommendation of a standing committee, Board members acting in concert, or the Executive Committee alone. The ad hoc committee shall be given a specific charge and an approximate time frame for deliberation and action. Whether members are elected or appointed will be determined by the Executive Committee. Representatives of organizations outside the Board of Directors may be appointed as needed, but they will serve in an ex-officio

capacity only. The chair may be appointed by the Executive Committee or elected by the committee as deemed most appropriate. The chair will be responsible for establishing an agenda of meetings, calling meetings and preparing appropriate reports. The committee will select a secretary, who will be responsible for the recording, preparing and distributing the meeting minutes.

Each member of the Board of Directors shall hold office for a term of four years, and may succeed himself/herself for one additional consecutive term of four years. Persons who are employed by the corporation are not eligible for membership on the Board of Directors until their association in that capacity has been terminated for three months. Any vacancy or vacancies in the Board because of death, resignation, removal in any manner, disqualification, an increase in the number of Directors, the expiration of a prior Director's eligibility or any other reason may be filled by a majority of the remaining members of the Board, though not less than a quorum, at any regular or special meeting. Each person so elected shall be a Director to serve for a full term of four years from the date of appointment.

Whenever the opportunity arises, AIDSNET recruits college level students to the Board whose major is to prepare them for medical school or public health. This provides AIDSNET the unique opportunity to educate them about HIV. The goal is for them to ultimately educate their fellow medical professionals about HIV and possibly impact on HIV care and policy. Although their tenure is usually only one or two years, the Board believes that it is important to include this population.

Each Board member shall execute a statement each year setting forth any possible conflicts of interest relative to the corporation or stating that no such conflicts exist. A conflict of interest query is part of the agenda at every Board meeting and is addressed by the full Board.

A Director may be removed from office upon an affirmative vote of two-thirds of the remaining Directors for any reason including, but not limited to, said Director having three unexcused absences in one fiscal year.

Recruitment

AIDSNET endeavors to constitute the Board of Directors in such a way as to assure reasonable representation consistent with the current regional demographics of the disease while addressing concerns in a culturally competent manner of all those who are affected. Every attempt is made to have representation from each of the six counties in the region. Volunteer recruiting web sites reaching the six counties in the region have been utilized with reasonable success. Board membership development is an ongoing activity of AIDSNET. The Executive Committee is responsible for the recruitment and orientation of new Board members.

AIDSNET strives to maintain a membership that is culturally diverse and reflective of the epidemic. Currently, clients represent 30% of the Board membership and Latinos represent 1%. The Board currently has one African-American member, as well as an African member. Increasing membership representation from the Black and Latino communities will continue to be a priority. The current membership does reflect a diversity of skill sets, including

professionals from the fields of accounting, education, finance, human services, marketing, mental health, nursing, private industry and public health.

With regard to the recruitment process, AIDSNET's Board of Directors adopted a matrix to guide filling vacancies. The matrix takes into consideration the fair representation on the Board from each of its six counties. The matrix attempts to include various segments of the general public by including representatives of government and human services, the private sector, communities of faith, higher education and medical-related fields. Because of their particular importance to the operation of the organization, the Board believes it is important to have at least one attorney and one certified public accountant as Board members. In addition to all of the above, the Board recognizes the importance of being representative of the community it serves by recruiting clients, members of various racial/ethnic backgrounds and people of all income levels.

Orientation and On-going Education

The Executive Committee has, as part of its mandate, the creation and periodic review of a comprehensive orientation process for new Board and Committee members. The Executive Committee instituted a Board orientation packet for new members. Board meetings have a segment on emerging issues or other items of interest to keep members current on important trends in the AIDSNET region, statewide and nationally. Board retreats are held either annually or biannually. The Board of Directors will also continue making progress toward cultural competency awareness to better meet the needs of a diverse region.

Recognition

AIDSNET recognizes the importance of acknowledging Board/committee members for their dedication to the organization and to the issues of HIV/AIDS prevention and care. It is important to acknowledge exceptional achievement, whether it is a member of the Board of Directors who is completing his/her second four-year term, a committee member who has held a leadership role for an extended period of time or a Board/committee member who has guided the organization through a difficult issue.

Leadership Succession Planning

AIDSNET Board does not have a formal leadership succession planning process in place at this time. Informally, the Chairperson mentors the Vice Chairperson who is expected to step into the position of Chairperson upon the expiration of the term and/or resignation of the Chairperson and the vote of the full Board.

10. Monitoring

Monitoring is a measurement of contract compliance, which occurs at two levels. AIDSNET, as the planning coalition and fiscal agent, is monitored annually by the Pennsylvania Department of Health (PA-DOH). In the event there are compliance concerns, AIDSNET submits and implements a corrective action plan to resolve the outstanding issues.

Other peer consortia are not part of AIDSNET's programmatic and fiscal monitoring of providers. However, a joint peer review of a specific process is done on a one- to two-year frequency, or more often if a specific need is identified,

The second level occurs when AIDSNET conducts fiscal and programmatic monitoring of all Subgrantees during the fall of each year and submits the summaries to the PA-DOH prior to December 31 of each fiscal year. The monitoring assures contract compliance regarding federal and state regulations. All Subgrantees receiving on-site monitoring will be debriefed at the end of the site visit. The agency's staff will have the opportunity to hear the monitor's concerns, if any, and discuss all of the findings prior to the issuance of a written report. The comprehensive, written report will be sent to the provider for review and signature within 30 business days of the last on-site visit.

In the event of a compliance concern, the agency submits a corrective action plan to AIDSNET for resolving outstanding issues. AIDSNET then ensures, through a second monitoring visit, that the plan was implemented and has resulted in a return to compliance. The monitor's conclusions regarding the follow-up monitoring visit are submitted to the PA-DOH by April 30 of that fiscal year.

Programmatic monitoring visits focus on agency contract compliance, quality of services and current service trends. AIDSNET monitors every contracted agency. Currently, AIDSNET contracts with five agencies. Programmatic monitoring will consist of the following components:

- Desk monitoring is used to determine whether the Subgrantee has complied with reports, invoices and other contract-related issues, as well as to review past monitoring reports.
- Prior to the monitoring visits, staff identifies a specific focus, which results in a mini assessment that may determine a need for technical assistance or provider training in an identified area.
- During the monitoring visit, interviews are conducted with Subgrantee staff to learn about any changes in the program and any issues the Subgrantee feels are important. In addition, AIDSNET's staff reviews charts using PA-DOH checklists, assures that both care and prevention standards are being met, examines the physical location to make sure it is appropriate for the activities occurring on site, asks about personal qualifications and supervision policies, examines the program's operations manual and Quality Management Plan, reviews other supporting documentation and inquires about quality improvement projects. Prevention activities are observed with the consent of the

participant(s); feedback is presented to the prevention worker and is included in the monitoring summary.

- The PA-DOH's general and service specific compliance checklists are completed during the on-site programmatic monitoring visit to insure standards are being followed and to provide insight into any contract-related issues that have changed since the last monitoring visit.
- AIDSNET's staff will provide ongoing technical assistance to assure that providers are meeting federal and state standards, as they are updated and will facilitate the adoption of the most current best practices guidelines.

This year, the PA-DOH has provided a slightly revised guideline for programmatic monitoring. They are currently receiving technical assistance with several issues, one of which is implementing the HRSA Monitoring Standards. As soon as that is complete, the new monitoring standards will be implemented by AIDSNET.

Fiscal monitoring visits include both a desk audit and an on-site visit.

- Desk audits will consist of the same components as outlined for programmatic monitoring. In addition, it includes the review of the agency's most recent audit and management letter to learn more about the fiscal operations and financial standing of the organization.
- On-site monitoring is used to confirm the fiscal integrity of the Subgrantee through the examination of financial records and the analysis of the organization's intern control and procedures. Specifically, AIDSNET examines the Subgrantees fiscal decision-making procedures, financial stability, the ability to track expenditures and the appropriateness of each program's unit cost. AIDSNET uses the PA-DOH's fiscal administration checklist for all on-site fiscal monitoring.

11. Evaluation

There are three levels of evaluation:

1. Evaluation of Coalition: An assessment to determine AIDSNET's effectiveness and quality in executing roles and responsibilities and also identifying areas in need of improvement.

2. Evaluation of Funded Programs and Services: An assessment of progress towards established outcomes and/or priorities to determine overall effectiveness and quality of a program or service. A summary of evaluations of funded agencies conducted by fiscal agents is submitted to DOH in January of each year.

3. State of the Region Report: A macro-level general overall assessment of the region's HIV/AIDS related services. It evaluates how well the region's services are currently meeting consumer needs. This evaluation is not limited to Part B services and it should be written from the consumer viewpoint. Evaluations conducted by the Coalition and the Fiscal Agent are taken into account. The report is included at the end of this section.

AIDSNET's Evaluation and Research Committee open to members of AIDSNET's Board of Directors, clients, and community members, evaluate AIDSNET's performance. The evaluation may include quarterly review of the following areas:

- AIDSNET's success at responding to service needs (outcome measures such as the availability and accessibility of services, client satisfaction and quality of services);
- AIDSNET's cost effectiveness in its approach to delivery of comprehensive care;
- AIDSNET's planning and allocations process;
- The cost-effectiveness of AIDSNET's administrative structure and operational procedures;
- The impact of Housing Opportunities for Persons With AIDS funding on housing;
- The impact of Ryan White CARE Act dollars on wellness; and
- The impact of Commonwealth dollars on HIV prevention,

The Evaluation and Research Committee will also assess AIDSNET's efforts to achieve the identified projects and desired results and will report to the entire Board of Directors during regularly scheduled meetings. The Evaluation and Research Committee will also provide feedback to the Allocations Committee to help shape upcoming goals and objectives, based on current year evaluations.

Through its Quality Management (QM) process, the AIDSNET staff, Evaluation and Research Committee and/or Board of Directors will also monitor, evaluate and address QM projects and results (e.g. updating best practices for both care and prevention services, increasing awareness of AIDSNET's role, resources and community involvement) to assure that all of the important steps that should lead to anticipated results are identified, prioritized and achieved. In addition, the formation of new Quality Improvement (QI) projects will be an ongoing part of the process.

The QM Team will review the QM plan quarterly to evaluate projects, results and identify areas in need of improvement.

Another type of evaluation is a peer review process. It consists of one Planning Coalition and/or Fiscal Agent arranging an on-site review of an identified process by another Planning Coalition or Fiscal Agent. Documents are exchanged for review prior to the meeting, an in-depth review of the process is conducted face-to-face and a summary of the evaluation is jointly written.

Client Satisfaction 2012

Another form of evaluation is obtaining client feedback. In 2010, the Statewide Part B QM Committee standardized a short client satisfaction survey. The survey was distributed statewide to the seven regions, and is required to be administered annually as part of the Consortia's Administration, Planning and Evaluation (APE) performance measures. The questions asked about the quality of services clients received. The survey is anonymous informing clients that their identity cannot be discerned by their responses and that the survey will be used to improve the quality of services. The following scale was used: 1 = Strongly Agree, 2 = Agree, 3 = Disagree and 4 = Strongly Disagree. The 2012 AIDSNET results, based on 182 respondents, follow:

1. I am able to get an appointment with my case manager when needed.

1 - Strongly Agree	122 (67%)
2 - Agree	51 (28%)
3 - Disagree	5 (3%)
4 - Strongly Disagree	4 (2%)

2. My case manager makes referrals to agencies/individuals that meet my needs.

1 - Strongly Agree	109 (60%)
2 - Agree	67 (40%)
3 - Disagree	3 (2%)
4 - Strongly Disagree	3 (2%)

2a. When those referrals cannot assist me, my case manager is able to help me.

1 - Strongly Agree	103 (57%)
2 - Agree	72 (40%)
3 - Disagree	4 (2%)
4 - Strongly Disagree	3 (2%)

3. My case manager allows me to be more independent in addressing my problems.

1 - Strongly Agree	112 (62%)
2 - Agree	66 (36%)
3 - Disagree	1 (<1%)
4 - Strongly Disagree	2 (1%)

No Response 1 (<1%)

4. I am comfortable sharing my feelings and problems with my case manager.

1 - Strongly Agree	130 (71%)
2 - Agree	43 (24%)
3 - Disagree	5 (3%)
4 - Strongly Disagree	2 (1%)
No Response	1 (<1%)

5. My case manager works with my HIV medical care providers to help me understand my medical care/options.

1 - Strongly Agree	117 (64%)
2 - Agree	60 (33%)
3 - Disagree	2 (1%)
4 - Strongly Disagree	2 (1%)
No Response	1 (<1%)

6. My case manager and I work together in making decisions about my goals, needs and options.

1 - Strongly Agree	113 (62%)
2 - Agree	62 (34%)
3 - Disagree	5 (3%)
4 - Strongly Disagree	2 (1%)

7. Overall, I am satisfied with the case management services I received over the past 12 months.

1 - Strongly Agree	131 (72%)
2 - Agree	45 (25%)
3 - Disagree	3 (2%)
4 - Strongly Disagree	3 (2%)

Subgrantee Evaluation

On the Subgrantees level, all agencies are contractually required to have a QM plan and show evidence of utilization. The QM Plan measures the quality of services and processes, as well as identified areas where quality can be improved. AIDSNET will plan and provide training and technical assistance to assure that there is a structure in place identifying members of the QM Team, documentation of the process and a completed annual QI project. QM plans and QI projects will be reviewed during on-site visits, becoming part of the monitoring process and the annual Evaluation of the Quality of Services report. In addition, providers will submit mid-year and year-end updates on the progress of their projects using the Statewide QI Storyboard. Table 1 below lists a sampling of QI projects undertaken by Subgrantees during the 2011-2012 fiscal year.

Table 1: 2011-2012 Subgrantee Quality Improvement Projects			
Subgrant Agency	QI Project/Goal	Interventions, Findings & Results	Next Step(s)
AIDS Activities Office of the Lehigh Valley Hospital (AAO)	Reduce "No Show" rate in HIV clinic from 20% to 15% in 6 months – to 10% in 12 months	Too many clients not showing for appointment and not calling to cancel, even with reminder calls that are provided two days prior to the appointment. Baseline Data: 265 Scheduled; 51 No Shows = 19% No Show Rate Focused QI project on approximately 60 clients that have missed at less 3 appointments and did not call to cancel. Used CAREWare to track clients that "No Show" and sent survey. Top reasons given for "No Show" were – don't feel well, weather conditions, and too far to come. Staff also noted that clients are moving and change phone numbers without informing staff making reminder calls impossible. Since AAO cannot change the reasons why a client does not show, decided to focus on the importance of a client calling to cancel or reschedule their appointment. Developed a "No Show" policy and posters with stop light giving a visual of the policy. Reminder calls will continue to be made until a live person can be reached to leave the appointment information with. "Frequent flyers" will not be given a scheduled appointment, but will be given a day to come in & have to wait to be seen when there is an opening. The new policy was sent to the 60 clients originally identified and the "No Show" poster was sent to all active clients. Overall there was a slight improvement in the "No Show" rate. The average no show rate for 12 months was 16% (666/4151). The best month was October with a no show rate of 12% (39/331).	Monthly monitoring of "No Shows" will continue and monthly stats will be shared with the team. Additional appointment phone calls will continue to be made until a live person is reached to provide the appointment information. Staff continues to stress the importance of clients keeping their appointments or calling to cancel. The AAO will continue to look at this problem and develop strategies to help reduce the no show rate.

AIDS Services Center at St. Luke's Hospital (ASC)	Identify barriers to clients receiving Mental Health screenings, referral to appropriate care and follow-through/completion	Currently, Case Managers and clinic staff are only required to document mental health status. Clinic staff uses a screening survey at least once a year to identify mental health status. Case managers rely on self-report from the client to identify mental health history. Once the status is documented, if documented at all, there is no referral process in place for treatment for those who are identified as having a mental health history. Case managers and clinic staff do make referrals to Lehigh Valley Mental Health and Bet-el, but there are long wait lists and the referrals seldom go through. As a result, there are ASC clients and St. Luke's Hospital clinic patients in need of mental health treatment who are not receiving it. Furthermore, there is no system in place to address clients and patients who have a mental health history, but who are refusing treatment. Total open ASC clients=201 Did client receive a mental health screening at least once during the fiscal year? NO=27% (n=54) YES= 73% (n=147) Of those who received a screening, 50% (n=74) did **not** have a mental health history 50% (n=73) yes, did have a mental health history Of those who have a mental health history, 4% (n=3) refused treatment 25% (n=18) are not receiving treatment	This project is ongoing as the protocol continues to be tweaked and the data reevaluated for improvement.
Co-County Wellness Services (CCWS)	Develop a strategy to ensure that 100% of new clients, clients new to treatment and clients experiencing difficulty with treatment are referred for adherence education/ counseling	Using CAREWare data, the team identified that the percentage of clients receiving adherence was low and that some clients in need of the service had not been referred; through review and discussion they concluded that there was a lack of clarity and consistency around adherence referrals; an internal protocol was established and implemented; an additional process was instituted to monitor that medical providers were also referring appropriate clients for adherence services; since implementation,	The team continues to monitor and evaluate the protocols and make adjustments as necessary.

		they have seen a marked increase in the number of adherence referrals	
Keystone Farmworker Health Network (KFP)	Develop a systematic way of tracking and documenting service delivery, including follow-up services	A work plan was written and implemented for use by the prevention worker to help track that documentation and follow-up were completed in a timely fashion; after the initial implementation of the work plan, the team noticed that factors other than clients were the cause documentation was not being completed; the work plan was rewritten to address these findings and ensure that task don't fall through the cracks; a weekly review of the revised work plan has provided ongoing evaluation and an opportunity to analyze how well certain tasks are being completed; the written record has also improved efficiency (i.e. providing a better record to help track the influx of new Farmworkers and increase follow-up)	After using the format for one fiscal year, they will revisit it to decide if additional changes are necessary; one change that has already been suggested is adding a section to track unexpected activities that arise and take precedence over the plan; this would help them track data regarding incomplete plans and help reorganize work.
Latinos for Healthy Communities (LHC)	Retention of clients provided HIV/AIDS services at their Chew Street office	LHC has a high number of clients coming to their Chew Street office to be referred to their Drug & Alcohol programs; HIV prevention has been incorporated into their D&A and other services and clients are referred to the prevention worker; however, since clients are not required to schedule an appointment and/or are only seen by the D&A specialist once, it is difficult to get them to return for further interventions; LHC revised their protocol for D&A referrals by making the HIV prevention interventions a part of the actual service; clients are seen by the prevention worker prior to seeing the D&A specialist or vice-versa and are required to see the prevention worker at each D&A visit; additional incentives were included to encourage retention	The team has seen a small increase in retention in multiple session Interventions Delivered to Individuals (IDI) since implementing the new protocol; however, they are continuing to evaluate it and looking at adding additional wrap-around services to improve retention

Subgrantees providing services during fiscal year 2013-2014 will be contractually required (as described in the Request for Proposals) to collect, analyze and report their outcomes to AIDSNET on a quarterly basis. Outcomes show an impact on the clients as a result of the services provided and are compared to the measurable objectives included in each Subgrantee's contract. AIDSNET, as part of the monitoring and evaluation process, reviews all outcome reports and provides a written analysis to Subgrantees, when appropriate.

In addition, Subgrantees will be required to submit semi-annual evaluations of their services based on outcomes, other achievements, and barriers to effective service delivery. The reports cover the period of July 1 through December 31 and January 1 through June 30, and must be submitted to AIDSNET by January 15 and July 15, respectively. AIDSNET's staff reviews the evaluations, offers comment on the Subgrantees' accomplishments, and shares the comments with the Subgrantees. The Subgrantees' evaluations and AIDSNET's comments are sent to the PA-DOH by January 31 and July 31, even though the state requires that the evaluation be completed only once a year (January 31).

Overall results of internal and external monitoring and evaluation are shared with the AIDSNET Evaluation and Research Committee and the Allocations Committee to help determine the future direction of the organization and select the most appropriate providers. The reports are also sent to Subgrantees for review and comment as discussed in the monitoring section of this document.

State of the Region Report

Care Services

The services currently being provided in case management (CM) for HIV infected/affected individuals includes Intake, Assessment, Follow-up and Referral, Medical/Medication Adherence, Risk Reduction Assessment and Planning, Patient Care Services[1] and Housing Services[2].

For care services for people living with HIV (PLWH), AIDSNET's six counties are split into two types, urban (Berks, Lehigh, Northampton) and rural (Carbon, Monroe, Schuylkill). The urban counties have sufficient medical, psychosocial and housing services; however, the rural counties have insufficient, sometimes non-existent services, requiring clients to travel to the urban areas for medical care.

AIDSNET has three CM agencies that serve the six counties. All of these agencies also provide prevention services. Two of the CM agencies, AIDS Activities Office of the Lehigh Valley

[1]For the purposes of this document, AIDSNET funds the following services under Patient Care: Outpatient/Ambulatory Medical Care, Oral Health Care, Home and Community-Based Health Services, Home Health Care, Emergency Financial Assistance (which includes Prescriptions and Ryan White Housing Support), Mental Health Services, Medical Transportation, Legal Services, Health Insurance Premiums and Cost Sharing Assistance and Substance Abuse Services - Outpatient.

[2] Short-Term Rent, Mortgage and Utilities (STRMU), Tenant-Based Rental Assistance (TBRA), Permanent Housing Placement and Transitional Housing.

Hospital in Lehigh County (AAO) and AIDS Services Center at St. Luke's Hospital (ASC) in Northampton County, are also Part C providers. ASC also serves Carbon and Monroe counties that have significant resource problems. Most physicians will not sign up with Medicaid or Medicare and there are no infectious disease specialists to service HIV clients. Of the six counties, Carbon, Monroe and Schuylkill have the least medical, psychosocial and housing resources. AIDSNET provides medical transportation services for clients to travel to the Lehigh Valley and to Scranton Temple Hospital for medical services. Our agency does not foresee being able to impact on this type of systems problem but would collaborate with the Pennsylvania Department of Public Welfare (PA-DPW) and/or PA-DOH to recruit medical providers.

CM Standards

Monitoring standards are changing based on U.S. Health Resources and Services Administration (HRSA) requirements, for instance the implementation of semi-annual certification of eligibility for clients to receive Ryan White (RW) services. This change requires the revision of the CM standards. AIDSNET is participating in a state-wide committee addressing these revisions. These standards must also keep current with the changes in medical treatment. It is imperative to reduce barriers for clients in order for them to get the medical treatment they need and any supportive services that will keep them in care. Given the advances in treatment, does every client need to be seen every 90 days? How can the newly instituted semi-annual recertification process influence the CM standards and the frequency of visits? Just like HIV is seen on the continuum, CM needs to make that change. One size does not fit all, especially in light of the upcoming, as yet unknown, further implementation of the Patient Protection and Affordable Care Act (ACA). During the HRSA monitoring visit, a consultant from Oregon talked about the changes they have made, such as more telephone contact with clients, putting into place different levels of CM care depending on where on the continuum the client's needs fall. The committee is looking at this state's standards to begin the process of implementing best practices.

