

**2016-2017 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE
CARE ACT PART A
QUALITY MANAGEMENT PLAN
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)**

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INTRODUCTION

MISSION

The Quality Management program shall be a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to people living with HIV/AIDS (PLWHA) throughout the Houston Eligible Metropolitan Area (EMA).¹ Ryan White Grant Administration (RWGA) will develop strategies to ensure that the delivery of services to all Ryan White Program (RWP) eligible PLWHA is accessible, equitable and adheres to the most recent Department of Health & Health Service (HHS) guidelines and clinical practice standards.

DEFINITION OF QUALITY

The Health and Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB) administers the Ryan White Program. HAB defines quality as “the degree to which a health or social service meets or exceeds established professional standards and user expectations.”

LEGISLATION

Section 2604(c) of the Ryan White legislation requires that the chief elected official (CEO) of a Part A eligible metropolitan area (EMA) establish a quality management program to evaluate the extent to which care provided under the grant meet and/or exceed the most recent HHS Guidelines for the treatment of HIV disease and related opportunistic infections.

STATEMENT OF PURPOSE

The purpose of the Quality Management Plan is to:

- Promote a commitment to quality of care throughout the Ryan White continuum of care
- Describe the EMA’s Quality Management infrastructure
- Identify strategic goals for each component of the RWGA QM Program
- Guide the development of structured activities that will enhance the delivery of services to PLWHA receiving care from all RWP Part A funded providers
- Communicate the roles, responsibilities, and expectations of RWGA staff and quality-related activities

PRIORITIES FOR THE QUALITY MANAGEMENT PROGRAM

- Establish a quality management structure within the Ryan White Grant Administration Section that supports quality improvement activities in the EMA.
- Utilize a planning mechanism that incorporates data from chart reviews, outcomes reports, inputs from service providers, consumers and the Ryan White Planning Council.

¹ The Ryan White CARE Act is now referred to as Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006. Under the new legislation Title I is now termed Part A.

- Adopt guidelines set forth by the DHHS, IAS-USA, CDC and other professional guidelines
- Evolve and refine measurement systems for identifying trends in care and tracking clinical outcomes by regularly collecting and recording data through the CPCDMS, clinical chart review abstraction, client satisfaction survey and program monitoring
- Employ assessment procedures to determine efficacy and appropriateness of services and to determine opportunities for improvement
- Educate providers about QI methodologies and techniques through technical assistance workshops
- Facilitate the active involvement of provider agencies in the implementation of multidisciplinary data driven quality improvement projects.
- Promote communication among grantee administration, provider agencies, RWPC, and HRSA regarding performance improvement issues.
- Document and report performance activities

SCOPE

The Houston Part A EMA funds nine (9) subcontractors providing core and related support services for about 11,000 HIV/AIDS clients in the EMA. Based on the organizational mission, the RWGA Quality Management program is committed to ensuring that clients receive comprehensive care based on mandated guidelines, professional standards and best practices. The QM program is therefore designed to address QI content regarding the following functional areas:

- Primary medical care
- Medical Case management
- Oral Health care
- Vision Services
- Substance Abuse - Outpatient Treatment
- Medical Nutrition Services
- Patient Satisfaction

QUALITY MANAGEMENT INFRASTRUCTURE

STATEMENT OF AUTHORITY AND ACCOUNTABILITY

The QM program is planned, implemented and evaluated by the RWGA QM staff in collaboration with the Clinical Quality Improvement (CQI) committee as outlined in the work plan (appendix A). The RWGA manager is ultimately responsible for all QM-related activities and authorizes the grantee administration QM staff and the CQI committee to plan, implement and evaluate performance improvements in the Houston EMA. At the beginning of each grant year, RWGA QM staff will collaborate with the RWPC's Office of Support and QI Committee to establish a timeline for collecting, reporting and analyzing QM data. RWGA reports on the results of all QM activities to service providers and council members at semi-annual intervals. Report due dates are specified in the Memorandum of Understanding between RWGA and the Planning Council, thereby ensuring the Grantee is

accountable for producing the reports in a timely manner. QM staff and the Manager of RWGA ensure that the timeline is followed and that data is presented.

