



Progress Report Form FY 2020-2021

Agency:

Submitted by:

Date submitted:

- Reporting period: **Quarter 1 and 2 (July 1-Dec 31, 2020)**
Due: Jan 31, 2021
- Quarter 3 and 4 (Jan 1-June 30, 2021)**
Due: July 31, 2021

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 data¹, **complete an Agency narrative below** describing your current and/or future plan at 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.

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.



HIV Care Continuum 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 diagnosis.		
CAREWare Custom Report: New HIV Dx Linkage to Medical Care (Dk11162016)			
Your Agency Outcome:	%	Part B Agencies Outcome:	%
Your Agency <i>N</i> :	<i>Numerator (N)</i> 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 <i>D</i> :	<i>Denominator (D)</i> description: # of clients who received a service and had an enrollment date within 30 days after the HIV+ date in CW		
Your Agency Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
Agency Narrative			
<input type="checkbox"/> Your clients did reach the 85% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being linked to medical care within 30 days. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain a medical visit:			
<input type="checkbox"/> 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 <u>identify and address</u> 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.			

² End HIV Oregon performance measure



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			
Your Agency Outcome:	%	Part B Agencies Outcome:	%
Your Agency <i>N</i> :	<i>Numerator (N)</i> description: Clients VL lab entry in CW in the last 12 months was under 200 copies/mL		
Your Agency <i>D</i> :	<i>Denominator (D)</i> 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 <u>did not</u> have a VL lab in 12 mo. (N)		N=	D= %
Agency Narrative			
<input type="checkbox"/> Your clients did reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of viral suppression or did not have a viral load lab in the last 12 months. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain their viral load labs and viral suppression:			
<input type="checkbox"/> 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.			

³ CW Performance Measure report definitions: SC=State County based programs; SR=State Regional based programs



HIV Care Continuum Performance Measure:	Retained In Care / In Care (previously: No Gap in medical visits in 12 months)		
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 Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
Your Agency <i>N</i> :	<i>Numerator (N)</i> description: Clients who had a CD4 or Viral load lab entry in the last 12 months		
Your Agency <i>D</i> :	<i>Denominator (D)</i> description: Clients who received a service this reporting period		
Agency Narrative			
<input type="checkbox"/> Your clients did reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being retained in medical care. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain a medical visit:			
<input type="checkbox"/> 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.			



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 Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
Your Agency <i>N</i> :	<i>Numerator (N)</i> 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 <i>D</i> :	<i>Denominator (D)</i> 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 1-4		
Agency Narrative			
<input type="checkbox"/> Your agency did reach the 90% goal: describe your agency or program's successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining MCM clients who did not reach this goal of having a RN Care Plan. Also describe any projects or changes you are planning in the next six months to ensure MCM clients have an RN Care Plan documented every six months:			
<input type="checkbox"/> 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.			



Performance Measure: Stable Housing			
Goal		95% of clients have stable housing.	
CAREWare Performance Measures Worksheet: SC or SR – 10			
Your Agency Outcome:	%	Part B Agencies Outcome:	%
Your Agency Outcome of clients from CoC	%	Part B Agencies Outcome of clients from CoC	%
Your Agency <i>N</i> :	<i>Numerator (N)</i> description: Clients CW Annual Tab “Housing Arrangement” entry is listed as “stable/permanent”		
Your Agency <i>D</i> :	<i>Denominator (D)</i> description: Clients who received a case management non-medical service this reporting period		
Agency Narrative			
<input type="checkbox"/> Your clients did reach the 95% goal: describe your agency or program’s successes with reaching this goal. Include any challenges and/or barriers encountered for the remaining clients who did not reach this goal of being stably housed. Also describe any projects or changes you are planning in the next six months to assist these clients to obtain stable housing:			
<input type="checkbox"/> Your clients did not reach the 95% 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 become stably housed. 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

- a) 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:

- b) Describe how your agency has identified communities of color and what outreach efforts have been made to this community:

2) Service delivery

- a) Describe your agency and/or program’s strengths and/or improvements in delivering services. Include examples of successes in how your agency prioritized clients from communities of color to receive services:

- b) Describe your agency and/or program problems and/or challenges in delivering services. Include a plan of how your agency will prioritize clients from communities of color to receive services if this has been identified as a challenge:

3) Client Access to Services

Enrolled Clients (in this reporting period)		# of clients
a)	# of Newly Enrolled clients (new in CAREWare)	
	• % of Newly Enrolled clients from CoC:	%
b)	# of Newly Diagnosed clients	
	• % of Newly HIV Diagnosed clients from CoC:	%
c)	Total # of All Clients who received a service (includes above newly enrolled and newly diagnosed clients)	
	• % of All clients who received a service from CoC:	%
Note: “Enrolled Client” disaggregated data by Race and Ethnicity is included in the quarterly Excel data worksheet OHA secure emails to agency leadership.		