The PA-DOH Part B Quality Management (QM) Committee adopted the HRSA Performance Measures (PM) designed and implemented for HRSA by the National Quality Center. Most of these measures are medically focused following the medical model of caring for PLWH. However, the Part B Committee adopted measures that are in line with the services they fund. The objectives for care services are meeting the national goals or the Pennsylvania Part B goals (when specified). Those PM that do not have goals will be reviewed and benchmarks will be established based on the state-wide data received. These performance measures are fully discussed with scores for Fiscal Year 10-11 in the Strategic Plan section of this document. These PM are replacing the Consumer Holistic Inventory Scale that was used to measure client outcomes.

Quality Improvement Projects

The above committee also designed and implemented a minimum standard that each Region and Subgrantee conducts at least one Quality Improvement (QI) project annually. To this end, a QI Storyboard was designed and implemented. This was discussed at AIDSNET's Planning

Committee on August 30, 2011, which was attended by providers across the region. AIDSNET hosted an all-day training on December 19, 2011, for providers on how to use the storyboard. The storyboard consists of a quarterly breakdown to demonstrate progress on an identified issue, whether it be clinical or administrative. These quarterly reports will be sent to AIDSNET and will be reviewed and technical assistance given when indicated. AIDSNET also mandated that prevention providers perform an annual QI project.

Following is the QI storyboard template:

QUALITY IMPROVEMENT MILESTONES STORYBOARD

Utilizing the FOCUS-PDSA process

Quality Improvement Project: _____ Agency: _____

QUARTER 1
July 1, 2011 - September 30, 2011 Due Date: October 15, 2011

TASK	PROCESS/TOOLS	RESULTS
Find a process to improve or a problem to solve		
Organize a team		
Clarify the Current Situation as it Exists Now:		
1. Review the process – map the process		
2. Identify customers and their expectations		
3. Determine indicators that measure the effectiveness of the process		
4. Collect baseline data from the process		

QUARTER 2
October 1, 2011 - December 30, 2011 Due Date: January 15, 2012

TASK	PROCESS/TOOLS	RESULTS
Strengthen Problem Statement by quantifying the Problem Statement		
Understand and Analyze Root Causes: ID issues, factors or barriers that reduce quality or lead to inefficiencies in the process		
Select a Process to Change:		

1. Based on data - determine which element(s) is(are) the leading contributor(s) to the problem		
2. Determine which element will be changed or improved		
Plan the change:		
1. Develop a "change plan" that address barriers		
2. Determine dates, task assignments, etc.		

QUARTER 3
January 1, 2012 - March 31, 2012 Due Date: April 15, 2012

TASK	PROCESS/TOOLS	RESULTS
Do the change: Agencies will be expected to execute the change plan		

QUARTER 4
April 1, 2012 - June 30, 2012 Due Date: July 15, 2012

TASK	PROCESS/TOOLS	RESULTS
Study the Change:		
1. Collect data & compare it to baseline to determine whether the change plan is working		
2. Determine whether further issues or opportunities need to be address (future QIs)		
Act: Standardize and implement the improvements or select different process if no improvement seen		
Act: Communicate the change throughout your organization		

LESSONS LEARNED: Sharing lessons learned can help us understand how to evaluate and sustain our quality improvement process. Please describe what went well, what went badly and what was lacking during the QI process. Describe any unusual events that caused you to deviate from the process. Assess your technical methods and tools used and offer recommendations for future enhancements or modifications.

Housing

Housing in all six counties is available, but in the rural areas, it is cost prohibitive, with closed public housing lists. Public housing lists in the urban areas have waiting periods of at least two years and some of the clients do not qualify for them because of past criminal and/or drug-related histories. AIDSNET has established a contract with clients who receive housing services funded by the Housing Opportunities for People with AIDS (HOPWA). They are made aware that this is not an entitlement program and that they must demonstrate need. Tenant-Based Rental Assistance (TBRA) is stringently reviewed before authorization because it is ongoing until the client's income changes or they move into public housing. In signing the contracts, the clients stipulate to specific things they will do as part of receiving this assistance. Such stipulations usually have to do with medical and medication adherence and other important aspects of their care. Clients are limited to receiving HOPWA Permanent Housing Placement funding (one month's rent and/or security) every two years. Since this has been put into place, clients are making better decisions about where to live, knowing that they cannot ask for additional assistance for two years. However, under special circumstances, for example a fire or flood, exceptions have been made.

AIDSNET has seen an increasing need for TBRA services and in 2009 had to establish a waiting list policy and implement a waiting list. AIDSNET has seen an increased need for TBRA assistance due to the overwhelming number of people who are living on fixed incomes and are at or below the Federal Poverty Level (FPL). In 2011-2012 there remained such a need that we continue to maintain a waiting list. As of this writing we have seven individuals on the waiting list. We are looking at the possibility of decreasing/not funding other HOPWA services if this upward trend continues.

Approximately 60% of clients are at or below the FPL and have not completed a high school education, making it difficult to separate their financial and psychosocial issues from their HIV needs. Longer survival with HIV disease has resulted in ever-increasing caseloads for case managers. This sometimes leads to case manager turnover. There has been turnover in two of our three agencies. This has the potential for an interruption in the continuity of care until the client becomes more trusting of a new CM. However, there are some occurrences when a client receives extra support during the transition. To insure retention, AIDSNET works with CM agencies to find ways to ensure staff retention, which is important for continuity of care and establishing long-term trusting relationships with the clients.

AIDSNET Leadership

AIDSNET's Board is strong and participates in committees, which improve the provision of services by AIDSNET. This, in turn, provides opportunities to improve client services. A significant percentage of Board members are clients in case management agencies mentioned earlier in this document. The Marketing Committee is investigating resources that might lead to increasing AIDSNET's fund balance. The Board is inviting political representatives from the six counties and on the Federal level to attend our Annual meetings.

AIDSNET's HIV Information for Victory (HI-V) continues to meet bi-monthly and plan its annual consumer educational summit. This planning consists of selecting the location of the summit, agenda, speakers and activities. The lack of support groups in the region and issues surrounding HIV and aging continues to be topics for discussion. The HI-V group is currently investigating ways in which to establish a peer support group to provide newly diagnosed clients with support, guidance and hope from long-term survivors, while fostering friendships. The goal is to get a local support group up and running; and if successful, present their model to the AIDSNET Board and Allocations Committee and other organizations for funding consideration. The group also envisions the support group as a tool to increase client retention and involvement and decrease isolation. In light of continued funding cuts, the group is also investigating ways to raise funds for the annual summit, other HI-V group initiatives, and AIDSNET care and prevention services.

AIDSNET's Allocations Committee has grown in size and expertise. Committee members are more sophisticated about the funding issues and changing standards. The change from two-year contracts with providers to one-year contracts with the option to renew for four years will be a big change for staff, providers, and the Allocations committee. PA-DOH foresees that renewal years will not incur responding with a proposal, but be an update. AIDSNET had established a Request for Information (RFI) going into the second year of the provider's grant. This document was a way for providers to inform us of their progress throughout the first year of the two-year grant, identify successes/challenges, and provide a plan for the next year to accomplish goals and overcome those challenges. Therefore, providers are used to providing updates to AIDSNET and the decreased administrative burden on AIDNET and its providers will be significant. Whatever changes occur, providers will be included in the planning and implementation process.

Prevention Services

Discussions about HIV testing, reducing risk behaviors, and staying healthy can all take place within a healthcare provider's sphere of influence.

1. Physicians already play a crucial role in HIV testing:
    - Approximately 53% of HIV tests are done by either a private physician or an HMO. 17% of these tests have positive results.
    - Approximately 18% of HIV tests are done in a hospital, emergency department, or outpatient clinic. 27% of these tests have positive results.

However, more people need to know their HIV status. Because about 1 in 5 of the more than 1 million persons living with HIV do not know it, HIV testing is critical.

2. The majority of new sexually transmitted HIV infections are transmitted by those unaware of their infection.
    - Learning one's HIV status has been shown to result in substantial reduction in risk behavior.
    - Patients listen to healthcare providers' advice.
    - Persons living with HIV who receive prevention services by a health care provider show significant reduction of unprotected sex over time.

- Providers can link patients to prevention services available in their communities.

Unfortunately, not all healthcare providers are talking to their patients about HIV. The Centers for Disease Control and Prevention (CDC) has resources to help providers talk to patients about HIV.

3. As part of its Act Against AIDS campaign, CDC has campaigns for physicians.
    - Prevention is Care (PIC) provides tools for physicians to talk to patients living with HIV about safe behaviors and staying healthy.
    - PIC was developed with input from physicians and other healthcare providers.
    - Nearly 800 physicians have been formally trained; and more than 8,000 full kits, as well as 25,000 individual campaign materials, have been distributed across the country to providers.

AIDSNET's prevention planning committee is made up of local providers from four of the six counties and the Allentown & Bethlehem health bureaus. We have begun a collaboration with the Philadelphia PA AIDS Education Training Center (PAETC) to plan a conference that will reach private physicians and educate them about the importance of testing and the changes in the requirements for pre-test counseling that took effect in late August 2011.[3]

The services currently provided by AIDSNET-funded prevention agencies include Interventions Delivered to Individuals (IDI) and Interventions Delivered to Groups (IDG). These interventions are targeted toward PLWH and high risk individuals. Over the last several years there have been many changes in the field of prevention, including definitions of prevention, the CDC's annual estimate of new HIV infections, the implementation of prevention standards, changes in monitoring of prevention agencies and the implementation of Effective Behavioral Interventions (EBI), to name a few. Providers have made significant progress in moving from quantitative to qualitative services since the significant changes in how prevention interventions are provided.

Within the Lehigh Valley (LV), there are four prevention agencies contracted by AIDSNET so there needed to be collaboration among these prevention providers to avoid any duplication. They jointly planned and chose different populations to reach so everyone wasn't selecting the same EBIs or if they did, they were focused on different high risk populations.

There are several barriers to delivering quality prevention services consistently. The biggest barrier is provider staff turnover. Entry-level prevention workers are not required by the PA-DOH Prevention Standards to meet any minimum education requirements or qualifications for providing prevention interventions. Many of the positions require bi-lingual capability. Being bi-cultural increases the ability to reach certain targeted populations. However, once a prevention worker learns various skills, s/he often leaves to accept a higher paying position with another agency. If that happens, all the resources used to train that person are lost. If the agency is conducting an EBI, the lack of a trained facilitator means that the provision of the intervention must be put on hold. Over the years, AIDSNET has strongly recommended that agencies providing prevention services hire full-time prevention workers. Following that

[3] Full details can be found in the Needs Assessment of this document

recommendation, approximately 75% of our prevention providers have full time prevention staff. This has cut down a significant amount of turnover and improved the quality and consistency of the services being delivered because a full-time worker usually is more invested in that position than a part-time worker. With the EBI interventions, it is also recommended that prevention providers have multiple staff trained in each intervention they are providing in the event of staff departure**.** Some prevention staff decides that the salary they receive is not fair compensation for the services they provide and is not adequate to meet their personal needs. In the last several years, we have seen a marked increase in the level of education the prevention staff has achieved. At this point in time, 75% of those who provide prevention interventions in the six counties have either an Associate's or Bachelor's degree.

Standardized minimum training has been put into place by the PA-DOH for prevention staff, but in-depth ongoing training is not always available locally or regionally. The CDC has sharply cut back on the availability of trainings for EBI, which puts the financial burden on the providers. As mentioned above, if a provider does send the prevention worker to training and that person leave**s** the agency, all of those spent resources are lost; and the agency will not be able to continue to provide the intervention until another staff member is hired, and training becomes available. In AIDSNET's Request for Proposals, applicants were encouraged to consider the cost of training for DEBI when calculating their unit cost.

One of the consequences of going to EBI is the limited focus toward high-risk populations that providers can implement in their communities due to the resource rich (funding, staff, and time) aspect of EBI interventions. In other words, reaching high-risk populations are limited to the ability to fund, train and implement these interventions. One of the positive aspects of implementing these interventions is the intensive training that is involved in preparing for each DEBI. These trainings have increased prevention staff's skills.

Some agencies will not have the capacity to provide these types of interventions due to lack of staff, or their focus is not on the high-risk populations cited by the CDC. For instance, one agency focused on Latino youth, implementing Cuidate, but it was not focused on the core goal of testing, finding positives and referring them to care. All will be limited to the types of individuals engaged in high-risk behaviors they will be able to reach through these interventions. In other words, they will have to prioritize the targeted behaviors they will be reaching based on the local transmission rate and demographics due to the specificity of the interventions and the degree of difficulty in recruiting and retaining participants. This is a learning process and even though the agencies have conducted an in-depth assessment of the provider's capability and resources to implement interventions, sometimes the biggest barriers are in the interventions themselves. Agencies have been advised to pick those interventions that have the least amount of sessions, but continue to experience difficulty in recruitment and retention. Providers are now in the process of looking over the last year, evaluating their successes and identifying those interventions that did not work.

The Treatment Cascade [4]

This year at its 2012 conference, The National Minority AIDS Council (NMAC) is discussing a potential new model for HIV prevention and care services that incorporates the recent bio-medical advancements [e.g. Treatment as Prevention (TasP), Pre-Exposure Prophylaxis (PrEP), etc.] with the implementation of the National HIV/AIDS Strategy (NHAS) for the U.S. and the ACA.

The premise of this model is to move people living with HIV along the treatment cascade so that approximately 81% of people living with HIV in the U.S. know their HIV status and have a suppressed viral load. This model asks Health Departments and Community-Based Organizations to:

- Identify people who do not know they are HIV positive
- Increase linkage to and retention of PLWH in high-quality care
- Improve treatment adherence among PLWH to achieve a suppressed viral load

This model reflects the massive change in the prevention paradigm. According to the CDC, only 41 percent of all PLWH are retained in care and only 28 percent have their viral load suppressed.[5]

It is imperative that a reduction of transmission by people who know their positive HIV status is achieved by facilitating retention in care, antiretroviral therapy treatment adherence, and continued suppressed viral load. It is well understood that reduction of the viral load is linked to reduction of transmission risk. The next focus is testing people to find out who is positive and do not know their status. Once linked to care, the focus again is to facilitate retention in care and treatment adherence with the goal of reducing viral load to undetectable levels. This is a much more focused approach to prevention, getting away from a community-based model. Certainly, the EBI that are focused toward reaching those who are positive have become the 'gold standard' along with increasing HIV testing efforts.

The progress of training and implementing EBI is described in more detail in the Strategic Plan section of this document.

[4] http://nmac.org/ending-the-epidemic/models-to-end-the-hivaids-epidemic-in-america/
[5] Vital Signs: HIV Prevention Through Care and Treatment — United States, December 2011 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6047a4.htm?s_cid=mm6047a4

12. Quality Management

The U.S. Health Resources and Service Administration's (HRSA) HIV/AIDS Bureau (HAB), an agency of the United States Department of Health and Human Services, has lead responsibility for implementing all parts of the Ryan White HIV/AIDS Modernization Act (ACT). HRSA sent guidelines to all states for instituting a quality management (QM) process. The Pennsylvania Department of Health (PA-DOH), in turn, set up a quality management (QM) committee to begin the process of implementing these guidelines. The committee consists of PA-DOH staff, as well as representatives from all coalitions and other parts of the ACT.

As AIDSNET has established and implemented an on-going QM Plan, staff has identified the following steps that are part of the QM process:

1. Hold quarterly brainstorming sessions among staff to identify ongoing QM efforts and results, as well as new ideas for Quality Improvement (QI) projects;
2. Establish AIDSNET, Subgrantee and Client Level Outcomes, Tracking indicators, and Benchmarks to measure the quality of care, support and prevention services and assess the effectiveness of the QM program;
3. AIDSNET will use its QM process to identify issues that may impact on Subgrantees. As these issues occur, AIDSNET staff will assist the Subgrantees in using the QI process for resolution. Identify projects for improvement from results of evaluation of the data and process; modify action steps for each project, if necessary, based on the results of the data evaluation;
4. At least one staff member will attend relevant QM training sessions to learn tools and techniques. These skills will, in turn, be passed along to other staff, as well as AIDSNET's Subgrantees; and
5. Each AIDSNET Subgrantee will be required to develop an HIV-specific QM plan and conduct at least one QI project annually.

AIDSNET has developed and implemented its QM plan. Staff used the operations cycle of the agency (See Appendix G) to form standards and objectives for each process the agency puts into place. The evaluation measures were also established. QM is part of the standing agenda for one of the two monthly staff meetings. There are written logs, charts and other tools used to measure outcomes and steps taken to remedy issues that arise. The logs provide documented evidence of the process. Further refinement of the QM plan will focus on the inclusion of contract deliverables by the Subgrantees and AIDSNET's evaluation of the results and action steps as required.

AIDSNET'S QUALITY MANAGEMENT PLAN

I. OVERVIEW & QUALITY STATEMENT:

AIDSNET is responsible for ensuring that Persons Living with HIV Disease (PLWH) in the diverse counties of Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill receive the highest quality care, support, and prevention services, that the system of care is accessible for hard-to-reach populations, and that services respond to trends in the local epidemic. It is also our mission to ensure that quality prevention services are provided throughout the region. To this end, AIDSNET, as the recipient of Pennsylvania Department of Health (PA-DOH) HIV/AIDS funding has developed a Quality Management Plan (QM) for the region.

AIDSNET's goal for quality management of care and prevention services is to assess high quality data to continually improve access to high quality HIV care and support services and effective prevention interventions. We seek to make continuous improvements for the care system to be better tomorrow. The agencies that are funded by AIDSNET (Subgrantees) have QM plans that are coordinated with planning activities and embedded in AIDSNET's administrative activities which include procuring and monitoring a multi-agency system that provides both HIV case management and prevention services.

AIDSNET covers a large and diverse six-county region. The region includes the third largest city in Pennsylvania (Allentown), other smaller cities, suburban counties and rural areas. There are three Ryan White (RW) HIV/AIDS Modernization Act Part B funded service providers, two of which also receive RW Part C funds. There are currently five agencies providing care and prevention services to PLWH and the communities in the region. As of December 2011, there are 2,722 people living with HIV in the region, with a majority living in Allentown, Bethlehem and Reading. Latinos comprise 40% of the PLWH in the region. African Americans are also disproportionately represented in the epidemic accounting for 20% of HIV cases. The risk profile for the region includes significant Heterosexual (30%), IDU (27%), and MSM (22%) populations.

AIDSNET administers the PA-DOH grant for the region, which includes RW Part B and Housing and Urban Development (HUD) Housing Opportunities for Persons with AIDS (HOPWA) federal funds, as well as Pennsylvania State 656 prevention funds. To carry out our mission, AIDSNET examines the needs and trends of the region and develops a plan to meet those needs, given federal and state funding constraints. Oversight includes, but is not limited to, financial and programmatic reporting to the state, as well as financial and programmatic monitoring of Subgrantees.

Given the diversity of the region, it is also AIDSNET's goal to integrate all quality management expectations for the region. That is to say, AIDSNET works with requirements from Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), HUD and PA-DOH, to create a cohesive, unified approach to QM. We strive to streamline reporting requirements and mechanisms, provide leadership locally

and statewide in implementing QM, and undertake innovative activities to evaluate and improve the quality of services people with HIV receive.

The region's QM program includes quality assurance, outcomes monitoring and evaluation, and continuous quality improvement. All of the QM activities that AIDSNET undertakes fall within one or more of these domains and are supported by:

- Efforts to support a culture of quality at all levels of the system;
- Defined service standards;
- Defined performance measures;
- Defined client level outcomes;
- Defined system level outcomes; and
- High quality data for decision-making: at the care level, for planning, for program monitoring, and service procurement.

Quality assurance encompasses the degree to which the providers adhere to the service provisions that define the administrative and programmatic requirements for each service category. These standards are based on Public Health Service (PHS) guidelines for medical care for PLWH, other federal guidance such as the Morbidity and Mortality Weekly Report (MMWR) for prevention with positives, as well as professional and locally developed guidelines. The service provisions describe requirements for staff training, service procedures, documentation, reporting, and participation in AIDSNET's QM activities. These standards are promulgated in Requests for Proposals and incorporated into contracts. Another component of quality assurance is the Subgrantees formal grievance process that responds to objectives in the AIDSNET Comprehensive Plan calling for an efficient process to handle client conflicts and concerns with their services and to analyze trends for use in planning.

Outcomes monitoring and evaluation tracks performance with respect to client outcomes, specifically, how the client has benefited from the service. The care outcomes are derived from the Part B Statewide QM Committee that also uses HIV/AIDS Bureau (HAB) guidelines and professional standards. In addition to client level outcomes, the QM plan monitors systemic outcomes, including the accessibility of services to minority populations, the uninsured, and other populations of concern.

Continuous quality improvement (CQI) focuses on solving problems to improve processes and the overall system and to ensure delivery of exceptionally high quality care and prevention services, and customer satisfaction. CQI projects are required of all funded providers. CQI links to outcomes evaluation and performance management in that low performance for an outcome is one factor that triggers the grantee initiating a CQI plan.

II. QUALITY INFRASTRUCTURE:

Framework

The QM Plan is overseen by AIDSNET's Quality Management Committee which is responsible for planning, directing, coordinating and improving services provided in the

region. The committee is convened by Greg Reppert, Board Chair; Dr. Judith Lasker, Research and Evaluation Committee Chair; and Ann Stuart Thacker, Executive Director. The committee meets quarterly to review HIV care and prevention services and to facilitate coordination between these systems. They also track trends, decide next steps for the QM Plan and monitor performance of the entire system of care.

Quality Management activities are a shared responsibility among all AIDSNET staff. The executive director provides leadership and guidance for the QM activities. The Quality Management Team, Victoria McKinzey-Gonzalez, Program Manager, and Robin Haydt, Fiscal Officer, oversees the QM activities and monitors AIDSNET and Subgrantee CQI projects. The team is also responsible for the consumer grievance process, providing QM expertise for case management and prevention services, identifying training needs as part of quality improvement efforts and has lead responsibility for developing, implementing, and coordinating HIV care and prevention QM activities for the region.