The EMA improvement activities and performance data are reported to the Ryan White Planning Council semi-annually to enable the council to evaluate programs and to appropriately allocate Part A funds to primary care and health-related support services that most adequately address the needs of the EMA's client population. The structure of the Houston EMA QM program includes the RWGA QM team, the Quality Improvement Committee of the Ryan White Planning Council and the Clinical Quality Improvement (CQI) Committee.

THE CLINICAL QUALITY IMPROVEMENT COMMITTEE

The membership of the CQI Committee reflects the diversity of disciplines involved in the HRSA defined RWPA HIV core and clinically related support services in the EMA. The committee structure consists of

- 2 Physicians/1 Dentist (1 HIV Specialist to serve as Chairperson)
- 2 Nurses
- 1 Medical/Clinical Case Manager
- 1 Pharmacist
- 1 Nutritionist
- 2 Program Administrators
- 1 Quality Management Coordinator
- 1 HIV Prevention Specialist
- 1 Data Manager
- 1 Substance Abuse Practitioner

The CQI team will be responsible for assisting with the following list of activities:

- A. Quarterly meetings to review system-wide CQI issues/challenges and development of strategies to improve care
- B. Annual meetings to:
 - i. Review chart review and outcome measures reports and other relevant data
 - ii. Determine EMA-wide quality initiatives and performance indicators and goals
 - iii. Review and recommend revisions to the Standards of Care to reflect current US Health and Human Services (HHS) Treatment guidelines as well as federal and state regulations for HIV care and services.
 - iv. Review and revise assessment and data collection tools/protocols as necessary
- C. Establish subcommittees as needed to address service specific quality issues.
- D. Plan and develop educational strategies for Part A-funded providers which may include grand rounds for HIV care and clinical updates according to HHS guidelines among other activities.
- E. Review and update the quality management plan yearly
- F. Provide input into an annual evaluation of the HIV Quality Management

program conducted by the Grantee.

The committee working process will be facilitated by the RWGA Clinical Quality Management staff. Meeting minutes will be recorded by the grantee administrative staff and distributed to all committee members prior to the next meeting.

RYAN WHITE PLANNING COUNCIL

The information loop between the administrative agency and the Planning Council ensures that Council members have the QM data they need when prioritizing funding and allocating resources.

QUALITY IMPROVEMENT (QI) COMMITTEE

The QI Committee operates as a formal committee of the Ryan White Planning Council. All annual chart review and client satisfaction survey reports, semi-annual outcomes, quarterly service utilization reports and annual revisions to standards of care are disseminated to the QI committee at appropriate intervals during the grant year. Members of the QI Committee collaborate with RWGA staff to address quality-related matters identified through the aforementioned reports. Committee members evaluate and share the information with the Planning Council, which in turn uses the data to evaluate funded programs and make decisions.

RYAN WHITE GRANT ADMINISTRATION QUALITY MANAGEMENT TEAM

- **Project Coordinator, Clinical Quality Improvement:** Assists in coordination of all program evaluation and QM activities, provides technical assistance for standards of care development and outcomes measurement activities, and monitors outcomes data. Performs clinical chart reviews for HRSA defined core and related support services. Provides QM related consultation to providers and other stakeholders. Conducts onsite QM program monitoring of funded services to ensure compliance with RWGA Standards of Care and QM plan.
- **Project Coordinator, Quality Management Development:** Oversees client satisfaction measurement activities; analyzes case management chart review and client satisfaction data; conceives, implements, and oversees a structured, system-wide approach for planning, implementing, and evaluating quality improvement efforts among Part A primary care and health-related support services providers. Conducts onsite QM program monitoring of funded services to ensure compliance with RWGA Standards of Care and QM plan.

THE CENTRALIZED PATIENT CARE DATA MANAGEMENT SYSTEM (CPCDMS)

The CPCDMS is a real-time, de-identified, client-level database that links service providers together through the Internet. Data captured within the CPCDMS include client registration, encounter and medical update information for each client: demographic, co-morbidity, biological marker, service utilization, and outcomes survey and assessment data.

LOCAL AND NATIONAL STAKEHOLDERS

The RWGA Section reports improvement activities and performance data to HRSA in the annual Ryan White Part A/MAI grant applications and annual progress reports. Through its Office of Performance Review (OPR), HRSA HAB conducts intermittent onsite performance

review to evaluate the effectiveness of Ryan White funded programs and provides recommendations based on identified priorities. RWGA works collaboratively with the OPR to implement these recommendations to improve HIV healthcare services.

