

**Ohio Department of Health
HIV Care Services (HCS) Section
Ryan White Part B Program
HIV Quality Management Program**

**HCS Quality Management Plan for Ryan White Year 25
(April 1, 2015 – March 31, 2016)**

I. Quality Statement

The mission of the Ohio Ryan White Part B Quality Management (QM) program is to systematically monitor, evaluate, and continuously improve equitable access to, and the quality of, HIV treatment and support services provided to persons living with HIV/AIDS (PLWHA). This is accomplished by 1) ensuring Part B-funded services meet the established national care standards; 2) establishing and monitoring quality improvement programs and activities of our sub-grantees and providers; 3) developing and implementing the QM Plan; 4) conducting and facilitating quality improvement projects; and 5) maintaining the performance measurement system in the HIV Care Services (HCS) Section.

The vision of the Ohio Ryan White Part B QM program is to create efficient processes that maximize available funding and increase program effectiveness. The ultimate goal is to improve client health outcomes for the greatest number of PLWHA who are eligible for our services.

Please see *Attachment 1: Key Terms Found in HCS Quality Management Plan* for definitions of terms used in this plan.

Legislative Background: Clinical Quality Management

Quality Management is so vitally important to the provision of quality services and client outcomes that language mandating a clinical quality management program was added to the federal Ryan White program legislation in 2006. Per legislation, clinical quality management programs must be established “to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and the related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.” (See also policy 11-RWB-14: Establishment of HIV Clinical Quality Management Program for all relevant citations requiring a clinical QM program in Ryan White programs.)

II. Quality Infrastructure

Leadership Support

HCS has a solid organizational infrastructure that is supportive of quality management initiatives. This support is critical in sustaining quality management, including quality improvement, activities over time. The HCS Ryan White Part B Program Administrator ultimately oversees all programs within the Ryan White Part B program, including the Quality Management (QM) program. The Quality Management Supervisor is responsible for the QM program's development, implementation, evaluation and improvement.

The Ohio Department of Health (ODH) also supports quality improvement in a number of ways, including having an Office of Performance Improvement (OPI) that includes a Quality Improvement Committee (QIC) and Quality Improvement Plan (QIP). OPI focuses on ODH's ability to meet its goals and achieve its mission by measuring the efficiency and effectiveness of its operations. OPI integrates agency strategic planning, quality improvement initiatives, and performance measures and standards. OPI is the department lead on coordinating CQI initiatives across the ODH. The QIC consists of at least one representative from each Office within ODH and the HCS QM Program Manager is a member of the committee. QIC members are responsible for assisting with creating department policy and procedures as it relates to QI and ensuring the alignment of the QI goals with the ODH strategic plan. The QIP is the policy and procedure guidance developed to empower ODH's systematic management, deployment and review of quality improvement throughout the agency.

HCS Quality Management Standards

HCS Quality Management Program Standards were established in October 2014. These standards lay the framework for HCS' QM program expectations and outline the components of a QM program. It is expected that the HCS QM program as well as all HCS sub-grantees and subcontractors will implement and abide by the standards. The standards are updated annually by the HCS QM team and HCS QI committee.

The HIV Quality Management Program Standards are included in Attachment 2.

HCS Quality Management Team

The HCS Quality Management team is composed of one program manager and four quality management coordinators. The team meets at least bi-weekly and is responsible for organizing HCS' quality improvement (QI) activities. The QM team is responsible for the oversight for the HIV Clinical Quality Management Program including the HCS QI committee and the HCS QM Plan. The QM program

manager reports to the Ryan White Part B Administrator and also works closely with the other Part B program managers and HCS staff.

HCS Quality Improvement Committee

The HCS Quality Improvement committee was formed to provide guidance for the quality management efforts within the Ryan White Part B program. The QI committee is made up of at least one representative from each of the HIV Care Services (HCS) Section program areas: Ohio HIV Drug Assistance Program (OHDAP), Community-Based Program, Data/Fiscal Management, and Quality Management. A representative from the Administrative Support team also participates. The committee meets a minimum of six times a year to standardize implementation of continuous quality improvement practices within the HCS programs and for sub-grantees and providers.

The scope of work and responsibilities of HCS QI committee include, but are not limited to:

- Standardize implementation of continuous quality improvement practices throughout all HCS programs
- Enhance the current culture of quality within the program by the use of continuous QI methods and tools to improve program performance
- Assess that medical services provided are consistent with the most recent Health and Human Services (HHS) treatment guidelines for individuals living with HIV
- Determine annual performance measures for HCS
- Collaborate with the HCS Program Administrator, HCS Program Managers, section staff and other stakeholders in the implementation of quality improvement activities
- Determine annual quality goals and review quarterly data on progress toward the annual goals
- Conduct and participate in quality improvement activities to achieve the annual goals using a formal QI process such as Lean Six Sigma (DMAIC), and PDSA (Plan/Do/Study/Act)
- Prioritize QI projects based upon available data and the immediacy of the section needs
- Develop and implement the HCS Quality Management Plan.

Quality Improvement Capacity Building

HIV Care Services continues to build QI capacity throughout all aspects of the Ryan White Part B Program by regularly implementing the following activities:

- Funded medical case management agencies are required to submit an annual QM Plan, an evaluation of their QM program, and to respond to QM requirements in their annual grant proposals. The HCS QM team reviews the

quality improvement documents from case management agencies and identifies where QI follow-up would be beneficial. If several agencies have identified a need, then QI training is created using the most effective method of delivery. If these needs cannot be grouped together, then direct technical assistance is provided to the sub-grantee agency.

- Funded medical providers are required to have a clinical QM program in place per their provider agreement. The HCS QM program is building a list of QI contacts for each of the funded providers in order to work closely with them on QI training and technical assistance.
- HCS data/fiscal team reviews HCS data and develops strategies to improve data collection as needed. They collaborate with QM team to ensure these improvement efforts have minimal burden on program or providers.
- The HCS web site contains e-learning QI opportunities for program staff and stakeholders based on identified needs. Progressive levels of CQI training and additional complimentary training are offered both in-person and via the web. Training and technical assistance needs are monitored each year and all training opportunities are evaluated.

Evaluation of HCS QI Infrastructure

The HCS QM program is evaluated using two QI tools adapted from the National Quality Center (NQC). The first tool, *Checklist for the Review of an HIV-Specific Quality Management Plan*, examines the HCS quality management plan by ensuring the presence of a quality infrastructure, creation of annual goals, participation of stakeholders, etc. The second tool, the *Organizational Assessment Tool for Quality Management Programs*, was developed by NQC and adapted by the HCS QM team and referred to as Quality Management Assessment Tool (QMAT).

Updated for each federal fiscal year, the HCS Quality Management Plan includes performance measures, work plans and methodology tools. The QI committee leader initiates the process to update and revise the QM Plan. The HCS Administrator, HCS Program Managers and a representative of the HCS QI committee each must sign-off on the final plan.

As part of the HCS QM Plan review, each performance measure is evaluated to determine whether the measure is still effective in assessing of clinical and non-clinical (program/process) HIV care. The HCS QI committee compares goals with results and those findings are reflected in the QM Plan for the following year. The Ryan White Part B Advisory Group also assists in the review of performance measures and may make suggestions for changes. In addition, the plan and other measures are evaluated to ensure alignment with the Statewide Coordinated Statement of Need and Comprehensive Services Plan. Additionally, the

effectiveness of the quality infrastructure is evaluated to identify areas of improvement.

