"Fan Fare" 2001, encaustic on canvas by Laurence Young, HIV-positive artist

Building Capacity of Statewide Quality Management Programs

NQC Guide for Ryan White HIV/AIDS Program Part B Grantees

New York State Department of Health AIDS Institute
Health Resources and Services Administration HIV/AIDS Bureau

NATIONAL QUALITY CENTER

Building Capacity of Statewide Quality Management Programs

NQC Guide for Ryan White HIV/AIDS Program Part B Grantees

Developed for the
U.S. Department of Health and Human Services
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By the New York State Department of Health AIDS Institute
National Quality Center (NQC)

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Introduction

Overview of the Guide

The overall intention of the Ryan White HIV/AIDS Program, as enacted by the U.S. Congress, is to reduce the unmet health needs of persons living with HIV/AIDS. Often referred to as the "payer of last resort," it provides primary health care and support services to those who cannot access them on their own or through other social programs.

The Institute of Medicine (IOM) report, "Measuring What Matters," which was sponsored by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) and the Centers for Disease Control and Prevention, was released in 2003. It recognized HAB's efforts in the area of quality management (QM), and noted that Ryan White HIV/AIDS Program-funded agencies in some ways were more sophisticated than general medical facilities in their approach to QM. However, it went on to state that more could be done to measure and improve the quality of care provided by Ryan White HIV/AIDS Program grantees. While noting that QM programs have been developed and that many providers are assessing their attempts to improve care, the report recommended that more effort should be made to assess the level of patient satisfaction with the care they receive and to measure quality at a broader population level.

The 2006 reauthorized Ryan White HIV/AIDS Treatment Modernization Act delineated quality mandates for the grantees and it was Congress' expectation was that there would be technical assistance (TA) provided to help them meet these requirements. With these goals is mind, HRSAHAB initiated a cooperative agreement to provide training and TA on QM, which resulted in the creation of the National Quality Center (NQC) in 2004. The NQC has emerged as a source of innovation, leadership and support in quality improvement for these grantees and in HIV care nationwide.

Through experience, the NQC has learned that grantees face many challenges in developing QM programs, including unfamiliarity with quality improvement concepts, lack of staff resources and organizational barriers. Through the engagement of Part B grantees in two NQC-sponsored national collaboratives, the role of the State Department of Health was emphasized in building a sound statewide quality program and promoting quality improvement principles and applications among HIV providers and consumers.

The NQC has worked over the past four years with Part B grantees to help build capacity and capabilities for quality improvement. This Guide captures the combined expertise and accomplishments of participating Part B programs in

these collaboratives, successes from on-site consultations, and the knowledge of NQC staff and consultants who guide Ryan White HIV/AIDS Program grantees through the challenges and key tasks related to improving the quality of HIV care.

Use of the Guide

This NQC Guide is designed to help Part B-funded states and territories to initiate or refine their QM-related activities. For programs that have not yet started or are fairly new to the process, it provides useful information on how to gain buy-in from leadership and staff and steps to initiate quality improvement activities. Those further along in the process can compare their methods to those of other states and territories, and consider ways to strengthen their current efforts. Any Part B program interested in improving quality in a statewide system can benefit from the use of the Guide.

The Guide does not provide a single, "cookie cutter" approach to implementing a QM program; instead, it focuses on the lessons learned from the NQC's work with Part B programs, including the Part B Collaborative Demonstration Project and the Low-Incidence Initiative. More information about these projects can be found in Appendices A and B.

This Guide is designed to take the lessons learned from Part B programs participating in these collaboratives and from the provision of on-site TA by experienced NQC consultants, and make them available to the wider audience of all Part B programs, their staff, and subgrantees. It is the intention that learning from the experience of others will help these three critical audiences to understand their role in the QM process and identify concrete tools that may be adapted for their programs.

Objectives of the Guide

The Guide is designed to:

- Provide a framework for the QM activities of Ryan White HIV/AIDS Program-funded Part B programs
- Present basic elements of a statewide Part B QM program
- Describe the process for developing QM infrastructure
- Establish effective performance measurement systems for HIV care
- Present examples of specific Part B program quality activities
- Provide quality-related tools that can be adapted by Part B programs

National Quality Center (NQC) Overview

The NQC is a quality improvement initiative funded in September 2004 through a cooperative agreement with HRSA/HAB. The NQC provides no-cost, quality improvement TA to Ryan White HIV/AIDS Program grantees. This TA is designed to build the capacity of grantees to improve the quality of HIV/AIDS care and services provided.

The NQC provides quality improvement services built around three core components:

- Sharing. Rapid dissemination of information related to quality improvement and QM through websites, listserv activities, direct mail, and at key HIV conferences.
- Training. Training and educational fora on a wide array of quality-related topics through conference calls, webcasts, educational workshops, online training courses, and the Training-of-Trainer Program.
- Consulting. Intensive, individualized on-site and off-site consultation, which may involve online and telephone consultation and review of QM materials.

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NQC Part B Collaboratives

Part B Collaborative Demonstration Project

The Part B Collaborative Demonstration Project: Improving Care for People Living with HIV Disease involved eight states and jurisdictions working together from April 2005 to November 2006. During this time, Collaborative participants developed and strengthened their existing QM programs, supported by an expert faculty. QM plans were developed by each participant. Support was provided by the NQC through three Learning Sessions and by facilitating continual contact between the participants and the collaborative leadership team and faculty members through email, a dedicated website, and conference calls. Participating states and territories included: Alabama, Georgia, Florida, Michigan, Missouri, Ohio, Oregon, and Washington, DC.

For the collaborative, four domains were used as a framework for the work of the teams. Participants selected measures reflecting these four domains, including:

- Alignment across jurisdictions and services to support a common vision of service delivery and quality of services;
- Data and information systems (including understanding outcomes and linking these to data management);
- Access to services and retention of clients; and
- Cost containment and managing resources.

For more information about this Part B Collaborative, see Appendix A.

Low Incidence Initiative

The multifaceted nature of Part B environments along with limited resources and other unique challenges faced by states with lower HIV incidence often result in less than optimal coordination and collaboration among subgrantees. In March 2007, 17 Part B low incidence states met to kick off a 12-month collaborative initiative. The goal of the initiative was to assist these states in the development and/or refinement of an effective quality management plan and program for the state and the implementation of processes to ensure and demonstrate quality of care and services, in accordance with the Ryan White Program legislation.

For more information about the Low Incidence Initiative, see the Appendix B.

Real World Example: Elimination of Alabama's ADAP Waiting List

For years, Alabama had one of the longest AIDS Drug Assistance Program (ADAP) waiting lists, both in terms of length of time clients had to wait to access ADAP and the number of individuals waiting to receive ADAP.

Prior to participation in the Collaborative, Alabama's ADAP implemented an internal assessment to review processes in an effort to identify areas needing improvement. Initial internal assessment efforts by the ADAP staff, in addition to efforts by Alabama's Part B Collaborative quality management committee to identify inactive and ineligible clients, resulted in opening of 300 ADAP slots and the elimination of Alabama's waiting list as of May 6, 2006.
Alabama established a process to recertify ADAP clients

twice a year, as directed by HAB. An important step in the process was the standardization of forms. Valuable technical assistance—a sample eligibility determination form—was provided by Kentucky. Alabama had worked with Kentucky before on a different project so a relationship was already in place.

Another important aspect of the process was verification of clients' enrollment in Medicaid, which is now done by cross-matching data on a quarterly basis. The QM Committee built on the Health Department's existing relationship with Medicaid to enter into a data sharing agreement. During the verification process, approximately 300 Medicare eligible clients, who were also eligible for Medicare Part D benefits, were identified. Alabama executed a sole source contract and began moving clients to a Medicare Part D plan that covered the coverage gap.

During the process, TA was also provided by the National Quality Center. A major challenge was working with case managers and social workers to correctly complete recertification forms—all fields had to be completed each time an action was requested.

According to Alabama's QM Committee, these dramatic results turned those who had doubts about the value of QM into ardent supporters. The Committee's work also provided several other lessons that served the QM Committee as they expanded their efforts. These included:

- An internal assessment is essential before expanding quality improvement efforts to care and service partners.
- While processes may be in place, QM can demonstrate the weaknesses in these processes and how they can be improved—just because you have a system does not mean it is the best system.
- For peer-based TA, pairing states of similar size is important since the experiences of states of differing size may not be applicable.
- Build on existing relationships to strengthen QM efforts.
- To make QM work, TA may be required at various levels.

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Background

HIV/AIDS Bureau Quality Management Requirements

The Ryan White HIV/AIDS Treatment Modernization Act, initially enacted in 1990 and subsequently reauthorized and amended in 2006, provides funding to cities, states, and other public and private entities to provide care and support services to individuals with HIV/AIDS who have low income, or are uninsured/underinsured, or lacking other resources to pay for care. Part B funding provides assistance to states and territories for health care and support service, including ADAP. Significant new legislative requirements of the reauthorization in 2000 directed grantees to develop, implement, and monitor QM programs to ensure that: service providers adhere to established HIV clinical practices; QM strategies include support services that help people receive appropriate HIV health care; and demographic, clinical and health care utilization information is used to monitor trends in the spectrum of HIV-related illnesses and the local epidemic. These requirements were re-emphasized in the 2006 reauthorization with the introduction of the term "clinical"- all grantees are required to establish clinical quality management programs.

The QM legislative requirements for Part B grantees outline that "the chief elected official/ grantee… shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Department of Health and Human Services (DHHS) guidelines for the treatment of HIV disease and 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." To learn more about the guidance for Part B grantees, see Appendix C.