The RWGA QM section works collaboratively with multiple Ryan White Parts in Southeast Texas. The cross-agency multidisciplinary CQI committee includes members representing Parts B, C, D, AETC and SPNS. Quality Management planning, priority setting, and improvement activities developed by this committee fully encompass the spectrum of RW funding. Geographically, this encompasses the six county Houston EMA of Chambers, Fort Bend, Harris, Liberty, Montgomery and Waller counties, as well as the four additional counties of Austin, Colorado, Wharton, and Walker that form the Houston HSDA.

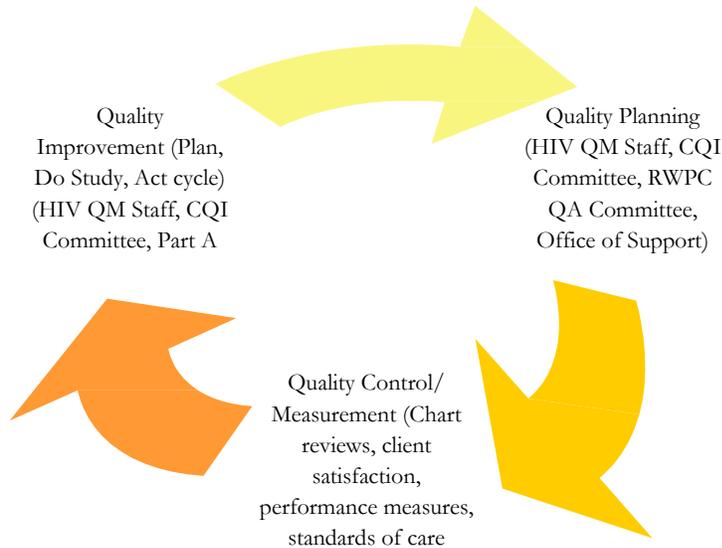
This collaboration increases alignment of QM activities across all Ryan White programs (Parts A, B, C, D AETC and SPNS) and reduces duplication of QM efforts, ensuring maximum utilization of resources and seamless access to quality HIV care services. The Houston EMA QM section monitors all measures collaboratively across funding source and exports required data into the *Texas Department of Health and Human Services (DSHS) AIDS Regional Information and Evaluation System (ARIES)*.

CAPACITY BUILDING

Ryan White Grant Administration conducts two trainings a year for all Council members regarding all aspects of the QM program. Additionally, RWGA staff provide multiple QM technical assistance workshops for providers annually. The QM staff participate in the National Quality Center (NQC) and other Ryan White quality management trainings offered for grantees as needed. In FY 2016, RWGA staff will organize one QM technical assistance (TA) for all case management staff in Part A agencies, in addition to ad hoc TAs that may be requested by individual agencies. In collaboration with the National Quality Center (NQC), RWGA will offer quality leadership training to leadership staff including QM coordinators from provider agencies. The RWGA Project Coordinator- CQI will communicate any process and systems issues identified from chart abstractions to providers and offer recommendations.

QUALITY MANAGEMENT FRAMEWORK

Continuous quality improvement refers to a management process or “approach to the continuous study and improvement of processes or providing health care services to meet the needs of individuals and others” (Joint Commission, Glossary CAMH). The continuous quality improvement process includes Quality Planning, Quality Control/Measurement, and Quality Improvement. Each of these components is incorporated into the Houston EMA’s approach to Quality Management and facilitates the primary goal of improving health outcomes and quality of life for PLWHA within the EMA.



QUALITY PLANNING: includes the strategic planning decisions, quality initiatives, and all design, development, and initial implementation efforts related to new and redesigned processes. Quality planning is performed by utilizing information gathered from the Quality Control/Measurement and Quality Improvement to identify priorities, determine if and how to modify processes, and to monitor the effectiveness of new initiatives. RWGA staff will continue to collaborate with Part A providers to plan, develop and implement new initiatives to enhance the quality of care provided to PLWHA within the Houston EMA.

QUALITY CONTROL/MEASUREMENT: includes the ongoing data collection, aggregation, display, and analysis of functions which support the identification of problems with organization processes and assist with developing new strategies for addressing the issues identified. The findings from this process enable organizations to identify priority areas that need to be targeted for quality improvement efforts.