The Quality Management Assessment Tool (QMAT), developed by National Quality Center and adapted by HCS QM Program, identifies all of the essential elements associated with a sustainable quality management program. This tool is used by the HCS QM team to assess our own QM program as well as those developed by our sub-grantee agencies. Scores from the QMAT assessments are compared with those from prior years to identify patterns or trends and to highlight strengths and areas for improvement. HCS provides capacity building support to funded agencies to help them improve their lowest scoring areas. For example, work plans were identified as an area of improvement in 2014 for both the internal HCS QM team as well as for the funded agencies. As a result, the HCS QM team educational coordinator created an online training about work plan development to meet this need.

III. Performance Measurement/ Annual Quality Goals

Performance Measurement

Performance measurement describes a system used to track outcomes and progress towards ensuring that provided services are as good as or better than the national treatment standards. There are two important steps to measuring performance:

- 1) Identify critical aspects of care and services provided, and
- 2) Develop indicators and measure the progress to determine how you are doing on these important aspects of care and service.

Our performance measures have been chosen based on guidance from several references:

- HRSA/HAB measures
- Case management work plan
- HCS implementation plan
- QI prioritization based upon available data

HCS obtains data from multiple sources, including but not limited to:

- Client outcome measures
- Client enrollment data
- Client claims data
- Annual surveys
- Needs assessments
- Client laboratory test results
- Epidemiology data for Ohio
- Other data collected through the Ohio HIV Drug Assistance Program (OHDAP)
- Established best practices for case managers and providers

When developing our ongoing performance measures, four criteria were used in selecting the final measures: relevance, measurability, accuracy and improvability. This is in keeping with our focus to “measure things that matter.”

The QI committee monitors data quarterly and makes recommendations for improvement strategies. Members of the HCS QM team and/or the HCS data/fiscal team prepare and analyze data for the QI committee and other stakeholders (e.g. Ryan White Part B Advisory Group) at least quarterly.

The Ryan White Year 25 (April 1, 2015 to March 31, 2016) QM Performance Measures selected are included in Attachment 3.

Annual Quality Goals for 2015-2016

The QI committee (with input from the Part B Advisory Group) selects Annual Quality Goals from the previously-identified performance measures. Benchmarks are then set for each annual goal and QI projects are designed based on the identified goals. These QI projects are conducted during the year.

The Annual Quality Goals selected for 2015-2016 are included in Attachment 3, entitled “Annual Quality Performance Measures Ryan White Year 25.” In summary, these goals include:

- Increasing the percentage of clients in HIV medical care who are prescribed antiretroviral therapy (ART) to 95% by March 31, 2016
- Improving viral suppression percentages for clients in HIV medical care to 73% by March 31, 2016
- Increasing the percentage of clients in medical case management who self-report HIV Medication Adherence by taking all doses of ART” to 80% by March 31, 2016

The Status Report on 2015-2016 Annual Quality Goals Outcomes are included in Attachment 4.

IV. Quality Process/Projects

HCS uses a quality improvement process whereby any internal or external stakeholder may suggest an idea for a QI project. The idea must be presented to a member of the HCS QM team and the QM team member works with the idea originator to further define the idea. In conjunction with the HCS QI committee, HCS managers, HCS staff and other appropriate stakeholders, the defined idea may be further analyzed and selected as a QI project.

Criteria for projects include one or more the following:

- Alignment with agency's mission or strategic plan
- Number of people affected
- Financial consequence
- Timeliness
- Capacity
- Availability of baseline data or present data collection efforts
- Alignment with Public Health Accreditation Board (PHAB) domains or prior review feedback

All QI ideas and QI projects are documented in a tracking system (called iTRACK) along with the status of each idea. Ideas are then vetted by QI committee or QM team to determine priority level. From this prioritized list, QI projects are selected.

Below is a sample of our present and pending QI projects:

- Investigation of fax issues in OHDAP
- Standardize Returned Mail Process
- Improve Clinical Data Collection
- Reduce Number of Returned OHDAP Checks
- Assess Any Negative Impact of Removing Printed Applications from Renewal Letters

All quality improvement project aims are focused on improving client outcomes and each QI project must have a clearly defined benchmark or method of measuring progress/movement. When creating the QI project team for each project undertaken, the question "Are the right people working on the quality improvement project?" is continually asked to ensure all relevant stakeholders are involved. If needed, additional staff or stakeholders are either added to the project team or consulted as subject matter experts. The project's status, progress, and results are communicated to staff, at a minimum, on a quarterly basis.

We use standard industry quality management tools and techniques to develop and implement projects (ex. PDSA, Lean, Six Sigma, etc.) which include QI tools such as charters, fish bones, solution and effect diagrams, impact control matrix, SIPOC, process mapping, etc. Documentation is completed throughout the QI process and storyboards are developed for recently completed QI projects.

Feedback is gathered from stakeholders throughout the QI project at the completion of each cycle or phase (e.g. PDSA) to identify areas where the QI staff and the QI project teams can improve for future cycles.

Evaluation is conducted at the end of the QI project cycle by QI committee/ QM team to determine if QI project met established benchmarks.

The *2015-2016 Current Quality Improvement Projects* are included in Attachment 5.

V. Priority Program Activities for 2015-2016

The QM team identified 6 specific program activities for 2015-2016 that have, as the ultimate aim, to improve client health outcomes. The QM team will continue to complete other activities (for example, increasing the number of site visits to provide technical assistance to case management and/or provider agencies surrounding quality improvement initiatives) but the below are the priorities for the 2015-2016 year. Activities are presented as SMART objectives and include benchmarks. All QI priorities link to the 2015-2016 selected performance measures.

Priority Program Activity #1: 50% of case management sub-grantee agencies will identify a quality improvement project by 3/31/2016

Activity 1.1: The QM team will define the scope of the QI projects to be proposed by the agencies.

Activity 1.2: The QM team will assess how many agencies currently have an identified quality improvement project.

Activity 1.3: The QM team will assess the current capacity and needs of the case management agencies regarding the ability to conduct QI projects.

Activity 1.4: The QM team will work with each agency to identify potential projects.

Activity 1.5: The QM team will continue to work with the CM agencies in regards to the identified projects to ensure agencies have the support they need to continue the full QI project cycle.

Priority Program Activity #2: An analysis of the number of Part B clients on anti-retroviral therapy (ART) who are not virally suppressed will be completed by 3/31/2016

Activity 2.1: The QM team will define the start and ends dates for the analysis.

Activity 2.2: The QM team will finalize the measure to be used for the analysis

Activity 2.3: Using the measure in Activity 2.2, analyze the data to determine characteristics of clients who are on ART but not virally suppressed.

Activity 2.4: Review analyzed data to determine possibility of future QI project(s) to increase viral suppression among the cohort of clients in analysis.

Activity 2.5: TBD based on outcomes of Activities 2.3 and 2.4

Priority Program Activity #3: The QM team will continue to facilitate the initiation, implementation and completion of a minimum of three (3) QI projects by 3/31/2016

Activity 3.1: The QM team will continue to accept and track QI ideas from any internal or external stakeholder.

Activity 3.2: The QM team will work with the QI idea originator to further define the idea and determine next steps.

Activity 3.3: The QM team will work with the HCS QI committee, HCS staff, HCS managers and other stakeholders as needed to gather data and background about the improvement idea and determine priority level.

Activity 3.4: The QM team will facilitate the creation, implementation and completion of QI projects taken from the highest priority improvement ideas.

Activity 3.5: The QM team will communicate results to necessary stakeholders and continue to work to build the QI process into an everyday routine within HCS.