The purpose of a QM program is to ensure that:

- Services adhere to DHHS guidelines and established clinical practice
- Program improvements include supportive services linked to access and adherence to medical care
- Demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic

The HAB defines quality as the "degree to which a health or social service meets or exceeds established professional standards and user expectations." Evaluations of the quality of care should consider the quality of:

- The personnel and resources available to them (structure)
- The service delivery process
- Outcomes

Quality improvement is an ongoing process that involves organizational members in monitoring and evaluating inputs, processes, outputs and outcomes in order to continuously improve service delivery. In contrast to quality assurance, which focuses on identifying and solving problems, quality improvement seeks to prevent problems and to maximize quality of care.

An effective QM program should be able to document five key characteristics:

- **Use a systematic process.** The process should include clearly identified leadership and accountability, and allocate sufficient dedicated resources to support the activities.
- **Establish benchmarks.** Data and measurable outcomes should be used to determine progress toward relevant, evidence-based benchmarks.
- **Be focused.** Linkages, efficiencies, and provider and client expectations should be a primary focus for addressing outcome improvement.
- **Be adaptable.** The process should be continuous, adaptive to change, and able to fit within the frame work of other programmatic quality assurance and quality improvement activities, (i.e., JCAHO, Medicaid and other HRSA programs).
- **Result in improved outcomes.** Data collected should be fed back into the QM process to assure that goals are accomplished and improved outcomes are realized.

Role of Part B Programs in Quality Management

As State Health Departments, Part B programs play the dual role of sponsoring their own QM programs and of championing quality improvement for subgrantees and other providers in the state. Since Part B programs do not usually provide direct services, they assume the role of regulators and payers of services. Consequently, states need to explore what the system is paying for as well as the quality of these activities and services.

Part B quality programs act on two levels: to champion quality programs within their respective Department of Health and its HIV/AIDS program, and within the HIV provider community across the entire state. Its dominant role provides an impetus to lead across the entire Ryan White HIV/AIDS Program-funded continuum and to build bridges between Ryan White HIV/AIDS Program-funded grantees within their constituency.

The end goal of quality-related activities is improvement, whether it is brought about by improved HIV care, enhanced access, or cost savings. At the state level, necessary steps include: building a sound quality program that establishes performance measures and data collection systems; developing written QM plans and annual goals; and overseeing the progress of quality improvement activity. At the provider level, steps include building capacity for quality improvement among HIV providers through training and the provision of TA.

Key Quality Management Terms - Glossary

NAME	DEFINITION
Collaborative	A systematic approach to health care quality improvement in which organizations and providers test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."
Guideline	Statements or standardized specifications for care to assist practitioners and patients with appropriate health care decisions for specific clinical circumstances. Guidelines are developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus. Guidelines may also be called clinical or practice guidelines.
HIVQUAL	The National HIVQUAL Project, sponsored by the HAB Division of Community Based Programs, is designed to build capacity and capability among Part C and D grantees to sustain quality improvement. The HIVQUAL Initiative promotes quality improvement activities and self-reporting of HIV performance data through the HIVQUAL software.
Indicator	A measurement tool or operational definition of one specific quality characteristic that can be measured (e.g., GYN exam, PPD) conforming to guidelines or standards of care. They are often categorized as either outcome or process indicator. It can also be called measure.
Model for Improvement	An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the pace of change. The Model includes use of "rapid-cycle improvement," successive cycles of planning, doing, studying, and acting (PDSA Cycles).

NAME	DEFINITION
Plan-Do-Study-Act (PDSA) Cycle	A process to describe a quality improvement cycle using four steps: Plan, Do, Study, and Act. It is sometimes referred to as the Shewart Cycle (Walter A. Shewart) or as the Deming Cycle (W. Edwards Deming). Also called Plan-Do-Check-Act (PDCA) Cycle.
Quality Assurance (QA)	A formal set of activities to review and to safeguard the quality of services provided. QA includes quality assessment and implementation of corrective actions to address deficiencies. It is focused on ensuring standards are adhered to, identifying problems, and solving single quality issues with problem resolution focused on the responsible individual. QA is used more in a regulatory environment.
Quality Improvement (QI)	Quality improvement (QI) is defined as an organizational approach to improve quality of care and services using a specified set of principles and methodologies. Those principles include, but are not limited to, leadership commitment, staff involvement, cross-functional team approach, consumer orientation, and a continuing cycle of improvement activities, and performance measurements. Synonyms include Continuous Quality Improvement (CQI), Performance Improvement (PI), and Total Quality Management (TQM).
Quality Management (QM) Programs	A QM program encompasses all grantee-specific quality activities, including organizational quality infrastructure (e.g., committee structures with stakeholders, providers, and consumers) and quality improvement related activities (performance measurement, quality improvement projects and quality improvement training activities).
Quality Improvement Team	A specially constituted working group to address one specific opportunity for improvement. A quality improvement team consists of those people who have regular involvement in the process and have a leader and sometimes a facilitator (e.g., quality improvement team to improve the patient adherence to antiretroviral therapy).

Key Quality Management Terms - Glossary (Cont.)

NAME	DEFINITION
Quality Management (QM) Plan	A written QM plan outlines the QM process for ongoing evaluation and assessment to identify and improve the quality of care, and the infrastructure that clearly indicates responsibilities and accountability for the quality program.
Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Standard of Care	Preformed and agreed upon statements issued for the purpose of influencing decisions and health interventions.

List of Acronyms

ACRONYM	TERM
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ARV	Antiretroviral
ASO	AIDS Service Organization
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CQI	Continuous Quality Improvement
CQM	Clinical Quality Management
DHHS	Department of Health and Human Services
DOH	Department of Health

ACRONYM	TERM
EMA	Eligible Metropolitan Area
HAB	HIV/AIDS Bureau
HRSA	Health Resourses and Services Administration
QM	Quality Management
SCSN	Statewide Coordinated Statement of Need
TA	Technical Assistance
TGA	Total Grant Area

Section 1: Steering the Statewide HIV Quality Management Program

Implementation Steps

- Identify the leaders to steer the statewide QM program
- Clarify the roles and responsibilities of these leaders
- Engage these leaders in the QM program
- Identify and engage other key stakeholders
- Ensure appropriate staffing to manage the QM program

Strong leadership is one of the most important ingredients of successful quality programs and contributes significantly to the end goal of ensuring the highest quality of care for all people living with HIV in the state. Leadership can take various forms:

- State Health Departments can integrate QM through all its programs from the "top down."
- Part B programs can conduct QM activities at a system level and integrate these activities with other key stakeholders in the State Health Department.
- Part B programs can support subgrantees in their QM efforts.
- Subgrantees can support frontline staff in collecting necessary data and initiating quality improvement activities.
- Collaboration with all Parts in the state receiving Ryan White HIV/AIDS Program funding.

The State Health Department fulfills the critical roles of 1) strengthening its internal HIV-specific QM program and, of 2) championing quality improvement for HIV providers across the state. A successful statewide QM program requires attention to both these roles.

For Part B programs initiating QM activities, leadership helps to get quality efforts off the ground and makes sure that they are thoroughly embedded throughout the Part B program for long-term sustainability, with the end result being improvement in the quality of HIV care. For those Part B grantees that have an existing quality program, leadership is crucial to maintain and support ongoing changes to the program.

Who are the Leaders for the Part B Program?
While it will be different for each jurisdiction, some of the leaders you may want to recruit for your effort include:

- State Health Comissioner
- State AIDS Director
- Part B Director/Manager
- Director/Manager of Quality
- Case Management Program Manager
- ADAP Director/Manager
- DOH Medical Director
- AETCs
- Key HIV providers
- Consumers

Fostering Leadership for Successful Quality Management Programs

Leaders are those individuals who have the ability to formally and informally influence and inspire others by providing a vision and direction for the statewide Part B quality program. Leaders create the culture in which quality is both prized and promoted. Infusing QM throughout the HIV/AIDS program starts from the top down.

Key leadership elements for statewide programs include:

- **Allocating resources.** Effective leadership ensures necessary resources for a successful QM program are available, such as the staff time necessary for data collection and analysis, dissemination of results, and discussion of quality improvement activities during staff and other department meetings. In addition, leaders support the availability of resources to build capacity for quality improvement on the provider level throughout the entire state. Important resources that leaders can help secure include: dedicated QM staff time, meeting space; information technology (IT) resources (including IT personnel), software, and funds for staff education and training.
- **Facilitating innovation and change.** Leaders provide the vision and strategically outline the goals and objectives to build a successful program and remove any constraints or barriers to achieving and sustaining improvements. Depending on the given situation, this may require changing policies that could potentially impede improvements.
- **Embedding QM.** Embedding QM throughout every aspect of a program can help to demystify it. Quality should be incorporated into job descriptions, contracts, strategic plans, and workplans. Staff should know that QM is part of their job, especially those that will be responsible for collecting data. As part of the process, staff can provide valuable insight. Consider asking frontline staff to identify areas and items for which they should be held accountable.
- **Establishing a common culture.** In order for a QM program to succeed, leaders must routinely gain the buy-in of staff, subgrantees, consumers, and other stakeholders and demonstrate a true commitment to the QM program.