The QM Team is supported in their activities by Carol Vanderhoff, Program Specialist and Cindy Berish, Administrative Assistant. They meet monthly and together:

- Provides technical support to Subgrantees for data collection and management;
- Collects and analyzes Subgrantee and client level data;
- Evaluates the quality of services;
- Assists Subgrantees in identifying quality improvement projects; and
- Monitors implementation of continuous quality improvement processes.

Subgrantees are required by contract to have internal CQI processes aimed at identifying and solving problems, improving processes, and ensuring delivery of quality services and high customer satisfaction.

When an opportunity for improvement is identified, an action plan is developed by the appropriate individual(s) (e.g. staff member closely associated with the process, committee of Subgrantees responsible for providing a particular service, committee convened to address a particular service area). CQI methodology will be utilized and will include, but not be limited to:

- Plan/Do/Study/Act (PDSA)
- Brainstorming
- Observational Studies
- Activity Logs

Improvement plans that will be developed and implemented may include:

- System Redesign
- Education/Training (AIDSNET staff and Subgrantees)
- Procedure and/or policy changes
- Form development and/or revision

All QI activities and progress are reviewed by AIDSNET staff during its regular staff meetings. Progress and results of QI activities will be reported to staff and the Board (internal stakeholders) and external stakeholders such as HRSA, HUD, PA-DOH, service

providers and consumers through email, mailings, meetings (including AIDSNET's Annual Meeting), Annual Report, required reporting and other appropriate means.

III. ANNUAL QUALITY GOALS:

The annual goals for quality improvement for fiscal year 2013-2014 are as follows:

1. To annually assess how well all AIDSNET and Service Provider agencies are carrying out their QM programs through monitoring of plans and review of QI Storyboards;
2. AIDSNET and Service Providers will routinely gather data for all established Part B performance measures;
3. To improve capacity to carry out quality improvement; and
4. AIDSNET and Service Providers funded by Ryan White will develop or implement one quality improvement (QI) project annually

IV. PARTICIPATION OF EXTERNAL STAKEHOLDERS:

AIDSNET's external stakeholders include any group that has a potential funding or programmatic impact upon any of the region's services. These stakeholders include the Pennsylvania HIV Planning Group (HPG), HRSA, HUD, PA-DOH, the other six Consortia across the state, service providers and consumers, the local health bureaus and other community agencies.

AIDSNET is required to report its QM activities and progress to the PA-DOH in its quarterly narrative and CRSSP. The report consists of quarterly data updates on the progress for a series of performance measures. In turn, the PA-DOH reports this data to HRSA, HUD and other applicable federal and state entities. AIDSNET staff also serves on the Part B Quality Management Committee.

Participation of Subgrantees occurs through involvement in the Service Coordination and Prevention Education Advisory Councils, and serving on various committees, such as the AIDSNET Planning Committee. Subgrantees also work together to research and/or develop best practices for the provision of care and prevention services. These best practices are shared with providers across the region and state to help ensure continuity of high quality services.

Consumer participation occurs in a variety of ways throughout the quality management program. AIDSNET maintains a consumer advisory council and in April 2012 we issued a client satisfaction survey for individuals receiving HIV case management and/or medical care at one of the four CM Subgrantees in the region. AIDSNET also seeks key-informant consumer input on specific aspects of the QM program from time to time.

V. CAPACITY BUILDING – DEVELOPING A CULTURE OF QUALITY:

Capacity building for service providers starts with AIDSNET offering peer meetings and group discussions on basic QM concepts, best practices, and using data; sending out advisories for upcoming QM trainings and webinars; and providing technical assistance. State and regional QM requirements and Performance Measures are shared with the Subgrantees in preparation of the development and submission of their annual quality improvement plans (included in their Request for Proposal). Case Management Subgrantees are expected to monitor their performance data, entered into CAREWare, and upload to the Statewide Web Portal bi-monthly. AIDSNET collects and analyzes the performance data from the CM Subgrantees and provides an annual summary of regional performance.

Performance data is also shared with the internal stakeholders (e.g. AIDSNET Board and staff) and with service providers in both aggregate and individual provider formats. External stakeholders will be provided with aggregate and blinded provider-level data as needed for a given purpose.

VI. ASSESSMENT AND EVALUATION:

Regular review and assessment of the QM program and plan, and quality improvement projects is critical to the program's success in sustaining improvements over time. AIDSNET assesses implementation of its QM program through 1) review of progress in quarterly Quality Management Committee meetings and regular staff meetings (described in the Quality Infrastructure section); 2) formal reports to the Part B QM Committee and participation by AIDSNET staff in its planning activities; 3) quarterly and annual progress reports to HRSA and HUD; and 4) CRSSP and quarterly narrative reports to the Pennsylvania Department of Health. Through this ongoing review process, AIDSNET will determine if data warrants further evaluation; if the performance measures and outcomes are appropriate to assess HIV care, support and prevention services; identify opportunities for improvement; and prioritize AIDSNET and region-wide QI activities.

AIDSNET assesses the quality of services rendered by Subgrantees through a number of standardized procedures. Activities related to quality assurance and continuous quality improvement are monitored through Subgrantee bimonthly performance measures reports on data submitted to the Web Portal, mid-year and year-end QI Storyboard reports, quarterly prevention reports on PaUDS data, performance measures outcomes, narrative reports, site visits, and through the RFP process. Monitoring tools specific for each service category have been developed for use by the PA-DOH for site visits to determine the extent to which providers meet defined service category standards and contractual obligations.

Consumer feedback is also formalized: (1) all Subgrantees are required to have their own internal process for feedback; and (2) AIDSNET responds to consumer grievances about funded services through a grievance procedure. Complaints are documented and investigated by the Executive Director and if necessary, resolved with the assistance of the Board. Resolutions of the complaints are shared with the consumer and Subgrantee in question. The goal is to ensure the client receives the services for which he or she is eligible, that the

services are high quality, that decisions are based on the facts and funding guidelines, that the consumer has a voice, and that Subgrantees are held accountable.

VII. PERFORMANCE MEASURES

a. For those CM agencies that are also Part C funded and have its own HIV medical clinics, the following indicators are being monitored. Please see Appendix D for the complete description of performance measures.
    - Medical visits
    - CD4T-Cell Count
    - PCP Prophylaxis
    - HAART
    - ARV Therapy for Pregnant Women
    - Viral load Testing

b. The following indicators are being monitored in **all** CM agencies
    - Mental Health History and Treatment Status
    - Substance Abuse History and Treatment Status
    - Documentation of Retention in Care
    - HIV Risk Counseling
    - Medication Assessment and Counseling
    - Case Management Training
    - Organizational Assessment

VIII. AIDSNET's Workplan for 2013-2014

OVERALL GOALS AND OBJECTIVES:

I. Use quality management programs to ensure that the quality of Part B services being delivered to patients meet or exceed professional standards and client/customer expectations

II. Use quality management programs to ensure that regional planning and administration meets or exceeds customer expectations (customers include the Department of Health, HRSA and the direct service providers with whom we subcontract)

Note: a quality management (QM) program includes the collection, analysis and use of data to make key programmatic decisions; the use of established quality improvement tools and processes to continuously improve programs and services; and the establishment of a quality infrastructure to ensure both the sustainability and the effective and efficient management of the QM program.

GOAL 1. To annually assess how well all AIDSNET and provider agencies are carrying out their QM programs

Key needs assessment findings supporting this goal: The Pennsylvania All-Parts QM initiative has utilized the NQC assessment tool twice in the past to collect

information about the state of QM in the Commonwealth. The assessment has showed both the progress being made in Pennsylvania and highlighted the areas most in need of improvement. This data can be sorted to show only the Part B information. It is critical that AIDSNET and Part B providers be evaluated each year to determine if progress is being made.

Objective: AIDSNET and its Part B Service Providers will have a QM plan (To ensure that all Part B service providers are developing and implementing QM plans that both meet HRSA and Department of Health requirements and are in harmony with the statewide all-parts plan).

Key Action Steps

- AIDSNET will develop a QM plan that is updated annually and follows the NQC Guidelines.
- AIDSNET will internally review and evaluate their QM plan.
- AIDSNET will submit their QM plan for review and incorporate Department of Health feedback.

Objective: Providers will have a QM Plan

Key Action Steps

- Each provider will develop a QM plan that is updated annually and follows the NQC Guidelines.
- Each provider will internally review and evaluate their QM plan.
- Each provider will submit their QM plan to AIDSNET for review.
- AIDSNET will provide feedback to their providers on the QM plan.
    - Completed during November/December 2011 monitoring and will be completed on an annual basis

Objective: Implement workplan for Part B Quality Management Plan

Key Action Steps

- AIDSNET will develop a workplan that is updated annually.
- AIDSNET will submit their workplan for review and incorporate Department of Health feedback.
    - This process has not been formalized by the Part B QM Committee

GOAL 2. AIDSNET and service providers will routinely gather data for all established part B performance measures

Key needs assessment findings supporting this goal: The Part B QM committee has established performance measures that represent the most important aspects of HIV service delivery. A system exists to collect and tabulate some of these performance measures, but for others there is no system yet established for statewide collection and tabulation of data. For all performance measures there is

a need to ensure the data is collected accurately and routinely. Finally, a system must be developed to analyze the data and use it to guide improvement activities.

Objective: Establish implementation plan for Administrative, Planning and Evaluation (APE) Performance Measures (PM).

Key Action Steps

- AIDSNET will receive the performance measures from the Part B QM Committee for use in implementation plan.
- AIDSNET Committee will submit performance measures to the Department of Health for review.
- AIDSNET will draft an implementation plan for APE performance measures approved by the Department of Health
- AIDSNET will incorporate Part B QM Committee feedback and resubmit the implementation plan for Department of Health final review.
    - AIDSNET APE PMs for 2011-2012 were collected and all met, but have not been submitted as they are currently under review by the PADOH and the Part B QM Committee.

Objective: Establish implementation plan for HRSA performance measures.

Key Action Steps

- Establish process to ensure that all providers are gathering and submitting data to the web portal on each of the established performance measures.
    - The initial reporting from the case management (CM) agencies showed marked discrepancies between what they were reporting in CAREWare and the activities they were actually doing.
    - AIDSNET's Program Specialist (PS) reviewed methodology for reporting PM at each CM agency.
    - Inconsistencies were found between CM agencies as to where they were recording PM in CAREWare.
    - All providers received individual technical assistance to insure that they would be reporting PM correctly and consistently.
    - Results demonstrated more accurate reporting.
- Insure that all providers respond to the Web Portal survey for administrators and providers provided by the Part B QM Committee. The Department of Health will initiate the electronic survey.
    - All providers received technical assistance as to the method of reporting PM to the web portal and their reporting improved over time.
    - Currently, the web portal, now known as the Virology Portal, has been redesigned and piloted in two regions. AIDSNET is anticipating receiving training and will also have all CM agencies present.

Objective: Develop performance measures for prevention providers.

- The above objective has been put on hold by the Part B QM committee.

GOAL 3. To Improve Capacity to Carry Out Quality Improvement.

Key needs assessment findings supporting this goal: There are over 100 Part B service providers in Pennsylvania and previous statewide QM assessments demonstrated that many organizations needed technical assistance or training to help them improve their capacity to carry out quality improvement programs.

Objective: Improve capacity of providers to carry out quality improvement projects.

Key Action Steps

- Identify Part B funded provider capacity based on findings and conclusions from statewide organizational assessment.
- Analyze and summarize current capacity building plans of Part B providers.
- Based on above analyses, develop specific action steps to address QM capacity deficits among Part B providers.

Objective: Strengthen capacity of AIDSNET's QM committee

Key Action Steps

- Utilize various resources to include but, not limited to: QM 101 Trainings, NQC Quality Academy Tutorials, NQC Quality podcasts, NQC National Technical Assistance Calls, NQC Training-of-Trainers (TOT) Program, NQC Training of Quality Leaders (TQL) Program, HRSA/HAB Webcasts/Calls, HAB Information Emails and HIVQUAL Web-based Trainings to strengthen the capacity of the AIDSNET's QM committee.
  - Members of AIDSNET staff have completed the HRSA Continuous Quality Improvement tutorials (required) and are strongly recommended to attend future tutorials addressing QM.
  - AIDSNET is currently recruiting members from board and community to become active on the QM committee following a number of resignations.
- AIDSNET will be prepared to offer guidance and suggestions to providers. Topic and responsibility will be rotated with discussions taking place during the bimonthly face to face meetings.
  - AIDSNET's Program Manager monitors QI plans and implementation of all providers, including prevention.
- AIDSNET will review the on-line list of selected topics for the NQC National Technical Assistance
  - The Part B committee communicates upcoming NQC webinars.

- All Coalitions will assess each other's QM plans for the coming fiscal year and offer recommendations for improvement.
  - This is done annually by the Part B QM Committee, as well as the QM specialist at the Department of Health.

Objective: Improve the capacity of Providers to carry out QM programs.

Key Action Steps

- Utilize various resources to include but, not limited to: QM 101 Trainings, NQC Quality Academy Tutorials, NQC Quality podcasts, NQC National Technical Assistance Calls, HRSA/HAB Webcasts/Calls, HAB Information Emails and HIVQUAL Web-based Trainings to improve the capacity of AIDSNET and Providers.
- AIDSNET will identify specific QM items to address with their Providers. (i.e. updates or changes that should be made to QM plans).
- AIDSNET and Providers that is directly responsible for oversight of their QM plan will receive at a minimum QM 101 Training. Training approach (presentation, training modules, etc) and calendar dates will be dependent on the audience.

<u>GOAL 4.</u> AIDSNET and all providers funded by Ryan White will develop or implement one Quality Improvement (QI) improvement project.

Key needs assessment findings supporting this goal: QM is more than just collecting performance measures - it is also about undertaking quality improvement projects when the data indicates improvement is needed. There is evidence that many AIDSNETs, s and service providers do not regularly undertake quality improvement projects.

Objective: AIDSNET will plan/implement one quality improvement project during the year (i.e. CAREWare survey).

Key Action Steps

- AIDSNET will identify possible QI projects to implement. The committee will select one of the suggested QI projects to implement during the year.
- AIDSNET will discuss the process and resources needed to complete the QI project.
- AIDSNET's QM Committee will utilize all available resources to complete its quality improvement project by the end of the fiscal year.
- AIDSNET'S FY 13-14 QI PROJECT
  - Assess, identify, plan, and implement necessary changes in processes that will require modifications both at the consortia and provider level as a result of implementation of HRSA guidelines, ACA, and/or PA-DOH processes.

Objective: Service providers will plan and implement one quality improvement project during the year.

Key Action Steps

- Each service provider will identify possible quality improvement projects to implement. The service provider will select one of the suggested quality improvement projects to implement during the year.
- Each service provider will discuss the process and resources needed to complete the quality improvement project.
- Each service provider will utilize all available resources to complete its quality improvement project by the end of the fiscal year.
  - AIDSNET's Program Manager monitors QM plans and implementation of QI projects of all subgrantees, including prevention. Plans are submitted annually with the Request for Proposal; annual QI projects are identified and submitted using the QI Storyboard on or before July 1st of each fiscal year with a mid-year update report (due 1/15) and end-year final report (due 7/15)

AIDSNET is represented on the State Part B QM Committee that has been charged with insuring that providers in each of the seven coalitions are implementing the QM policies and procedures as outlined by HRSA. As part of the committee, we are charged with developing a standardized QM implementation plan for the consortia throughout the Commonwealth in order to insure that all RW-funded agencies have a QM Plan and QI projects in place that are updated, implemented and evaluated annually, as is contractually required. A standardized set of policies and procedures, definitions and QM criteria are used to measure compliance of Subgrantees QM plans. Across the state, the seven coalitions use the National Quality Center's checklist for the review of an HIV-Specific Quality Management Plan. Below are the domains of a QM plan that are checked by AIDSNET staff when monitoring Subgrantees. See Appendix H for the complete document.

1. Quality Statement
2. Quality Infrastructure
3. Performance measurement
4. Annual quality goals
5. Participation of stakeholders
6. Evaluation
7. Capacity Building
8. Process to update the QM plan
9. Communication
10. Formatting
11. QM plan implementation

The QM Plan measures the quality of services and processes, as well as identified areas where quality can be improved. Currently all of AIDSNET's Subgrantees have a QM plan in place. The plans are required to be updated annually and must address the specific services they provide that are funded through AIDSNET. The sophistication and detail of the plans

are varied. Many of the agencies that only provide HIV prevention services are small and struggle adhering to the required infrastructure; the programs that are part of a larger agency have incorporated the provision of HIV services into its organization's QM plan.

AIDSNET will plan and provide training and technical assistance to assure that there is a structure in place identifying members of the QM Team, documentation of the process and a completed annual QI project. QM plans and QI projects will be reviewed during on-site visits, becoming part of the monitoring process and the annual Evaluation of the Quality of Services report. During the fall of 2011, all providers across the region were monitored for QM plans using the above standardized checklist. In addition, copies of completed QI project(s) completed during the last fiscal year and reported on the final QI Storyboard were reviewed. The following table lists a sampling of QI projects undertaken by Subgrantees during the 2011-2012 fiscal year. These results are also included in the Evaluation section of this document.

Table 1: 2011-2012 Subgrantee Quality Improvement Projects			
Subgrant Agency	QI Project/Goal	Interventions, Findings & Results	Next Step(s)
AIDS Activities Office of the Lehigh Valley Hospital (AAO)	Reduce "No Show" rate in HIV clinic from 20% to 15% in 6 months – to 10% in 12 months	Too many clients not showing for appointment and not calling to cancel, even with reminder calls that are provided two days prior to the appointment. Baseline Data: 265 Scheduled; 51 No Shows = 19% No Show Rate Focused QI project on approximately 60 clients that have missed at less 3 appointments and did not call to cancel. Used CAREWare to track clients that "No Show" and sent survey. Top reasons given for "No Show" were – don't feel well, weather conditions, and too far to come. Staff also noted that clients are moving and change phone numbers without informing staff making reminder calls impossible. Since AAO cannot change the reasons why a client does not show, decided to focus on the importance of a client calling to cancel or reschedule their appointment. Developed a "No Show" policy and posters with stop light giving a visual of the policy. Reminder calls will continue to be made until a live person can be reached to leave the appointment information with. "Frequent flyers" will not be given a scheduled appointment, but will be given a day to come in & have to wait to be seen when there is an opening. The new policy was sent to the 60 clients originally identified and the "No Show" poster was sent to all active clients. Overall there was a slight improvement in the "No Show" rate. The average no show rate for 12 months was 16% (666/4151). The best month was October with a no show rate of 12% (39/331).	Monthly monitoring of "No Shows" will continue and monthly stats will be shared with the team. Additional appointment phone calls will continue to be made until a live person is reached to provide the appointment information. Staff continues to stress the importance of clients keeping their appointments or calling to cancel. The AAO will continue to look at this problem and develop strategies help reduce the no show rate.

AIDS Services Center at St. Luke's Hospital (ASC)	Identify barriers to clients receiving Mental Health screenings, referral to appropriate care and follow-through/completion	Currently CMs and clinic staff are only required to document mental health status. Clinic staff uses a screening survey at least once a year to identify mental health status. Case managers rely on self-report from the client to identify mental health history. Once the status is documented, if documented at all, there is no referral process in place for treatment for those who are identified as having a mental health history. Case managers and clinic staff do make referrals to Lehigh Valley Mental Health and Bet-el, but there are long wait lists and the referrals seldom go through. As a result, there are ASC clients and SLH clinic patients in need of mental health treatment who are not receiving it. Furthermore, there is no system in place to address clients and patients who have a mental health history, but who are refusing treatment. Total open ASC clients=201 Did client receive a mental health screening at least once during the fiscal year? NO=27% (n=54) YES= 73% (n=147) Of those who received a screening, 50% (n=74) did **not** have a mental health history 50% (n=73) yes, did have a mental health history Of those who have a mental health history, 4% (n=3) refused treatment 25% (n=18) are not receiving treatment	This project is ongoing as the protocol continues to be tweaked and the data reevaluated for improvement.
Co-County Wellness Services (CCWS)	Develop a strategy to ensure that 100% of new clients, clients new to treatment and clients experiencing difficulty with treatment are referred for adherence education/ counseling	Using CW data, the team identified that the percentage of clients receiving adherence was low and that some clients in need of the service had not been referred; through review and discussion they concluded that there was a lack of clarity and consistency around adherence referrals; an internal protocol was established and implemented; an additional process was instituted to monitor that medical providers were also referring appropriate clients for adherence services; since implementation, they have seen a marked increase in the number of adherence referrals	The team continues to monitor and evaluate the protocols and make adjustments as necessary.

Keystone Farmworker Health Network (KFP)	Develop a systematic way of tracking and documenting service delivery, including follow-up services	A work plan was written and implemented for use by the prevention worker to help track that documentation and follow-up was completed in a timely fashion; after the initial implementation of the work plan the team noticed that factors other than clients were the cause documentation was not being completed; the work plan was rewritten to address these findings and ensure that task don't fall through the cracks; a weekly review of the revised work plan has provided ongoing evaluation and an opportunity to analyze how well certain tasks are being completed; the written record has also improved efficiency (i.e. providing a better record to help the track the influx of new Farmworkers and increase follow-up)	After using the format for one fiscal year, they will revisit it to decide if additional changes are necessary; one change that has already been suggested is adding a section to track unexpected activities that arise and take precedence over the plan; this would help them track data regarding incomplete plans and help reorganize work.
Latinos for Healthy Communities (LHC)	Retention of clients provided HIV/AIDS services at their Chew Street office	LHC has a high number of clients coming to their Chew Street office to be referred to their Drug & Alcohol programs; HIV prevention has been incorporated into their D&A and other services and clients are referred to the prevention worker; however, since clients are not required to schedule an appointment and/or are only seen by the D&A specialist once, it is difficult to get them to return for further interventions; LHC revised their protocol for D&A referrals by making the HIV prevention interventions a part of the actual service; clients are seen by the prevention worker prior to seeing the D&A specialist or vice-versa and are required to see the prevention worker at each D&A visit; additional incentives were included to encourage retention	The team has seen a small increase in retention in multiple session Interventions Delivered to Individuals (IDI) since implementing the new protocol; however, they are continuing to evaluate it and looking at adding additional wrap-around services to improve retention

In addition to the QI projects completed by our Subgrantees, AIDSNET also undertook a QI project to identify issues that result from encumbering funds for Oral Healthcare under patient care services and develop strategies to improve the process and ensure expenditure of these funds.