Performance Measures

The RWGA QM program utilizes strategies outlined in the HIV/AIDS Bureau (*HAB*) *HIV/AIDS Performance Measures for Adults and Adolescents*, the Institute for Health Care Improvement performance measures for HIV/AIDS quality of care indicators and the New York State AIDS Institute HIV Quality Improvement (HIVQUAL) project to evaluate performance measures for HIV health care (Appendix B). RWGA uses a logic model that evaluates outcomes in the following domains:

- Health outcomes such as changes in CD4 counts, viral load tests and viral load suppression;
- KAP (knowledge, attitudes and practices) outcomes such as changes in service utilization rates and adherence to drug treatment regimens
- Service provider performance outcomes such as wait time for initial outpatient/ambulatory care appointment

Client-level outcomes and indicators are tailored to the goals and objectives of each Part A

service category, including core services such as primary medical care, drug reimbursement, oral health care, medical case management, transportation and substance abuse treatment. Performance data are obtained primarily from client-level data entered directly into the CPCDMS by service providers. RWGA regularly monitors the EMA's data collection system to make sure service providers are entering their outcomes data as required by their Part A contracts. Performance data are monitored, analyzed and reported annually to the Ryan White Planning Council and the provider agencies. Data analysis is performed quarterly for performance improvement measures (Appendix C). As appropriate, some performance measures are also monitored through annual chart reviews.

Indicators to be measured are reviewed and revised annually to reflect identified needs, HHS guidelines and best practices. They are also incorporated into annual planning for quality improvement activities.

Standards of Care

Ryan White Grant Administration annually facilitates workgroups composed of RWPC members, service providers, consumers and subject experts to review and revise the standards of care for each funded service category. Local standards are derived from HHS guidelines, HRSA, HAB national monitoring standards, as well as other relevant industry standards and federal, state and local licensing requirements. Annual site visits are conducted by RWGA at all agencies to ensure compliance with the standards of care.

Annual clinical chart reviews

Chart abstractions are performed on an annual basis for each primary medical care and selected health-related services delivery agency. The RWGA Project Coordinator – CQI performs the chart abstractions and data entry. Annual reports are distributed to these agencies.

Chart review results are used to assist in the development of agency specific quality management plans (see agency level QM program development section for additional details). Agencies review the results from their chart reviews and identify areas of care in need of improvement. Agencies develop QM plans to address the identified areas.

Standardized client satisfaction measurement

Each Part A- and MAI-funded provider in the EMA is contractually required to measure client satisfaction. A standardized methodology for measuring client satisfaction is used to ensure comparability of results across Part A- and MAI-funded service categories. This methodology employs the use of a self-administered survey tool with questions that address the service, the provider and the Part A system as a whole. On an annual basis, a 10% convenience sampling is surveyed for each service category.

QUALITY IMPROVEMENT

The information gathered from quality measurement activities is used to plan further in-depth evaluation of quality indicators in need of improvement. Quality improvement activities examine existing processes and modify them accordingly to address quality challenges.

New patient care standards are added and/or existing standards are modified based on findings from the chart review, consumer feedback and HRSA guidance. RWGA will select EMA-wide indicators that subcontractors will be required to address. Agencies must also select care

indicators in need of improvement (based on findings from the chart reviews or agency's internal assessment of their system and processes) and develop and submit a detailed QM plan which describes their quality improvement approach to address their selected indicators.

Agencies will submit QM plan updates periodically, as dictated by quality improvement activity timelines, to monitor the progress toward the goals outlined in each agency's QM plan. Each agency will be required to submit data along with their quarterly updates. Methodology to be utilized for performance improvement activities may include but is not limited to:

- ✓ Plan, Do Study Act (PDSA)
- ✓ Flow charts
- ✓ Root cause analysis
- ✓ Fish diagram

ANNUAL QUALITY GOALS AND OBJECTIVES

- A. Update and Implement FY 2016 QM Plan
- B. Ensure that primary care and health-related support services adhere to the most recent US Health and Human Services (DHHS) treatment guidelines, federal and state regulations
- C. Improve self-advocacy skills of consumers through consumer education
- D. Facilitate the implementation of QI activities in provider agencies to attain FY 2016 EMA-wide performance goals (appendix C).