An important first step for engaging leaders is to seek out their input in the development and maintenance of the Part B quality program. It is critical that an open, two-way communication is promoted with key leaders to ensure that they have a voice in the QM program. Creating a dialogue among key leaders can provide valuable insight. Objectives of the dialogue are to:

- Better understand the environment in which the QM program works
- Get input and buy-in in key areas for the QM program
- Understand the barriers for implementing the statewide quality program
- Identify potential members for a QM committee or leaders of quality activities

Real-World Tips: How to Engage Key Leaders in the State Health Department

- Send a letter explaining HAB's quality requirements, proposed quality activities, and the expected outcomes—in the memo, do not let your message get bogged down with quality jargon.
- Emphasize that QM is a requirement for funding.
- Share key performance data in clear and simple formats (e.g., graphs, charts, storyboards).
- Provide a learning session on quality improvement; make it a required activity if possible or provide it at regular meetings of senior management.
- Share success stories from other states; invite out-of-state speakers.
- Ask senior leadership to officially sign off on the QM plan; if they sign off on it, they are more interested in its success.

- Turnover in senior management can make it difficult to sustain interest in QM; cultivate mid-level staff, these members are less prone to political turnover.
- Routinely bring up quality issues in meetings with senior leadership.
- Show cost benefit and resource savings (taking money away from direct services can save money and make more money available for direct services); consider focusing initially on high-cost areas where QM may result in larger savings.
- Invite key leaders to give a presentation or participate on a panel at a QM-related meeting.
- Work with others in your jurisdiction (e.g., Part A or Part C grantees, local health departments, other service providers) that may have more influence
- Discuss QM in public as a posititve strategy to improve services.

Within the Part B program, successful leaders provide support on a daily basis to ensure that the implementation activities are on track and in accordance with identified priorities. The following suggestions are ways in which leaders can guide the implementation process:

- Publicly show support for QM at all possible opportunities.
- Bring together key department and internal stakeholders to discuss a common vision and enable participation across programs.
- Actively reduce barriers to implementing quality improvement activities through tailored interventions.
- Provide necessary resources and manpower.
- Enable communications across departments.

Real World Example: Florida Takes Advantage of Champions to Move QM Forward

In Florida, a new Secretary of the Department of Health brought with her a commitment to quality when she took over agency leadership. The "top down" integration of quality had a significant impact on the work of the QM committee. Most importantly, it gave people who wanted to move QM efforts forward the support they needed. For example, the reporting unit within the patient care system moved forward with developing a common dataset, with the end goal of tracking data at the client level. Patients with HIV will be tracked from the counseling and testing database to HMS and the ADAP database. New leadership with a commitment to quality helped move this forward.

Real-World Tips: Integrating Quality Management across Departments

- Link QM activities to the Statewide Coordinated Statement of Need (SCSN) process.
- Link QM to other Health Department priorities, such as reducing health disparities.
- Attend other quality-related meetings within the Health Department.
- Link Part B QM to other QM efforts in the state (e.g., Healthy People 2010, public health accreditation).
- Use QM as an opportunity to increase alignment across Ryan White HIV/AIDS Program grantees in the jurisdiction.
- Integrate QM across diseases (e.g., STD, TB, chronic disease) and bureaus/departments.
- Communicate your successes to other departments, especially those related to saving money or improving

Identifying Key Stakeholders for the Statewide HIV Quality Program

In addition to leaders, key stakeholders are also instrumental for a successful Part B quality program. Stakeholders are those who have an interest in seeing the quality efforts succeed.

For Part B programs, these stakeholders are often subgrantees (i.e., contracted providers)—as they may be the ones collecting the necessary data to assess quality. In addition to ADAP, other key stakeholders include programs within the Health

Department such as Epidemiology or Medicaid, which are not involved in the daily QM activities but responsible for data collection and reporting. Part A and C grantees, because of their roles in the delivery of HIV services in the jurisdiction, can also be important stakeholders. Consumers, advocacy groups and external funders are also important stakeholders to include in QI efforts.

With some stakeholders, you may have a little more leverage in encouraging their participation. For example, some Part B programs include specific language that stipulates their involvement in QM activities in contracts with subgrantees.

Real World Example: Georgia Builds Quality into Contracts with Subgrantees

Several Part B programs report including specific language in their contracts with subgrantees that requires that quality-related activities are carried out. Georgia includes the following language in their contracts with subgrantees.

Program Requirements:

The contractor will:

A. Ensure that the medical management of HIV infection is in accordance with the U.S. Department of Health and Human Services (DHHS) HIV-related guidelines including:
   - Antiretroviral treatment
   - Maternal-child transmission
   - Post-exposure prophylaxis
   - Management of tuberculosis and opportunistic infections
   - HIV counseling and testing

B. Ensure compliance with the HIV Section manual, *Medical Guidelines for the Care of HIV-Infected Adults and Adolescents*, January 2008.

C. Ensure that registered nurses and nurse practitioners practice under current HIV/AIDS-related nurse protocols. The recommended protocols include:
   - Division of Public Health, Nurse Protocols for Registered Professional Nurses in Public Health, Section 12. HIV/AIDS-related; and
   - AIDS Education and Training Centers National Resource Center, The Clinical Manual for the Management of the HIV-Infected Adult.

D. Ensure that all Medical Doctors, Pharmacists, and all other licensed medical professionals possess current licensure and/or certification. Ensure that all Medical Doctors are practicing under current HIV/AIDS-related protocols and are practicing under the current laws of the State of Georgia. If there is any lapse in licensure and/or the occurrence of suspension that deems a medical professional unable to practice medicine under current laws, the HIV Section's District Liaison is to immediately be notified.

E. Develop and implement a quality management (QM) program according to the HRSA/HAB Quality Management TA Manual. Include the following:
   - A written QM plan.
   - A leader and team to oversee the QM program.
   - Organizational goals, objectives, and priorities.
   - Performance measures and mechanisms to collect data.
   - Project-specific continuous quality improvement plan (CQI).
   - Communication of results to all levels of the organization, including consumers when appropriate.

F. Participate in the statewide Part B QM Program.

G. Monitor performance measures as determined by the QM Core Team/Performance Measurement Subcommittee.

H. Provide information related to the local QM program as requested by the HIV Section District Liaison and/or State Office QM staff. Allow the HIV Section District Liaison and/or State Office QM staff access to all QM information and documentation. Participate in the collection of statewide outcome indicators as identified by the HIV Section.

I. Participate in the development and implementation of statewide case management standards.
J. Ensure that all case managers enrolling clients into case management use the statewide standardized intake form and mental health and substance abuse screening tool.

Real World Tips: Involving Senior Clinicians

Having clinicians involved in the Part B quality program is essential. Here are various strategies to engage clinicians in quality-related activities:

- Convene a medical advisory panel; ask for volunteers as they are the most motivated to participate.
- Start a dialogue with providers to engage them in the process; with a communication process in place, providers will be more likely to provide advice on how to facilitate their involvement.
- Include a clinician as a consultant to your program to provide advice and serve as a model for other providers.
- Network with medical schools to reach future providers.
- ADAP Advisory Committees are required to have clinician membership. Incorporate ADAP QI into ADAP Advisory Committee meetings as a way to involve clinicians in the larger QM program.

Real World Example: Georgia Gains Input from Clinicians?

To help guide their work, Georgia's QM committee obtains input from clinicians in two ways. A senior clinician with significant quality-related expertise serves as a consultant to the QM committee. The QM committee also gets guidance from a medical advisory panel, made up of physicians from subgrantees. Input from the advisory panel is received primarily via e-mail. In recruiting participants for the advisory panel, the QM committee requested volunteers, as they are more likely to participate in the process. Their input has been important in addressing ADAP and with treatment guidelines.

Real World Tips: Involving Consumers

QM programs require routine feedback from consumers to improve services. Here are some strategies for obtaining consumer input:

- Include consumer representation on your QM committee; ask subgrantees and providers to recommend consumers for this purpose as a starting point; consider developing an orientation package for this purpose.
- Establish a statewide consumer advisory committee for consumers to communicate concerns and ideas for improving quality of care; be sure to follow-up on recommendations, where appropriate, and develop a communication link to your statewide QM committee.
- Involve consumers in the process of developing quality performance indicators, often consumers and clinicians prioritize needs differently.
- Use patient satisfaction surveys, focus groups, and/or key informant interviews to obtain feedback on quality of care issues.
- Include consumers on specific quality improvement projects and teams to improve specific HIV care issues.
- Include consumers as paid or volunteer staff for regular consumer feedback to your program and to facilitate/moderate other forms of consumer feedback in your state.
- Build the capacity of consumers for quality improvement by provide learning opportunities and opportunities to meet key stakeholders.

Real World Example: Linking Consumers to Quality Efforts in Maine

Obtaining input from consumers can be difficult in a low incidence state. For example, since it is a rural state, distance is an issue in Maine. To reach consumers, an annual conference is held. The 1.5 day conference is open to any consumer and support is provided for travel and lodging. In 2007, the

focus of the first day of the conference was the NQC's curriculum, Making Sure Your HIV Care is the Best it Can Be. This training curriculum introduces people living with HIV to factors that are important to their HIV care, performance measurement, and helps build the skills consumers need to actively contribute to improvements in their care. A diverse group of 65 consumers attended the meeting, ranging from people living with HIV who were very well educated about their care, those who were less informed, and consumers from the various immigrant communities within the state. The curriculum was modified to meet these diverse educational needs and additional worksheets were added to give participants more "take aways." Providers attended on the second day of the conference, giving participants the opportunity to discuss what they learned with providers. The conference was the first step in increasing peer involvement in the provision of services. Maine plans to develop a peer advocate program that will focus on treatment adherence. Fostering a greater understanding of the state's quality efforts and the specific clinical outcome measures used will help consumers understand the direction the state is moving in the provision of HIV care and the role that consumers can play in this process.