Table 2: 2011-2012 AIDSNET Quality Improvement Project

QI PROJECT/GOAL	INTERVENTIONS, FINDINGS & RESULTS	NEXT STEP(S)
Improve process of determining amount of funds to encumber for this service	There was a large variance between the dollars encumbered and the dollars spent for patient care services, primarily oral health care. In fiscal year 2010-2011, only 55% of the dollars encumbered for oral health care authorizations were actually billed. We identified processes that needed to change in order to reduce this discrepancy. Implement changes in the processes identified and monitor the progress. • The first change, increasing the time frame of the authorization to allow time for work to be done, resulted in a slight increase in the percentage. This did not resolve the problem entirely. • More research was done to find the root of the problem. • The second change implemented involved the authorization process itself. This change resulted in an increase of the percent billed to 70%.	The next step is to change the period of the authorization. The results of this step have not been measured as yet.

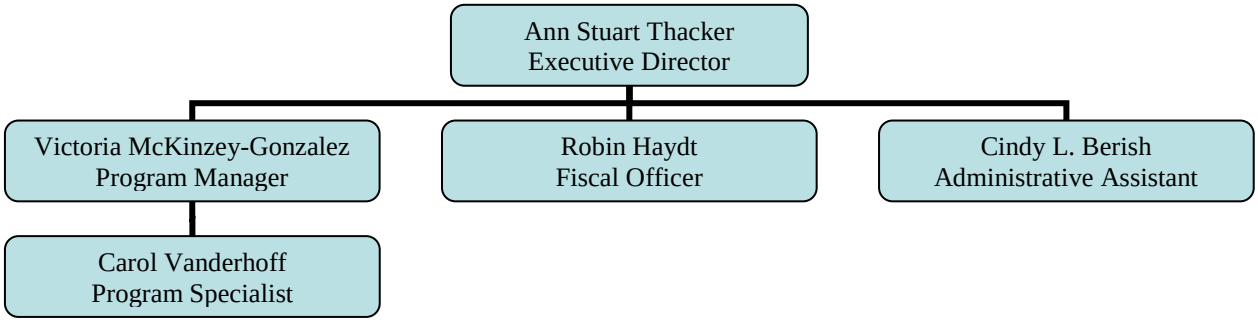
13. Attachments and Appendices

AIDSNET Organizational Chart	Appendix A
AIDSNET Pre-Authorization Policy and Authorization Form	Appendix B
Performance Measures	Appendix C
AIDSNET TBRA Waiting List Policy	Appendix D
Ryan White HIV/AIDS Treatment Modernization Act of 2006 Definitions for Eligible Services	Appendix E
AIDSNET Bylaws	Appendix F
AIDSNET Operations Cycle	Appendix G
National Quality Center Checklist for the Review of an HIV-Specific Quality Management Plan	Appendix H
Decision Makers List – Fiscal Year 2013-2014	Appendix I
Regional Care Resource Inventory	Appendix J
Regional Prevention Resource Inventory	Appendix K
Public Comments to CRSSP	Appendix L

APPENDIX A

AIDSNET ORGANIZATIONAL CHART

AIDSNET
ORGANIZATIONAL CHART



APPENDIX B

AIDSNET PRE-AUTHORIZATION POLICY AND AUTHORIZATION FORM

POLICY: Accessing Pooled Dollars

PURPOSE: Provide funding for approved care and housing services throughout the AIDSNET region

PERSONS RESPONSIBLE: Ryan White Case Managers, Ryan White Service Providers AIDSNET Program Specialist, and AIDSNET Program Manager

PROCEDURE: Authorization of Services

ATTACHMENT: AIDSNET Authorization Form – July 2012

I. Authorization Process

A. Services must be authorized *before* services are rendered. An exception may be made in the case of life-threatening situations or extenuating circumstances. Retroactive authorizations will only be considered within 30 days of service and must include an explanation as to why the service was not pre-authorized.

B. Modes of Authorization
   1. Fax completed authorization form and any required supporting documentation to AIDSNET.
   2. **For Immediate/Emergency Authorization Consideration:** Call the AIDSNET Program Specialist for verbal approval and then follow up with faxed authorization form and any required supporting documentation.

C. Authorizations will be processed by AIDSNET within two business days from time of receipt unless additional supporting documentation or details are needed.

D. If a case manager does not supply AIDSNET with the necessary supporting documentation or details for consideration of assistance within one (1) week of authorization submission, the authorization will be denied. Once the case manager has ALL the necessary supporting documentation or details a new dated authorization with the supporting documentation must be faxed to AIDSNET.

E. The AIDSNET Program Specialist will assign an authorization number to an approved request. The approved authorization will be faxed to the case management agency and appropriate service provider (if applicable).

F. Authorizations that are requested for a period of time that bridges two fiscal years will be broken into two authorizations: one which expires June 30 and a second that begins July 1.

G. In the event an authorization is denied, the case manager will be notified by phone and in writing.

H. If a case manager knows that an authorization will not be used, the Program Specialist must be notified immediately so that allocated funds may be used to assist other clients.

I. The AIDSNET authorization number must be used on all invoices on which the service is billed.

J. Authorizations for Ryan White (RW) funds must be billed as follows: All services rendered between July 1 and March 31 must be submitted for invoicing by April 5. Services rendered between April 1 and June 30 must be submitted for invoicing by July 5. This DOES NOT apply to HOPWA funds and it does not contradict the travel log submission deadline mentioned in the NOTE on page 3 of this document.

II. Authorization Instructions

A. Please provide the following information:

1. **Check box** verifying that AIDSNET's funding is the Payer of Last Resort for the service requested.
2. **Check box** acknowledging client meets Recertification requirements
3. **DATE:** List the date the form is being completed.
4. **AGENCY:** List the name of the case management agency.
5. **CASE MANAGER:** List the name of the case manager or health professional assigned to the case.
6. **CLIENT NUMBER:** List the client's unique identifier number.
7. **GENDER:** Circle the appropriate gender of the client.
8. **STATUS:** Circle the appropriate diagnosis of the client.
9. **ETHNICITY:** Circle the appropriate ethnicity of the client.
10. **RACE:** Circle the appropriate race of the client.
11. **EXPOSURE CATEGORY:** Circle the exposure category of the client that designates the highest risk. (IDU, MSM, Hetero, etc.)
12. **AGE:** List the age of the client.
13. **CLIENT HOUSEHOLD SIZE:** List the number of persons living in the household
14. **CLIENT ANNUAL HOUSEHOLD INCOME:** List the total annual household income for all persons living in the household. Income sources include, but are not limited to: earned/working wages**,** SSI/SSD (regardless of age), unemployment, child support and military pay.
    a. Don't include earned income from minors under the age of 18
    b. Include only $480 of earned income for dependents 18 years and older that are a full-time student
    c. Include all earned income from dependents 18 years and older and NOT a full-time student

15. **SERVICE:** Circle the type of eligible service for which authorization is requested and circle/write in subservice where asterisks apply. (NOTE: All COBRA, co-pays, premiums, and deductibles should be submitted for authorization under the Health Insurance Premium and Cost Sharing Assistance Program.)
16. **AGENCY REFERRED TO:** List the name of the agency that will be providing the requested service (if appropriate).
17. **UNITS OF SERVICE:** List the estimated number of units (please specify hours, days, visits, weeks, or months) of service to be used over the life of the authorization.
18. **RATE:** List the cost per unit of service.
19. **TOTAL COST:** Units of Service *x* Rate = Total Cost estimate.
20. **LIFE OF AUTHORIZATION:** List the starting date and expiration date of the authorization (not to exceed 90 days; exception: TBRA = 180 days). The majority of the services should require authorization for no more than 30 days, except in the case of legal services, mental health services, TBRA and transitional housing. If the life of an authorization is greater than 30 days, AIDSNET should be invoiced on a monthly basis, not as one lump sum.
21. **ADDITIONAL COMMENTS:** List other relevant information.
    (a) Please provide the medical insurance status of the client. (If appropriate for the service requested.)
    (b) Please provide the reason the authorization is requested.
    (c) If requesting prescription assistance, please include the name(s) of the medication(s).
    (d) If requesting Outpatient/Ambulatory Medical Care assistance, please describe all services, including lab work.

NOTE: Medical Transportation authorizations for the bulk purchase of gas/gift cards or local bus passes DO NOT require completion of #s 2 and 6-14. Bulk purchases of gas/gift cards and local bus passes are invoiced to AIDSNET prior to being distributed. Travel logs for travel reimbursement and agency bus pass logs for distribution of bus passes should be submitted to AIDSNET along with monthly invoicing, no later than the month after the travel occurred or passes were distributed. See *Client Travel Log Policy – September 2009* for details.

III. Renewal of Authorizations

A. *Consumer Progress Reports* – To facilitate communication between legal service providers and case managers *Ticklers* are sent to the legal service providers around the 1st of every month. The *Ticklers* will inform the legal service providers of all the Legal Service authorizations that will expire on or before the end of the current month (i.e. around September 1, 20XX ticklers will be faxed for all authorizations that will expire on or before September 30, 20XX). Service providers should complete a

Consumer Progress Report for each client on the *Tickler*. *Consumer Progress Reports* are to be sent to the case management agencies and the AIDSNET Program Specialist by the 15th day of the month in which the authorizations are to expire. See the AIDSNET's *Consumer Progress Report Policy – August 2009* for details.

B. *Ticklers* are also sent to the case management agencies around the 15th of every month. The *Ticklers* will inform case managers of all open authorizations (excluding PHP & STRMU auths.) that are going to expire on or before the end of the following month (i.e. around September 15, 20XX ticklers will be faxed for all other authorizations that will expire on or before October 31, 20 XX).

C. If services are still needed, case management agencies will complete a new authorization form, including "re-authorization" and the most recent authorization number in the additional comments section. If requesting a re-authorization of Legal Services, please note type of service (i.e. SSI appeal, POA, DNR, etc.). *Note: STRMU requests cannot be re-authorized and a new authorization must be completed and signed by client for each request.*

D. At this point, the re-authorization process will follow the authorization process described in Section I.

IV. Services Eligible for Ryan White and HOPWA* Reimbursement
(* services will be funded with HOPWA funds, all others with Ryan White)
Please refer to the Ryan White taxonomy and HOPWA regulations for a more detailed description of the services.

A. **Health Insurance Premium & Cost Sharing Assistance Program** – To ensure continuous coverage when HIV+ client is unable to make health insurance premium payments, including COBRA, and is ineligible for other federal/state health insurance programs. Also includes all co-pays and deductibles regardless of type of care (i.e. doctor visit, mental health, prescription, etc.). ***NOTE:*** *Funds may only be used for HIV+ person(s). Use Federal Poverty income guideline of 300% of the federally defined poverty level for eligibility determination. (See AIDSNET Subgrant Appendix D – Program Specific Provisions)*

B. **Home and Community-Based Health Services** – Provided to HIV+ client. Skilled health services furnished to the individual in home, based on a written plan established by case management team that includes appropriate health care pro*fessionals. Includes Home Health Aid /Personal Care Services, Durable Medical Equipment, and Specialized Care services.*

C. **Legal Services** – *Includes assistance with SSI/SS*D appeals, Power of Attorney (POA), Do Not Resuscitate (DNR's), Living Wills,

landlord/tenant disputes, housing and employment discrimination and welfare cases; as a RW funded service, all legal services must qualify as interventions to ensure access to eligible benefits.

I. Bankruptcy, Wills/Trusts, and Permanency Planning Guardianship are no longer covered services under Ryan White Part B.

II. The eligibility of legal services for housing matters is considered on a case-by-case basis. Factors considered include, but are not limited to, the reason(s) why a client was evicted, denied housing, or deemed ineligible for the public housing list. Additionally, legal housing assistance will be considered only after the applicable local or federal appeals process and/or waiting period for reapplication after eviction from public housing has expired.

D. **Outpatient/Ambulatory Medical Care Services** – For the care of HIV+ client for services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified to prescribe ARV therapy in an outpatient setting, when insurance programs do not allow for expenditure or when client does not have insurance program coverage. Includes Diagnostic Primary & Specialist Care, Therapeutic Primary and Specialist Care, and Vision Care services (glasses/contact lenses not included).

E. **Medical Transportation Services** – Services for eligible HIV+ clients to access *HIV-related* core medical services and support services. Authorized services include Bus Tickets, Bus Passes, Taxi Service, and Mileage/Tolls/Parking. Gas/Food/Gift Cards, which are authorized via bulk purchases, are to be used to reimburse clients, while volunteers can be reimbursed with cash. Please review AIDSNET's *Client Travel Log Policy – September 2009* for further details about documentation required for distribution of gas/gift cards and bus passes.

F. **Mental Health Services** – Refers to professional/licensed mental health services for HIV+ client; please include a note from the provider stating that Mental Health therapy is HIV-related**. *Provider agency cannot be considered for reimbursement if agency accepts or is certified for reimbursement from client's health insurance provider***

G. **Oral Health Care** – Includes diagnostic, therapeutic, and prophylactic services for HIV+ client without dental insurance; request must include a note from the dentist stating that required dental work is HIV-related and services are NOT covered by any other insurance resource.

1. Oral Health Care is limited to a maximum of $2,000 per client during any annual Fiscal Year, 7/1/XX-6/30/XX

H. **Permanent Housing Placement (formerly Supportive Services)*** – To provide security deposit and/or 1st month rent assistance to place HIV+ client in stable housing; this service must be provided in accordance with the rules/regulations contained in the HOPWA manual.

I. **Prescriptions (over $25)** – To provide HIV related medications or nutritional supplements for a HIV+ client when pharmacy or insurance programs do not allow for expenditure or when client does not have pharmacy or insurance coverage (Prescription should be listed on the SPBP formulary in order to be covered. *Exceptions may apply if first approved by AIDSNET*)

J. **Ryan White Housing Support** – To provide short-term assistance to support temporary housing to enable an HIV+ individual and their family (if applicable) to gain or maintain medical care when no other housing options are available. *Typically a hotel or mote1 stay until a long-term housing plan is established.*

   i. Hotel/Motel stays are limited to a maximum of four (4) consecutive weeks per client/household during any annual Fiscal Year 7/1/XX-6/30XX

K. **Short-Term Rent/Mortgage/Utility Payments (STRMU)*** – To provide short-term assistance with rent, mortgage, or utility payments to prevent the homelessness of HIV+ client; this service must be provided in accordance with the rules/regulations contained in the HOPWA manual

L. **Substance Abuse, Outpatient** – To provide medical or other treatment and/or counseling to HIV+ client to address substance abuse problems in an outpatient setting by a physician, under supervision of a physician, or by other qualified personnel. Includes Counseling, Methadone, Acupuncture, and Neuro-Psychiatric services

M. **Tenant-Based Rental Assistance (TBRA)*** – A form of monthly rental assistance in which the assisted tenant may move to a different housing unit while maintaining their assistance (must follow TBRA policy guidelines); the assistance is provided for the HIV+ tenant, not a specific housing unit and must be provided in accordance with the rules/regulations contained in the HOPWA Manual

N. **Transitional Housing*** – A program that is designed to provide housing and appropriate support services to homeless HIV+ client to facilitate movement to independent living within 24 months (HUD timeframe); this service must be provided in accordance with the rules/regulations contained in the HOPWA manual. *Note: Cannot be Ryan White funded*

V. Tracking Authorized Services in CAREWare (CW)

A. Be sure to use the correct units when entering the quantity of service ($1, 15 min, 1 hr, 1 visit, etc.). Check the CW taxonomy if you are unsure. Be especially careful when entering units for support groups, group counseling, etc.

B. *Health Insurance Premium & Cost Sharing Assistance (HIP)* should be tracked in CW under one of three categories: Medicare supplement, Other Health Insurance, or High Risk Insurance Pool. ***(Note:** All health insurance premium, deductible, and co-payment information will now have to be reported on Section 7 in CW v5 of the RDR, so it is imperative that you track the date, demographic information, health insurance type [Medicare, Other, High Risk], category [premium, deductible, co-pay] and amount paid for each client.)*

C. All medical transportation funded by AIDSNET's RW Part B patient care funds should be tracked in CW under **Medical Transportation**.

D. The following CW categories should ***not*** be used to track Part B expenditures. Instead, these services should be tracked under Case Management.

1. Housing Services – Housing Assistance/Information Services – RW
2. Housing Services – Housing Assistance/Information Services – HOPWA
3. Referral for Health Care/Supportive Services – Referral Health Care/Supportive
4. Referral to Clinical Research/Referral Clinical Research

E. Mental Health:

1. Professional/licensed mental health services for HIV+ clients should be tracked in CW under Mental Health Services/Professional Counseling or Psychiatric.

F. Legal Assistance:

1. Use Legal Services to track SSI/SSD appeals, Power of Attorney, Do Not Resuscitate orders, Living Wills, landlord/tenant disputes, public housing appeals*, housing and employment discrimination, and welfare cases. *Bankruptcy, Wills/Trusts, and Permanency Planning Guardianship are no longer covered services under Ryan White*

*The eligibility of legal services for housing matters is considered on a case-by-case basis. Factors considered include, but are not limited to, the reason(s) why a client was evicted, denied housing, or deemed ineligible for the public housing list. Additionally, legal housing assistance will be considered only after the applicable local or federal appeals process and/or waiting period for reapplication after eviction from public housing has expired

G. Food Bank:

1. If receiving any Part B funding for food during the course of the year please track visits to the food bank in CW under the category of Emergency Financial Assistance. ***Be sure to attach the visits to the correct contract, i.e. State 656.***

AUTHORIZATION FORM (July 2012)

Fax this form to AIDSNET at (610) 954-7921

AIDSNET USE ONLY _____ Billed

Auth. # _____

Auth. Expires: _____

_____

Authorized AIDSNET Signature

☐**Case Manager verifies Ryan White Part B or HOPWA is the payer of last resort for this authorization request.**

☐**Client meets Recertification eligibility requirements**

Date: _____

Agency: _____

Case Manager: _____

Client #: _____

Gender: Male Female Transgender

Status: HIV-positive AIDS HIV-negative/Affected

Ethnicity: Hispanic Non-Hispanic

Race: White Black Asian American Indian/Alaskan Native Multiple Races

Exposure : HETERO IDU MSM Perinatal Transfusion Unknown Other :_____

Age: _____ Client Household size: _____ Client Annual Household Income: $_____

Eligible Services (only one service per form): Review the *Accessing Pooled Dollars Policy* for definitions of services.

Part B Care

Health Insurance Premium & Cost Sharing Assist. (HIP)*
Home & Community-based Health Services**
Legal Services
Medical Transportation
Mental Health Services
Oral Health Care: (Diagnostic/Therapeutic/ Prophylactic)
Outpatient/Ambulatory MC: (Diagnostic/Therapeutic) ***
Prescription
RW Housing Support
Substance Abuse: Outpatient****

HOPWA

Permanent Housing Placement (1st month rent/security deposit)
STRMU
TBRA
Transitional Housing

*List type: **Health Insurance Premium**, **Co-pay**, **Deductible** (regardless of type/category of care)_____

List type: **Homemaker Services, **Personal Care, Durable Medical Equipment**, **Specialized Care**_____

***List type: **Diagnostic** Primary/Specialist, **Therapeutic** Primary/Specialist or **Vision**_____

****List type: **Counseling, Methadone, Neuro Psychiatric** _____

Agency Referred To	Units of Service	Rate	Total Cost
_____	_____	_____	_____

Life of Authorization (not to exceed 90 days; exception: TBRAs up to 180 days)**:** From: _____ To: _____

Authorization is not a guarantee of payment. Payment is based on client status in treatment, eligibility and availability of funds.

Additional Comments: _____

_____

_____

Fax Notes: FOR AIDSNET USE ONLY

Case Management Agency_____
To_____
Date_____
Number of Pages_____
From_____

Provider Agency_____
To_____
Date_____
Number of Pages_____
From_____

APPENDIX C

PERFORMANCE MEASURES

Part B QM Subgrantees
Performance Measures (PM)
2009-2010

UNIVERSAL (ALL CM AGENCIES)

PERFORMANCE MEASURE #1: **DOCUMENTATION OF RETENTION IN CARE**	
Service Category:	Addressing Unmet Need
Definition:	Percentage of clients with HIV infection whose records indicate retention in care
Numerator:	Number of clients whose records indicate 1. CD4 count performed within the measurement year; OR 2. Viral load test administered within the measurement year; OR 3. ARV therapy prescribed or discussed with a medical provider within the measurement year
Denominator:	Number of clients who have accessed services at least twice during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources:	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: All agencies (both medical and supportive service providers) must obtain documentation of when the most recent CD4 and/or viral load tests were performed and/or when the most recent prescription for ARV therapy was issued and maintain it on file as evidence that their clients are participating in care. If a supportive service agency cannot obtain the documentation which confirms a client is participating in care, the supportive service agency cannot continue to provide supportive services for that client. Client self reporting is not acceptable; rather documentation should be obtained from medical providers Supportive services are designed to support a person's ability to participate in care. Obtaining documentation related to the timing of CD4 counts, viral load tests and prescriptions of ARV therapy is one way to insure that services are provided as intended, while reducing the level of unmet need within the system.	

PERFORMANCE MEASURE #2: MENTAL HEALTH HISTORY AND TREATMENT STATUS	
Service Category:	Case management (non-medical) and Medical case management
Definition:	Percentage of clients with HIV infection who have their mental health history and treatment status documented
Numerator:	Number of clients who have their mental health history and treatment status documented at least once during the measurement year
Denominator:	Number of clients who have at least one face-to-face case management visit during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: Mental health problems can escalate quickly and significantly alter the lifestyle and health of a patient. Patients referred to mental health programs should be assessed within thirty days in order to address and alleviate the mental condition before related problems arise. Distressed or mentally unstable patients may be less likely to adhere to treatment plans and are at risk for poor judgment. Without counseling, patients are more likely to engage in risky sexual behaviors, are more likely to miss appointments, and are at risk for poor health related decisions. Suspected mental illnesses must be quickly addressed to ensure the patient is capable of properly caring for him/her and is not a danger to themselves or those around them.	

PERFORMANCE MEASURE #3: **SUBSTANCE ABUSE HISTORY AND TREATMENT**	
Service Category:	Case management (non-medical) and Medical case management
Definition:	Percentage of clients with HIV infection who have their substance abuse history and treatment status documented
Numerator:	Number of clients who have their substance history and treatment status documented at least once during the measurement year
Denominator:	Number of clients who have at least one face-to-face case management visit during the measurement year
Patient Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Data Sources:	1. Client Files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: Substance abuse is a growing problem in HIV infected communities. Patients successfully completing substance abuse programs are in need of less acute medical care, have less frequent trips to emergency rooms, and are more likely to adhere to treatment plans and attend scheduled doctors' appointments. Patients able to maintain recovery are more socially, financially, and medically stable. Immune function and overall wellness is increased after a decrease in substance abuse and use. Successful programs teach patients the skills needed to maintain and identify triggers related to addiction, and patients are expected to incorporate learned behaviors into everyday life.	