EVALUATION

The CQI Committee will evaluate the QM program at the end of the Part A grant year (e.g. February 2017). Evaluation will include assessment of the effectiveness of the QM infrastructure and QI activities in achieving QM goals, evaluation of QM goals to determine if goals were achieved and whether performance measures were appropriate. To facilitate this process, all core service providers will submit annual evaluation/organizational assessment reports of their agency's QM programs to the RWGA QM section to be incorporated into the overall EMA QM program evaluation. The CQI committee will analyze these reports in addition to the RWGA annual outcomes and chart review reports to determine the overall effectiveness of the EMA QM program.

Appendix A

Quality Management Work Plan

Goal A: Update and Implement FY 2016 QM plan			
Objectives	Key Action Steps	Target End Dates	Person/s Responsible
A-1 Develop Houston EMA Quality Management Plan	A-1.a Prepare planning information for annual quality goals (data collection, needs assessment program assessment /information, client satisfaction survey /focus group reports, organizational priorities, HRSA requirements etc)	October 2015	RWGA QM & Data Management staff, CQI committee
	A-1.b Update QM plan for FY 2016 utilizing data/information from: <ul style="list-style-type: none"> • FY 2014 chart review report • FY 2014 Final year outcomes data report • QM Program evaluation report • Other sources of information listed above 	November 2015	
	A-1.c Review and revise plan at CQI meeting	January 2016	CQI committee
	A-1.d Finalize plan and post QM plan on the Ryan White Grant Administration website	February 2016	RWGA QM Staff
A-2 Implement QM Plan across agencies in the EMA	A-2.a Require core agencies to submit updated QM Plans for FY 2016 <ul style="list-style-type: none"> • Submission of agency QM Plans 	March 2016	Subcontractor QM Staff
	A-3.b Monitor implementation of QM plans through on-site visits and at bi-monthly Primary Care Subcommittee meetings	Monitoring-Ongoing	RWGA QM Staff
A-3 Evaluate QM Program annually	A-3.a Conduct EMA QM program assessment utilizing the NQC Part A program assessment tool	November 2016	CQI Committee members RWGA Staff
	A-3.b Submission of annual evaluation/organizational assessment reports on QI activities from various agencies.	February 2017	Agency QM Coordinators
	A 3.d Draft annual evaluation report	March 2017	RWGA QM Staff, CQI Committee

Goal B. Facilitate the implementation of QI activities in provider agencies to meet annual quality goals			
B-1. Incorporate EMA performance goals into agency QI activities	B-1.a Disseminate EMA performance goals to agencies	February 2016	RWGA QM Staff
	B-1.b Submission of improvement plans by agencies for EMA performance goals	March 2016	RW Part A/MAI-funded Agencies QM Coordinators,
	B-1.c Implementation of QI Projects in Agencies to meet annual goals. Current projects are : <ul style="list-style-type: none"> • Linkage/Retention in Care • Viral Load Suppression among A.A. • Intimate Partner Violence Screening • Mental Health Screening 	March 2016	
	B-1.d Establish or utilize existing ad hoc subcommittees to identify best practices (e.g. data integrity subcommittee etc.)	As needed	RWPA AA Data Manager & Analyst QM Staff
B.2. Monitor implementation of improvement projects in agencies	B-2.a Submission of intermittent progress reports related to the annual quality goals	Bi-Monthly Sub-Committee Meetings	RWGA QM Staff, RWPA /MAI-funded Agencies QM Coordinators
B.3. Increase capacity building for QM programs at the agencies	B-3c. Conduct QM TA needs assessment	November - February	RWGA QM Staff
	B-3.b Plan and Provide one CM related QM TA	February 2016	RWGA QM Staff
	B-3.a Communicate relevant chart review findings to agency medical directors	November 2016	RWGA Clinical QM Coordinator
	B-3.d Provide one QM TA for providers consistent with learning needs:	As Needed	
C. Ensure that primary care and health-related support services adhere to the most recent US Health and Human Services guidelines, federal and state regulations			
C-1. Implement federal and professional guidelines and, best practices in HIV health care services	C-1.a Implement revised FY 2016 Standards of Care (SOC) and Performance measures	March 2016	RWGA
	C-1.b Revise SOC and Performance (FY2016) measures to reflect current professional and federal guidelines	December 2016	RWGA QM Staff
	C-1.c Revise Chart abstraction and assessment tools to reflect current guidelines	January 2016	RWGA QM Staff, CQI Committee

