Fiscal Year quarterly reports will be submitted by email to the Oversight and Monitoring Coordinator, Amanda Ladd at Amanda.L.Ladd@dhhs.nh.gov, and to the Quality Coordinator, Lisa.B.West@dhhs.nh.gov by the due dates listed below. Call Amanda with any questions at 603-271-9321.

|  |  |
| --- | --- |
| **Agency**:  |  |
| **Submitted By**: |  |
| **Date**: |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Report Title** | **Quarter** | **Due Date** |
| [ ]  | Quarter 1 Report | July – September | 15 Business Days after Rec’d |
| [ ]  | Quarter 2 Report | October – December  | 15 Business Days after Rec’d |
| [ ]  | Quarter 3 Report | January – March | 15 Business Days after Rec’d |
| [ ]  | Quarter 4 & Final Progress Report | April – June | 45 Business Days after Rec’d |

**Program Administration**

List any changes that occurred during this quarter with your agency’s service delivery structure (ie. case managers & administrative staff allocation of time; changes in services provided; changes in policy & procedures).

List any changes to the Board of Directors, Executive Leadership, Program Management, and/or AIDS Service Organization Staff during this quarter.

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| **Name** | **Title** | **Start Date** | **End Date** |
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List any volunteers used by the program during this quarter.

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| --- | --- | --- |
| **Service Category** | **Title (ie. consumer, board member, family member, etc.)** | **# of Hours** |
|  |  |  |
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Describe the major accomplishments and/or challenges your organization has encountered over the past quarter (Examples: events hosted, publications printed, outreach efforts including social media).

**Trainings and Meetings**

List and describe any HIV staff/agency training(s) that occurred during the quarter.

|  |  |  |  |
| --- | --- | --- | --- |
| **Description of Training** | **Date Provided** | **Staff in Attendance for Training** | **Outcome of Training** |
| ***Example****- How to Work with a Medical Interpreter* | *04/21/2017* | *Melissa, Kim, Liz, Jane, Chris, Sarah* | *Staff will encourage the use of medical interpreters instead of family members/friends for interpretation services.* |
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List and describe any proposed training(s) for your HIV staff/agency.

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| --- | --- | --- | --- |
| **Description of Training** | **Goal of Training** | **Method of Delivery** | **Proposed Training Date(s)** |
| ***Example****- Update on HIV Medications* | *Provide Case Managers with an overview of HIV medications currently on the market* | *Webinar (or in-person, conference call, written guidance, template)* | *06/09/2017* |
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**Spending**

Please complete the table below, including the Fiscal Year Program Budget. Put in the cumulative % of funds spent for each quarter. Briefly describe spending activity for the quarter, including any variances in expenditures.

|  |  |
| --- | --- |
| **Fiscal Year 20XX Program Budget Amount** |  |
|  | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
| **Total Amount Billed to Date (%)** | % | % | % | % |
| **Agency Narrative:**  |
| [ ]  Technical Assistance Requested |

**Service Report**

Please provide the following service data. Complete the “Total” column every quarter and answer the questions as outlined in the Notes/Comments.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1st Quarter** | **2nd Quarter** | **3rd Quarter** | **4th Quarter** | **Total** |
| **Total # of Active Clients** |  |  |  |  |  |
|  | **1st Quarter** | **2nd Quarter** | **3rd Quarter** | **4th Quarter** | **Total** |
| **Assessment** |  |  |  |  |  |
| **Bus Pass** |  |  |  |  |  |
| **CARE Program Enrollment** |  |  |  |  |  |
| **Food Voucher** |  |  |  |  |  |
| **General Case Management** |  |  |  |  |  |
| **Home Visit** |  |  |  |  |  |
| **Interpretation** |  |  |  |  |  |
| **Licensed Clinician Service Plan** |  |  |  |  |  |
| **Nutritional Supplement** |  |  |  |  |  |
| **PMI Submission** |  |  |  |  |  |
| **Reassessment** |  |  |  |  |  |
| **Registered Dietician** |  |  |  |  |  |
| **Rental Assistance** |  |  |  |  |  |
| **Service Plan** |  |  |  |  |  |
| **Taxi Voucher** |  |  |  |  |  |
| **Utility Assistance** |  |  |  |  |  |
| **Written Translation** |  |  |  |  |  |
| **Notes/Comments regarding the Part B Client Services Data:**  |

**Performance Measures Narrative**

The NH CARE Program has provided performance measure data as shown below. Please provide an agency narrative sharing successes and challenges in reaching, or not reaching, the performance measure goal. If you would like technical assistance with the goal, please check the box provided for that performance measure.

|  |  |
| --- | --- |
| **Goal 1** | 90% of clients will have had a HIV viral load <200 copies/mL at last HIV viral load test during the measurement period. |
| **Measurement Dates**: |  |
| **Your Agency Outcome**: |  | **Statewide ASOs Achieved:** |  |
| **Numerator:** | Number of patients in the denominator with a HIV viral load <200 copies/mL at last HIV viral load test during the measurement period. |  |
| **Denominator:** | Number of patients, regardless of age, with a diagnosis of HIV with at least one HIV viral load test in the measurement period.  |  |
| **Agency Narrative:**  |
| [ ]  Technical Assistance Requested |

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| **Goal 2** | 90% of clients will self-identify as having excellent medication adherence when assessed during the measurement period |
| **Measurement Dates**: |  |
| **Your Agency Outcome**: |  | **Statewide ASOs Achieved:** |  |
| **Numerator:** | Number of clients from the denominator with excellent medication adherence who were assessed at least once during the measurement period. |  |
| **Denominator:** | Number of clients with at least one MCM encounter in the measurement period. |  |
| **Agency Narrative:**  |
| [ ]  Technical Assistance Requested |

|  |  |
| --- | --- |
| **Goal 3** | Less than 2% of clients self-identified as homeless or unstably housed during the measurement period.  |
| **Measurement Dates**: |  |
| **Your Agency Outcome**: |  | **Statewide ASOs Achieved:** |  |
| **Numerator:** | Number of clients who were homeless or unstable housed during the measurement period. |  |
| **Denominator:** | Number of persons receiving HIV services during the measurement period. |  |
| **Agency Narrative:**  |
| [ ]  Technical Assistance Requested |

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| --- | --- |
| **Goal 4** | Less than 10% of clients self-reported Food Insecurity during the 12-month measurement period of one (1) year.  |
| **Measurement Dates**: |  |
| **Your Agency Outcome**: |  | **Statewide ASOs Achieved:** |  |
| **Numerator:** | Number of clients from the denominator who identify as food insecure and who were assessed at least once during the measurement year. |  |
| **Denominator:** | Number of clients, regardless of age, with a diagnosis of HIV who had at least one assessment for food insecurity in the measurement year. |  |
| **Agency Narrative:**  |
| [ ]  Technical Assistance Requested |