Priority Program Activity #4: The QM team will explore the possibility of QI Innovation Grants and, if approved by senior leadership, the Request for Proposal (RFP) will be posted by 12/31/2015

Activity 4.1: The QM team will create a QI Innovation Grants proposal to define the purpose, outcomes and monitoring of the initiative.

Activity 4.2: The QM team will develop specific data measures and outcomes for the innovation grants and work with ODH grants/contracts units to develop Request for Proposal (RFP) if approved.

Activity 4.3: The QM team will work to convene a review team to analyze grant applications to determine the projects best suited for the purpose of the grant (e.g. based on data, availability of baseline data and benchmarks, degree to which they affect the HIV Care Continuum, ability to be replicated, etc.)

Activity 4.4: The QM team will oversee the implementation of the selected innovation grants and meet all ODH grant requirements.

Activity 4.5: The QM team will work with the funded innovation projects and other stakeholders regarding sustainability after the initiative.

Priority Program Activity #5: QI training, including at a minimum QI concepts, tools and ideas, will be provided to the HCS QI committee by 12/31/2015

Activity 5.1: The QI committee requested training from the QM team to increase quality improvement knowledge among committee members. Training will be provided to QI committee members with the goal of providing training to 100% of the members.

Activity 5.2: Increased QI knowledge will be measured through pre and post-test questionnaires (or similar methods of data collection)

Activity 5.3: Analyze quality data (pre/post-tests), determine opportunities for improvement for the training and apply what was learned from the pre/post-test analysis to eliminate gaps between current and desired levels of performance

Activity 5.4: Identify how identified gaps will be addressed. Identify process by which training(s) will be reviewed and modified to maximize quality.

Activity 5.5: Continue to provide training(s) and assess if the goals defined in 5.1 and measured in 5.2 are met through initial and subsequent trainings. Assess possibility of expanding to other staff and stakeholders.

The 2015-2016 Priority Program Activities are included in Attachment 6.

VI. Participation of Stakeholders

Stakeholder	Type of Involvement	Communication
HCS Managers	<ul style="list-style-type: none"> • communicate specific programmatic reporting needs to the QM Program Manager or HCS Administrator; • select program representatives to serve on the HCS Internal QI committee; • communicate outcomes to internal partners (including staff) and external stakeholders 	<ul style="list-style-type: none"> • collaborate with the QI committee to implement quality improvement activities
Bureau of Health Services Composed of Women Infants Children (WIC), Children with Medical Handicaps (CMH), Early Intervention (EI) and HIV Care Services (HCS).	<ul style="list-style-type: none"> • provide leadership support; • share ODH QM information with HCS section as needed 	<ul style="list-style-type: none"> • share our QM information with other bureaus in the Department.
HCS Advisory Group composed of representatives from all Ryan White Parts, consumers, physicians, pharmacists, nurses, dentists, medical case management,	<ul style="list-style-type: none"> • responsible for providing guidance on Part B programming, reviewing the quality of HIV care, and recommending medications to the Director for approval for 	<ul style="list-style-type: none"> • collaborate with the QI committee to implement quality improvement activities

Stakeholder	Type of Involvement	Communication
other state agencies, and ODH HIV/STD Prevention and Surveillance.	the OHDAP formulary.	
<p>Community-Based Network composed of medical case managers and clinical supervisors, agency-based quality improvement personnel, and representatives from the Ohio AIDS Coalition (OAC).</p>	<ul style="list-style-type: none"> • case managers are responsible for collecting and submitting client intake and eligibility data, client outcomes data, and claims data. • Supervisors and quality improvement personnel are responsible for quality management activities in the agencies and in the network. • OAC is responsible for providing access to consumer input. 	<ul style="list-style-type: none"> • collaborate with the QI committee to implement quality improvement activities
<p>Ohio All Parts Group composed of representatives from all Ryan White Parts that are funded in Ohio: Part A (two TGAs – Cleveland and Columbus), Part B (HCS - statewide), Part C (seven grantees from across the state), Part D (two grantees – Cleveland and Toledo), Part F (AETC – Columbus and Cincinnati).</p>	<ul style="list-style-type: none"> • responsible for providing guidance to and setting goals/actions for the Statewide Coordinated Statement of Need (SCSN). 	<ul style="list-style-type: none"> • meets simultaneously in person and by conference call at least twice a year • collaborate with the QI committee to implement quality improvement activities
<p>The HIV Cross-Part Care Continuum Collaborative (H4C) is a time limited HIV/AIDS Bureau (HAB) initiative that is facilitated by the National Quality Center (NQC).</p>	<ul style="list-style-type: none"> • designed to apply the Collaborative Model to a multi-state effort to improve viral suppression rates and other areas of the HIV care continuum. Selected states were asked to volunteer for this new collaborative • H4C reflects the National HIV/AIDS Strategy's goals to use evidence-based activities to improve HIV/AIDS prevention and care in areas hardest hit by the epidemic and, additionally, supports implementation of the White House's HIV Continuum of Care Initiative, which focuses on efforts to increase HIV testing, care, and treatment to 	<ul style="list-style-type: none"> • the initiative started September 2013. It is the aim of this national quality initiative not only to improve viral load suppression rates but also to potentially impact other components of the care continuum.

Stakeholder	Type of Involvement	Communication
	better address drop-offs along the continuum.	

- Data resources – software available to HCS QM Program includes: SAS, Crystal Reports, MS Office products, RW CAREWare, and an ODH-developed web-based programs for data management (i.e., Ryan White Application Database). HCS receives IT support from the ODH Bureau of Information Technology to provide database management, interface development, and to build reporting tools.
- Miscellaneous resources – provided as needed through ODH (e.g., travel and transportation, administrative functions, equipment).

VII. Evaluation

Evaluation HCS QM Program

The QM team evaluates the HCS QM program annually by using the National Quality Center’s Part B QM Program Assessment Tool. The tool is completed by the HCS QI committee to identify areas of strengths and weaknesses. Areas of weakness are used to develop the goals and areas of improvement for the upcoming year. Please see *Section II: Quality Infrastructure, Evaluation of HCS QI Infrastructure*.

Evaluation of the HCS QI committee structure and work takes place throughout the year as activities are completed and a more comprehensive QM program evaluation is completed annually. The annual evaluation is completed by the members and other stakeholders allowing them opportunity to provide feedback on the committee. The evaluation purpose is two-fold: 1) to evaluate the scope of the committee's work including assessment of the relevance of the committee's activities, the quality of the committee's efforts and results of activities; and 2) to evaluate committee member satisfaction including their experience regarding input on activities, clarity of their role as a committee member, etc. The content and format for surveying the QI committee members is still under development. The HCS QI committee reports to the HCS Program Administrator and HCS Program Managers on a regular basis.

Evaluation results and subsequent workplans as a result of evaluations are shared with stakeholders.

Evaluation of RW Part B Case Management Agencies & Providers

The Ryan White Part B case management agencies are evaluated using the same quality improvement tools used to evaluate the HCS QM program. (Please see *Section II: Quality Infrastructure, Evaluation of HCS QI Infrastructure*)

Additionally the Ryan White Part B case management agencies provide quarterly reports to HCS on their work plan activities and objectives as stated in the RFP.

HCS developed an electronic database system (Ryan White Application Database, a.k.a. RWAD) which allows for consistency across agencies for the reported objectives. RWAD was implemented on June 16, 2014 and the following client health outcomes are measured in RWAD and reviewed quarterly by HCS staff and CM agencies.

