**Biannual Progress Report** FY 2023-2024

Agency:       Submitted by:

Date submitted:

**Reporting period:  Quarter 1 and 2 (July 1-Dec 31, 2023)**

**Due: Jan 31, 2024**

**Quarter 3 and 4 (Jan 1-June 30, 2024)**

**Due: July 31, 2024**

HIV case management providers are required to submit progress reports to the HIV Community Services Program in order to provide a program narrative of each Agency’s service delivery system, including strengths, challenges, outcome performance measurement, and Quality Management efforts. The HIV Community Services team reviews these reports and follows up with providers on identified items and offers technical assistance and training. Report information is used for program planning and evaluation purposes.

**Section I: Performance measures narrative**

HIV Community Services will provide your Agency’s performance measure data in the below tables by the 10th of the month following the end of the reporting period. Once you receive your performance measure data[[1]](#footnote-1), **complete an Agency narrative below** describing your current and/or future plan for reaching, maintaining or exceeding the identified goal for each performance measure below. The program may not be able to provide specific disaggregated data by race and ethnicity on the reporting forms if the data meets the following: the Oregon Health Division HIV Surveillance Program does not publish counts of HIV cases by age, race, sex or transmission group if fewer than 10 people with HIV are believed to be living in this county, the county population is less than 10,000, or the estimated county population of any race group or age group typically used to group cases in its HIV reports is less than 50.

You are encouraged to include the following information in your plan: data analysis for health disparities across different demographics, including clients from communities of color (CoC), client outreach/referral, service delivery evaluations and/or changes, assessment of barriers, quality improvement project, and/or request for program TA/training.

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| HIV Care Continuum[[2]](#footnote-2) Performance Measure: | **Linked to Care** | | | | |
| Goal | 85% (by 2021) of newly diagnosed clients are in medical care within **30 days**, as defined as having CD4 or VL test after date of HIV diagnosis. | | | | |
| CAREWare Custom Report: New HIV Dx Linkage to Medical Care (Dk11162016) | | | | | |
| **Your Agency Outcome**: | % | Part B Agencies Outcome: | | % | |
| Your Agency *N:* | *Numerator (N)* description:  Clients with 1 CD4 or VL test at least 1 day after their diagnosis date within **30 days** of the HIV+ date in CW | | | | |
| Your Agency *D:*   * Of the clients in D,   # who were excluded last reporting period: | *Denominator (D)* description:  # of clients who received a service and had an enrollment date within **30 days** after the HIV+ date in CW | | | | |
| Excluded: | # of clients who did not have enough time to meet the measure and were not included (clients were enrolled less than 30 days at the end of the reporting period). These clients will be included in the next Biannual Progress Report. | | | | |
| Your Agency Outcome of clients from CoC | % | | Part B Agencies Outcome of clients from CoC | | % |
| **Agency Narrative**  Your agency met this goal: no narrative is needed.  Your agency’s clients **did not** reach the 85% goal: describe your Quality Improvement project or; any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges, and/or barriers to reaching this goal and in linking clients to medical care within 30 days. Include your plan to address potential racial inequities based on the data. | | | | | |

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| HIV Care Continuum  Performance Measure: | **Virally Suppressed** | | | |
| Goal | 90% of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test. | | | |
| CAREWare Performance Measures Worksheet: SC or SR - 01[[3]](#footnote-3) | | | | |
| **Your Agency**  **Outcome**: | % | Part B Agencies Outcome: | % | |
| Your Agency *N:* | *Numerator (N)* description:  Clients whose last VL lab entry in CW in the last 12 months was under 200 copies/mL | | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a service this reporting period **and had a VL lab entry in CW in the last 12 months**. | | | |
| Your Agency Outcome of clients from CoC | % | Part B Agencies Outcome of clients from CoC | | % |
| |  |  | | --- | --- | | **All Clients who received a service (D) and did not have a VL lab in 12 mo. (N)** | N=      D=             % |   **Agency Narrative**  Your agency met this goal: no narrative is needed.  Your clients **did not** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and barriers to reaching this goal and for clients to obtain viral load labs and viral suppression. Include your plan to address potential racial inequities based on the data. | | | | |