Staffing for Quality Management

Real World Tips: Dedicate Staff for QM

- Designate a single person to be responsible for QM activities
- Determine how much time is necessary to fulfill the requirements of the position (i.e., full-time, part-time)
- Develop job description
- Explore use of a consultant with expertise in QM

You can not have a QM program without people to manage it and to establish a structure for accountability. Dedicating the necessary staff resources for QM is critical to the success of the effort. Dedicated staff is required at two levels.

QM Manager. One person should be responsible for the QM program. This person will schedule meetings, arrange for training, assign tasks, and ensure that tasks are completed. A key characteristic for this individual is strong support of and passion for QM. Their enthusiasm will spread to other participants.

The amount of time necessary to lead QM efforts depends on the size of your Part B program and the complexity of your QM goals. Larger programs may require a full-time staff person. Smaller programs may require less staff time. Some Part B programs have hired consultants that specialize in QM to oversee their efforts, bringing both experience and expertise to the process.

Additional Dedicated Staff Time. In addition to a single person overseeing the daily QM activities, it is essential that sufficient time is available for other staff to carry out their quality-related functions (e.g., run reports in the Medicaid database, assist in data analyses, collect data, participate on quality improvement teams). QM needs to be included in all job descriptions. This will let staff know that QM is not to be done in addition to their job, but is their job.

Real World Example: Iowa Makes a Case for Dedicated QM Staff

To document the need for dedicated staff to carry out quality-related activities, the Part B program in Iowa set out to quantify staffing demands related to administering the Part B formula and ADAP grants. The assessment looked at specific required tasks across seven categories: supportive services; Minority AIDS Initiative; ADAP; quality management; collaboration; planning; and "other." For each task, the staff member responsible was identified and required hours estimated. It was also indicated whether the task was being accomplished and how well (i.e., the task is fully accomplished, partially accomplished, not accomplished). Staff compiled their information using an Excel spreadsheet.

The Part B program used the assessment to make a case with the health department for more staff. This resulted in approval to add staff to focus on quality.

Real World Example: Sample QM Manager Job Description from Ohio

Ohio Department of Administrative Services
Working Title of Position: HIV Quality Management Administrator
Job Description:
85% FTE - Supervises assigned staff (e.g., assigns and directs work, completes performance evaluations and other supervisory duties) and plans, manages and directs quality management activities of the HIV CARE Services Section (e.g., develops policies, procedures and objectives, formulates administrative controls and approaches to problems, assigns and schedules project activities and monitors to completion). Oversees the planning and quality assurance activities of all programs authorized under Part B of the Ryan White HIV/AIDS Program and/or operated by the HIV CARE Services Section (HCS) including HIV case management, HIV home health, Consortia, Health Insurance Premium Payment (HIPP), Medicaid spend-down payment, the Emergency Financial Assistance program and the Ohio HIV Drug Assistance program (OHDAP). Assists in completing the application for funding for programs and all related reports, surveys and other requests for information (e.g., inquiries from clients, community physicians, pharmacists and/or case managers) related to planning and/or quality assurance. Responsible for grants administration, preparing grant proposals and RFP/RFQs. Coordinates all activities related to annual statewide needs assessment and Statewide Coordinated Statement of Need. Represents section and participates in federal teleconferences, workshops and national meetings related to programs authorized under Part B of the Ryan White HIV/AIDS Program and quality assurance programs. Develops the section's Quality Management Plan as guided by HRSA directives and develops the policies, procedures and objectives related to this plan's development and implementation. Ensures that design of the plan meets current and changing needs and relates to all programs in the section. Updates plan at least annually to include recommendations to improve each of the Section's programs.

15% FTE - Coordinates planning activities with and provides technical assistance to HCS staff, local AIDS service organizations and Consortia regarding quality management issues as needed. Develops a network of communication with other state programs to improve quality assurance and program planning methods. Reviews and analyzes legislation for potential impact on HIV related programs. Assists staff with community assessment activities by monitoring audits and service utilization reviews. Assumes a lead role for Prevention of HIV Perinatal Transmission Committee activities. Acts as a liaison to hospital and community based programs serving women and children. Participates in meetings related to all programs authorized under Part B of the Ryan White HIV/AIDS Program (e.g., case management, OHDAP Advisory board, Statewide Care Coordination Council). Participates in department response to proposed legislation regarding HIV/AIDS. Assists in the development of Public Health Council and Administrative rules. Acts as a liaison for ODH and Cleveland Part A. Attends related meetings and serves on committees as assigned. Prepares speeches and presentations as assigned. Writes and submits reports and technical evaluations related to the quality management of the section's programs. Uses research findings to direct on-going modification of projects and programs. As assigned, serves as a member of a Disaster Recovery/Business Resumption team, Incident Response Team, or similar public health response team which may include the conduct of operations on a 24/7 basis at remote locations.

Minimum Acceptable Characteristics:
Knowledge of: (4) accounting, (5) management, (11a) public relations, (13b) agency policies & procedures (e.g., Ryan

White HIV/AIDS Program, licensure, rule writing, ODH guidelines related to HIV/AIDS), (14) government structure & process (e.g., legislative & administrative policy making)
Skill in: (25b) word processing (e.g., Word), (29) equipment operations (e.g., personal computer with spreadsheet & database software)
Ability to: (30l) define problems, collect data, establish facts & draw valid conclusions, (30m) interpret extensive variety of technical material in books, journals & manuals, (32p) interview job applicants effectively, (32q) understand manuals & verbal instructions, technical in nature [e.g., quality assurance, outcome evaluation, research design, statistical analysis], (32u) prepare & deliver speeches before specialized audiences & general public, (32v) originate and/or edit articles for publication, (32x) develop complete reports & position papers, (34c) cooperate with co-workers on group projects, (34e) establish friendly atmosphere as supervisor of work unit, (34f) handle sensitive inquiries from & contacts with officials & general public, (34h) develop good rapport with inmates and/or patients, (34i) resolve complaints from angry citizens & government officials.

Toolbox: Identification of Quality Management Leadership

a) Who are the Leaders of your Statewide HIV Quality Management Program?

FUNCTION	NAME
DOH Commissioner of Health	
State Health Director	
State AIDS Director	
Part B Director	
ADAP Director	
DOH Medical Director	
Part B Director/Manager	
ADAP Director/Manager	
QM Director Manager	

b) What are Key DOH Committees that Require Representation or Input?

COMMITTEE	NAME
Part B Assemblies or Consortia	
SCSN Steering Committee	
Part B Statewide & Regional Planning Bodies	

COMMITTEE	NAME
ADAP Advisory Committee	
HIV Medical Case Management Advisory Committee	

c) Who are the Key Stakeholders for your Statewide HIV Quality Management Program?

FUNCTION	NAME
DOH Medicaid	
DOH Epidemiology	
Key Medical Providers	
Part A Representatives	
Part B Funded Representatives	
Part C Representatives	
Part D Representatives	
AETC	
SPNS Grantees	
Dental Reimbursment Program Grantees	

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. One tutorial, called 'Leading a Quality Efforts' – Tutorial 17, outlines the key functions of leadership in HIV quality programs. NationalQualityCenter.org

The HIVQUAL Group Learning Guide "Leadership for Quality" exercises can help you teach small groups about a quality leader's roles and responsibilities. They could also be used as icebreakers when quality program leaders meet for the first time. www.HIVQUAL.org

A Guide to Consumer Involvement: Improving the Quality of Ambulatory HIV Programs was developed by the New York State DOH AIDS Institute with the New York State Quality Consumer Advisory Committee. It contains best practices collected from New York on engaging consumers in quality efforts and is available at NationalQualityCenter.org.

The Making Sure Your HIV Care Is the Best It Can Be training curriculum was developed by the New York State Department of Health AIDS Institute. It is an interactive consumer training to raise awareness of quality of care issues and teach self-advocacy and self-management skills to consumers. Available at NationalQualityCenter.org

Section 2: Establishing a Statewide HIV Quality Management Committee

Implementation Steps

- Establish the overall purpose of the Part B QM committee.
- Identify or revisit QM committee membership and composition to ensure cross-functional representation.
- Decide on meeting logistics (e.g., chairperson, meeting frequency, location).
- Establish annual HIV-specific quality goals for the statewide quality program.
- Support activities to implement the QM program.

Establishing a Statewide HIV Quality Management Committee

The Part B QM committee drives the statewide HIV quality program. This committee is responsible for planning and implementing the QM process at the state level. It ensures that QM becomes a continuous coordinated system-wide approach.

The work of the QM committee is to discuss important issues and to develop and implement changes related to these issues. For example, the QM committees of states participating in the Part B Collaborative looked at various issues including ADAP waiting lists and reducing gaps in ADAP re-enrollment. By assessing their performance in these areas, the states were able to identify areas in which improvement was necessary and take steps to bring about change at the program level. The result was a reduction in, or even an elimination of, ADAP waiting lists and gaps in enrollment, which made lifesaving therapies available to more clients.

The major task of a Part B QM committee is to help ensure everything is in place at the state-level for improvement efforts to succeed and be sustained over time. Members of the QM committee have four main areas of responsibility:

- **Strategic planning.** The committee is charged with strategizing how to best establish and maintain a sustainable QM program. It develops the written Part B QM plan and prioritizes goals and projects so that the most critical areas are addressed first. The committee assumes responsibility for outlining the QM program infrastructure, identifying performance measures, and planning for program assessment.
- **Oversee statewide QM implementation.** The committee oversees the implementation of the QM plan by developing a statewide action plan. This action plan ensures that all quality improvement activities are done effectively and in line with key quality priorities.
- **Providing guidance and reassurance.** On a routine basis, the committee oversees the progress of quality activities to ensure that they are on track and to provide guidance. Quality improvement activities will involve changes to the status quo—which can be challenging. The committee needs to listen, observe, and be

responsive to staff, subgrantee and consumer needs during the improvement process. Support and encouragement at appropriate junctures is also necessary.