PERFORMANCE MEASURE: #4. SECONDARY RISK ASSESSMENT (CLIENTS IN CM RECEIVING PREVENTION MESSAGES)	
Service Category:	Evaluation
Definition:	Percentages of active case management clients that do a risk reduction plan at least one time annually.
Numerator:	Number of clients for whom a risk assessment was completed.
Denominator:	Number of active clients in case management.
Date Sources:	CAREWare or audit of client files.
Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Goals:	100%
Description:	Each agency uses AIDSNET's risk assessment tool. If using client files as a data source, only a sample of the files needs to be audited.
Rationale:	The only individuals that can transmit HIV are those who are positive. Reducing the risky behavior of HIV positive individuals will ultimately reduce the infection rates.

PERFORMANCE MEASURE **#5: MEDICATION ASSESSMENT and COUNSELING**	
Service Category:	Medication Adherence
Definition:	Percentage of clients with HIV infection on ARVs who were assessed and counseled for adherence two or more times in the measurement year.
Numerator:	Number of HIV-infected clients, as part of their HIV medical and/or case management care, who were assessed and counseled for adherence two or more times at least three months apart.
Denominator:	Number of HIV-infected clients on ARV therapy who had a visit with his/her HIV medical provider and/or case manager at least two or more times in the measurement year.
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year 2. Patients who initiated ARV therapy during last six months of the year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 90%	
Rationale: Adherence is a key determinant in the degree and duration of virologic suppression. Among studies reporting on the association between suboptimal adherence and virologic failure, non adherence among patients on HAART was the strongest predictor for failure to achieve viral suppression below the level of detection. HIV viral suppression, reduced rates of resistance, and improved survival has been correlated with high rates of adherence to antiretroviral therapy. Interventions can also assist with identifying adherence education needs and strategies for each patient.	

PERFORMANCE MEASURE **#6** CASE MANAGEMENT TRAINING	
Service Category:	Case management (non-medical) and Medical case management
Definition:	Percentage of case managers and supervisors meeting their *prorated* mandatory hours of case management project approved training in a measurement year. *The annual mandatory training hours will be prorated for the quarter of the measurement year and/or for the number of quarters a new case manager or supervisor has been in her/his position. See below for explanation and example.*[*]
Numerator:	Number of case managers and supervisors who met or exceeded *prorated* mandatory hours of case management project approved training
Denominator:	Number of case managers and supervisors employed at the end of the measurement year
Patient Exclusions:	1. Case managers and supervisors hired during the last quarter of fiscal year 2. Case managers and supervisors whose employment has been terminated during the measurement year
Data Sources:	1. Case Management Project Annual Training Report 2. Certificate of completion from Case Management Project 3. Certificate of completion of other project-approved training
National Goals, Targets, or Benchmarks for Comparison: None available at this time	

Rationale: HIV/AIDS is a continually evolving disease and requires HIV case managers to keep abreast of the improvement in its treatment, management, disease trends, etc. The Pennsylvania Part B Case Management Standards of Care recognize training as an important aspect of a case manager's employment. The Standards require all case managers and case management supervisors to complete at least 20 hours of case management training per year (July – June), of which 6 hours have to be medically oriented.

Newly hired case managers and supervisors are required to complete training credit hours based on the quarter employment begins as a case manager/supervisor at a given agency (with each quarter representing 25% of the required training.) For example, if the date of hire commenced during the second quarter (December) then a total amount of fifteen credit hours (75%) should be completed by the end of the training year.

Each case manager and supervisor's hours of completed training are tracked by the Pennsylvania Case Management Coordination Project. The Project sends quarterly updates to each coalition stating the number of hours each case manager has completed. The Project has been in operation for a number of years and has well established procedures.

[*] Explanation and Example: The prorated mandatory hours will vary by quarter of the year. By the end of the first quarter, the prorated mandatory hours would be 1/4 of the total mandatory hours, by the end of the second quarter it would be 1/2 the hours, and by the third quarter it would be 3/4 of the hours.

The hours will also be prorated for newly hired case managers and supervisors. If an individual has only worked for 1/4, 1/2 or 3/4 of the year, the mandatory hours would be prorated accordingly.

For example, if the case manager must complete 20 hours for the year, she/he would be "on track" if she/he completed 5 hours by the end of the first quarter, 10 hours by the end of the second quarter, and 15 hours by the end of the third quarter. Additionally, a case manager who has only worked in the position for two quarters would only be expected to complete 10 hours for the year (1/2 of 20 = 10). At the end of the third quarter, a case manager hired at the end of the first quarter would be "on track" if she/he completed 10 hours (20 mandatory hours x 3/4of year will be worked = 15 mandatory hours for year. 15 mandatory hours required for year x 2/3 of "prorated" year completed = 10 hours.

Prorated Mandatory Training Hours by Quarter of Year and Time of Hire

	End of 1st Quarter	End of 2ndQuarter	End of 3d Quarter	End of 4th Quarter
Hired before 1st Quarter of Year	25% of mandatory hours	50% of mandatory hours	75% of mandatory hours	100% of mandatory hours
Hired during 1st Quarter of Year	0% of mandatory hours	25% of mandatory hours	50% of mandatory hours	75% of mandatory hours
Hired during 2nd Quarter of Year	n/a	0% of mandatory hours	25% of mandatory hours	50% of mandatory hours
Hired during 3d Quarter of Year	n/a	n/a	0% of mandatory hours	25% of mandatory hours
Hired during 4th Quarter of Year	excluded from performance measure	excluded from performance measure	excluded from performance measure	excluded from performance measure

CLINICAL PM (AAO & ASC ONLY)

PERFORMANCE MEASURE **#7:** PCP PROPHYLAXIS	
Service Category:	Prevention of PCP
Definition:	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis
Numerator:	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm who were prescribed PCP prophylaxis
Denominator:	Number of HIV-infected clients who: 1. Had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and 2. Had a CD4 T-cell count below 200 cells/mm
Patient Exclusions:	1. Patients with CD4 T-cell counts below 200 cells/mm^3 repeated within 3 months rose above 200 cells/mm 2. Patients newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 95%	
Rationale: Pneumocystis pneumonia (PCP) is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV infection, yet is almost entirely preventable and treatable. Measure reflects important aspect of care that significantly impacts survival and mortality.	

PERFORMANCE MEASURE **#8:** HAART	
Service Category	HIV Monitoring
Definition:	Percentage of clients with AIDS who are prescribed HAART
Numerator:	Number of clients with AIDS who were prescribed a HAART regimen within the measurement year
Denominator:	Number of clients who: 1. Have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm or other AIDS-defining condition), and 2. Had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, and NP in the measurement year.
Patient Exclusions:	Patients newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: IHI Goal: 90%	
Rationale: Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm. Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission.	

PERFORMANCE MEASURE **#8** ARV THERAPY FOR PREGNANT WOMEN	
Service Category:	Prevention of Perinatal Transmission
Definition:	Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy
Numerator:	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester
Denominator:	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year
Patient Exclusions:	1. Patients whose pregnancy is terminated 2. Pregnant patients who are in the 1st trimester and newly enrolled in care during last three months of the measurement year
Data Sources:	CAREWare
National Goals, Targets, or Benchmarks for Comparison: None available at this time.	
Rationale: Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. Antiretroviral therapy can reduce Perinatal HIV-1 transmission by nearly 70%. Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission.	

PERFORMANCE MEASURE **#9 :** VIRAL LOAD TESTING	
Service Category:	HIV Monitoring
Definition:	Percentage of clients with HIV-infection who had a viral load test administered within 3 to 4 months of most recent medical visit
Numerator:	Number of HIV-infected clients who had a viral load test administered within 3 to 4 months of most recent medical visit
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, at least once in the measurement year
Exclusions:	Patients newly enrolled in care during last six months of the year
Data Sources:	1. Client files 2. CAREWare
National Goals, Targets, or Benchmarks For Comparison: None available at this time	
Rationale: A viral load test is ordered when a patient is first diagnosed with HIV. The test result functions as a baseline measurement that shows how actively the virus is reproducing and whether treatment is immediately necessary. If the viral load measurement is high, it indicates that HIV is reproducing and that the disease will likely progress faster than if the viral load is low. Change in viral load is also a very important measurement. A rising count indicates an infection that is getting worse, while a falling count indicates improvement and suppression of the HIV infection.	

ORGANIZATIONAL (ALL CARE/PREVENTION PROVIDERS)

PERFORMANCE MEASURE **#10 ORGANIZATIONAL ASSESSMENT** (THIS ALSO INCLUDES AIDSNET)		
Service Category:	Quality Infrastructure and Activities	
Definition:	A.1. Are appropriate resources committed to support the HIV quality program?	
	A.2. Does the HIV leadership support the HIV quality program?	
	A.3. Does the HIV quality program have a comprehensive quality plan?	
	B.1. Did the HIV program routinely measure the quality of care?	
	C.1. Did the HIV program conduct quality projects to improve the quality of care?	
	D.1. Is the staff routinely educated about quality?	
	E.1. Is a process in place to evaluate the HIV quality program?	
	F.1. Does the HIV program have an information system in place to track patient care and measure quality?	
Numerator:	None	
Denominator:	None	
Exclusions:	None	
Data Sources:	1. Quality Plan 2. Interviews with leadership, staff, medical providers 3. Organizational chart 4. QM Committee minutes 5. Other committee minutes 6. Data Reports	7. Team meeting minutes 8. Education logs 9. Training agendas and attendance records 10. Evaluation tools 11. Organizational documents, i.e., policies and procedure manuals, IT disaster recovery plans
National Goals, Targets, or Benchmarks For Comparison: None available at this time		

Rationale:

A formal quality of care program that embraces quality improvement (QI) philosophy should be developed and implemented as part of the HIV service delivery program. An effective HIV quality management program includes the following components:

- Adequate resources
- Clear staff expectations related to quality
- Engagement of multidisciplinary team(s) and a QM Committee
- Commitment of leadership
- Quality management plan that is periodically reviewed and updated as needed
- Processes and systems in place to routinely collect and analyze data

The infrastructure of the quality program should be fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.

Performance measurement should include clearly defined indicators that address clinical, case management, and other services as prioritized by the program. A plan for follow-up of results should be outlined.

QI activities should be based on performance data results. Specific QM projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.

QI activities should be based on performance data results. Specific QI projects should be undertaken, which include action steps and a mechanism for integrating change into routine activities.

Staff should be actively involved in the HIV Quality Program and its QM activities. Participation in the quality program should be part of job expectations. Provisions should be made for ongoing education of staff about quality management.

AIDSNET's
Administration, Planning & Evaluation (APE)
Performance Measures (PM)
FY 2009-2010

PERFORMANCE MEASURE: #**1. STAFF DEVELOPMENT**	
Service Category:	Capacity Building
Definition:	Percentage of Coalition and Fiscal agent staff members who complete 8 hours or more of training per year.
Numerator:	Number of HIV staff completing at least 8 hours of training.
Denominator:	Total number of HIV staff.
Date Sources:	Documentation or certificates of trainings
Exclusions:	Employees with 6 months or less of service, time are prorated by percentage worked of the year. Trainings do not include: Peer review, Integrated Planning Council, Community Planning Group, staff fiscal agent meetings.
Goals:	80%
Description:	None
Rationale:	Continuing education enhances professional skill levels and improves the effectiveness and efficiency of services provided.

PERFORMANCE MEASURES: #**2. Inclusion of a Minimum Set of Elements in a Needs Assessment**	
Service Category:	Planning and Evaluation
Definition:	Percentage of HRSA- defined elements of Needs Assessment contained in the document
Numerator:	Number of elements contained in the document
Denominator:	Number of HRSA- defined elements recommended for inclusion
Data Sources:	Department of Health, CDC, HRSA, consumer surveys, key informant interviews, focus groups, national studies, CPG, HIV Integrated Planning Council, Statewide Coordinated Statement of Need, CAREWare, HOPWA, PaUDS
Exclusions:	Data that is not available
Goals:	100%
Description:	Each region will use the standardized elements to measure the extent its needs assessment meets the inclusion criteria.
Rationale:	Needs Assessment is the foundation for the development of a regional plan; therefore the quality of the data collection and analysis process should be based upon solid methodology as outlined by HRSA, the funding source for Ryan White Care Act.

Elements of a Needs Assessment

Completeness Criteria: The following information should be included in the Needs Assessment

- **An Epidemiological Profile (Regional Epi-data and the template chart)**

An epidemiologic profile to describe the current status of the epidemic in the service area, specifically the prevalence of HIV and AIDS overall and among defined subpopulations

- **Assessment of service needs (including barriers)**

An assessment of service needs among affected populations, including barriers that prevent People Living with HIV/AIDS (PLWHA) from receiving needed services

(Discussion of the most recent study)

a. Topic/focus of study
b. Time period covered
c. Methodology used
d. Description of tools used
e. Use of secondary data/epi data
f. Staffing utilized
g. Consumer and provider input
h. Health Department interface
i. Funding for the study
j. Summary of results
k. Factors influencing results
l. Specific recommendations

- CAREWare data
- Prevention data
- Barriers to care
- Availability and accessibility to care
- Emerging populations, including WICY, housing, minority populations, Early Intervention Services

- **Provider capacity and capability**

A profile of provider capacity and capability that identifies the extent to which services identified in the resource inventory are accessible, available, and appropriate for PLWHA, including specific subpopulations

- **Assessment of needs of PLWH's not in care**

An assessment of unmet need and service gaps, which brings together the quantitative and qualitative data on service needs, resources, and barriers to help set priorities and allocate resources

- **Resource Inventory**

A resource inventory that describes organizations and individuals providing services across the full spectrum of HIV services accessible to PLWHA in the service area

PERFORMANCE MEASURE: #3. SECONDARY RISK ASSESSMENT (CLIENTS IN CM RECEIVING PREVENTION MESSAGES)	
Service Category:	Evaluation
Definition:	Percentages of active case management clients that do a risk reduction plan at least one time annually.
Numerator:	Number of clients for whom a risk assessment was completed.
Denominator:	Number of active clients in case management.
Date Sources:	CAREWare or audit of client files.
Exclusions:	Patients who died or relocated, were discharged by a provider or were incarcerated during the measurement year
Goals:	100%
Description:	Each agency uses it's own risk assessment tool. If using client files as a data source, only a sample of the files needs to be audited.
Rationale:	The only individuals that can transmit HIV are those who are positive. Reducing the risky behavior of HIV positive individuals will ultimately reduce the infection rates.

PERFORMANCE MEASURE: #4. CUSTOMER SATISFACTION REGARDING SERVICE DELIVERY	
Service Category:	Evaluation
Definition:	Percent of consumers who agreed or strongly agreed for each of the 7 standardized core questions asked
Numerator:	Number of clients who indicated satisfaction or extreme satisfaction with each individual element
Denominator:	Number of clients who participated in survey
Data Sources:	The completed survey (minimum 25 respondents)
Exclusions:	Clients in CM for less than 6 months
Goals:	50%
Methodology:	Each region must survey a sample of their consumers for all of the standardized core questions and any additional questions they would like to ask.
Rationale:	In quality management, quality is defined as meeting or exceeding customer (client) expectations. The core questions will allow the agency to measure how its clients are evaluating the agency's services.

PERFORMANCE MEASURE #5. ADDRESSING PRIORITY POPULATIONS AND SERVICES THROUGH FUNDING	
Service category	Administration
Definition	Percentage of priority populations or services identified in the needs assessment that were addressed in the funding plan
Numerator	Number of priority populations or services identified in the biannual needs assessment that were addressed in the funding plan
Denominator	Number of priority populations that were identified in the biannual needs assessment
Data source	Coalition Region Services and Strategic Plan • Needs assessment • Priority setting • Implementation table • Work plan
Exclusions	None
Goals	75%
Description	As a part of the biannual Coalition Region Services and Strategic Plan (CRSSP), each region conducts a needs assessment. Needs assessment is a process of collecting information about the needs of persons living with HIV (both those receiving care and those not in care), identifying current resources available to meet those needs, and determining what gaps in care exist. Through the needs assessment, each region identifies priority populations in need of services and/or services that need to be enhanced or funded.
Rationale	Regions should make every effort to address the priority populations and needs that are identified through the needs assessment and planning process.

APPENDIX D

AIDSNET TBRA WAITING LIST POLICY

POLICY: TBRA Waiting List

PURPOSE: To establish a process for creating a waiting list for new TBRA requests when the balance of the AIDSNET TBRA pool is insufficient to fund new requests.

PERSONS RESPONSIBLE: HOPWA Case Managers, HOPWA Service Providers, AIDSNET Program Specialist, AIDSNET Program Manager

PROCEDURE: Adding Clients to the AIDSNET Waiting List for HOPWA Tenant Based Rental Assistance (TBRA)

Program Specialist will evaluate each TBRA request (written or verbal) submitted to AIDSNET by Case Managers for eligibility and need.

- If the client is eligible for TBRA housing assistance, based on the case manager's review of the client's monthly income and expenses, the Program Specialist will discuss client's need for TBRA assistance with the AIDSNET Fiscal Officer and the Program Manager and/or Executive Director to determine if funds are available to assist client. (The c*ase manager should have supporting documentation of all the monthly expenses at the time of reviewing the financial need for TBRA assistance. Determination for need is based on the client's inability to pay his/her recurring monthly expenses.)*

- If a client is eligible for TBRA, but funds are not available to assist client, the Program Specialist will notify the Case Manager and work with the Case Manager to determine if alternate funding is available to assist the client.

- If alternate funding is not available to assist the client, or if the alternate assistance is only temporary, the client's UCN number will be added to the AIDSNET TBRA Waiting List on the date the Program Specialist notifies the Case Manager that TBRA funding is not available.

- Based on a first added first served basis, client will be reconsidered for TBRA assistance when TBRA funds become available. At that time, the Program Specialist will notify the Case Manager that TBRA funds are available for the client. If the client is still in need of TBRA assistance, the Case Manager will then complete and submit a current TBRA authorization request to the Program Specialist within 5 business days of requesting the same if the client is already in a TBRA eligible unit and 10 business days for clients who will have to find a unit.

- **Exceptions to first added first served basis**:
  a. A client is homeless and has no income.
  b. Domestic violence.

- The new request will be reviewed by the Program Specialist to determine if the client is still eligible and demonstrates a need for TBRA assistance. If the request meets the required criteria and includes the necessary documentation, the Program Specialist will authorize the request, notify the Case Manager, and fax the authorization to the Case Manager for the client's file.

APPENDIX E

RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006
DEFINITIONS FOR ELIGIBLE SERVICES

Ryan White HIV/AIDS Treatment Modernization Act of 2006
Definitions for Eligible Services

Part A funds eligible metropolitan areas and transitional grant areas.
Part B funds States.
Part C funds early intervention services.
Part D grants support services for women, infants, children & youth.
Part F comprises Special Projects of National Significance, AIDS Education & Training Centers, Dental Programs and Minority AIDS Initiative.

Core Medical Services

Core medical services are a set of essential, direct health care services provided to persons living with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

- ***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
- ***Local AIDS pharmaceutical assistance*** (APA, not ADAP) are local pharmacy assistance programs implemented by a Part A, B, or C Grantee or a Part B Grantee consortium to provide HIV/AIDS medications to clients. These organizations may or may not provide other services (e.g., primary care or case management) to the clients that they serve through a Ryan White HIV/AIDS Program contract with their grantee. Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:
    - Have a client enrollment process;
    - Have uniform benefits for all enrolled clients;
    - Have a record system for distributed medications; and
    - Have a drug distribution system.

  Programs are not APAs if they dispense medications in one of the following situations:
    - As a result or component of a primary medical visit;
    - On an emergency basis (defined as a single occurrence of short duration); or
    - By giving vouchers to a client to procure medications.

Local APAs are similar to AIDS Drug Assistance Programs (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP.

- ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
- ***Early intervention services*** for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.
- ***Health insurance premium & cost sharing assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
- ***Home health care*** is the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.
- ***Home and community-based health services*** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. NOTE: Inpatient hospital services, nursing homes and other long term care facilities are not included as home and community-based health services.
- ***Hospice services*** are end-of-life care provided to clients in the terminal stage of an illness. It includes room, board, nursing care, counseling, physician services, and palliative therapeutics. Services may be provided in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services.
- ***Mental health services*** are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
- ***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.

  Nutritional services not provided by a licensed, registered dietician shall be considered support service. Food, nutritional services and supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.

- ***Medical case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
- ***Substance abuse services (outpatient)*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.

Support Services

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person with HIV/AIDS.

- ***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.
- ***Child care services*** are the provision of care for the children of clients who are HIV-positive while the clients are attending medical or other appointments or attending RWHAP-related meetings, groups, or training. This does not include child care while a client is at work.
- ***Pediatric developmental assessment and early intervention services*** are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant or a child's developmental status and needs in relation to the education system, including early assessment of educational intervention services. They include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools also should be reported in this category.

  NOTE: Only Part D programs are eligible to provide pediatric development assessment and early intervention services.

- ***Emergency financial assistance*** is the provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in the Division of Service Systems Program Policy Guidance No. 2 (formerly Policy No. 97-02).
- ***Food bank/home-delivered meals*** is the provision of actual food or meals. It does not include finances to purchase food or meals but may include vouchers to purchase food. The provision of essential household supplies such as hygiene items and household cleaning supplies, also should be included in this item.
- ***Health education/risk reduction*** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.
- ***Housing services*** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.
- ***Legal services*** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program.
  NOTE: Legal services do not include any legal services to arrange for guardianship or adoption of children after the death of their normal caregiver.
- ***Linguistics services*** include the provision of interpretation and translation services, both oral and written.
- ***Medical transportation services*** are conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
  Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services. Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.
- ***Outreach services*** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with

HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

- ***Permanency planning*** is the provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
- ***Psychosocial support services*** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non-registered dietitian, but excludes the provision of nutritional supplements.
- ***Referral for health care/supportive services*** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals for health care/supportive services that were not part of ambulatory/outpatient medical care services or case management services (medical or non-medical) should be reported under this item. Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be included under outpatient/ambulatory medical care services category. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category, Medical Case Management or Case management (non-medical).
- ***Rehabilitation services*** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.
- ***Respite care*** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
- ***Substance abuse services (residential)*** are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).
  NOTE: Part C programs are not eligible to provide substance abuse services (residential).
- ***Treatment adherence counseling*** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

APPENDIX F

AIDSNET BY-LAWS

AIDSNET

BYLAWS

ARTICLE I - NAME

1.1 The name of this organization shall be AIDSNET.

ARTICLE II - ORGANIZATION

2.1 The organization shall be a voluntary, not for profit corporation incorporated under the laws of the Commonwealth of Pennsylvania and dedicated to HIV/AIDS related services and activities in Berks, Carbon, Lehigh, Monroe, Northampton and Schuylkill Counties.