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| HIV Care Continuum  Performance Measure: | **Retained In Care / In Care** | | | |
| Goal | 90% of clients have a medical visit in the last 12 months | | | |
| CAREWare Performance Measures Worksheet: SC or SR - 05 | | | | |
| **Your Agency Outcome**: | % | Part B Agencies Outcome: | % | |
| Your Agency *N:* | *Numerator (N)* description:  Clients who had a CD4 or Viral load lab entry in the last 12 months | | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a service this reporting period | | | |
| Your Agency Outcome of clients from CoC | % | Part B Agencies Outcome of clients from CoC | % |
| **Agency Narrative**  Your agency met this goal: no narrative is needed.  Your clients **did not** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or social determinants of health-related challenges and barriers to reaching this goal and for clients to assist these clients to obtain a medical visit. Include your plan to address potential racial inequities based on the data. | | | | |

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| Performance Measure: | **RN Care Plan** | | | |
| Goal | 90% of Medical Case Management (MCM) clients have a RN Care Plan developed and/or updated 2 or more times a year. | | | |
| CAREWare Performance Measures Worksheet: SC or SR - 12 | | | | |
| **Your Agency Outcome**: | % | Part B Agencies Outcome: | % | |
| Your Agency *N:* | *Numerator (N)* description:  Clients with at least one of the following service entries in CW this reporting period:  Regional=RN Care Plan County=RCP-RN Care Plan | | | |
| Your Agency *D:* | *Denominator (D)* description:  Clients who received a Medical Case Management service this reporting period and the client’s most recent Acuity was one of the following:  Regional=Acuity RN 3 or RN 4 County=Acuity 3-4 | | | |
| Your Agency Outcome of clients from CoC | % | Part B Agencies Outcome of clients from CoC | | % |
| **Agency Narrative**  Your agency met this goal: no narrative is needed.  Your agency **did not** reach the 90% goal: describe your Quality Improvement project or any changes you are planning (or currently completing) in the next six months to identify and address agency, program, systemic, and/or challenges and barriers to reaching this goal, and ensure compliance with the Standards of Services. Include your plan to address potential racial inequities based on the data. | | | | |

**Section II: Program narrative**

**Please answer the following eight sections for this reporting period:**

1. **Community Resources and Referrals**
   1. Describe efforts undertaken by your Agency and/or case manager(s) to build and/or maintain relationships with community resources and ensure Ryan White funds are payer of last resort:

1. **Service delivery** 
   1. Describe your agency and/or program’s strengths and/or improvements in delivering services.