C-2 Evaluate processes and effectiveness of HIV programs	C-2.a Clinical chart abstraction and dissemination of results to the council and agencies	April - September 2016	RWGA QM Staff
	C-2.b Client satisfaction surveys	Ongoing	Coordinator, QM Dev.
	C-2.c Dissemination of FY 2015 Client Satisfaction survey results to the agencies, the RWPC, and CQI Committee	April 2016	Coordinator, QM Dev.
	Focus group discussions and dissemination of results to agencies, the RWPC and the CQI Committee	As Needed	
	C-2.b FY 2015 Performance measure evaluation and benchmarking and dissemination of results to the council, agencies, and CQI Committee	May 2016	Coordinator, QM Dev.
C-2.c QM Program monitoring through site visits	May –November , 2016	RWGA QM Coordinators	
Goal D. Improve self-advocacy skills of consumers			
D. Develop and facilitate an annual training/workshop for PLWHA on quality of care (What their HIV care should be)	D-1.a CQI committee meeting to suggest training content, presenters and venue	November 2015	RWGA Staff/CQI Committee
	D-1.b Planning meeting with the RWPC Consumer Council	February 2016	RWGA Staff
	D-1.c Implementation of workshop	As Needed	

Appendix B

HIV Performance Measures

The following performance indicators are measured system wide to assess the impact of HIV services on the health status of the people living with HIV/AIDS in the Houston EMA. These indicators are based on current HHS Guidelines for HIV/AIDS health care and community input, and will be revised annually to reflect new directives.

Clinical Case Management

- A minimum of 75% of clients will utilize Part A/B/C/D primary care at least two or more times three months apart after accessing clinical case management
- Percent of clinical case management clients who utilized mental health services.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- Percentage of HIV-infected clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year.
- Percent of clients identified with an active substance abuse condition receiving Ryan White funded substance abuse treatment
- Percent of clients who are homeless or unstably housed

Legal Services

- Change in the number of permanency planning cases completed over time
- 65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits

Local Pharmacy Assistance

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Medical Case Management

- A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management
- Percent of medical case management clients who utilized mental health services.
- Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management.
- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one

medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

- Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- 60% of HIV-infected medical case management clients will have a medical case management care plan developed and/or updated two or more times in the measurement year.
- Percent of clients who are homeless or unstably housed

Medical Nutritional Supplements

- 75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- 90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year

Oral Health

- 75% of HIV-infected oral health patients will have a dental and medical health history (initial or updated) at least once in the measurement year.
- 90% of HIV-infected oral health patients will have a dental treatment plan developed and/or updated at least once in the measurement year.
- 85% of HIV-infected oral health patients will receive oral health education at least once in the measurement year.
- 90% of HIV-infected oral health patients will have a periodontal screen or examination at least once in the measurement year.
- 60% of HIV-infected oral health patients will have a Phase 1 treatment plan that is completed within 12 months.
- 75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up.

Primary Medical Care

- 100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care
- Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment to receive outpatient/ambulatory medical care
- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year

- Less than 20% of clients who have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care
- 80% of patients aged six months and older with a diagnosis of HIV/AIDS, will have at least two CD4 cell counts or percentages performed during the measurement year at least 3 months apart
- 100% of patients with a diagnosis of HIV/AIDS, will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis
- 100% of pregnant women with HIV infection will be prescribed antiretroviral therapy
- Percent of female clients with a diagnosis of HIV who have a pap screening in the measurement year
- 55% of clients with HIV infection will complete the vaccination series for Hepatitis B
- 95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection
- 85% of clients with HIV infection will receive HIV risk counseling within the measurement year
- 95% of clients with a diagnosis of HIV will have been screened for substance abuse (alcohol and drugs) in the measurement year
- 90% of patients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and will have a fasting lipid panel during the measurement year
- Percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year
- 65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year.
- 85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year
- 75% of patients with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
- 95% of clients with HIV infection will have been screened for Hepatitis B virus infection status (ever)
- 65% of patients seen for a visit between October 1 and March 31 will receive an influenza immunization OR who reported previous receipt of an influenza immunization
- 95% of patients will be screened for clinical depression using a standardized tool and follow up plan documented.
- 90% of clients with HIV infection will have ever received pneumococcal vaccine
- 100% of patients will be screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
- 90% of patients with a diagnosis of HIV/AIDS will have a viral load test performed at

least every six months during the measurement year

- 80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)
- Percentage of patients with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- 95% of patients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
- Percentage of patients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- 85% of patients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year