Measure	Case Management Client Outcome
1	Clients with a primary care/ID physician visit in the past six months
2	Clients prescribed HIV ART medications
3	Clients self-report of taking all doses of medication, as prescribed
4	Clients with a CD4/Viral load lab work completed in the past six months
5	Clients self-report of using condoms for oral sex more than half the time or always
6	Clients self-report of using condoms for vaginal sex more than half the time or always
7	Clients self-report of using condoms for anal sex more than half the time or always
8	Clients self-report of avoiding needle sharing practices (didn't share needles or shared less than half the time)
9	Clients with at least one oral health visit in the past six months
10	Clients with secondary HIV prevention /info education to increase knowledge about transmission, resistance, and reinfection
11	Clients who report stable or permanent housing

The HCS QM team also is responsible for conducting standard of care reviews for funded outpatient/ambulatory medical care (OAMC) providers. Funded medical services must meet established Health and Human Services HIV Treatment Guidelines. A priority in 2015-2016 is to improve clinical data collection which will allow the standard of care reviews to take place for all providers. All funded OAMC providers will receive a QI Standard of Care review before 3/31/2018.

VIII. Communication on Reports/ Initiatives

The purpose of this section is to detail how HCS will share QI stories, successes and other quality related updates in order to strengthen our efforts to infuse QI throughout HCS and to internal/external stakeholder agencies. Project storyboards will be distributed to internal and external stakeholders (i.e. see section II for list of stakeholders) for completed QI projects. Team members will be recognized when providing updates on the QI projects and in the storyboard. Project descriptions and results will be included on the program's website when applicable. QI updates will be communicated at HCS staff meetings, RW Part B advisory group meetings, all RW parts meeting, and to case management agencies. A detailed list of the minimum reports/activities that are to be reported on for RW year 25 is included below.

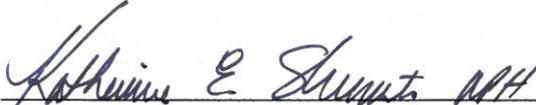
Annual Quality Improvement Reports/Reviews

WHAT	WHO	HOW	TO WHOM	WHEN
CM Agency QMAT template and feedback	Sub-grantee QM Coordinator	Electronic	RW B CM Agencies (sub-grantees)	Annually
CM Agency QM Plan feedback	Sub-grantee QM Coordinator	Electronic	RW B CM Agencies (sub-grantees)	Annually
QM Quarterly report on CM client outcomes	Sub-grantee QM Coordinator	Electronic	CM coordinator then to RW B CM Agencies (sub-grantees)	Quarterly
HCS QM Program Evaluation (HCS QI QMAT)	HCS QI committee	Electronic	HCS QM Manager	Annually
HCS QM Plan Revision	HCS QI committee	Electronic	QI Coordinator then to HCS QM Manager	Annually
Standard of Care Provider Reviews	Provider QM Coordinator	Electronic	RW B Providers	All by 3/31/2018
QM Program Standards	QM team/QI committee/ QM Manager	Electronic	Sub-grantees, Providers, Staff, all Stakeholders	Annually
QM Plan Performance Measures/Annual Goals/Program Activities Updates	QM team/QI committee	Electronic	Sub-grantees, Providers, Staff, all Stakeholders	Quarterly
Updated QM Language in RFPs, Contracts, etc.	QM team/QI committee	Electronic	Sub-grantees, Providers	Annually
H4C Performance Measures Data	Provider QM Coordinator	Electronic	Staff, All-Parts, All Stakeholders	Bi-monthly
QI Project Storyboards	QM team/QI Project teams	Electronic	All Stakeholders	At completion of each QI project

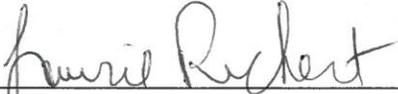
Please refer to the attachment sections 3-6 for ongoing updates.

HCS Quality Management Plan Ryan White Year 25

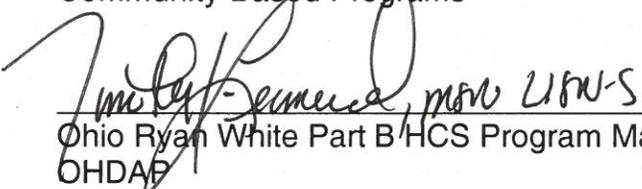
- Attachment 1: Key Terms Found in HCS Quality Management Plan
- Attachment 2: HIV Quality Management Program Standards
- Attachment 3: Quality Management Performance Measures RW Year 25
- Attachment 4: Status Report on 2015-2016 Annual Quality Goals Outcomes
- Attachment 5: 2015-2016 Current Quality Improvement Projects
- Attachment 6: Status Report on 2015-2016 Priority Program Activities


Ohio Ryan White Part B HCS Program Administrator

4-23-15
Date


Ohio Ryan White Part B HCS Program Manager
Community-Based Programs

5/6/15
Date


Ohio Ryan White Part B HCS Program Manager
OHDAP

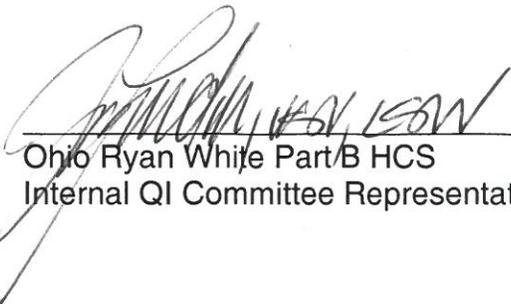
5/12/15
Date


Ohio Ryan White Part B HCS Program Manager
Quality Management

4/29/15
Date


Ohio Ryan White Part B HCS Program Manager
Data/Fiscal

5/5/15
Date


Ohio Ryan White Part B HCS
Internal QI Committee Representative

5/19/15
Date

Attachment #1: Key Terms Found in HCS Quality Management Plan

Annual Quality Goals: These are the goals selected by staff in the HIV Care Services (HCS) Section for each year's quality improvement focus.

ART—Antiretroviral Therapy: Antiretroviral therapy is prescription medication given to individuals infected with human immunodeficiency virus (HIV) infection using anti-HIV drugs.

Baseline: an initial measurement of a population or program.

Benchmark: A target to be reached; a near-term standard with which an indicator or particular performance measure is compared; a level of performance established as a standard of quality.

Cause and Effect Diagrams: This quality management tool used for problem solving offers a systematic way to brainstorm the various factors that may be causing a problem. It prompts people to ask: *Why is this occurring?* (Sometimes called a Fish Bone Diagram)

CQI—Continuous Quality Improvement: An agency's ongoing effort to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured. Also, CQI is an ongoing effort to improve the efficiency, effectiveness, quality or performance of services, processes, capacities and outcomes. Among the most widely used models for continuous improvement is a four-step quality model, the Plan-Do-Study-Act (PDSA) cycle, also known as the Plan-Do-Check-Act (PDCA) cycle and Lean Six Sigma.

CQM—Clinical Quality Management Program: A CQM program is a systematic process with identified leadership, accountability, and dedicated resource that uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and are adaptive to change. (<http://nationalqualitycenter.org/index.cfm/5857/12591>)

DMAIC: This acronym, comprised of the first letters of the words used to comprise the approach (Define, Measure, Analyze, Improve, and Control), is a systematic, data-driven approach to improvement that is a core process of the Six Sigma set of techniques. DMAIC is very similar to PDSA.

Fish Bone Diagram: (See Cause and Effect Diagrams)

Flow Chart: This quality management tool is used to describe a process being studied. It is a type of diagram that can be used to represent a workflow or process and shows the steps as boxes of various kinds the order and connection of which shows inter-relationships and decision points. It is less detailed than a process map.