ARTICLE III - PURPOSE

MISSION

3.1 AIDSNET builds healthier communities by planning and funding HIV/AIDS care and prevention services.

ARTICLE IV - LEADERSHIP

A Board of Directors shall govern this organization. All shall serve without compensation. The Board shall insure that the corporation does not engage in any activity that will jeopardize the corporation's federal tax exemption and will not attempt to influence legislation except as permitted in Section 501 or any succeeding or related section of the Internal Revenue Code. The Board assumes full responsibility and authority for the overall management of the organization. The Board is responsible for providing overall guidance, direction and monitoring for the completion of regional goals as well as review and approval of the organization's budget and fiscal management.

4.1 Number, Election, Eligibility and Terms of Membership

(a) The Board of Directors shall consist of no less than fifteen or more than twenty-five voting members.

(b) Each Director shall hold office for a term of four (4) years, and may succeed himself/herself for one additional consecutive term of four years. Any Director who has served two consecutive full four-year terms shall be ineligible for re-election for at least one year. However, the Board of Directors reserves the right to extend the second consecutive four-year term of a Director on a case-by-case basis. Persons who are employed by the Corporation are not eligible for membership on the Board of Directors until their association in that capacity has been terminated for three months.

(c) Any vacancy or vacancies in the Board because of death, resignation, removal in any manner, disqualification, an increase in the number of Directors, the expiration of a prior Director’s eligibility or any other reason may be filled by a majority of the remaining members of the Board, though less than a quorum, at any regular or special meeting; and each person so

elected shall be a Director to serve for a full term of four years from the date of appointment.

(d) All members of the Board shall serve without compensation other than reasonable reimbursement for out-of-pocket expenses as determined by the Board from time to time. Members of the Board can request reimbursement for mileage at the current approved rate for travel to Board and Committee meetings.

(e) No person shall be eligible to serve as a Director if such person is also employed by or serves on the Board of Directors of any organization funded by AIDSNET.

(f) AIDSNET will endeavor to constitute the Board of Directors in such a way as to assure reasonable representation consistent with the current regional demographics of the disease while addressing concerns of all those affected in a culturally competent manner.

4.2 Powers

(a) The Board shall have full power to conduct, manage and direct the business and affairs of the Corporation; and all powers of the Corporation are hereby granted to and vested in the Board.

4.3 Meetings

(a) Meetings of the Board may be held at such place within or without Pennsylvania as the Board may from time to time appoint or as may be designated in the notice of the meeting. The Board may meet through telephone or other electronic devices as long as all members can communicate with one another.

(b) Regular Meetings. Regular meetings of the Board shall be held at such time and place as shall be designated from time to time by resolution of the Board. If the date fixed for any such regular meeting be a legal holiday under the laws of the State where such meeting is to be held, then the same shall be held on the next succeeding business day, not a Saturday, or at such other time as may be determined by resolution of the Board. At such meetings, the Board shall transact such business as may properly be brought before the meeting. Notice of regular meetings need not be given unless otherwise required by law or these By-Laws.

(c) Special Meetings. Special meetings of the Board shall be held whenever called by the Chair or by a majority of the Directors then in office. Notice of such meeting shall be given to each Director by telephone or in writing at least three days immediately preceding the date of such meeting.

(d) A quorum shall consist of no fewer than six voting members who are in attendance**.** However, in lieu of a sixth voting member, the Executive Director's attendance shall constitute a quorum.

(e) The fiscal year shall be from July 1 to June 30. The annual meeting of the Board shall be held no later than October 31 of each fiscal year.

4.4 Removal of Directors

A Director may be removed from office upon an affirmative vote of two-thirds of the remaining Directors for any reason including, but not limited to, said Director having three unexcused absences in one fiscal year.

ARTICLE V - OFFICERS

5.1 Number and Qualifications

The officers of the Corporation shall be a Chair (President), Vice Chair (Vice President), and Secretary/Treasurer. An officer shall be required to co-sign checks in excess of $2,000.

5.2 Election and Terms of Office

The officers shall be elected by the Board of Directors and shall hold office for a term of two years from the date of election.

5.3 Chair and Vice Chair

The Chair, or in his or her absence, the Vice Chair, shall preside at all meetings of the Board and of the Executive Committee, and shall perform such duties as may from time to time be requested by the Board.

5.4 Secretary/Treasurer

The Secretary/Treasurer shall be the Secretary of the Board of Directors and the Executive Committee. The Secretary/Treasurer shall insure that minutes are kept and distributed, that general correspondence of the board is prepared and distributed, and shall perform all such duties as are incident to the office.

The Secretary-Treasurer shall insure that all functions of fiscal oversight are adequately performed and shall perform such other duties as may be authorized and directed by the Board.

ARTICLE VI - COMMITTEES

There shall be six standing committees of the organization. A Director shall chair each committee. The committee chair shall meet regularly with the committee and shall report committee activity to the Board of Directors. With the exception of the Executive Committee, all committees shall consist of directors and volunteers recruited by the committee and appointed by the Board of Directors striving toward adherence with membership in accordance with AIDSNET principles of inclusiveness. The Executive Director, or his or her designee, is expected to attend and participate in all committee meetings except Executive Committee meetings dealing with personnel issues.

6.1 Executive Committee

Shall consist of the officers of AIDSNET and of the Chairs of all standing committees; staffed by the Executive Director. This committee shall be responsible for**:**

- formulating the organization's positions on issues;
- hearing grievances from subgrantees;
- supervising the Executive Director;
- monitoring the operation of the organization between Board meetings;
- identifying constituencies lacking representation on the Board and/or committees;
- developing a Board and/or committee member recruitment strategy;
- creating and updating a comprehensive orientation process for new Board and committee members;

- assisting in the retention of Board and committee members;
- performing self-evaluations of the Board;
- updating the organization's Personnel Policies;
- hearing grievances from staff;
- recommending changes in staff compensation (salary and/or benefits);
- recommending the formation of task forces and special committees; and
- overseeing the agenda for Board and staff retreats.

The Executive Director shall keep the Executive Committee informed, in a general nature, of all employee evaluations.

6.2 Finance Committee

Shall consist of Board Directors and community representation; staffed by the Fiscal Officer and Executive Director. This committee shall be responsible for**:**

- reviewing the two annual operating budgets to be included in the Coalition Regional Services and Strategic Plan (CRSSP);
- reviewing monthly financial statements;
- reviewing the annual audit;
- reviewing, in a general manner, the financial monitoring of subgrantees;
- reviewing budget revisions to subgrants in cases where the subgrantee is moving more than 10% between previously approved activities or where the scope of the services to be provided is changing;
- reviewing amendments to AIDSNET's budget in cases where the increase in funding exceeds 10% of the organization's original grant amount or any services in a subgrant increase by more than 10%.
- reviewing modifications to the organization's budget in cases where the scope of the services to be provided is changing;
- reviewing year-end spending reports; and
- providing technical assistance to staff on an as-needed basis.

6.3 Planning Committee

Shall consist of Board Directors and community representation; staffed by the Program Manager, Program Specialist, and Executive Director. This committee shall be responsible for:

- overseeing the preparation of the Coalition Regional Services and Strategic Plan (CRSSP), most notably the Resource Allocation Plans and the Strategic Plan;
- overseeing the development of needs assessments;
- overseeing the development of gap analyses;
- overseeing the development and the updating of the organization's long-range plan;
- overseeing the development of annual goals and objectives that are consistent with the long-range plan;
- overseeing the reporting of annual outcomes that are in response to the annual objectives;
- reviewing proposals for the expansion of the organization's services; and
- reviewing changes in services proposed by subgrantees.

6.4 Allocations Committee

Shall consist of Board Directors and community representation; staffed by the Program Manager, Program Specialist, Fiscal Officer and Executive Director. This committee shall be responsible for:

- overseeing the preparation of the Request for Proposal;
- reviewing, in a general manner, the fiscal and programmatic monitoring reports of subgrantees;
- reading and scoring of proposals;
- developing a proposed budget for the provision of services;
- formulating policy recommendations regarding the allocation of funds;
- formulating recommendations for the use of amendment funds; and
- visiting subgrantees to learn more about their services and operations, as time permits.

6.5 Evaluation and Research Committee

Shall consist of Board Directors and community representation; staffed by the Program Manager, Program Specialist and Executive Director. This committee shall be responsible for:

- reviewing, in a general manner, the programmatic monitoring reports of subgrantees;
- evaluating AIDSNET's effectiveness and overall performance;
- formulating tools for the evaluation of the organization by the subgrantees and conducting the evaluation;
- overseeing the development and the implementation of the organization's Quality Management Plan;
- overseeing the research portion of the needs assessments;
- developing performance standards and overseeing their implementation; and
- reviewing proposals for research projects and evaluating the end products.

6.6 Marketing and Development Committee

Shall consist of Board Directors and community representation; staffed by the Program Manager, Program Specialist and Executive Director. This committee shall be responsible for:

- preparing and updating the organization's marketing plan;
- implementing the marketing plan;
- overseeing the preparation of the Annual Meeting;
- overseeing the preparation of the Annual Report;
- overseeing the preparation of marketing materials;
- overseeing the preparation of grant applications; and
- developing and coordinating the organization's local fundraising efforts.

6.7 Other Committees

The Board may create and disband ad hoc committees from time to time.

ARTICLE VII - STAFF

7.1 The Board of Directors shall employ an Executive Director to oversee the day-to-day operations of AIDSNET. The Executive Director shall submit bimonthly written reports to the Board prior to each Board meeting and report regularly to each standing committee those issues governed by that committee.

The Executive Director will supervise all other AIDSNET staff according to the personnel policy of the organization. The Executive Director position will be counted in the establishment of a quorum for each Board meeting. The Executive Director shall be responsible for the hiring of such additional staff within approved salary guidelines as established by the Board.

ARTICLE VIII - CONFLICT OF INTEREST

8.1 Upon joining the Board, the Board member shall execute a statement setting forth any possible conflicts of interest relative to the corporation or stating that no such conflicts exist. Thereafter, each Board member shall execute the aforesaid statement at the beginning of each fiscal year. Additionally, as part of every Board meeting the agenda will include a query to the attending members if any circumstance has changed that might constitute a conflict of interest or might be construed by someone outside of AIDSNET as a conflict of interest. Any director, officer, employee, or committee member having an interest in a contract or other transaction presented to the Board or a committee thereof for authorization, approval or ratification shall give prompt, full and frank disclosure of her/his interest to the Board or committee prior to its acting on such contract or transaction. The body to which such disclosure is made shall thereupon determine, by majority vote, whether the disclosure shows that a conflict of interest exists or can reasonably be construed to exist. If a conflict is deemed to exist, such person shall not vote on, nor use her/his personal influence on, nor participate (other than to present factual information or to respond to questions) in the discussions or deliberations with respect to such contract or transaction. The minutes of the meeting shall reflect the disclosure made, the vote thereon, and, where applicable, the abstention from voting and participation.

ARTICLE IX - PARLIAMENTARY AUTHORITY

9.1 Robert's Rules of Order, the most recent revised edition, shall constitute the ruling authority in all cases wherein such rules do not conflict with the rules of this organization or any statute of the state.

ARTICLE X - AMENDMENTS

10.1 These By-Laws may be amended by the affirmative vote of two-thirds (2/3) of the Board present at any regular meeting of the Board of Directors or at any meeting of the Board called for the express purpose of amending these By-Laws, providing that those present constitute a quorum, and provided that the general purpose of the amendment(s) shall have been stated in the notice of the meeting and that such notice shall have been sent to all members of the Board at least fourteen (14) days prior to the meeting.

ARTICLE XI - FINAL DISPOSITION

11.1 In the event of the liquidation or dissolution of the Corporation, whether voluntary or involuntary, no member shall be entitled to any distribution or division of its remaining property, assets or the proceeds of the same. In the event of liquidation or dissolution, the Board shall, after paying or making due provision for the payment of all liabilities of the Corporation, dispose of all remaining properties or assets or properties solely to an organization(s) or entity(ies) which organized exclusively for charitable, educational or scientific purposes and which is set at that time fully and duly qualified as an exempt organization(s).

ARTICLE XII - INDEMNIFICATION

12.1 The organization shall indemnify each person who is or was a Board member, officer, or employee of the organization, against any liability and reasonable expense that may be incurred by her/him in connection with or resulting from any claim, action, suit, or preceding (whether brought by or in the right of the organization or otherwise), civil or criminal, or in connection with an appeal relating thereto, in which she/he may become involved, as a party or otherwise, by reason of his/her being or having been a Board member, officer, or employee, whether or not she/he continues to be such at the time of the liability or expense is incurred, provide such person acted, in good faith, in what she/he reasonably believed to be the best interests of the organization and, in addition, in any criminal action or proceeding, had no reasonable cause to believe that his/her conduct was unlawful. As used in this Article, the terms "liability" and "expense" shall include, but shall not be limited to, counsel fees and disbursements and amounts of judgments, fines, or penalties against, and amounts paid in to the organization itself.

12.2 The termination of any claim, action, suit or proceeding, civil or criminal by judgment, settlement (whether with or without court approval) or conviction or upon a plea of quality or of nolo contendere, or its equivalent, shall not create a presumption that a Board member, officer, or employee, did not meet the standard set forth in the first sentence of the Article, except where there shall have been a judgment rendered specifically finding that the action or conduct of such Board member, officer, or employee constituted willful negligence or misconduct. Any such Board member, officer, or employee referred to in this Article shall be entitled to indemnification as of right, unless the Board, acting by a quorum consisting of members who are not parties to (or who have been wholly successful with respect to) such claim, action, suit, or proceeding, shall find that the Board member, officer, or employee has not met the standards of conduct set forth in the first sentence of this Article, or two (2) independent legal counsel (who may be the regular counsel of the organization) shall deliver to the Board counsel's written advice that, in counsel's opinion, such Board member, officer, or employee has not met such standards. Expenses incurred with respect to any such claim, action, suit, or proceeding may be advanced by the organization prior to the final disposition thereof upon receipt of an undertaking by or on behalf of the recipient to repay such amount in the event that it shall ultimately be determined that she/he is not entitled to indemnification under this Article. The Rights of Indemnification provided in this Article shall be in addition to any rights to which any person concerned may otherwise be entitled by contract or as a matter of law, and shall insure to the benefit of the heirs, executors, and administrators of any such person.

12.3. The organization shall purchase and maintain General Liability and Directors' and Officers' insurance on behalf of any person who 1) is or was a Director, officer, employee or agent of the Corporation**;** or 2) is or was serving at the request of the Corporation**;** or 3) is or was serving at the request of the Corporation as a Director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against any liability asserted against such person and incurred by such person in any capacity or arising out of such person's status as such, whether or not the Corporation would otherwise have the power to indemnify such person against such liability.

ARTICLE XIII - AUDIT

13.1 The books of the organization shall be audited annually by an independent certified public accountant appointed by the Board. The Auditor's Report shall be filed with the records of the organization. A summary of this report shall be presented to the Board of Directors.

APPENDIX G

AIDSNET OPERATIONS CYCLE

Due No Later Than	Required Reports	Report Period
Year Round	Board Committee Meetings (Planning, Marketing/Development, Evaluation/Research)	
Year Round	Prevention Observation	
2nd & 4th Wed of ea. Month	Staff Meetings	
Quarterly	Prevention Education Advisory Council	
Quarterly	Service Coordination Advisory Council	
Every 1-2 months	HI-V Group Advisory Council	
Semi-Annually	Joint PRE-SCAC	
5-Jul	Provider invoices for June services	6/1 to 6/30
5-Jul	Providers direct upload Prevention data to PaUDS	6/1 to 6/30
5-Jul	Quarterly RW HIV/AIDS Program Data Report (RDR) due to AIDSNET	4/1 to 6/30
10-Jul	Outcomes and Prevention Narrative due to AIDSNET	4/1 to 6/30
Mid-July	CRSSP Meetings	
15-Jul	Cash Needs Request for August	---
15-Jul	Cash Needs Request for June final	6/1 to 6/30
15-Jul	HOPWA Supplemental Invoice for June	6/1 to 6/30
15-Jul	Quarterly Financial Report	4/1 to 6/30
15-Jul	Providers email Year-End QI Storyboard to AIDSNET	4/1 to 6/30
15-Jul	Quarterly RW HIV/AIDS Program Data Report (RDR) due to the DOH	4/1 to 6/30
15-Jul	Fixed Asset Inventory Report	4/1 to 6/30
15-Jul	HOPWA Annual Progress Report due to AIDSNET	7/1 to 6/30
15-Jul	Annual SHIP Work Plan	7/1 to 6/30
31-Jul	Outcomes due to the DOH	7/1 to 6/30
31-Jul	Quarter payroll tax reports	
1-Aug	HOPWA APR emailed to DOH (Joanne)	7/1 to 6/30
1-Aug	Semi-Annual CAREWare RDR	4/1 to 6/30
5-Aug	Provider invoices for July services	7/1 to 7/31
5-Aug	Providers direct upload Prevention data to PaUDS	7/1 to 7/31
Early August	Begin working on Annual Report and PowerPoint Presentation for Annual Meeting	
15-Aug	Cash Needs Request for September	---
15-Aug	Provider Performance Measures Report uploaded directly to WebPortal	as of 6/30
5-Sep	Provider invoices for August services	8/1 to 8/31
5-Sep	Providers direct upload Prevention data to PaUDS	8/1 to 8/31
15-Sep	Cash Needs Request for October	---
	Semi-Annual CAREWare RSR	4/1 to 6/30
Mid-September	Start planning for June HI-V Retreat	
Late September	Annual Meeting	
1st Wed of October	CRSSP approval at Board meeting	
5-Oct	Provider invoices for September services	9/1 to 9/30

Due No Later Than	Required Reports	Report Period
5-Oct	Providers direct upload Prevention data to PaUDS	9/1 to 9/30
5-Oct	Quarterly RW HIV/AIDS Program Data Report (RDR) due to AIDSNET	7/1 to 9/30
5-Oct	Request Semi-Annual Run of RDR from Providers (submit page 6 only)	4/1 to 9/30
10-Oct	Outcomes and Prevention Narrative due to AIDSNET	7/1 to 9/30
15-Oct	Provider Performance Measures Report uploaded directly to WebPortal	as of 8/31
15-Oct	Cash Needs Request for November	---
15-Oct	HOPWA Supplemental Invoice for September	9/1 to 9/30
15-Oct	Quarterly Financial Report	7/1 to 9/30
15-Oct	RW Quarterly Progress Report	7/1 to 9/30
15-Oct	RW Mid-Year Progress Report	4/1 to 9/30
15-Oct	Quarterly RW HIV/AIDS Program Data Report (RDR) due to the DOH	7/1 to 9/30
15-Oct	Coalition Regional Services and Strategic Plan (CRSSP) due to the DOH	
4th Tues of October	Quarterly Fiscal Review of Provider Status	7/1 to 9/30
31-Oct	Quarter payroll tax reports	
31-Oct	Audit due to the DOH	
Mid-October - November	Monitoring Visits (Programmatic)	
5-Nov	Provider invoices for October services	10/1 to 10/31
5-Nov	Providers direct upload Prevention data to PaUDS	10/1 to 10/31
15-Nov	Cash Needs Request for December	---
15-Nov	HOPWA Supplemental Invoice for October	10/1 to 10/31
15-Nov	990 and BCO 10 due	
Mid-November	PA DOH Public Health Institute Trainings	
November	Prepare and distribute RFP/RFI - Bi-annually	
30-Nov	Programmatic Monitoring Complete	
November - December	Monitoring Visits (Fiscal)	
1-Dec	World AIDS Day events	
Early December	Proposal Meeting	
5-Dec	Provider invoices for November services	11/1 to 11/30
5-Dec	Providers direct upload Prevention data to PaUDS	11/1 to 11/30
10-Dec	Provider Performance Measures Report uploaded directly to WebPortal	as of 10/31
10-Dec	Fiscal Monitoring Complete	
15-Dec	Cash Needs Request for January	11/1 to 11/30
15-Dec	HOPWA Supplemental Invoice for November	11/1 to 11/30
31-Dec	Staff Delete appropriate email documents due for disposal	
31-Dec	Request for greater than 10% budget revision request to DOH, if applicable	
31-Dec	Subgrant Monitoring Reports due to the DOH (Fiscal and Programmatic)	
5-Jan	Provider invoices for December services	12/1 to 12/31
5-Jan	Providers direct upload Prevention data to PaUDS	12/1 to 12/31
5-Jan	Quarterly RW HIV/AIDS Program Data Report (RDR) due to AIDSNET	10/1 to 12/31

Due No Later Than	Required Reports	Report Period
10-Jan	Outcomes and Prevention Narrative due to AIDSNET	10/1 to 12/31
13-Jan	Report 656 dollars spent on pt care services - emailed to DOH (Joanne)	1/1 to 12/31
15-Jan	Cash Needs Request for February	---
15-Jan	HOPWA Supplemental Invoice for December	12/1 to 12/31
15-Jan	Quarterly Financial Report	10/1 to 12/31
15-Jan	Quarterly Implementation plan progress report/Narrative to DOH	10/1 to 12/31
15-Jan	Providers Mid-Year QI Storyboard due to AIDSNET	7/1 to 12/31
15-Jan	Quarterly RW HIV/AIDS Program Data Report (RDR) due to the DOH	10/1 to 12/31
4th Tues of January	Quarterly Fiscal Review of Provider Status	10/1 to 12/31
Late January	RFP/RFI Applications Due - Initial Review; Send to Allocations Committee - Bi-annually	
31-Jan	Quarter payroll tax reports	
31-Jan	Send out W-2's and 1099's	
31-Jan	Evaluation of Quality Services (Outcomes) due to the DOH	7/1 to 12/31
5-Feb	Provider invoices for January services	1/1 to 1/31
5-Feb	Providers direct upload Prevention data to PaUDS	1/1 to 1/31
15-Feb	Provider Performance Measures Report uploaded directly to WebPortal	as of 12/31
15-Feb	Cash Needs Request for March	---
15-Feb	HOPWA Supplemental Invoice for January	1/1 to 1/31
15-Feb	Annual RW HIV/AIDS Program Data Report (RDR) mailed to DOH	1/1 to 12/31
15-Feb	Annual RW HIV/AIDS Client Level Data Report (RSR) uploaded directly to HRSA	1/1 to 12/31
28-Feb	Year end tax reconciliation reports	
February	Staff review care and prevention proposals; email summaries to allocations committee - Bi-annually	
End of Feb - Early March	Allocations Committee Meetings - Bi-annually	
5-Mar	Provider invoices for February services	2/1 to 2/28
5-Mar	Providers direct upload Prevention data to PaUDS	2/1 to 2/28
Mid-March	Prepare/Mail Final Allocations Budget and Program Presentation to Board of Directors - Bi-annually	
15-Mar	Cash Needs Request for April (No Ryan White)	---
15-Mar	Cash Needs Request for March Ryan White supplemental	
15-Mar	HOPWA Supplemental Invoice for February	2/1 to 2/31
March - Mid-April	Subgrant Follow-up Monitoring (Programmatic)	
April	Subgrant Follow-Up Monitoring (Fiscal)	
5-Apr	Provider invoices for March services	3/1 to 3/31
5-Apr	Providers direct upload Prevention data to PaUDS	3/1 to 3/31
5-Apr	Quarterly RW HIV/AIDS Program Data Report (RDR) due to AIDSNET	1/1 to 3/31
10-Apr	Outcomes and Prevention Narrative due to AIDSNET	1/1 to 3/31
15-Apr	Provider Performance Measures Report uploaded directly to WebPortal	as of 2/28
Mid-April	Prepare Award Letters/Negotiate Contracts	
15-Apr	Cash Needs Request for May	3/1 to 3/31