- **Build capacity for quality improvement.** Training is necessary to prepare staff and subgrantees to implement quality improvement. It is the role of the QM committee to plan trainings and ensure that providers are fully knowledgeable. In addition to trainings, on-site technical assistance by quality improvement experts should be provided to individualize the QM approach. There are many resources that can be used in the education and training effort. A list of resources is included in Appendix F. The NQC also offers trainings and technical assistance on an ongoing basis.

Real World Tips: Focus on Key Activities

- Develop a Part B QM plan and committee
- Identify measures, data sources, and indicators
- Collect and analyze data
- Interpret results
- Identify and implement programmatic changes
- Communicate outcomes of QM activities to leaders, subgrantees and others

Who should be on the Statewide HIV Quality Management Committee?

While each jurisdiction will vary, there are some key people to include on the committee.
These members include the Part B QM staff, representatives from other branches or divisions within the Department of Health, subgrantees, and consumers of HIV services.

Suggestions for committee members are listed below. Not all states have distinct positions dedicated to these functions; in these instances, it is more important to look at the skill sets of potential members rather than their title.

Real World Tips: Building a Committee that Works

- Create a cross-sectional group; draw from different disciplines and key programs.
- Include representatives from all Ryan White HIV/AIDS Program funding streams in your state.
- Identify individuals who are potential influencers and can get things done.
- Start with a small group of individuals who are most critical to the QM program's success.
- Educate all committee members about quality improvement methodologies.
- Review existing performance data as a starting point.
- Develop a committee charter or MOU to outline the committee purpose and member responsibilities.
- Spend time to develop an agenda and necessary handouts for meetings and share them prior to the meeting. Keep minutes, as even brief minutes are better than no minutes.
- Create a 'notebook' that includes the QM plan, action plans, agendas, and minutes.
- Identify consumers with the ability to speak on behalf of HIV communities.

Reach out to other DOH departments that are instrumental in the success QM efforts.

Suggested QM committee members:

- Senior DOH managers in leadership positions with broad management responsibility and the authority to influence system changes that will improve quality (e.g., State AIDS Director, Part B Program Director/ Manager).
- Manager of drug assistance program (e.g., ADAP Director/ Manager).
- DOH management staff who oversee the structure and processes associated with HIV QM (e.g., Director/ Manager of HIV Quality Management).
- Management staff that oversee HIV data systems, coordination with external data systems, and information technology (e.g., Director/Manager of Management Information Systems).

- Management staff that have a good working knowledge of how Ryan White HIV/AIDS Program-funded services (Part B, as well as Part A and C) are delivered (e.g., Director of HIV Clinical Services, Director of Field Operations, Directors of Contracts/Service Monitoring).
- Senior clinician involved with the state's HIV services (If no senior clinician is a member of the State's HIV committee, consider involving a consultant or trusted provider that is involved in policy decisions).
- Consumer leaders familiar with the state's programs or who participate in an advisory or planning groups (e.g., Consumer Member of ADAP Advisory Committee, Part B Planning Group, or SCSN Steering Committee).
- Management staff from the state Medicaid Program with responsibility for data systems and/or QM (e.g., Director of Medicaid Management Information Systems, Director of Medicaid Quality Assurance).
- Management staff that oversee the state's HIV/AIDS case surveillance system (e.g., Director of HIV/AIDS Epidemiology).
- Health care providers, HIV/AIDS social service agency providers, local/regional planning body members (Part B consortia, Part A planning councils, SCSN steering committee members), and AETC representatives who are directly involved with health care provision.
- Infected and affected consumers of HIV care and services who will share their experiences and voice their thoughts and suggestions to improve the quality of HIV care in your state.

It is important to note that you should not wait until you have the commitment of all the suggested participants to initiate your activities. Participants in the Part B Collaborative and Low Incidence Initiative reported that it is important to identify a start date and begin the process with those assembled. It is also realistic to expect that committee members will drop out as the process goes on and that it will be necessary to continually recruit more members.

Real World Tips: Reaching Out to Other DOH Departments

- Stress mutual benefits.
- Demonstrate how QM is not discipline specific, but relevant to all disciplines
- Link with larger department-wide efforts.
- Involve key representatives from other units early in the process so they can benefit from any training provided to committee members and have a clear understanding of the goals and work of the committee.
- If the department head or high-level staff members, such as the medical epidemiologist, are not available to participate, find other staff to involve on the committee.
- Provide training across the department to build interest in QM.
- Provide ongoing training to committee members.

Toolbox: Checklist for the HIV Quality Management Committee

FUNCTION	NAME
DOH Senior Leaders	
State AIDS Director	
Manager of ADAP	
Director/Manager of HIV Quality Management	
Management staff who oversee HIV data systems	
Senior HIV Clinicians	
Consumers	
Medicaid Program	
HIV/AIDS Case Surveillance	
Health Care Providers	
Local/Regional Planning Bodies (SCSN Steering Committee)	

Real World Example: Establishing a Statewide QM Committee in Georgia

In setting up a QM committee, there can be questions in terms of how wide to cast the net—and this can be dependent on the size of the state. Georgia opted to include representative across the Ryan White HIV/AIDS Program. In part, this was to help the state move toward statewide quality measures. Also, it was in recognition of the fact that most providers in the state receive funding from various Ryan White HIV/AIDS Program Parts. Including them would be a step toward greater coordination across quality-related efforts.

How do you go about getting people involved? Georgia found it was effective to ask for volunteers. With volunteers, you gain people who are committed to quality but also, in many cases, they have influence with their peers. Initially, the QM committee had representatives from Part C and D. Later, a representative from the Atlanta EMA (Part A) joined. The committee has also put in place processes to gain input from both the Part A Planning Committee and the Grantee Office. In retrospect, a representative from the committee stated that it would have been beneficial to have Part A representation from the beginning.

Another way to gain input from important stakeholders is through subcommittees. The committee established several subcommittees (e.g., case management and performance measures), which had open membership. Representatives from various stakeholders were welcome to participate on these subcommittees. Involving stakeholders at this level is a great opportunity to learn what works well at the local level. It also serves to build trust with local providers.

Coordinating a statewide committee can be a challenge. Since committee members are spread over a wide geographic area, it is necessary to conduct most meetings via conference call. When meeting face-to-face, if most members are based in one location, other members may need to be teleconferenced into the meetings.

Outlining the Roles and Responsibilities of Members

After identifying potential members, it is necessary to decide on who to actually invite, how large to make the committee, and to assign specific committee roles.

The chairperson is responsible for directing the activities of the QM committee, mediating and resolving conflicts among committee members, and representing the QM committee to other parts with the Department of Health or externally. This chairperson needs to fully understand the HIV quality goals and principles. To select the committee chair, the Part B leadership could select the HIV QM manager to serve as the "acting" chair and to run meetings. The New York State Part B program has selected a trusted HIV provider to chair the committee and identified a group of 2-3 providers to co-chair the committee.

Role of the Committee Chair:

- Calls and facilitates meetings.
- Orchestrates all committee activities and manages administrative details.
- Oversees preparation of reports and presentations and follow-up.
- Ensures timelines of key miles stones of the QM program.
- Shares responsibilities with other committee members.
- Trusts the group to arrive at the best solution.
- Acts as the contact point for communication between the committee, other participants, and others in the department.
- Acts as the official keeper of committee records, including: correspondence; records of meetings and presentations; meeting minutes and agendas; and charts, graphs and other data related to the project.

Role of Committee Members:

- Participation is a priority responsibility, not an intrusion on their "real jobs."
- Contribute fully, sharing knowledge and expertise.
- Participate in all meetings and discussions.
- Carry out assignments between the meetings and meet deadlines.
- Report back to the committee at each meeting on their assignments.
- Communicate major discussion points back to their constituencies.

Getting Started and Sustaining the Committee

To be effective, the QM committee needs to have basic operational ground rules in place.

Meeting frequency and duration. A regular QM committee meeting schedule should be set up. It is advisable to schedule meetings at least every other month with times that are as convenient as possible for committee members. Meetings should start and end on time and attendance should be facilitated (e.g., allowing members to participate by phone).
Clear and comprehensive documentation. The committee must document its activity. In addition to recording each meeting in formal minutes, processes must be in place to maintain other important committee-related documents, such as the QM plan, work assignments, and progress reports. The goal should be that key members of the committee, including the committee chairperson, could leave and new members will be able to track pervious activities and future plans through existing documentation.

Orientation activities and ongoing education. While an initial orientation is essential for members, it is also necessary to have a process in place to bring new members, who join after the process is underway, up to speed. It is more than likely that as the committee delves into its work, more education and training will be necessary. In most cases, the committee can draw on its own expertise or expertise within the health department and hold "in house" trainings. Trainings are also available online through the NQC Quality Academy (see Resource Section below). It may also be beneficial to hear about other quality-related initiatives underway in the state.

Regular communication. Ongoing and clear communication is key to the progress of the committee. More than just meeting reminders, members must be kept up to speed on the various activities carried out by the committee through presentations at meetings, clear, concise reports, and other forms of documentation. The focus should be on what committee members need to know to effectively participate. It is important to note that it is possible to over communicate. Too many emails or overly detailed reports can be too much for people already burdened with information overload.