Goal: A broad, general statement of what will be achieved and how things will be different after implementing a project; what it takes to reach the vision. A goal may or may not be measureable.

HAB—HIV/AIDS Bureau: Within HRSA, the HIV/AIDS Bureau has responsibility for oversight of the Ryan White HIV/AIDS Program (RWHAP).

HCS—HIV Care Services Section: The HIV Care Services (HCS) Section at the Ohio Department of Health houses the team that administers the Ryan White Part B program for the state of Ohio.

Attachment #1: Key Terms Found in HCS Quality Management Plan

HCS Quality Improvement Committee: provides ongoing operational guidance to the HCS Quality Improvement team within the Ryan White Part B program to implement the HIV Clinical Quality Management program objectives. It meets at least quarterly and consists of members from each program within the HIV Care Services Section.

HCS Quality Management Program Standards: These standards are updated annually by HCS and lay the framework for HCS' QM program expectations and outline the minimum components of a QM program.

HCS Quality Management Team: is composed of one program manager and four quality management coordinators. The team meets at least bi-weekly and is responsible for organizing HCS' quality improvement (QI) activities. The QM team is responsible for the oversight for the HIV Clinical Quality Management Program including the HCS QI committee and the HCS QM Plan.

HHS—Health and Human Services: In the US, HHS is the government's principal agency for protecting the health of all Americans and providing essential services, especially for those who are least able to help themselves. Health and Human Services includes HRSA (where the Ryan White program is located) and the CDC.

HRSA—Health Resources and Services Administration: HRSA is an agency within the US Department of Health and Human Services (HHS) and is the federal agency that funds the Ryan White programs in the United States.

Impact Control Matrix: This quality management tool is used to compare multiple potential solutions against two key variables in order to select the items the team should begin to implement first. This tool is typically used when there is a long list of good ideas but a limited amount of resources available to work on the improvements.

Indicator(s): a measure which helps to quantify the progress towards achievement of a goal.

iTRACK: The HCS tracking system to collect and monitor the status of all ideas suggested for QI projects and those that are adopted for study.

Measure(s): a basis for comparing performance or quality through quantification.

Metrics: a collection of measures used in assessing performance. Metrics can include such things as goals, indicators, measures, standards, baselines, and benchmarks.

National Monitoring Standards: In 2011, the HIV/AIDS Bureau at HRSA developed national monitoring standards (fiscal, program, and universal) to guide grantees in operating a Ryan White program. The Monitoring Standards define performance measures/methods, grantee responsibility, provider/sub-grantee responsibility (if any), and include source citations for each standard.

- Universal: <http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringpartab.pdf>
- Fiscal: <http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringpartb.pdf>
- Program: <http://hab.hrsa.gov/manageyourgrant/files/programmonitoringpartb.pdf>

Attachment #1: Key Terms Found in HCS Quality Management Plan

NQC—National Quality Center: in conjunction with HRSA HIV/AIDS Bureau, NQC provides no-cost, state-of-the-art technical assistance for all Ryan White HIV/AIDS Treatment Modernization Act of 2006 funded grantees to improve the quality of HIV care nationwide.

OHDAP—Ohio HIV Drug Assistance Program: OHDAP is the mechanism by which eligible Ohioans with HIV are able to receive prescription medication to treat their HIV disease and related conditions. The program includes distribution of formulary medications directly to eligible program clients (formulary client) or as a result of providing wrap-around services (e.g., paying insurance premiums, payment of medication copayments, etc.), most commonly referred to as a HIPP (health insurance premium payment) client.

Part B—Ryan White Part B Program: This refers to the federal program established by the Ryan White HIV/AIDS Treatment Modernization Act, 42 USC 300ff et seq (as in effect on January 1, 2009) and administered by the Director of health under division (D) of section 3701.241 of the Revised Code Part B.

PDSA: is a continuous quality improvement model consisting out of a logical sequence of four repetitive steps for continuous improvement and learning: Plan, Do, Study (Check) and Act. PDSA is very similar to DMAIC.

Performance Measure: A measure of how well a program is working; the efficiency and effectiveness of the work performed and the results achieved; may relate to knowledge, skills, attitudes, values, behavior condition, or status, (e.g., % of patients who keep appointment)

Process Mapping: This quality management tool used to display the current process and information flow. The purpose is to understand the current process in order to identify opportunities for improvement by mapping all of the steps in the current process and identifying the job function that completes each step. It is a more detailed approach than a flowchart.

Program Activities: These are specific program activities that have been selected by HCS with the aim to improve client health outcomes. These are presented as SMART objectives and include baseline/benchmark data.

QMAT—Quality Management Assessment Tool: An organizational assessment tool developed by the National Quality Center (NQC) and adapted by HCS Quality Management team that identifies all of the essential elements associated with a sustainable quality management program.

Quality: an essential characteristic or attribute of a product, program, service or process that helps determine the level of excellence or intrinsic value. Quality is determined by the end-user or customer of the product and can be expressed in a range from low to poor quality to high quality.

QA—Quality Assurance: The maintenance of a desired level of quality in a service or product, especially by means of inspection to measure compliance with established standards.

QI—Quality Improvement: Quality improvement is a formal approach to the analysis of performance and systematic efforts to improve it. It is accomplished through continuously improving processes to meet or exceed established standards. Opportunities for quality improvement are often detected through quality assurance activities.

Attachment #1: Key Terms Found in HCS Quality Management Plan

Quality Improvement Capacity Building: Use of various methods to expand quality improvement knowledge, skills, resources, and implementation throughout all aspects of the Ryan White Part B Program.

Quality Improvement Projects: A quality improvement project contains a planned sequence of systematic and documented activities aimed at improving a process. Improvements can be made in two ways, either by 1) improving the process itself, and/or 2) by improving the outcomes of the process.

Quality Improvement Tools: This term references the variety of tools used to identify how processes, programs, and services can be improved. These tools include such things as flow charts, cause and effect diagrams, logic models, SWOT analyses, SIPOC, and process mapping for examples.

QM—Quality Management: QM ensures that an organization, product, or service is of consistent high quality. It includes both quality assurance and quality improvement activities.

Quality Management Plan: A written document that outlines the HIV Clinical Quality Management program, 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.

RWAD—Ryan White Application Database: This ODH web-based system (also known as RWAD) is designed to document client eligibility and enrollment in any of the Ryan White Part B programs in Ohio.

RWHAP—Ryan White HIV/AIDS Program: This is the name of the program within the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA). Originally named the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the program had several name changes when reauthorized in 1996, 2000, 2006, and 2009 (as the Ryan White HIV/AIDS Treatment Extension Act of 2009) and is now called the Ryan White HIV/AIDS Program (RWHAP).

SCSN—Statewide Coordinated Statement of Need: A document, first developed in 1997, concentrated on methods to assess the needs of people living with HIV/AIDS (PLWHA) in Ohio. The document is a collaborative mechanism to identify and address significant HIV/AIDS care issues related to the needs of people living with HIV/AIDS (PLWHA) in Ohio, and to maximize coordination, integration, and effective linkages across the Ryan White HIV/AIDS Program Parts. The document is required by HRSA and is updated every three years.

SIPOC: This quality improvement tool used for process improvement derives its name (an acronym) from the words used to describe its relevant parts: Supplier, Input, Process, Output, and Customer. The results of a SIPOC analysis are displayed in a table format.

Six Sigma: A set of tools originally developed by Motorola in 1986. The tools are used to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimizing variability in manufacturing and business processes.