Due No Later Than	Required Reports	Report Period
15-Apr	Cash Needs Request Supplement for end of March Ryan White fiscal year	---
15-Apr	HOPWA Invoice Supplement for March	3/1 to 3/31
15-Apr	Quarterly Financial Report	1/1 to 3/31
15-Apr	RW Quarterly Implementation plan progress report/Narrative to DOH	1/1 to 3/31
15-Apr	Quarterly RW HIV/AIDS Program Data Report (RDR) due to the DOH	1/1 to 3/31
15-Apr	2nd budget modification	
15-Apr	WICY report due to the DOH	4/1 to 3/31
4th Tues of April	Quarterly Fiscal Review of Provider Status	1/1 to 3/31
30-Apr	Quarter payroll tax reports	
30-Apr	Subgrant Follow-Up Monitoring Reports due to the DOH (Fiscal and Programmatic)	
1-May	Request for equipment purchases	
5-May	Provider invoices for April services	4/1 to 4/30
5-May	Providers direct upload Prevention data to PaUDS	4/1 to 4/30
15-May	Cash Needs Request for June	---
15-May	HOPWA Invoice Supplement for April	4/1 to 4/32
21-May	Planned FY Allocations Report	4/1 to 3/31
21-May	Planned FY Implementation Plan	4/1 to 3/31
21-May	Consolidated List of Contracts	4/1 to 3/31
Mid May	Mail contracts to the DOH	
Late May	***PA DOH Public Health Institute Trainings***	
June	Schedule Annual Meeting	
1st wk June	RW Final Annual Progress Report to DOH Project Officer/Julia Montgomery	4/1 to 3/31
1st wk June	Final RW Expense Report	4/1 to 3/31
1st wk June	Final RW Implementation Plan	4/1 to 3/31
5-Jun	Provider invoices for May services	5/1 to 5/31
5-Jun	Providers direct upload Prevention data to PaUDS	5/1 to 5/31
10-Jun	Provider Performance Measures Report Uploaded directly to WebPortal	as of 4/30
15-Jun	Cash Needs Request for July	---
15-Jun	HOPWA Supplemental Invoice for May	5/1 to 5/31
Mid-June	HI-V Retreat	
30-Jun	Staff Delete appropriate email documents due for disposal	
30-Jun	Destroy appropriate documents due for disposal	
June - July	Annual State Monitoring Visit	
Bold/Italics = not mandatory/listed as an FYI		

APPENDIX H

NATIONAL QUALITY CENTER CHECKLIST FOR THE REVIEW OF AN HIV-SPECIFIC QUALITY MANAGEMENT PLAN

NQC Checklist for the Review of an HIV-Specific Quality Management Plan

Grantee: _____ Date: _____

How to use this checklist:
A Quality Management (QM) Plan defines a quality program's strategic direction and provides a blueprint for upcoming improvement activities for the HIV program. While there is no universal "how-to" template for creating a quality management plan, this document outlines the basic domains that should be covered in each plan: Quality statement, Quality improvement infrastructure, Quality Plan Implementation, Performance measurement, Annual quality goals, Participation of stakeholders, Evaluation, Capacity Building, Process to update the Plan, and Communication.
This checklist has been created to assist those who are: 1) working with grantees to develop an HIV-specific Quality Management (QM) Plan; and/or 2) reviewing a QM Plan for completeness. Keep in mind that this checklist should be used as a reference and assessment tool and that the most important step is to get started.

Definition of terms:
The term Quality Management Program encompasses all systematic and continuous quality processes, including the formal organizational quality infrastructure and quality improvement related activities, consistent with other QI and QA programs with identified leadership, accountability and resources to develop a strategy for using and measuring data to determine progress toward evidence-based benchmarks with a focus on linkages and provider and client expectations using data collection practices to ensure that goals are accomplished and result in improved outcomes.
Quality Management Plan: is a written document that outlines how the quality management program will be implemented, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the program.

Domain in QM Plan	Description	√ - Comments
Quality statement	• Provides brief purpose describing the end goal of the HIV quality program and a shared vision to which all other activities are directed; assume an ideal world and ask yourselves, "What do we want to be for our patients and our community?"	
Quality infrastructure	The quality infrastructure includes the following elements: • Leadership: Identifies who is responsible for the quality management initiatives. • Quality committee(s) structure: Documents who serves on the quality committee, who chairs the committee, and who coordinates the QM activities • Roles and Responsibilities: Defines all key persons, organizations, and major stakeholders and clarifies their expectations for the quality management program. • Resources: Identifies the resources for the QM program	
Performance measurement	• Identifies and quantifies the critical aspects of care and services provided in the organization; ensures integration with other Titles or accrediting bodies,	

	GPRA, Program Assessment Rating Tool (PART) measures and unmet need • Identifies indicators to determine the progress of the QM Program • Indicates who will collect, and analyze data • Indicates who is accountable for collecting, analyzing, and reviewing performance data results and for articulation of findings • Includes strategies on how to report and disseminate results and findings; communicate information about quality improvement activities • Processes in place to use data to develop new QI activities to address identified gaps	
Annual quality goals	• Quality goals are endpoints or conditions toward which quality program will direct its efforts and resources • Selects only a few measurable and realistic goals annually (not more than 5); uses a broad range of goals • Indicates that those annual goals are established priorities for the QM Program • Establishes thresholds at the beginning of the year for each goal	
Participation of stakeholders	• Lists internal and external stakeholders and specify their engagements in the QM program • Provides opportunities for learning about quality for staff • Includes community representatives, as appropriate • Specifies how feedback is gathered from key stakeholders	
Evaluation	• Evaluates the effectiveness of the QM/QI infrastructure to decide whether to improve how quality improvement work gets done • Evaluates QI activities to determine whether the annual quality goals for quality improvement activities are met • Reviews performance measures to document whether the measures are appropriate to assess the clinical and non-clinical HIV care	
Capacity Building	• QI capacity building of providers and spread of QI performance measurement systems and QI activities. • Identifies methods for QI training opportunities • Provision of technical assistance on QI and support for QI activities • Indicates how data are being fed back to providers and key stakeholders	
Process to update QM Plan	• Identifies routine schedule to at least annually update QM Plan • Specifies accountability – indicates who will initiate process to update/revise plan. • Indicates a sign-off process to finalize plan; potentially include internal/external stakeholders; include signatures of key stakeholders	
Communication	• Outlines process to share information with all stakeholders at appropriate intervals	

	• Identifies format for communication • Identifies communication intervals	
Formatting	• Clear and easy to follow layout and organization of content • Clear dating of document, including date of 'expiration'; page numbers	
QM Plan implementation	• Specifies timelines for implementation to accomplish those goals – workplan • Specifies accountability for implementation steps • Provides milestones and associated measurable implementation objectives	

APPENDIX I

DECISION MAKERS LIST – FISCAL YEAR 2013-2014

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Allocations Committee
Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 8 Number of those who are Consumers: Confidential

Brief Description of the Role of this entity in the process:

The Allocations Committee oversees the preparation of the Request for Proposals. It is also responsible for reading and scoring the proposals and developing a proposed budget for the provision of services.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Evaluation and Research Committee
Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 5 Number of those who are Consumers: Confidential
Brief Description of the Role of this entity in the process:

The Evaluation and Research Committee is responsible for reviewing the programmatic monitoring process and evaluating the organization's overall performance. The Committee also monitors the need for local research projects and reviews proposals for the same.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Executive Committee
Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 5 Number of those who are Consumers: Confidential

Brief Description of the Role of this entity in the process:

The Executive Committee consists of the Officers of AIDSNET and the Chairs of all standing committees. The Committee oversees the Executive Director and operation of the corporation. The Executive Committee is also responsible for developing a board and/or committee member recruitment strategy.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Finance Committee

Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 4 Number of those who are Consumers: Confidential

Brief Description of the Role of this entity in the process:

The Finance Committee is responsible for reviewing the operating budget, financial statements and annual audit.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Marketing and Development Committee

Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 6 Number of those who are Consumers: Confidential

Brief Description of the Role of this entity in the process:

The Marketing and Development Committee prepares, implements and updates the organization's marketing plan. It is also responsible for developing and coordinating the organization's local fundraising efforts. The Committee oversees the preparation of the Annual Report, Annual Meeting and marketing materials.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Planning Committee
Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 14 Number of those who are Consumers: Confidential
Brief Description of the Role of this entity in the process:

The Planning Committee oversees the preparation of the Coalition Regional Services and Strategic Plan and the development of needs assessments and gap analyses.

DECISION MAKERS FY 13-14
Committees and Boards

AIDSNET
Coalition

DIRECTIONS: Duplicate this page for use with each decision-making entity of the Coalition and contractor related to the Department contract.

Name of Decision Making Entity: Board of Directors

Decision making entity of: the Coalition **T** the Contractor: **T**

Number of Persons: 13 Number of those who are Consumers: Confidential

Brief Description of the Role of this entity in the process:

The role of the Board is to set, direct, implement and monitor policy.

DECISION MAKERS FY 13-14
Individuals

AIDSNET
Coalition

DIRECTIONS: Complete and submit this page for all persons included in decision-making processes in your region related to the Department contract. Coalition and contractor information should be combined for those Coalitions who do not provide their own fiscal responsibilities. Duplicate this page as necessary should more room be needed.

No.	Profession	Agency Affiliation	Age	Ethnicity	Race	Gender	Participation on Decision-Making Entities
1.	Management		50-59		W	F	Board
2.	Human Services		20-29		W	F	Planning
3.	Human Services		50-59		W	M	Planning
4.	Volunteer		40-49		W	M	Board, Marketing & Development
5.	Banking		20-29		W	F	Board, Executive, Marketing & Development
6.	Educator		60-69		W	F	Board, Evaluation & Research
7.	Volunteer		40-49		W	F	Board
8.	Private Sector		40-49		W	M	Board, Allocations, Executive, Planning, Finance
9.	Educator		40-49	Latina	W	F	Board, Evaluation & Research
10.	Administration		60-69		W	F	All Committees
11.	Fiscal Officer		50-59		W	F	Finance, Allocations, Planning
12.	Insurance		30-39	African	B	F	Board, Marketing & Development
13.	Human Services		40-49		W	F	Planning
14.	Private Sector		50-59		W	M	Allocations
15.	Administration		30-39		B	F	Allocations, Planning
16.	Human Services		30-39		W	F	Board, Allocations, Executive, Finance, Planning
17.	Human Services		30-39	Latina	W	F	Planning
18.	Human Services		50-59		W	F	Planning
19.	Marketing		40-49		W	F	Board, Allocations, Marketing & Development
20.	Education		60-69		W	F	Evaluation & Research
21.	Marketing		20-29		W	F	Board, Marketing & Development
22.	Medical		40-49		W	M	Board, Executive, Evaluation & Research
23.	Human Services		40-49		W	F	Planning
24.	Human Services		20-29	Latina	W	F	Planning
25.	Human Services		50-59		W	F	Planning
26.	Human Services		40-49		W	M	Planning
27.	Volunteer		20-29	African - American	B	F	Board, Allocations

APPENDIX J

REGIONAL CARE RESOURCE INVENTORY

REGIONAL CARE RESOURCE INVENTORY
AIDSNET

1. Core Services

a. Primary HIV Medical Care

Berks County

- Dr. Felipe Arias
  FARIAS Medical Clinic
  525 Penn Street
  Reading, PA 19601
  Phone: 610-898-0766

- The Reading Hospital Center for Public Health
  Sixth Avenue and Spruce Street
  A-Building, 3rd Floor
  West Reading, PA 19611
  Phone: 610-988-9386

Carbon County

- None

Lehigh/Northampton Counties

- Dr. Marcelo Gareca
  Lehigh Valley Hospital
  AIDS Activities Office
  P O Box 7017
  17th & Chew Streets
  Allentown, PA 18105-7017
  Phone: 610-969-2500

- Dr. Timothy Friel
  Lehigh Valley Hospital
  AIDS Activities Office
  P O Box 7017
  17th & Chew Streets
  Allentown, PA 18105-7017
  Phone: 610-969-2500

- Dr. Margaret Hoffman-Terry
  Lehigh Valley Hospital
  AIDS Activities Office
  P O Box 7017
  17th & Chew Streets
  Allentown, PA 18105-7017
  Phone: 610-969- 2500

- Dr. Jeffrey A. Jahre
  St. Luke's Internal Medicine
  801 Ostrum Street
  Bethlehem, PA 18015-1000
  Phone: 610-954-6643

- Dr. Gina Karess
  Lehigh Valley Physicians Group
  1210 S. Cedar Crest Boulevard
  Ste. 3600
  Allentown, PA 18103-6229
  Phone: 610-402-1150

- Dr. Wesley Kozinn
  Valley Infectious Disease Specialists
  2061 Fairview Avenue
  Easton, PA 18042
  Phone: 610-253-7818

- Dr. Edgardo Maldonado
  Centro De Salud Latino Americano
  17th & Chew Streets
  Ste. 101
  Allentown, PA 18104
  Phone: 610-969-3600

- Dr. Luther Rhodes
  LVPG Lehigh Valley Infectious Disease Specialists
  1250 South Cedar Crest Boulevard
  Suite 200
  Allentown, PA 18103-6271
  Phone: 610-402-8430

- Dr. Carla Rossi
  Northwood Medical Center
  3735 Easton Nazareth Highway
  Suite 201
  Easton, PA 18045-8338
  Phone: 610-923-9663

- Dr. Carla Rossi
  Easton Community HIV Organization
  111 North 4th Street
  Easton, PA 18042
  Phone: 610-253-9868

- St. Luke's Southside Medical Center
  511 East Third Street
  Suite 200
  Bethlehem, PA 18015
  Phone: 484-526-4700

- Dr. David Stein
  Primary Care Associates
  1941 W Hamilton Street, Suite 102
  Allentown, PA 18104-6470
  Phone: 610-776-1603

- Dr. Roman Tuma
  Infectious Disease Associates of Lehigh Valley
  3735 Easton Nazareth Highway
  Suite 201
  Easton, PA 18045-8338
  Phone: 610-923-9663

- Dr. Joseph Yozviak
  Lehigh Valley Hospital
  AIDS Activities Office
  P O Box 7017
  17th & Chew Streets
  Allentown, PA 18105-7017
  Phone: 610-969-2500

Monroe County (and surrounding areas)

- Dr. Mary Louise Decker
  250 Pierce Street
  Suite 203
  Kingston, PA 18704
  Phone: 570-714-2524

- Dr. Lisa Marie Esolen
  Geisinger Medical Center Infectious Diseases
  100 N. Academy Avenue
  Danville, PA 17822
  Phone: 570-271-6211

- Dr. Robert Gotoff
  Geisinger Medical Center Infectious Diseases
  100 N. Academy Avenue
  Danville, PA 17822
  Phone: 570-271-6211

- Dr. Stephen Pancoast
  748 Quincy Avenue, Ste. 1A
  Scranton, PA 18510-1739
  Phone: 570-342-5253

Schuylkill County

- None

b. **HIV-related Medications**

AIDSNET recognizes that the Ryan White CARE Act is the payer of last resort, and requires the three case management agencies to seek payment through Health Choices, Medical Assistance, Special Pharmaceutical Benefit Program, private insurance coverage and pharmaceutical company programs before requesting the use of Ryan White funds. If the client has no other option, AIDSNET will pay for HIV-related prescriptions.

c. **Mental Health Treatment**

Berks County

- Berks County Human Services
  633 Court Street, 3rd Floor
  Reading, PA 19601
  Phone: 610-478-6194

- Family Guidance Center
  Suites 205-206
  1235 Penn Avenue
  Wyomissing, PA 19610-2100
  Phone: 610-374-4963 x3477

- The Reading Hospital
  Behavioral Health Services
  Sixth Ave. and Spruce St.
  West Reading, PA 19611
  Phone: 610-988-8070
  24 hr. Substance Abuse Treatment Addiction Hotline: 610-988-8186

- Service Access and Management Corporation (MH/MR's crisis intervention program)
  19 North Sixth Street, Suite 300
  Reading, PA 19601
  Phone: 877-236-4600 or 610-236-0530

Carbon County

- Carbon-Monroe-Pike Mental Health/Mental Retardation Program
  428 S. 7th Street, Suite 2
  Lehighton, PA 18235
  Phone: 610-377-0773
  24-hour Mental Health Crisis hotline: 800-338-6467

Lehigh/Northampton Counties

- AIDS Activities Office of the Lehigh Valley Hospital
  1627 Chew Street
  Allentown, PA 18102-3698
  Phone: 610-969-2400

- Family Answers
  411 W. Walnut Street
  Allentown, PA 18102-5427
  Phone: 610-435-9651

- Hispanic American Organization Counseling Services
  462 Walnut Street
  Allentown, PA 18102-4027
  Phone: 610-351-2292

- Lehigh County Mental Health Program
  17 South 7th Street
  Allentown, PA 18101
  Phone: 610-782-3200
  Phone: 610-782-3127 – 24 hr. Emergency Line 610-782-3127

- Lehigh County Conference of Churches Daybreak Program
  534 Chew Street
  Allentown, PA 18102
  Phone: 610-433-6421

- Lehigh Valley Community Health Centers
  Bethlehem: 865 East 4th Street
  Bethlehem, PA 18015
  Phone: 610-691-4357

Allentown: 210-214 North 6th Street
Allentown, PA 18102
Phone: 610-432-4356
Easton: 226 Northampton Street
Easton, PA 18042
Phone: 610-330-0489

- Northampton County Mental Health
520 East Broad Street
Bethlehem, PA 18018
Phone: 610-974-7555

- Migdalia Roman, LCSW
35 E. Elizabeth Avenue
Ste. 22
Bethlehem, PA 18018
Phone: 610-442-5217

- Christy E. Yerk-Smith, MA, NCC, LPC
825 N. Cedar Crest Boulevard
Allentown, PA 18104
Phone: 610-248-8257

Monroe County

- Nicole D. Brogna, LCSW
134 Broad Street, Box #9
Stroudsburg, PA 18360
Phone: 570-872-9323

- Carbon-Monroe-Pike Mental Health/Mental Retardation Program
730 A Phillips Street
Stroudsburg, PA 18360-2224
Phone: 570-420-1900
24 hr. Mental Health Crisis Hotline: 800-338-6467

- Nancy L. Lupton, LCSW
134 Broad Street, Box #9
Stroudsburg, PA 18360
Phone: 570-872-9324

- Cynthia L. Roth, LCSW
134 Broad Street, #9
Stroudsburg, PA 18360
Phone: 570-872-7752

Schuylkill County

- Schuylkill County Mental Health and Drug & Alcohol
108 South Claude A. Lord Boulevard
2nd Floor
Pottsville, PA 17901
Phone: 570-621-2890

- Service Access and Management Corporation (MH/MR's crisis intervention program)
One South 2nd Street
Pottsville, PA 17901
Phone: 570-621-2700

d. **Substance Abuse Treatment**
(Intake units are the access point for substance abuse services)

Berks County

- ADAPPT
  428 Walnut Street
  #901-909
  Reading, PA 19601
  Phone: 610-478-8800

- Berks Counseling Center
  645 Penn Street
  2nd Floor
  Reading, PA 19601
  610-373-4281

- Berks County Human Services
  633 Court Street, 3rd Floor
  Reading, PA 19601
  610-478-6194

- Service Access and Management Corporation (SAM)
  Treatment Access Services Center (TASC - MH/Substance Abuse Treatment)
  19 North Sixth Street
  Suite 300
  Reading, PA 19601
  Phone: 610-236-0530

Carbon County

- Carbon-Monroe-Pike Drug and Alcohol Commission
  428 South 7th Street
  Ste. 1
  Lehighton, PA 18235-1824
  Phone: 610-377-5177

- Referral Center for Carbon County
  Phone: 866-824-3578

Lehigh/Northampton Counties

- Addiction Treatment Center 24-hr Help Line
  Allentown, PA
  Phone: 610-435-4450

- Lehigh County Drug & Alcohol Abuse Program
  17 S. 7th Street
  Allentown, PA 18101
  Phone: 610-782-3200

- Lehigh Valley Drug & Alcohol Intake Unit
  Location of treatment facility is dependent on diagnosis, substances & severity
  29 S. Law Street, 3rd Floor
  Allentown, PA 18101
  Phone: 610-432-2228

- Lehigh Valley Drug & Alcohol Intake Unit
  Location of treatment facility is dependent on diagnosis, substances & severity
  44 E. Broad Street, Suite 20
  Bethlehem, PA 18018
  Phone: 610-866-4088

- Lehigh Valley Drug & Alcohol Intake Unit
  Location of treatment facility is dependent on diagnosis, substances & severity
  6 South Third Street, Suite 403
  Easton, PA 18042
  Phone: 610-923-0394

- North East Treatment (NET) Centers
  44 East Broad Street
  Ste. 20
  Bethlehem, PA 18018
  Phone: 610-868-0435

- North East Treatment (NET) Centers
  6 South Third Street
  Suite 508
  Easton, PA 18042
  Phone: 610-253-6760

- Northampton County Drug & Alcohol
  520 East Broad Street
  1st Floor
  Bethlehem, PA 18018
  Phone: 610-997-5800