- a) Newly **Enrolled** Clients (not newly diagnosed) from table above: describe services provided to newly enrolled clients this reporting period in the following areas:
 - i) Newly enrolled—Successes and/or barriers:
 - ii) 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?
 - iii) Newly enrolled—Special client populations/emerging needs:
 - iv) Newly enrolled—any challenges/barriers with engagement/communication with non-English speaking clients?
 - v) Provide examples of how your agency prioritized new clients from communities of color in your Intake process to receive services:

- b) Newly **Diagnosed** Clients (from table above: describe services provided to newly diagnosed clients this reporting period in the following areas:
 - i) Newly diagnosed—Successes and/or barriers:
 - ii) Provide examples of how your agency prioritized newly HIV diagnosed clients from communities of color in your intake process to receive services:
 - iii) How did you monitor and track 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?
 - iv) How did you monitor and track 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)?
 - v) Regular case conferences are strongly encouraged for clients newly diagnosed, in particular to address viral suppression, homelessness, or having a high acuity life area in housing, mental health and substance use. How are you monitoring and tracking to ensure newly diagnosed clients are receiving case conferencing for these issues/needs?

- c) All Clients who received a service (not new) from table above: describe services provided to enrolled clients who received a service this reporting period in the following areas:



- i) All Clients who received a service—Special client populations/emerging needs:
- ii) All Clients who received a service—Communication with non-English speaking clients:
- iii) Provide examples of how your agency prioritized current (not new) clients from communities of color when providing services:

Closed Clients Enrollment Status at closing (Reason)		# of closed cases
Referred or discharged		
Removed		
Incarcerated		
Relocated		
Deceased		
Total		
d)	Of the Total above, # that were Lost to Follow-up:	
	• % of clients Lost to Follow-up from CoC:	%

d.) Of the number of “Closed Clients” in above table d) who were **Lost to Follow-up** (*County based programs, enter the # in the table*): describe efforts, successes and challenges, to providing follow up and engagement with clients who were at risk of following out of care or were lost to follow-up. Include your current QA and/or QI efforts to reduce the number of Lost to Follow-up, including specific efforts to address any potential racial inequities based on the data.

4) Quality Management

a) Describe your Quality Assurance (QA) activities or projects⁴ to become or remain in compliance with the Support Services Guide, data requirements outlined in the CAREWare User Manual, and/or the Standards of Services. Include changes made or planned to improve QA compliance:

⁴ Examples of QA activities: site visits (compliance plan), data entry and chart reviews, service utilization reviews/committee, and other data quality evaluations.



- b) Describe your current or upcoming Quality Improvement (QI) activities or projects⁵ to improve client care, health outcomes and/or client satisfaction. If your agency or program does not currently have a specific QI project, describe how you are ensuring you are using performance measure data to identify needed changes to improve client care or health outcomes, including efforts at addressing potential racial health and/or service inequities.

- c) Describe what type of formal client complaints/grievances agency leadership received and if it was resolved (no client name or specifics). What program changes or QI activities are planned to address client satisfaction for this type of complaint/grievance received, including efforts at addressing potential racial health and/or service inequities:

5) Trauma Informed Care

- a) Describe efforts made by your agency or case manager(s) to implement the principles of trauma informed services: safety, trust, empowerment, choice, and collaboration. Include efforts at addressing racial health and/or service inequities.

6) Training and technical assistance

- a) Describe training received/attended by your agency or case manager(s):

- b) Provide information on changes to your training program. Include specific changes made to the onboarding training process for new staff:

- c) List any training or technical assistance needs you have at this time:

7) Service Delivery: Staffing:

- a) Has your staff supervision or agency program structure changed? If yes, briefly explain the changes below and attach a current Organizational chart showing the new structure.

- b) Briefly describe staff turnover/vacancies and retention efforts or improvements planned during this reporting period. Include how you addressed service delivery disruptions.

⁵ QI activities are aimed at improving client care, health outcomes, and client satisfaction.



8) Recommendations or improvements

- a) 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.