SMART: A method to create objectives where the acronym is comprised of the first letters of the words used to comprise the approach (Specific, Measurable, Attainable, Relevant, Timely)

Attachment #1: Key Terms Found in HCS Quality Management Plan

Solution and Effect Diagrams: This quality improvement tool used to identify changes and recommendations. It offers a systematic way to brainstorm the various solutions to reach a positive outcome (effect). It prompts people to ask: *How can we do this?* Similar to cause and effect diagram.

Standards: An established level of performance or quality; the minimum acceptable measurement expected or desired.

Storyboards: Collection of information in a written format that offers a clear, logical, and convincing picture of key points in the improvement project and can be an effective venue for telling the story as the team moves through its improvement work.

SWOT Analysis Model: This quality improvement tool used for process analysis derives its name (an acronym) for the words used to describe its relevant parts: Strengths, Weaknesses, Opportunities, and Threats.

TPA—Third Party Administrator: The Ryan White Part B program may use the services of a TPA to pay for HIV-related medical services and medications.

Attachment #2: HIV Quality Management Program Standards

Ohio Ryan White Part B / HIV Care Services Section
HIV Clinical Quality Management Program
Knowledge. Excellence. Innovation.

HIV Quality Management Program Standards

As the Ohio Ryan White HIV/AIDS Part B grantee, the HIV Care Services (HCS) Section at the Ohio Department of Health (ODH) is required by our funder, the Health Resources and Services Administration (HRSA), to set quality expectations for Part B program services. A formal quality management program that embraces quality improvement (QI) philosophy must be in place as part of the HIV service delivery program. The minimum components of an HIV Quality Management Program are the following:

1) Infrastructure for HIV Quality Program

- Each HIV quality program should have a quality plan that is reviewed and updated annually describing the mission of the quality program, key quality principles and objectives, and the infrastructure of the quality program.
- The quality plan should specifically a) outline quality committees including membership, frequency of meeting and reporting mechanisms, b) specify accountability for all quality improvement activities within the HIV program, c) describe processes to evaluate, assess, and follow-up on HIV quality findings, d) link the HIV quality program to organization's overall quality program and e) detail the roles and responsibilities of leadership and its commitment of resources for the quality program.
- Specific programmatic annual goals regarding quality projects and performance measures should be set and shared with program staff. These goals should be formally reviewed and updated by the quality committee at least annually.

2) Staff Involvement in Quality Improvement Activities

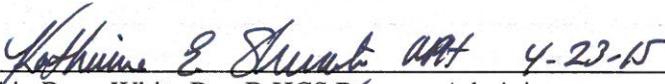
- The objectives, progress, and results of quality activities and performance measurement indicators should be routinely communicated to staff and stakeholders to increase participation in the HIV quality program.
- Members of different professional disciplines and programmatic backgrounds should be included in the quality committee membership to ensure multiple stakeholders are represented and to encourage sharing of ideas.
- At a minimum, education should be provided to all section staff annually. Education should include QI-related topics including, but not limited to, quality improvement principles, and HIV quality program goals and objectives.

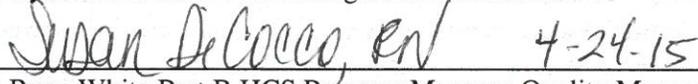
3) Performance Measurement

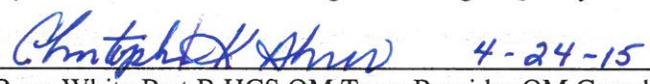
- The quality program should describe its clinical and non-clinical indicators including written definitions, desired health outcomes, and frequencies of review in the quality plan. Indicators should be updated at least annually and reflect current standards of care.
- The HIV program should routinely measure the quality of care with the involvement of staff and consumers and review results in quality committees. A work plan for follow-up action(s) should include implementation steps, anticipated barriers (including how to mitigate them) and a timetable for completion of each step.

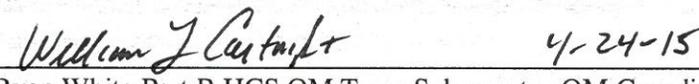
Attachment #2: HIV Quality Management Program Standards

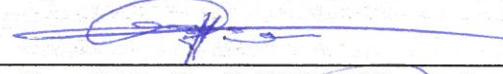
- Performance data results should be shared with staff, clients, and other stakeholders.
- 4) Quality Improvement Projects
- The process of selection and prioritization of quality improvement activities should be clearly outlined and should respond to external expectations and internal priorities. Staff should be involved in the selection of quality initiatives and these quality initiatives should be documented as part of a written work plan.
 - A process of reviewing results of quality initiatives should be integrated into the HIV quality program.
 - The agency/program's quality committee should oversee and provide support and feedback on quality improvement projects.
 - Project specific quality improvement teams with cross-functional representation should be formed to address specific quality improvement opportunities and continue to monitor change.
 - Results of quality improvement projects should be presented to quality committees, stakeholders, shared among staff, and used for future planning.
- 5) Consumers Involvement
- The quality program should routinely assess patients' needs and/or satisfaction, and integrate consumer feedback into the quality program.

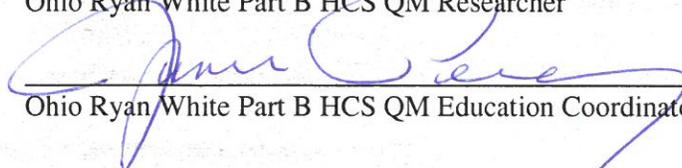

Ohio Ryan White Part B HCS Program Administrator


Ohio Ryan White Part B HCS Program Manager Quality Management


Ohio Ryan White Part B HCS QM Team Provider QM Coordinator


Ohio Ryan White Part B HCS QM Team Sub-grantee QM Coordinator


Ohio Ryan White Part B HCS QM Researcher


Ohio Ryan White Part B HCS QM Education Coordinator

Date last revised: 4/22/2015

Attachment #3: Quality Management Performance Measures RW Year 25

The first three pages that follow show the annual goals selected for Ryan White Year 25 (April 1, 2015 to March 31, 2016). For each goal, the following details are provided:

- The measure itself
- The timeframe
- The baseline data or benchmark being used and the time period for which the baseline data were collected
- The Year 25 goal (several measures do not have stated goals because they were not selected as annual goals for this coming year.)
- Four columns that will be populated on a quarterly basis with data to illustrate progress in meeting each of the articulated goals.

Following the itemized list of goals described above are several pages (pages 4-8) that explain the actual data elements and definitions being used to derive the data. This ensures that data assessments are standardized and that calculations done from quarter to quarter are based on the same queries and understanding of how each percentage was derived.

Several notes are useful in understanding the particular service codes and other data sources that are included in each equation used to calculate the measures. These are included at the end of Attachment 3 (on page 9).