1. Describe your agency and/or program problems and/or challenges in delivering services.

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| **Clients Served and**  **Food and Housing Security Data** | | **Active**  **Clients** | | **High Acuity (County)** | | **High CC Acuity** | | | **High MCM Acuity** | |
| **#** | **%** | **#** | **%** | **#** | **%** | **#** | | **%** |
| 1) | **All Clients Served** (includes closed cases) |  |  |  |  |  |  |  | |  |
| 2) | **All Active Clients** |  |  |  |  |  |  |  | |  |
|  | * New Enrollments |  |  |  |  |  |  |  | |  |
|  | * New Enrollments with a new HIV Diagnosis |  |  |  |  |  |  |  | |  |
|  | * Received a Triage/Screening1 |  |  |  |  |  |  |  | |  |
|  | * Received a food voucher/supplement service2 |  |  |  |  |  |  |  | |  |
|  | * Received a “Food Security Status” service |  |  |  |  |  |  |  | |  |
|  | * + SNAP ineligible box checked |  |  |  |  |  |  |  | |  |
|  | * + SNAP application submitted box checked |  |  |  |  |  |  |  | |  |
|  | * + SNAP benefits currently active box checked |  |  |  |  |  |  |  | |  |
|  | * Received financial housing assistance service |  |  |  |  |  |  |  | |  |
|  | * Temporary Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Unstable Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Virally Suppressed |  |  |  |  |  |  |  | |  |
| 3) | **Active Clients with 0% FPL**4 |  |  |  |  |  |  |  | |  |
|  | * Received a Triage/Screening1 |  |  |  |  |  |  |  | |  |
|  | * Received a food voucher/supplement2 |  |  |  |  |  |  |  | |  |
|  | * + - * Received a “Food Security Status” service |  |  |  |  |  |  |  | |  |
|  | * + - * + SNAP ineligible box checked |  |  |  |  |  |  |  | |  |
|  | * + - * + SNAP application submitted box checked |  |  |  |  |  |  |  | |  |
|  | * + - * + SNAP benefits currently active box checked |  |  |  |  |  |  |  | |  |
|  | * Received financial housing assistance |  |  |  |  |  |  |  | |  |
|  | * Temporary Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Unstable Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Virally Suppressed |  |  |  |  |  |  |  | |  |
| 4) | **Active Clients with 1-200% FPL**4 |  |  |  |  |  |  |  | |  |
|  | * Received a Triage/Screening1 |  |  |  |  |  |  |  | |  |
|  | * Received a food voucher/supplement2 |  |  |  |  |  |  |  | |  |
|  | * Received a “Food Security Status” service |  |  |  |  |  |  |  | |  |
|  | * SNAP ineligible box checked |  |  |  |  |  |  |  | |  |
|  | * SNAP application submitted box checked |  |  |  |  |  |  |  | |  |
|  | * SNAP benefits currently active box checked |  |  |  |  |  |  |  | |  |
|  | * Received financial housing assistance |  |  |  |  |  |  |  | |  |
|  | * Temporary Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Unstable Housing Arrangement3 |  |  |  |  |  |  |  | |  |
|  | * Virally Suppressed |  |  |  |  |  |  |  | |  |
| 1 (Added 2/12/24) Denominator in CW PM 43: these clients should have a CW Food Security Status service.  2 CW PM 43 Numerator: these clients should receive a CW Food Security Status service.  3 Housing Arrangement in CAREWare on the last day of the reporting period.  4 FPL=Federal Poverty Level in CAREWare on the last day of the reporting period; income qualify for SNAP  Note: % column is the % of active clients in that section (Active Clients, 0% FPL, and 1-200% FPL) | | | | | | | | | | |

* 1. **Newly Enrolled** Clients (not newly diagnosed) from the data table above: describe services provided to newly enrolled clients this reporting period in the following areas:
     1. Newly enrolled—Successes and/or barriers:

* + 1. Were all newly enrolled clients given an Acuity 4 (CC 4) if they were incarcerated within 90 days of enrollment or homeless at the time of enrollment?

How are you monitoring and tracking to ensure you are meeting this Standard of Service?

* + 1. Provide examples of how your agency provided equitable service delivery, centering those with the highest acuity and most in need to newly enrolled clients:

* 1. Newly **Diagnosed** Clients from the data table above: describe services provided to newly diagnosed clients this reporting period in the following areas:
     1. Newly diagnosed— Successes and/or barriers:

* + 1. Provide examples of how your agency provided equitable service delivery, centering those with the highest acuity and in most need to newly diagnosed clients?

* + 1. Describe your process for monitoring to ensure all newly HIV diagnosed clients are offered an expedited Intake process (less than 2 weeks), Psychosocial Screening and Nursing Assessment, and referral to CAREAssist?

* + 1. Describe your process for monitoring to ensure all the newly diagnosed clients listed in the table were given an automatic Acuity 4 (or CC 4) and then reassessed in 60 days to determine if they should continue to be an Acuity 4 (or CC 4)?

* 1. Food and Housing Security:

Note: reference the Food and Housing Security Data table above when answering these questions.

* + 1. Describe how your agency evaluated the data for client need for equitable food and housing services and then delivered services to eligible clients most in need.

* + 1. Provide successes and challenges of delivering equitable food and housing services centering on clients with the highest acuity and the most need.

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| **Closed Clients**  **Enrollment Status at closing (Reason)** | **# of closed cases** |
| Referred or discharged |  |
| Removed |  |
| Incarcerated |  |
| Relocated |  |
| Deceased |  |
| **Total Closed Clients** |  |
| Of the Total Closed Clients above, # **Lost to Follow-up:**  *(County based programs, enter the #)* |  |
| # of Closed Clients Lost to Follow-up from CoC: |  |
| % of Closed Clients Lost to Follow-up from CoC: | % |

* 1. **Lost to Follow-up** successes and challenges (include efforts to address any potential racial inequities based on the data):

1. **Quality Management**
   1. What are your current QI activities/projects to address unmet performance outcome goals, and/or efforts to improve client care/services, health outcomes, and/or client satisfaction. Include overall changes made to your agency’s Quality Management Plan:

* 1. For those areas in the Compliance-QA Performance Measures table below that did not meet a minimum of 80% compliance, describe QA activities or projects to become in compliance in the “Plan of Correction” column.