- Service Access and Management Corporation (SAM)
  Treatment Access Services Center
  701 West Broad Street
  Suite 110
  Bethlehem, PA 18018
  Phone: 610-419-9102

Monroe County

- Catholic Social Services
  724 Phillips Street, Suite A
  Stroudsburg, PA 18360-2224
  Phone: 570-517-0892

- NHS Pennsylvania
  663 Pocono Boulevard
  Mt. Pocono, PA 19334
  Phone: 570-839-3097

Schuylkill County

- Conewago
  202-204 S. Centre Street
  Pottsville, PA 17901
  Phone: 570-628-5835

- Service Access and Management Corporation (SAM)
  Treatment Access Services Center
  One South 2nd Street
  Pottsville, PA 17901

Phone: 570-621-2700
Phone: 877-216-5035

- Schuylkill County Mental Health and Drug & Alcohol
  108 South Claude A. Lord Boulevard
  Pottsville, PA 17901
  Phone: 570-621-2890

e. **Oral Health**

Berks County

- SJMC Dental Clinic
  145 N. 6th Street
  Second Floor
  P O Box 316
  Reading, PA 19601
  Phone: 610-378-2445

- Dental Dreams
  3302 N. 5th Street Highway
  Reading, PA 19605
  Phone: 610-929-4040

- Donated Dental Services
  P O Box 5025
  Harrisburg, PA 17110
  Phone: 800-716-8721

- Welsh Mountain Medical and Dental Center
  584 Springville Road
  New Holland, PA 17557
  Phone: 717-354-4711

- Weston Centre for Dental Health
  1439 Centre Turnpike
  Rt. 61
  Orwigsburg, PA 17961
  Phone: 570-366-1014

- Weston Centre for Dental Health
  2642 Bernville Road
  Reading, PA 19605
  610-621-2099

Carbon County (only dentist that takes MA is in Luzerne County)

- Dr. Michael Weiss (cannot perform surgery)
  14 S. Cedar Street
  Hazleton, PA 18201
  Phone: 570-455-6275
  Toll Free: 800-598-5984

- Donated Dental Services
  P O Box 5025
  Harrisburg, PA 17110
  Phone: 800-716-8721

Lehigh/Northampton Counties

- Dental Dreams
  2180 MacArthur Road, #15
  Whitehall, PA 18052
  Phone: 610-437-1800

- St. Luke's Union Station
  240 Union Station Plaza
  Bethlehem, PA. 18015
  Phone: 484-526-2460

- St. Luke's Easton Dental Center
  100 N. 3rd Street
  2nd Floor
  Easton, PA 18042
  610-419-7330

- Northampton Community College Litwak Hygiene Dental Clinic
  (Provides cleaning, x-ray and referral to St. Luke's Dental Clinic)
  3835 Green Pond Road
  Penn Building Room 216
  Bethlehem, PA 18020
  Phone: 610-861-5442

- St. Luke's Hospital Mobile Dental
  801 Ostrum Street
  Bethlehem, PA 18015
  Phone: 610-954-2106
  (Serve children ages 3 – 18 years of age only)

- Donated Dental Services
  P O Box 5025
  Harrisburg, PA 17110
  Phone: 800-716-8721

- Sacred Heart Hospital Dental Clinic
  Sigal Center for Family Medicine
  450 W. Chew Street
  Ste. 201
  Allentown, PA 18102
  Phone: 610-776-4802

- Lehigh Valley Hospital Dental Clinic
  17th and Chew Streets
  Allentown, PA 18102
  610-402-2245

- Easton Hospital Dental Clinic
  250 S. 21st Street
  Easton, PA 18042
  Phone: 610-250-4460

- Northampton Dental Initiative
  Two Rivers Health & Wellness Foundation
  1101 Northampton Street
  Easton, PA 18042
  866-903-9104

- William Penn Family Dental
  4013 William Penn Highway
  Suite 701
  Easton, PA 18045
  610-258-2000

- Lehigh Valley Hospital – Muhlenberg
  2545 Schoenersville Road
  Bethlehem, PA 18017
  Phone: 484-884-2315

Monroe County (only dentist that takes MA is in Luzerne County)

- Dr. Michael Weiss (cannot perform surgery)
  14 S. Cedar Street
  Hazleton, PA 18201
  Phone: 570-455-6275
  Toll Free: 800-598-5984

- Abeloff Community Health Center
  200 Brown Street
  East Stroudsburg, PA 18301
  Phone: 570-476-3585
  (Serves children and adolescents up to age 18 only)

- Donated Dental Services
  P O Box 5025
  Harrisburg, PA 17110
  Phone: 800-716-8721
  (Due to lengthy waiting list, applications are not being accepted for Monroe County residents at this time)

Schuylkill County (and surrounding areas)

- Dr. Edward Kolonsky
  27 W. Washington Street
  Shenandoah, PA 17976
  Phone: 570-462-4710

- Dr. Chris Boseovski
  1349 W. Market Street
  Pottsville, PA 17901
  Phone: 570-622-0386

- Dr. Chris Boseovski
  710 Centre Street
  Ashland, PA 17921
  Phone: 570-875-1260

- Mahanoy City Family Dental Center
  1 South Main Street
  Mahanoy City, PA 17948
  Phone: 570 773-2285

- Dr. James Spector (Oral Surgeon)
  34 S. Main Street
  Wilkes-Barre, PA 18701
  Phone: 570-825-7575

- Donated Dental Services
  P O Box 5025
  Harrisburg, PA 17110
  Phone: 800-716-8721

- Good Samaritan Medical Center Dental Clinic
  700 E. Norwegian Street
  Pottsville, PA 17901
  Phone: 570-621-4110

- Rural Health Corporation of NE PA – Black Creek Health Center
  75 Pineapple Street
  P O Box 670
  Nuremberg, PA 18241-0670
  Phone: 570-384-3238

- Weston Centre for Dental Health
  1439 Centre Turnpike
  Rt. 61
  Orwigsburg, PA 17961
  Phone: 570-366-1014

f. **Medical Case Management/Adherence Counseling**

Berks County

- Co-County Wellness Services d/b/a
  Berks AIDS Network
  429 Walnut Street, P O Box 8626
  Reading, PA 19603-8626
  Phone: 610-375-6523
  Uses community list for client referrals which is updated to reflect services that accept Health Choices or Medicare

Carbon County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202
  Please see ASC Resource Inventory
  Also uses Partnership Organizations at The United Way of the Greater Lehigh Valley found online at http://unitedwayglv.org

Lehigh/Northampton Counties

- AIDS Activities Office of the Lehigh Valley Hospital
  17th & Chew Streets
  P O Box 7017
  Allentown, PA 18105-7017
  Phone: 610-969-2400
  Uses the Valley Wide Help Directory published by the American Red Cross of the Greater Lehigh Valley available online at http://www.irissoft.com/vwhp/

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202
  Please see ASC Resource Inventory

Also uses Partnership Organizations at The United Way of the Greater Lehigh Valley found online at http://unitedwayglv.org

Monroe County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202
  Please see ASC Resource Inventory
  Also uses Partnership Organizations at The United Way of the Greater Lehigh Valley found online at http://unitedwayglv.org

Schuylkill County

- Co-County Wellness Services d/b/a
  Schuylkill Wellness Services
  512 North Centre Street
  Pottsville, PA 17901
  Phone: 570-622-3980
  Uses East Central PA Area Health Education Center resource list for client referrals

2. Non-Core Services

a. Non-Medical Case Management/Adherence Counseling

Berks County

- Co-County Wellness Services d/b/a
  Berks AIDS Network
  429 Walnut Street
  P O Box 8626
  Reading, PA 19603-8626
  Phone: 610-375-6523

Carbon County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202
  Please see ASC Resource Inventory
  Also uses Partnership Organizations at The United Way of the Greater Lehigh Valley found online at http://unitedwayglv.org

Lehigh/Northampton Counties

- AIDS Activities Office of the Lehigh Valley Hospital
  17th & Chew Streets
  P O Box 7017
  Allentown, PA 18105-7017
  Phone: 610-969-4266

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202

Monroe County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street,
  Bethlehem, PA 18018
  Phone: 484-526-6202
  Please see ASC Resource Inventory
  Also uses Partnership Organizations at The United Way of the Greater Lehigh Valley found online at http://unitedwayglv.org

Schuylkill Counties

- Co-County Wellness Services d/b/a
  Schuylkill Wellness Services
  512 North Centre Street
  Pottsville, PA 17901
  Phone: 570-622-3980

b. **Alternative Funding**

As a mechanism to insure that Ryan White Part B funds are payer of last resort, all four case management agencies have the responsibility of obtaining pre-authorization from AIDSNET for most services.

Berks, Carbon, Lehigh, Monroe, Northampton & Schuylkill Counties

- Fighting AIDS Continuously Together (F.A.C.T.)
  PO Box 1028
  245 North 12th Street
  Allentown, PA 18105
  Phone: 610-820-5519

Provides limited funding for PLWH/A in the AIDSNET region

- Utilities: Heating oil, gas, electric, basic phone service
- Rent and mortgage payment assistance
- Durable medical equipment
- Prescriptions
- Non-prescription medications, nutritional supplements
- Repair expenses of primary vehicle for travel to work, doctor and other needs
- Eyeglasses
- Counseling expenses
- Funeral expenses assistance

c. **Food Banks Located at AIDS Service Organizations**

(A listing of individual food banks provided by churches is too extensive to include here. Clients would be referred to same on a case-by-case basis)

Berks County

- Co-County Wellness Services d/b/a
  Berks AIDS Network
  429 Walnut Street
  P O Box 8626
  Reading, PA 19603-8626
  Phone: 610-375-6523

Carbon County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street
  Bethlehem, PA 18018

Phone: 484-526-6202
(Provide gift cards only to Weis or Giant markets)

Lehigh and Northampton Counties

- AIDS Activities Office of Lehigh Valley Hospital
  Food bank located at New Bethany Church
  224 North 6th Street
  Allentown, PA 18102
  Phone AIDS Activities Office for information: 610-969-2290

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street
  Bethlehem, PA 18018
  Phone: 484-526-6202

Monroe County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street
  Bethlehem, PA 18018
  Phone: 484-526-6202
  (Provide gift cards only to Weis or Giant markets)

Schuylkill County

- Co-County Wellness Services d/b/a
  Schuylkill Wellness Services
  512 North Centre Street
  Pottsville, PA 17901
  Phone: 570-622-3980

d. Home Health Care/Visiting Nurse Organizations

Berks County

- Berks Visiting Nurse Association
  1170 Berkshire Boulevard
  Wyomissing, PA 19610
  Phone: 610-378-0481

- Covenant Home Care
  1223 Pottsville Pike
  Shoemakersville, PA 19555
  Phone: 800-726-8761

Carbon County

- Blue Mountain Home Health Care
  800 Mahoning Street
  Lehighton, PA 18235
  610-377-7157

Lehigh & Northampton Counties

- Berks Visiting Nurse Association
  1170 Berkshire Boulevard
  Wyomissing, PA 19610
  610-378-0481
  (Serves Lehigh & Northampton counties)

- Blue Mountain Home Health Care
  800 Mahoning Street
  Lehighton, PA 18235
  610-377-7157
  (Serves upper Lehigh & Northampton counties)

- Family Answers Homemakers
  411 Walnut Street
  Allentown, PA 18102-5427
  Phone: 610-867-3946

- Visiting Nurse Association of St. Luke's, Inc.
  1510 Valley Center Parkway, Suite 200
  Bethlehem, PA 18017
  Phone: 484-526-1100
  Toll Free: 800-211-4788

Monroe County

- Blue Mountain Home Health Care
  800 Mahoning Street
  Lehighton, PA 18235
  610-377-7157
  (Serves western Monroe County)

- VNA Hospice of Monroe County
  502 VNA Road
  East Stroudsburg, PA 18301
  Phone: 570-421-5390

Schuylkill County

- Blue Mountain Home Health Care
  800 Mahoning Street
  Lehighton, PA 18235
  610-377-7157
  (Serves eastern Schuylkill County)

- Covenant Home Care
  1223 Pottsville Pike
  Shoemakersville, PA 19555
  800-726-8761

- Berks Visiting Nurse Association
  1170 Berkshire Boulevard
  Wyomissing, PA 19610
  610-378-0481
  (Serves Schuylkill County)

e. Housing Authorities

Berks County

- Berks County Housing Authority
  1803 Butter Lane
  Reading, PA 19606
  Phone: 610-370-0822

- Reading Housing Authority
  400 Hancock Boulevard
  Reading, PA 19611
  Phone: 610-372-3933

Carbon County

- Carbon County Housing Authority
  215 South Third Street
  Lehighton, PA 18235
  Phone: 610-377-9375

Lehigh County

- Lehigh County Housing Authority & Valley Housing Development Corporation
  333 Ridge Street
  Emmaus, PA 18049-2765
  Phone: 610-433-2312

- Allentown Housing Authority
  1339 West Allen Street
  Allentown, PA 18102-2197
  Phone: 610-439-8678

Monroe County

- Monroe County Housing Authority
  1055 W. Main Street
  Stroudsburg, PA 18360
  Phone: 570-421-7770

Northampton County

- Bethlehem Housing Authority
  645 Main Street, Front
  Bethlehem, PA 18018
  Phone: 610-865-8300

- Easton Housing Authority
  157 South 4th Street
  Easton, PA 18042
  Phone: 610-258-0806

- Northampton County Housing Authority
  15 S. Wood Street, P O Box 252
  Nazareth, PA 18064
  Phone: 610-759-8488

Schuylkill County

- Schuylkill County Housing Authority
  245 Parkway
  Schuylkill Haven, PA 17972
  Phone: 570-385-3400

- Pottsville Housing Authority
  410 Laurel Boulevard
  Pottsville, PA 17901
  Phone: 570-628-2702

f. Legal Services

Berks & Schuylkill Counties

- MidPenn Legal Services
  501 Washington Street, Suite 401
  Reading, PA 19601-3471
  Phone: 610-376-8656 or -800-299-6599

Carbon, Lehigh, Monroe & Northampton Counties

- North Penn Legal Services
  65 E. Elizabeth Avenue, Suite 800
  Bethlehem, PA 18018-6516
  Phone: 610-317-8757

g. HIV Nutritional Counseling in a Community Setting

Berks County

- Co-County Wellness Services d/b/a
  Berks AIDS Network
  429 Walnut Street
  P O Box 8626
  Reading, PA 19603-8626
  Phone: 610-375-6523

Lehigh/Northampton Counties

- AIDS Activities Office of the Lehigh Valley Hospital
  17th & Chew Streets
  P O Box 7017
  Allentown, PA 18105-7017
  Phone: 610-969-4266

- St. Luke's University Hospital
  801 Ostrum Street
  Bethlehem, PA 18015
  Phone: 484-526-1000

Schuylkill Counties

- Co-County Wellness Services d/b/a
  Schuylkill Wellness Services
  512 North Centre Street
  Pottsville, PA 17901
  Phone: 570-622-3980

h. HIV Support Groups

Berks County

- Co-County Wellness Services d/b/a
  Berks AIDS Network
  429 Walnut Street
  P O Box 8626
  Reading, PA 19603-8626
  Phone: 610-375-6523

Lehigh/Northampton Counties

- AIDS Activities Office of Lehigh Valley Hospital
  17th & Chew Streets
  P O Box 7017
  Allentown, PA 18105-7017
  Phone: 610-969-4266

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street
  Bethlehem, PA 18018
  Phone: 484-526-6202

Monroe County

- AIDS Services Center at St. Luke's University Hospital
  641 E. Broad Street
  Bethlehem, PA 18018
  Phone: 484-526-6202

Schuylkill Counties

- Co-County Wellness Services d/b/a
  Schuylkill Wellness Services
  512 North Centre Street
  Pottsville, PA 17901
  Phone: 570-622-3980

APPENDIX K

REGIONAL PREVENTION RESOURCE INVENTORY

AIDSNET's Regional Prevention Resource Inventory

Six-county population estimate as of July 2011 is 1,446,750

Key for Target Populations:	Key for Services:
People Living with HIV/AIDS: **PLWH/A**	HIV Counseling, Testing and Referral Services: **CTR**
Injection drug user: **IDU**	HIV Partner Counseling and Referral Services: **PCRS**
Men who have Sex with Men: **MSM**	Sexually Transmitted Disease Testing: **STD**
Men who have Sex with Men who are IDUs: **MSM/IDU**	Tuberculosis Testing: **TB**
High Risk Heterosexual - Sex Partners of individuals w/above risks: **H**	Intervention Delivered to Individual: **IDI**
Emerging Risk Group: **ERG**	Intervention Delivered to Groups: **IDG**
Perinatal: **P**	

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
BERKS COUNTY		
Co-County Wellness Services d/b/a Berks AIDS Network 429 Walnut Street PO Box 8626 Reading, PA 19603 610.375.6523 www.cocountywellnessservices.org	CTR PCRS STD IDI IDG	PLWH/A Black/Hispanic/White **IDU** Black/Hispanic/White **H** Black/Hispanic/White **MSM** General Public
Berks County State Health Center Reading State Building 625 Cherry Street Room 442 Reading, PA 19602 610.378.4377	CTR PCRS STD TB	General Public
Keystone Rural Health Program Suite 102 145 North 6th Street Reading, PA 19601 610.372.5001 www.keystonehealth.org	IDI IDG	Hispanic **H**
Kutztown University PO Box 730 121 Beck Hall Kutztown, PA 19530 610.683.4000 www.kutztown.edu	STD	Enrolled Kutztown University Students Only
Latinos for Healthy Communities of New Directions Treatment Services 525 Penn Street, Reading, PA 19601 610.478.0646 www.ndts.org	CTR	Methadone Clinic Clients Only

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Reading Medical Center (Operated by Planned Parenthood) 48 South Fourth Street Reading, PA 19602 610.376.8061 http://www.plannedparenthood.org	CTR	General Public
The Reading Hospital Center for Public Health A-Building, Third Floor Sixth Ave. and Spruce St. West Reading, PA 19611 610.988.9386 www.readinghospital.org	CTR	Black/Hispanic/White **IDU** Black/Hispanic/White **H** General Public
CARBON COUNTY		
Carbon County State Health Center HIV Clinic 616 North Street Jim Thorpe, PA 18229 570.325.6106	CTR PCRS TB	General Public
Co-County Wellness Services d/b/a Berks AIDS Network 429 Walnut Street PO Box 8626 Reading, PA 19603 610.375.6523 www.cocountywellnessservices.org	CTR STD IDI IDG	PLWH/A Black/Hispanic/White **IDU** Black/Hispanic/White **H** Black/Hispanic/White **MSM** General Public
LEHIGH COUNTY		
AIDS Activities Office Lehigh Valley Hospital 17th and Chew Streets 6th Floor PO Box 7017 Allentown, PA 18105 610.969-2400 www.lvh.org	CTR IDI IDG	**PLWH/A** General Public
Allentown Health Bureau Alliance Hall 245 North Sixth Street Allentown, PA 18102 610.437.7742 (STD/HIV Services) 610.437.7632 (TB Services) www.allentownpa.org	CTR PCRS STD TB	**PLWH/A** **MSM** Black/White **IDU** Black/Hispanic/White **H** General Public
Latinos for Healthy Communities of New Directions Treatment Services 716 Chew Street Allentown, PA 18012 610.434.6890 www.ndts.org	CTR IDI IDG	Hispanic **IDU/MSM/H** General Public
Lehigh County State Health Center HIV Clinic 3730 Lehigh Street Suite 206 Whitehall, PA 18502 610.821.6770	CTR PCRS STD TB	Black/Hispanic/White **H** Black/White **H** **ERG** (Homeless General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Allentown Medical Center 29 N. 9th Street (Operated by Planned Parenthood) Allentown, PA 18101 610.439.1033 http://www.plannedparenthood.org	CTR STD	General Public
MONROE COUNTY		
Co-County Wellness Services d/b/a Berks AIDS Network 429 Walnut Street PO Box 8626 Reading, PA 19603 610.375.6523 www.cocountywellnessservices.org	IDG	Black/Hispanic/White **H** Black/Hispanic/White **MSM**
Monroe County State Health Center 1972 West main Street Suite 102 Stroudsburg, PA 18360 570.424.3020	CTR PCRS TB	Black/White **H** **ERG** (Homeless) General Public
Stroudsburg Medical Center (Operated by Planned Parenthood) 28 North Seventh Street Stroudsburg, PA 18360 570.424.8306 http://www.plannedparenthood.org	CTR STD	Black/White **H** General Public
NORTHAMPTON COUNTY		
AIDS Service Center at St. Luke's Hospital 641 East Broad Street Bethlehem, PA 18018 484-526-6202	CTR IDI IDG	**PLWH/A** Black/Hispanic/White **IDU** Black/Hispanic/White **MSM** Black/Hispanic/White **H** General Public
Bethlehem City Health Bureau 10 East Church Street Bethlehem, PA 18018 610.865.7087 www.bethlehem-pa.gov	CTR PCRS STD TB	**PLWH/A** Black/Hispanic/White **H** **ERG** (Homeless) General Public
Community Care Center 111 North 4th Street Easton, PA 18042 610.253.9868	CTR STD	Black/Hispanic/White **H** General Public
Hispanic Center of the Lehigh Valley 520 East Fourth Street Bethlehem, PA 18015 610.868.7800	CTR	Black/Hispanic/White **IDU** Black/Hispanic/White **MSM** Black/Hispanic/White **MSM/IDU** Black/Hispanic/White **H** Black/Hispanic/White **P** General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Easton Medical Center (Operated by Planned Parenthood) 2906 William Penn Highway, Suite 212 Easton, PA 18045 610.253.7195 www.plannedparenthood.org	CTR STD	Black/Hispanic/White **H** General Public
Northampton County State Health Center 1600 Northampton Street Easton, PA 18042 610.250.1825	CTR PCRS TB	Black/White **H** **ERG** (Homeless) General Public
SCHUYLKILL COUNTY		
Maternal & Family Health Services 2510 W. Market Street Pottsville, PA 17901 570.622.1244 http://mfhs.org/familyplanning_locations_Schuylkill.php	CTR	General Public
Schuylkill County State Health Center Clinic One Norwegian Plaza Ste. 103 Pottsville, PA 17901 570.621.3112	CTR PCRS TB	General Public
Schuylkill Wellness Services 512-514 North Center Street Pottsville, PA 17901 570.622.3980 www.cocountywellnessservices.org/	CTR STD IDI	General Public

APPENDIX L

PUBLIC COMMENTS TO CRSSP

No comments were received.

Tom Corbett, Governor
Eli N. Avila, MD, JD, MPH, FCLM, Secretary of Health

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