Attachment #3: Quality Management Performance Measures RW Year 25

Annual Goals							
Measure	Measure Timeframe	Date/Baseline(Benchmark) 2014	Goal	Report Date ending with March 2015	Report Date ending with June 2015	Report Date ending with Sept. 2015	Report Date ending with Dec. 2015
<u>Goal #1:</u> Increase the percentage of clients in HIV medical care prescribed ART	12 months	94.2% (1-1-2014 to 12-31-2014)	95%	0%	0%	0%	0%
<u>Goal #2:</u> Improve viral suppression percentages for clients in HIV medical care	12 months	67.9% (1-1-2014 to 12-31-2014)	73%	0%	0%	0%	0%
<u>Goal #3:</u> Increase the percentage of clients in medical case management who report HIV medication adherence by taking all doses of ART	12 months	75% (1-1-2014 to 12-31-2014)	81%	0%	0%	0%	0%
Core							
Medical Visit Frequency	24 months	42.3 % (1-1-2013 to 12-31-2014)		0%	0%	0%	0%
Gap in Medical Visits	12 months	43.5% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Clinical (Adolescent/Adult)							
Tuberculosis (TB) Screening	12 months	22.5% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Viral Load Monitoring	12 months	28.7% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Syphilis Screening	12 months	8.9% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Hepatitis C Screening	12 months	25.2% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Oral Health							
Dental Treatment Plan	12 months	62.3% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Periodontal screening or examination	12 months	52.1% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%

Attachment #3: Quality Management Performance Measures RW Year 25

Medical Case Management							
Measure	Measure Timeframe	Date/Baseline(Benchmark) 2014	Goal	Report Date ending with March 2015	Report Date ending with June 2015	Report Date ending with Sept. 2015	Report Date ending with Dec. 2015
Case Management Visit Frequency	24 months	64.4% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Gap in Case Management Visits	12 months	16.4% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Housing Status (Stably Housed)	12 months	87.9% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
Secondary HIV Prevention	6 months	88.6% (7-1-2014 to 12-31-2014)		0%	0%	0%	0%
Condom use with oral sex (if applicable)	6 months	42.9% (7-1-2014 to 12-31-2014)		0%	0%	0%	0%
Condom use with vaginal sex (if applicable)	6 months	71.7% (7-1-2014 to 12-31-2014)		0%	0%	0%	0%
Condom use with anal sex (if applicable)	6 months	74.1% (7-1-2014 to 12-31-2014)		0%	0%	0%	0%
Avoiding needle-sharing (if applicable)	6 months	85.7% (7-1-2014 to 12-31-2014)		0%	0%	0%	0%
OHDAP (ADAP)							
OHDAP Service Frequency	24 months	60.8% (1-1-2013 to 12-31-2014)		0%	0%	0%	0%
Gap in OHDAP Services	12 months	33% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%
OHDAP Application Completion Rate	12 months	92.2% (1-1-2014 to 12-31-2014)		0%	0%	0%	0%

Attachment #3: Quality Management Performance Measures RW Year 25

Quality Performance Measures Definitions			
Measure	Numerator	Denominator	Most Recent Result/ Data Source
Annual Goals			
<u>Goal #1:</u> Increase the percentage of clients in HIV medical care prescribed ART	Number of Part B clients in the denominator who are prescribed ART in the 12-month measurement period, as determined by receipt of ART ¹ dispense or report by medical provider on the Medical Provider Visit Form	Number of Part B clients who had at least one medical visit ² in the 12-month measurement period	
<u>Goal #2:</u> Improve viral suppression percentages for clients in HIV medical care	Number of Part B clients in the denominator with a viral load <200 copies/mL at last test in the 12-month measurement period	Number of Part B clients who had at least one medical visit ² in the 12-month measurement period	
<u>Goal #3:</u> Increase the percentage of clients in medical case management who report HIV medication adherence by taking all doses of ART	Number of case management clients who report taking all doses of ART, as prescribed, as reported on question #3 on the Medical Case Management Outcome Measures in the Ryan White Application Database (RWAD) , "Over the last week have you skipped/missed taking one or more of your HIV/AIDS medication doses in a day?"	Number of case management clients who were prescribed ART as per their Medical Case Management Outcome Measure completed in the measurement period	
Core (All Part B Clients)			
Medical Visit Frequency	Number of clients in the denominator who had at least one medical visit ² in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period	Number of clients with at least one medical visit ² in the first 6 months of the 24-month measurement period	

Attachment #3: Quality Management Performance Measures RW Year 25

Measure	Numerator	Denominator	Most Recent Result/ Data Source
Medical Visit Frequency	Number of clients in the denominator who had at least one medical visit ² in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period	Number of clients with at least one medical visit ² in the first 6 months of the 24-month measurement period	
Gap in Medical Visits	Number of clients in the denominator who did not have a medical visit ² in the last 6 months of the measurement year	Number of clients who had at least one medical visit ² in the first 6 months of the measurement year	
Clinical (All Adolescent/Adult Part B Clients)			
Tuberculosis (TB) Screening	Clients for whom there was documentation that a tuberculosis (TB) screening test ³ was performed at least once since the diagnosis of HIV infection.	All clients aged 3 months or older who had at least two medical visits ² during the measurement year, with at least 90 days in between each visit.	
Viral Load Monitoring	Number of clients in the denominator with a viral load test performed at least every 6 months	Number of clients who had at least two medical visits ² during the measurement year, with at least 60 days in between each visit	
Syphilis Screening	Number of clients who had a serologic test for syphilis performed at least once during the measurement year	Number of clients who: <ul style="list-style-type: none"> • were >18 years old in the measurement year or had a documented history of sexual activity < 18 years, and • had a medical visit with a provider with prescribing privileges at least once in the measurement year 	

Attachment #3: Quality Management Performance Measures RW Year 25

Measure	Numerator	Denominator	Most Recent Result/ Data Source
Hepatitis C Screening	Number of clients with a diagnosis of HIV who have had at least one Hepatitis C screening since testing HIV-positive	Number of clients with a diagnosis of HIV who had a medical visit ² with a provider with prescribing privileges at least once in the measurement year	
Oral Health (Service Recipients Only)			
Dental Treatment Plan	Number of oral health clients who had a dental treatment plan ⁴ developed and/or updated at least once in the measurement year	Number of oral health clients that received a clinical oral evaluation ⁵ at least once in the measurement year.	
Periodontal screening or examination	Clients who report of having had at least one oral health evaluation in the measurement year	Number of distinct clients with at least one periodontal screen or examination completed in the measurement period	
Medical Case Management (Case Management Clients Only)			
Case Management Visit Frequency (Adapted from HIV/AIDS Bureau Performance Measure Medical Visit Frequency)	Number of clients from the denominator, who had at least one case management visit in each 6 month period of the 24 month measurement period	Number of clients with at least one case management visit in the first 6 months of the 24-month measurement period	
Gap in Case Management Visits (Adapted from HIV/AIDS Bureau Performance Measure Gap in Medical Visits)	Number of clients in the denominator who did not have a case management visit in the last 6 months of the measurement year	Number of clients who had at least one case management visit in the first 6 months of the measurement year	
Housing Status (Stably Housed)	Number of clients with a Medical Case Management Outcome Measure who responded “yes” for question #6, being stable/permanently housed in the 12-month measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period	

Attachment #3: Quality Management Performance Measures RW Year 25

Measure	Numerator	Denominator	Most Recent Result/ Data Source
Secondary HIV Prevention	Number of distinct clients with a response of “yes” for question #7, “In the past 6 months, did your case manager talk to you about ways to protect yourself and others from HIV infection or re-infection?” of the Medical Case Management Outcome Measures in the measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period	
Condom use with oral sex (if applicable)	Number of distinct clients with a response of “Always” or “More than half the time” for question #8A, “In the past 3 months, how often were condoms used during oral sex?” of the Medical Case Management Outcome Measures in the measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period who did not respond “did not engage in the activity” for question “In the past 3 months, how often were condoms used during oral sex?” of the Medical Case Management Outcome Measures	
Condom use with vaginal sex (if applicable)	Number of distinct clients with a response of “Always” or “More than half the time” for question #8B, “In the past 3 months, how often were condoms used during vaginal sex?” of the Medical Case Management Outcome Measures in the measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period who did not respond “did not engage in the activity” for question “In the past 3 months, how often were condoms used during vaginal sex?” of the Medical Case Management Outcome Measures	
Condom use with anal sex (if applicable)	Number of distinct clients with a response of “Always” or “More than half the time” for question #8C, “In the past 3 months, how often were condoms used during anal sex?” of the Medical Case Management Outcome Measures in the measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period who did not respond “did not engage in the activity” for question “In the past 3 months, how often were condoms used during anal sex?” of the Medical Case Management Outcome Measures	