Non-Medical Case Management/Service Linkage

- A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)
- Percent of clients who accessed primary medical care for the first time after accessing service linkage for the first time
- Number of days between first ever service linkage visit and first ever primary medical care visit (Mean, Median, &/or Mode)
- 60% of newly enrolled patients will have a medical visit in each of the 4-month periods of the measurement year

Substance Abuse

- A minimum of 70% of clients will utilize Part A/B/C/D primary medical care after accessing Part A funded substance abuse treatment services
- Change in the rate of program completion over time
- 55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)

Transportation

- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing Van Transportation services.
- 35% of clients will utilize Part A/B LPAP services after accessing Van Transportation services.
- A minimum of 50% of clients will utilize Part A/B/C/D primary care services after accessing Bus Pass services.

- A minimum of 20% of clients will utilize Part A/B LPAP services after accessing Bus Pass services.
- A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services.

Vision

- 75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve, or stay the same over time
- 100% of HIV-infected vision patients will have a vision and medical health history (initial or updated) at least once in the measurement year.
- 100% of HIV-infected vision patients will have a comprehensive eye examination at least once in the measurement year

Appendix C

Performance Improvement Goals for FY 2016

The following performance goals consist of process and outcome indicators and are based on US Department of Health and Human Services guidelines and areas identified for improvement from review of the Houston EMA FY 2014 chart review reports, outcomes and needs assessment data. National goals and Benchmarks being utilized for comparisons include Institute of Health Care Improvement (IHI) goals for HIV/AIDS care and the 2011 HIVQUAL Performance Data Report. Ryan White Part A funded providers are required to implement improvement projects that will facilitate the attainment of these system-wide goals.

Primary Medical Care

- 90% of clients with HIV infection will have two or more medical visits, 90 days apart, in an HIV care setting in the measurement year
- Fewer than 20% of clients will have more than a 6 month gap in medical care in the measurement year
- 95% of clients will be prescribed Antiretroviral Therapy (ART)
- 80% of all clients will be virally suppressed (<200)
- 80% of African-American clients who are retained in care will be virally suppressed (<200)

Non-Medical Case Management/Service Linkage

- 60% of newly enrolled patients will have a medical visit in each of the 4-month periods of the measurement year

Appendix D

Frequently Asked Questions (FAQ):

Is there any potential conflict about the role of this committee and the standards set by the RW planning council (see page 4, section ii, where the CQI Committee will determine EMA-wide indicators and goals)? In practice, per Ryan White guidelines/rules and the Memorandum of Understanding (MOU) between the stakeholders in the RW Part A process, the Grantee (RWGA) has the final authority on Standards of Care (SOC) and Outcome Measures (OM). The Council provides input into Part A standards of care, but does not "approve" the final product. RWGA (not the planning council) facilitates the annual SOC and Outcome Measure workgroups. The output from the workgroups does go to the Council for additional "input," and the Council does **endorse** the SOC and OM. However, the Council does not approve the final the product. SOC and OM are a Grantee responsibility. The CQI committee will provide input into EMA-wide Quality Management indicators and goals promulgated by RWGA. As with SOC and OM, the ultimate responsibility and authority in regard to CQI indicators rests with the Grantee.

On page 3 of the Plan, it states that the CQI Committee will have some responsibility in regard to EMA-wide planning, implementing, and evaluating performance improvements. The CQI committee will be an important advisor to RWGA in these efforts. RWGA will endeavor to clarify this advisory role in the CQI Committee "mission statement" as well when describing the CQI committee's efforts and in the dissemination of any recommendations which may come from the committee. In addition, the CQI committee will **not** be involved with solving problems at an agency level. The CQI committee's input and output will be focused on system-wide indicators at the macro level. As with all things Ryan White, RWGA and CQI committee members will need to be vigilant with respect to each stakeholder's roles and responsibilities in this effort.