Manage expectations. Let your team and staff members know what to expect. Many people will come to the process fearing that it is their performance that will be measured. This can lead to resistance and make it difficult to implement QM-related activities. Also QM can seem overwhelming and intimidating to many at first, especially those who are unfamiliar with it. But the reality is, QM is already incorporated into many people's work—they are doing it without realizing it. Let people know that it could be several months before they start seeing the results of their efforts.

Show successes. As part of your regular communication with committee members and others participating in the QM process, be sure to report successes. Show how quality-related activities have actually contributed to system change, and if possible, improved services for consumers.

Establishing Annual HIV Goals for the Quality Management Committee

One of the key functions of the QM committee is to identify and establish annual goals for the statewide Part B quality program. These goals serve as endpoints or conditions toward which work will be directed—they help staff focus on improvement.

The following steps will help to establish annual HIV goals:

1. **Assess where you are.** Analysis of historical performance data helps to identify areas of strength and weakness where improvement may be needed the most. Understanding the current status-quo most often leads to meaningful goals that both staff and subgrantees will relate to and support. Consider sources such as performance data from various sources, staff and subgrantee input, or external benchmarks. Also be sure to assess the quality and reliability of your data.
2. **Understand your parameters.** Identify the basic parameters that describe your program, subgrantees, and consumers served. Putting together a succinct description, including the aspects of services provided, the demographics of the patient population, and the external expectations of funding/regulatory agencies, helps to identify where to focus quality improvement efforts.
3. **Prioritize your annual goals.** The assessment of past performance and the picture of the current environment give the committee the necessary information to develop and prioritize a list of annual HIV goals.
4. **Quantify where you want to be.** Annual HIV quality goals need to be measurable. Based on the information gathered in the previous three steps, the annual quality goals need to be restated in quantitative terms such as: "85% adherence to antiretroviral therapy for all HIV+ patients receiving HAART therapy" or "To reduce patient 'no shows' by 15%."

Establishing Workgroups

Once goals have been identified, some committees prefer to break into workgroups (also known as subcommittees) to focus on these specific goals or other priorities. Workgroups often establish their own processes—how they meet (e.g., in person or by phone), how often they meet, and how specific tasks will be accomplished. Workgroups can include people who are not on the committee, especially those who possess expertise in the area of focus. For example, some QM committees have formed workgroups of practitioners, such as case managers, to assist in the development of statewide practice guidelines.

If your committee does use workgroups, be sure to establish a timeframe for them to accomplish their charge. Asking workgroups to report their progress at regular QM committee meetings is one way to ensure that their work stays on track.

Toolbox: Sample Quality Planning Meeting Agenda

Purpose: Develop first draft of the annual quality management plan

Date: December 3, 2007

Time: 1:00 – 4:00 pm

Place: Conference Room A

Participants: Dr. Jane Dissan, Dr. Vincent Seaton, Taimi Miller, Rene Santos

TIME	TOPIC	WHO
1:00	Check-in	All
1:05	Review meeting purpose and agenda	Dr. Dissan
1:15	Review and discussion of 2008 quality improvement goals (Handout A)	All
1:45	Review of project improvement team results for 2007 (Handout B)	All
2:15	Review of project improvement team results for 2007 (Handout B)	All
3.45	Determine the focus of the quality management plan for 2008	Rene Santos

Toolbox: Template for Meeting Minutes

PARTICIPANTS	X	(Team member name)
	X	(Team member name)
	X	(Team member name)
	X	(Team member name)
Minutes taken by: (Team member name)		(Team member name)
		(Team member name)
		(Team member name)
		(Team member name)

Toolbox: Template for Meeting Minutes (Cont.)

TIME	TOPIC	WHO
Agenda Item	Any key items of discussion or how something is to be done	What is to be done? By whom? Date expected to be done
Agenda Item		
Agenda Item		
Next Meeting | Call		

Toolbox: Sample Meeting Minutes from Missouri

Date: April 6, 2006

Call to Order: 8:30 am

Meeting was Adjourned at: 10:00 am

Facilitator: Barbara Boshard

Minutes: Chiquita Russell

Members Present: Jill Berry, Bob Holtkamp, Terry Bray, Melissa Tiffany, Ben Laffoon, Michael McLay

Members Absent: Sheila Jackson, Darryl Lampkin, Lola Anderson, Meg Ebersoldt, Rita McElhany, Carmen Gaebler

TOPIC/ISSUE	DISCUSSION	ACTION/WHO/WHEN
Announcements:	• Any changes needed to March 23, 2006 minutes • WEBEX meeting conflicts with Medicaid Chart Review and ADAP teleconference	• None needed • Chiquita will get room and equipment together for WE BEX meeting • Barb will see if can change date for chart review • Bob will change time for ADAP teleconference
NQC TA for QI 101 (Contract deliverables)	• Focus on CD4 viral load • Discovered data was pulling from the wrong place	• Mike M. create cheat sheet on how to pull data • Will get with Meg/Anthony on Monday for clarification
QM Plan	• St. Louis signature was received	• Terry B. will send over a signed copy to Barb for K.C.
PDSA Cycles	• RPO1-ADAP enrollment 2/06	• Bob give number of new clients for Feb. and Mar.
	• RPO2-ADAP current eligibility 2/06	• Bob will get Barb current data
	• RPO3-Intake Feb.	• Barb will get with Meg for March data

TOPIC/ISSUE	DISCUSSION	ACTION/WHO/WHEN
PDSA Cycles	• RPO4-Med. Wastage	• Will get with Jill on were to go next
	• RPO5-CM Enrollment (84.12% current)	• Wrong data was pulled • Mike will start a new data pull • Mike will notify QSM about the wrong data given out
	• RPO6-Medicaid enrollments 2/06	• Bob will get data on new Medicaid application enroll ment study into ADAP and how many on file • Barb will get with Barbara Boush on and Ginna Crowe about data issues and 5-11-06 Webex conflict
	• TCM#1: 68/96=71%	• Increase the number of people released getting a CD4 Viral Load • Rita and Barb will do more clean up on data
	• TCM#2: Increase to 76% by 1/07	• Rita and Barb will do more clean up on data
	• R.Out01-04: Due April 20, 2006	• Ben will get data
	• R.Out05-06: Results and where to post	• Ben started excel spreadsheet • Will bring data to next meeting on 4-20-06` • Building new measures around TB • TB teleconference scheduled for May 15, 2006 from 1:30-3:00 • Chiquita-send Melissa and Jill TB appointment • Terry will find a more appropriate representative from K.C. to participate on the TB call (Lola) • Online Clinical Satisfaction Survey-Carmen still checking dates to set up meeting • Carmen is also checking with physicians to see who would like to participate

Toolbox: Sample Meeting Minutes from Missouri (Cont.)

TOPIC/ISSUE	DISCUSSION	ACTION/WHO/WHEN
Aware Not In Care-Ben	• Client level data were pulled from 7 different databases to see how many clients were getting into care • Data were from Metropolitan St. Louis from years 98-02 • Newly infected get straight into care and then drop out • CD4 viral load is a good marker to see if clients are receiving care and have good access to care • Hope to receive data from Hospitals, VA Medicaid, etc. • Start in house discussions with HIV Care Team/Management to start project statewide • Look for outside contractor to develop project	• Start in house discussions with HIV Care Team/Management to start project statewide • Look for outside contractor to develop project • Get data from FACTORs and Part B or Part D to get database statewide
Next meetings	• April 20, 2006/8:30-10:00 • May 4, 2006/9:00-10:30 • May 25, 2006/9:00-10:30 • Webex meeting 5/11/06 from 10:00-4:00 (tentative)	

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. One tutorial, called 'QM Infrastructure' – Tutorial 6, outlines how to assess a quality program and establish a QM committee. NationalQualityCenter.org/QualityAcademy/

The HIVQUAL Group Learning Guide includes several related exercises on this topic. Review the document and choose the most relevant workshop topics for your program. www.HIVQUAL.org

Section 3: Developing a Written Statewide HIV Quality Management Plan

Implementation Steps

1. Decide on the general format and elements for the QM plan (learn from others)
2. Strategize how to write and update the QM plan
3. Involve internal and external stakeholders to review the QM plan
4. Widely communicate the QM plan and its goals to HIV providers and consumers

Basic Elements for the Quality Management Plan

A written QM plan defines a quality program's strategic direction and provides a blueprint for upcoming improvement activities for the Part B program. The plan describes the overriding purpose of the statewide quality program, the infrastructure that supports quality activities and its goals for the upcoming year. It also serves as a reference tool for both current and future staff, and as a communication tool with providers and consumers.

While there is no universal "how-to" template for creating a QM plan, this section outlines the basic elements:

- Quality Statement
- Quality Improvement Infrastructure
- Performance Measurement
- Annual Quality Goals
- Participation of Stakeholders
- Evaluation

Quality Statement

Describes the purpose of the HIV quality program—the ultimate goal of quality efforts. Some programs may refer to this as their quality mission statement, others as their guiding purpose for quality activities. To write a quality statement for the QM plan, assume an ideal world and ask, "How can we ensure we meet the needs and provide high quality care for clients while optimizing resources?"

Toolbox: Sample Quality Statements

West Virginia

The West Virginia HIV Care and Support Services Quality Management Program (QMP) is established to assess and ensure the degree to which the performance of funded HIV care and support services in West Virginia achieve the standards established in the Ryan White HIV/AIDS Treatment Modernization Act for Part B Programs and the Public Health Service Guidelines. Through adherence to the Act and Guidelines, the mission of the QMP is to ensure equal access to quality comprehensive HIV care and support services for all eligible PLWHA in West Virginia. In support of the mission, West Virginia has established four goals for the QMP:

1. Promote quality medical care and support services based on current DHHS Guidelines and on professional standards.
2. Maximize the retention in care of PLWHA in West Virginia.
3. Promote accessible and appropriate HIV care and support services based on the monitoring of epidemiological trends in West Virginia.
4. Support the efficient and effective use of federal and state resources to meet the care and support needs of PLWHA in West Virginia.