Attachment #3: Quality Management Performance Measures RW Year 25

Measure	Numerator	Denominator	Most Recent Result/ Data Source
Avoiding needle-sharing (if applicable)	Number of distinct clients with a response of “Never” or “Less than half the time” for question #9, “In the past 3 months, how often have you shared needles, syringes, cookers, cotton or rinse water with others?” of the Medical Case Management Outcome Measures in the measurement period	Number of distinct clients with a Medical Case Management Outcome Measure completed in the measurement period who did not respond did not engage in the activity” for the question “In the past 3 months, how often have you shared needles, syringes, cookers, cotton or rinse water with others?” of the Medical Case Management Outcome Measures	
Ohio HIV Drug Assistance Program (OHDAP Clients Only)*			
Measure	Numerator	Denominator	Most Recent Result/ Data Source
OHDAP Service Frequency (Adapted from HIV/AIDS Bureau Performance Measure Medical Visit Frequency)	Number of clients from the denominator, who had at least one OHDAP service ⁶ in each 6 month period of the 24 month measurement period	Number of clients with at least one OHDAP service ⁶ in the first 6 months of the 24-month measurement period	
Gap in OHDAP Services (Adapted from HIV/AIDS Bureau Performance Measure Gap in Medical Visits)	Number of clients in the denominator who did not have a OHDAP service ⁶ in the last 6 months of the measurement year	Number of clients who had at least one OHDAP service ⁶ in the first 6 months of the measurement year	
OHDAP Application Completion Rate	Number of completed OHDAP applications received that were reviewed and approved in 14 days (twoweeks) in the measurement period	Number of completed OHDAP applications received in the measurement period	

*OHDAP is Ohio’s AIDS Drug Assistance Program (ADAP)

Attachment #3: Quality Management Performance Measures RW Year 25

Notes/Comments:

- ¹"ART" dispense is defined as getting a dispense from the contracted pharmacy for antiretroviral drug or getting an exception for medication dispense (29.12, 29.22, 29.32 or 29.62)
- ²"Medical Visit" is defined as OHDAP service including service code 29.12,29.22, 29.32 or 29.62, having medication dispensed from the contracted pharmacy, Case management funded Lab or Medical Service (service code 25 and 26 except 26.35, 26.55 and 26.15)
- ³"Tuberculosis (TB) screening test" as indicated on the Medical Provider Visit Form or through CPT codes (86480, 86580, 87116, 86481, 87556 and/or 87557) from third party administrator disbursement data.
- ⁴"Dental treatment plan" is required for disbursement of any ADA code through the third party administrator (TPA) except for ADA codes that do not require an exception (all ADA code in service code category 27.10, 27.20 or 27.60, ADA code D4910 and ADA code D7140). It can be assumed that if client got any of the services that require exception through PPL then they have submitted a treatment plan
- ⁵"Clinical oral evaluations" include dental evaluation, diagnosis and treatment planning. Pertinent ADA CDT codes may include the following: D0120-Periodic Oral Evaluation-established patient; D0150-Comprehensive oral evaluation, new or established patient; D0160-Detailed and Extensive Oral Evaluation; D0170-Re-evaluation, limited, problem focused (established patient; not post-operative visit); and D0180-Comprehensive Periodontal Evaluation-new or established patient
- ⁶"OHDAP Service" is defined as receiving dispense from the contracted pharmacy, OHDAP premium and copay assistance services (service code 29) and/or OHDAP spenddown services (service Code 30)

Attachment #4: Status Report on 2015-2016 Annual Quality Goals Outcomes

Goal #1	Increase the percentage of clients in HIV Medical Care prescribed Antiretroviral Therapy (ART)
Baseline	94.2% baseline / goal is to have 1% improvement from original 1-1-14 to 12-31-14 data
Why	The benefits of ART Therapy: reduced HIV-related morbidity, decrease inflammation, and prevents the development of drug-resistance mutations
How to measure	Using <u>numerator</u> of (number of clients in the denominator who are prescribed ART in the 12-month measurement period, as determined by receipt of ART ¹ dispense or report by medical provider on the Medical Provider Visit Form) and <u>denominator</u> of (number of clients with an HIV diagnosis and who had at least one medical visit* in the 12-month measurement period)
How to improve	TBD
Status Update	
Goal #2	Improve viral suppression percentages for clients in HIV Medical Care (2-3 year measure)
Baseline	67.9% baseline / goal is to have 5% improvement from original 1-1-14 to 12-31-14 data
Why	The benefits of Viral suppression in PLWHA: improved health, longer life, and dramatically reduced chances of infecting others
How to measure	Using <u>numerator</u> of (number of clients in the denominator with a viral load <200 copies/mL at last test in the 12-month measurement period) and <u>denominator</u> of (number of clients with an HIV diagnosis and who had at least one medical visit ² in the 12-month measurement period)
How to improve	Current strategy is to focus on improving missing clinical data (QI clinical data collection project) which includes viral load counts
Status Update	

Attachment #5: 2015-2016 Current Quality Improvement Projects

QI Project Name	Description	Project Phase (P, D, S, A or other?)	Next step(s)	Status
Investigation of fax issues in OHDAP	Incoming OHDAP faxes are sometimes out-of-order which results in considerable staff time to reorder the documents; need to investigate to see root cause	In progress (Plan phase)	Complete process mapping	
Standardize Returned Mail Process	During a previous QI project, it was discovered there is inconsistency in how staff process returned mail. A standardized process is required.	Complete (Act phase)	Storyboard development	
Improve Clinical Data Collection	There are numerous stakeholder complaints about the two HCS clinical data forms (Physician Verification Form and Medical Provider Visit Form) including duplicate copies, confusion between the two forms, etc. Need to discover ways to obtain the clinical data so it is more complete and reduces frustrations of stakeholders	In progress (Plan phase)	Implementing identified strategies	
Assess for Any Negative Impact of Removing Printed Applications from Renewal Letters	In order to reduce the volume of paper used and to support a paper-free application system, printed OHDAP applications will no longer be included in client renewal letters starting with the November mailing (which includes clients due to re-enroll in January 2015). Request is to run pre- and post-enrollments to ensure there is not an unintended change.	N/A	Baseline data collected for two months; will recheck data after change is made	

The status of the above Quality Improvement Projects are reported out periodically to stakeholders in the most efficient manner including the use of storyboards.

Attachment #6: Status Report on 2015-2016 Priority Program Activities

Priority Program Activity Name	Tools Used (if applicable)	Next step(s)	Status
50% of case management sub-grantee agencies will identify a quality improvement project by 3/31/2016			
An analysis of the number of Part B clients on anti-retroviral therapy (ART) but not virally suppressed will be completed by 3/31/2016			
The QI team will continue to facilitate the initiation, implementation and completion of a minimum of three (3) QI projects by 3/31/2016			
The QI team will explore the possibility of QI Innovation Grants and, if approved by senior leadership, the Request for Proposal (RFP) will be posted by 12/31/2015			
QI training, including at a minimum QI concepts, tools and ideas, will be provided to the HCS QI committee by 12/31/2015			

All Program Activities for RW Year 25 were established in March 2015 therefore all are currently in the define phase.