**Continued on the next page**

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| **Compliance – QA Performance Measures (PM)[[4]](#footnote-4)** | | |
| **CAREWare PM**  **Criteria for Compliance** | **Compliance**  **%** | **Plan of Correction**  **to reach 80% compliance** |
| **County Providers only** | | |
| Clients have an Eligibility Review every twelve months  CAREWare PM: SC-20 | N=  D=  **%** |  |
| Low acuity clients[[5]](#footnote-5) have an annual Triage or a Nurse Assessment  CAREWare PM: SC-34 | N=  D=  **%** |  |
| Acuity 3 clients have case management contact at least once every 30 days  CAREWare PM: SC-25 | N=  D=  **%** |  |
| Acuity 4 clients have case management contact at least once every 14 days  CAREWare PM: SC-27 | N=  D=  **%** |  |
| High acuity clients[[6]](#footnote-6) have an annual MCM Nurse Assessment  CAREWare PM: SC-35 | N=  D=  **%** |  |
| Not Virally Suppressed and are High Acuity  CAREWare PM: SC-40 | N=  D=  **%** |  |
| No Current VL Lab and are High Acuity  CAREWare PM: SC-41 | N=  D=  **%** |  |

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| **Compliance – QA Performance Measures (PM)[[7]](#footnote-7)** | | |
| **CAREWare PM**  **Criteria for Compliance** | **Compliance**  **%** | **Plan of Correction**  **to reach 80% compliance** |
| **Regional Providers only** | | |
| Clients have an Eligibility Review every twelve months  CAREWare PM: SR-20 | N=  D=  **%** |  |
| Low CC Acuity clients have an annual Triage or a Screening  CAREWare PM: SR-21/E | N=  D=  **%** |  |
| Low RN Acuity clients have an annual Triage or an Assessment  CAREWare PM: SR-22/E | N=  D=  **%** |  |
| CC Acuity 3 clients have CC contact at least once every 30 days  CAREWare PM: SR-23/E | N=  D=  **%** |  |
| CC Acuity 4 clients have CC contact at least once every 14 days  CAREWare PM: SR-24/E | N=  D=  **%** |  |
| High CC Acuity clients have an annual Psychosocial Screening  CAREWare PM: SR-28/E | N=  D=  **%** |  |
| RN Acuity 3 clients have MCM contact at least once every 30 days  CAREWare PM: SR-25/E | N=  D=  **%** |  |
| RN Acuity 4 clients have MCM contact at least once every 14 days.  CAREWare PM: SR-26/E | N=  D=  **%** |  |
| High RN Acuity clients have an annual MCM Nurse Assessment  CAREWare PM: SR-29/E | N=  D=  **%** |  |
| Not Virally Suppressed and are High Acuity  CAREWare PM: SR-40 | N=  D=  **%** |  |
| No Current VL Lab and are High Acuity  CAREWare PM: SR-41 | N=  D=  **%** |  |

1. **Recommendations or improvements**
   1. Please provide any recommendations or improvement ideas (related to case management standards, policies, forms, technical assistance, CAREWare, Reporting, communication, etc.) you have for the HIV Community Services Program.

1. Performance Measure data is preliminary and may not match final annual figures due to data entry delay, end of the year data clean-up, and exclusions. [↑](#footnote-ref-1)
2. End HIV Oregon performance measure [↑](#footnote-ref-2)
3. CW Performance Measure report definitions: SC=State County based programs; SR=State Regional based programs [↑](#footnote-ref-3)
4. Data can be obtained from CAREWare 6 Performance Measure (PM) reports shown in each row [↑](#footnote-ref-4)
5. Clients who have not been a low acuity for at least 12 months are excluded. [↑](#footnote-ref-5)
6. Clients who have not been a high acuity for at least 12 months are excluded. [↑](#footnote-ref-6)
7. Data can be obtained from CAREWare 6 Performance Measure (PM) reports shown in each row [↑](#footnote-ref-7)