Georgia

The ultimate goal is to ensure a seamless system of comprehensive HIV services that provides a continuum of care and eliminates health disparities across jurisdictions for people living with HIV/AIDS in Georgia. This will be accomplished by:

- Developing and implementing a statewide quality management plan.
- Improving access to ADAP services by improving the application and recertification processing.
- Improving alignment across health districts by developing core performance measures that are tracked across Part B programs.
- Improving alignment across services through standardization of case management.

Quality Improvement Infrastructure

Describes how the QM program is structured and staffed.

- **Leadership**. Who is ultimately responsible for the program's quality initiatives?
- **QM committee structure.** Who chairs the QM committee? Which staff serves on the QM committee?
- **QM committee meeting frequency.** When will the QM committee meet to assess progress and plan future activities?
- **QM committee reporting.** What is the relationship of the QM committee to the overall Part B program? How will the QM committee communicate its progress to staff and subgrantees?

Performance Measurement

Performance measurement is a method for identifying and quantifying the critical aspects of your program. It is essential to assembling baseline performance data and measuring the effectiveness of improvement efforts over time.

Quality measures should focus on other aspects of programs, such as effective enrollment and re-enrollment of clients or the number of clients receiving specific care, such as regular viral load tests, from subgrantees. In identifying performance measures, four main criteria are important:

- **Significance**. Does the indicator relate to a condition that occurs frequently or has a great impact on consumers, subgrantees, or the overall program?
- **Measurability**. Can the indicator realistically and efficiently be measured overtime given resources and capabilities?
- **Improvability**. Can measurable change be demonstrated over time?
- **Accuracy**. Is the indicator based on accepted guidelines or developed through formal group-decision making methods?

More information on developing performance measures is included in Section 4.

Annual Quality Goals

While it is possible to measure several key performance indicators, the available resources for quality improvement work might limit the HIV program to conducting only a limited number of improvement projects per year. The QM committee needs to work with staff, subgrantees and other HIV providers from across the state to develop annual goals so that

they are understood and embraced by everyone. Prioritizing goals can help the QM committee to focus on the most important issues. The following three criteria can be helpful to a committee in prioritizing goals:

- **Relevance**. How large is the problem (e.g., number of patients on the ADAP waiting list)?
- **Impact**. What is the effect on the program?
- **Feasibility**. Can something be done about this problem with the resources available?

Toolbox: Prioritization Exercise

The following exercise can be used to help familiarize the QM committee with the prioritization process.

Sticky and Dots (40 minutes)
Step 1: State the question to the group. Be precise in your description. (5 min)
Step 2: Silently generate ideas in writing. Each participant gets several sticky notes to briefly describe one idea per sheet. (10 min)
Step 3: Post your ideas and group ideas. Allow group to get up and post their ideas on wall. Participants arrange similar ideas in groups. (10 min)
Step 4: Review posted groups with group. Clarify ideas and re-group, if necessary. (5min)
Step 5: Silently rank priorities. Hand out five dots to each participant. Ask participants to post dots next to the group of ideas. Count the dots for each group. (10 min)

Toolbox: Sample Annual Goals

Georgia - 2005-2006 Goals

- Develop a statewide quality management plan by December 2005
- Increase the percentage of Georgia ADAP clients recertified for ADAP eligibility criteria at least annually to 50% or greater
- Increase the percentage of newly applying Georgia ADAP clients approved or denied for ADAP services within 2 weeks of ADAP receiving a complete application to 60% or greater
- Increase the percentage of correctly completed new ADAP applications submitted to ADAP
- Develop core performance indicators that are tracked across Part B programs by June 2006
- Develop uniform case management standards through consensus building process by June 2006
- Improve integration of data and information systems by monitoring statewide outcome measures

Participation of Stakeholders

If quality improvement activities are to become a reality within the program, provisions need to be outlined in the QM plan for actively engaging staff and subgrantees, communicating information about quality improvement activities, and providing opportunities to learn about quality.

- **Engage staff and subgrantees.** Gaining staff and subgrantee support for quality improvements requires capturing and integrating their voices. The needs and expectations should be understood and their feedback reflected in the QM plan. To accomplish this, the committee should seek staff and subgrantee input to the extent feasible through such methods as staff meetings, one-on-one discussions, or through a short survey.
- **Communicate information about quality improvement activities.** It is important that staff, subgrantees, and consumers know about the program's quality initiatives on an ongoing basis. A QM plan should document how a Part B program will share information about its quality activities and project results. Options include providing updates at staff meetings, sharing QM committee meeting minutes, and publishing short newsletters.
- **Provide opportunities for learning about quality.** Because staff members and subgrantees ultimately bring the QM plan to life, it is likely that both Part B program and subgrantee staff will need to be educated in some basic quality concepts and skills. The QM plan should describe how training and learning opportunities will be made available. Options include workshops at statewide conferences, online courses, and self-study of quality manuals. Consider training opportunities for consumers, as well.
- **Evaluation.** Performance measurement provides the hard data about improvements to care delivery over time, but it is also important to assess how efficiently the statewide quality program is operating as a whole. There are two areas to consider in evaluation:
  - Quality improvement activities conducted during the year. The projects should be a worthwhile investment in the program's activities and result in improvements that are sustainable over time.
  - Effectiveness of the QM infrastructure. The QM plan should provide the vision and organization required to evaluate the effectiveness of the entire quality program, including the QM plan, the QM committee structure, and the performance of the QM committee.

Toolbox: NQC QM Plan Checklist

Grantee: _____Date: _____

How to use this checklist:

A Quality Management (QM) Plan defines a quality program's strategic direction and provides a blueprint for upcoming improvement activities for the HIV program. While there is no universal "how-to" template for creating a quality management plan, this document outlines the basic domains that should be covered in each plan: Quality statement, Quality improvement infrastructure, Performance measurement, Annual quality goals, Participation of stakeholders, Evaluation, Capacity building, Process to update the Plan, and Communication.

This checklist has been created to assist those who are: 1) working with grantees to develop an HIV-specific Quality Management (QM) Plan; and/or 2) reviewing a QM Plan for completeness. Keep in mind that this checklist should be used as a reference and assessment tool and that the most important step is to get started.

DOMAIN IN QM PLAN	DESCRIPTION	✓ COMMENTS
Quality statement	• Provides brief purpose describing the end goal of the HIV quality program and a shared vision to which all other activities are directed; assume an ideal world and ask yourselves, "What do we want to be for our patients and our community?"	
Quality infrastructure	The quality infrastructure includes the following elements: • *Leadership:* Identifies who is responsible for the quality management initiatives. • *QM Committee(s) structure:* Documents who serves on the QM committee, who chairs the Committee, and who coordinates the QM activities • *Roles and Responsibilities:* Defines all key persons, organizations, and major stakeholders and clarifies their expectations for the quality management program • *Resources:* Identifies the resources for the QM program	

DOMAIN IN QM PLAN	DESCRIPTION	✓COMMENTS
Performance measurement	• Identifies and quantifies the critical aspects of care and services provided in the organization; ensures integration with other Parts or accrediting bodies, GPRA, Program Assessment Rating Tool (PART) measures and unmet need • Identifies indicators to determine the progress of the QM program • Indicates who will collect, and analyze data • Indicates who is accountable for collecting, analyzing, and reviewing performance data results and for articulation of findings • Includes strategies on how to report and disseminate results and findings; communicate information about quality improvement activities • Processes in place to use data to develop new quality improvement activities to address identified gaps	
Annual quality goals	• Quality goals are endpoints or conditions toward which quality program will direct its efforts and resources • Selects only a few measurable and realistic goals annually (not more than 5); uses a broad range of goals • Indicates that those annual goals are established priorities for the QM program • Establishes thresholds at the beginning of the year for each goal	

DOMAIN IN QM PLAN	DESCRIPTION	✓COMMENTS
Participation of stakeholders	• Lists internal and external stakeholders and specify their engagements in the QM program • Provides opportunities for learning about quality for staff • Includes community representatives, as appropriate • Specifies how feedback is gathered from key stakeholders	
Evaluation	• Evaluates the effectiveness of the QM/QI infrastructure to decide whether to improve how quality improvement work gets done • Evaluates QI activities to determine whether the annual quality goals for quality improvement activities are met • Reviews performance measures to document whether the measures are appropriate to assess the clinical and non-clinical HIV care	
Capacity building	• QI capacity building of providers and spread of QI performance measurement systems and QI activities • Identifies methods for QI training opportunities • Provision of technical assistance on QI and support for QI activities • Indicates how data are being fed back to providers and key stakeholders	
Process to update QM Plan	• Identifies routine schedule to at least annually update QM Plan • Specifies accountability – indicates who will initiate process to update/revise plan • Indicates a sign-off process to finalize plan; potentially include internal/external stakeholders; include signatures of key stakeholders	

DOMAIN IN QM PLAN	DESCRIPTION	✓COMMENTS
Communication	• Outlines process to share information with all stakeholders at appropriate intervals • Identifies format for communication • Identifies communication intervals	
Formatting	• Clear and easy to follow layout and organization of content • Clear dating of document, including date of 'expiration'; page numbers	

Deciding on a Planning Approach

The planning process to develop a QM plan provides an opportunity to create a sense of ownership among staff, DOH departments, subgrantees, and consumers for the statewide improvement initiatives. Before diving into the details of your QM plan, decide on a general approach for developing and finalizing the plan that includes a wide representation of staff and stakeholders. Suggestions for gaining input include:

- Planning meeting. Facilitate an annual meeting in which decisions are made regarding the key components of the QM plan. Prior to this meeting, gather and distribute background information to participants pertaining to the meeting and prepare a draft of recommendations to give focus to the decision-making process.
- Series of planning meetings. Break the annual meeting down into smaller steps and plan a series of short meetings.
- Planning workgroup. Rather than a large group meeting, form a group comprised of two to three individuals who are responsible for delineating a process to gather staff and stakeholder input to subsequently finalize the QM plan.

Real World Example: Missouri's Cross-Part Buy-In on Quality Management Plan

As a participant in the Part B Collaborative, Missouri assembled a QM committee in 2006 that was charged with developing a QM plan. Within Missouri, there has been a long history of cross-Part collaboration. For example, statewide case management standards were already in place and all Ryan White HIV/AIDS Program grantees in the state use a single database for reporting case management data. The original QM committee included representatives from all Parts and this representation continues today.

While the QM committee was convened by the Part B program, because it included representatives from all Parts, it was decided to focus the QM plan on areas that impacted all Ryan White HIV/AIDS Program-funded providers in the state. The logical choice was the statewide case management system, with consistent processes, policies and standards across providers. Case management also constitutes a major investment of Ryan White HIV/AIDS Program funds in the state, second only to ADAP, which means improvements can have far reaching impact.

Representation on the committee by other Parts ensured their participation in implementation of the QM plan.

They were involved in the process from day one so there was a sense of ownership of the QM plan. There were also clear benefits to participation. For providers, they had an opportunity to take part in a process that could result in changes to existing case management processes, policies, and standards. There was also an emphasis on ensuring consistency across case management services in the state, regardless of the provider or the funding stream supporting the service, so that all consumers receive the same quality of services, even if they switch providers.

Case management continues to be a focus of the QM committee's efforts and cross-Part participation is still taking place. Besides their participation in the QM committee's quality-related activities, Ryan White HIV/AIDS Program grantees receiving funding from other Parts also conduct their own quality-related efforts, which are often tied into the work of the QM committee.

Toolbox: Arizona Part B Quality Management Plan for 2007-08

Quality Statement

The Arizona Ryan White Part B Quality Program will improve the quality of care for people living with HIV in the state by creating an effective quality management (QM) program and by supporting quality improvement activities throughout Arizona. In keeping with the legislative mandate in the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the Part B QM Program will help ensure care and services are integrated, consistent, accessible, appropriate, and compliant with the Health Resources and Services Administration (HRSA) requirements and HIV/AIDS Bureau quality expectations.

Goals:

The goal of the QM program is to ensure the quality of the Part B Program by:

- Analyzing program data and providing performance data results to programs;
- Sharing QM findings with stakeholders;
- Providing consultative services for QM activities to HIV providers;
- Routinely assessing the quality of Part B Program activities and making ongoing adjustments; and
- Meeting HRSA quality program requirements.

Infrastructure

The Arizona Ryan White Part B Program is located within the Arizona Department of Health Services. Two components of the program exist: the Care and Services Program and the AIDS Drug Assistance Program (ADAP). A large portion of the Care and Services Program's funded services is coordinated through regional planning bodies/consortia, including medical clinics and two large AIDS Service Organizations (ASOs). Coordination, communication and stakeholder input to the program occur regularly through the Part B Statewide Advisory Council (SAC).

Leadership of the Quality Management Program is the responsibility of the Part B Program Manager, who also chairs the Quality Management Committee (QMC). Responsibility for monitoring progress on quality initiatives rests with the Program Manager and the Program Monitor.

The Part B Quality Management Committee (QMC) is a standing committee of the Part B Statewide Advisory Council (SAC), with overlapping membership. The QMC will meet quarterly to review program data, determine priorities for improvement, and oversee improvement projects. Projects will be designed to ensure improvements in compliance with current clinical guidelines and standards of care, consumer satisfaction, and fiscal responsibility.

QMC Membership:

Membership will be recruited from both internal and external stakeholders, including:

- Regional Program Coordinators
- Medical clinic representatives who have expertise and knowledge of QM processes and/or treatment adherence Providers
- Program Manager for HIV Prevention
- Representatives of Part A, C, and D programs
- Program Manager for HIV Surveillance
- Epidemiologist III or other data system expert
- ADAP representative
- Tribal Representatives
- Consumers

Quality Data Collection Plan

Data will be routinely collected by contractors and program leadership, and analyzed by the Program Manager and Monitor, who will then present it to the QMC on a semi-annual basis. A standardized data collection tool will be utilized. Data to be reviewed will include:

- Hospital discharge data
- AHCCCS HIV expenditure data
- ADAP/Apothecary prescription and enrollment data
- Integrated Epidemiology profile data and annual report updates
- Annual client satisfaction surveys
- Statewide annual needs assessment survey results
- Lab data from annual unmet need estimate (LabCorp, Sonora Quest, Maricopa Medical Center Laboratory)
- Collected data from site visits
- New client information collected from case management intake

Systemwide Indicators:

Overall health and effectiveness of the system will be assessed using the following "vital sign" indicators:

1. Percent of newly identified HIV-positive individuals who enter medical care within 6 months of diagnosis.
2. Number or percentage of patients diagnosed with HIV who already have an AIDS diagnosis at presentation.
3. Percent of clients who receive a minimum of 2 medical visits and/or labs every 12 months.
4. Number of clients experiencing a gap in ADAP coverage.
5. Progress to implementation of statewide standards of care.
6. Client satisfaction.
7. Percent of clients enrolled in case management or primary care who have a dental visit.
8. Percent of women clients reported on CADR as receiving a yearly Pap smear.

Improvement Planning

At least yearly, the QMC will identify gaps and trends as identified through data reports and the system wide indicators, as well as provider/consumer experiences. Once an opportunity for improvement has been identified, the Program Manager will convene a multidisciplinary team with suggestions (and some members) from the QMC, to analyze the process and develop improvement plans, activities, projects, and interventions. Whenever possible, these teams will include individuals from the involved provider programs, other experts, consumers, and representatives of other involved State agencies, where appropriate. The Improvement Teams will report back to the QMC via the Program Manager and Monitor.

Improvement activities may include:

- Education (local and state staff, providers, consumers, stakeholders)
- Program guidelines review, revision or development
- Policy development and/or changes

- Form development or revision
- Procedural change(s)

At least yearly, the QMC will determine priorities for improvement and approximately 3-5 goals toward which the quality program will direct its efforts and resources in the coming year.

Possible Domains/Topics for 2007 Goals:

1. Alignment of care standards across the state:
   a. One standard of care that addresses: record keeping, services, allocations, site visit review, capacity building, cultural competence and trainings.
   b. Alignment of care processes.
2. Optimization of resources across the State: are resources allocated fairly and responsibly?
3. Improving access to care.

Communication

All improvement activities and priorities will be communicated to stakeholders and consumers via e-mail/listserv, any reports or updates can be posted to the ADHS website, at an annual community forum, and updates to the Part B SAC. Special efforts will be made to communicate with key external stakeholders, including Department of Corrections, Indian Health Service, Tribal Governments, local Health Departments, AHCCCS, the Veteran's Administration, Behavioral Health, Parts A, C, and D, AETC, and private clinicians whose patients utilize the services.

Evaluation of QM Program Effectiveness

The effectiveness of the QM Program will be assessed regularly as follows:

- Quarterly: compare activities completed to those planned.
- Quarterly: compare current outcome measurements to goals; is progress being made?
- Ongoing: review data analysis and get subjective feed back from providers and consumers; can we see that changes are happening?
- Annually: review and update plan.
- Annually: progress towards QM activities specific to contractors will be analyzed during ADHS' annual site visit.

Updating the QM Plan

The Plan will be updated annually each July. Leadership will be responsible for initiating the process and updating/revising the plan and presenting proposed changes to the QMC. The QMC will sign off on the updated plan via a majority vote. Each year, there will be updated goals and thresholds.

In addition, lessons and conclusions will be sent to the Part B SAC and Part B leadership team. (What did we learn this year? What were "ahas", surprises, etc?) These conclusions may be appropriate to include in the Comprehensive Plan, policies and procedures; changes in the QM plan itself, or other documents.

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. One tutorial, called 'Quality Management Plan' – Tutorial 5, outlines the elements of a successful QM plan.
NationalQualityCenter.org

The HIVQUAL Group Learning Guide includes related exercises how to write and review a quality management plan. Review the document and choose the most relevant workshop topics for your program.
www.HIVQUAL.org

Section 4: Establish Routine Performance Measurement Systems

Implementation Steps

1. Identify data systems and data sources
2. Prioritize key areas for performance measurement
3. Select and validate key data sources and appropriate data collection methods
4. Define performance indicators and establish written descriptions
5. Collect statewide performance data
6. Analyze the data and follow-up on key findings

Involving data staff, members of the QM committee, subgrantees and consumers in the development of measures and the selection of appropriate data collection methods will ensure that the necessary data exist and are accessible. This can also help in identifying what data are needed and in the design of a solid data collection approach.

Indentifying Data Sources

The first task is to identify appropriate data sources that will allow for the effective measurement of performance. Key considerations in this process are the pertinence, accessibility, and quality of the data.

Take advantage of any existing performance data when selecting indicators. Statewide performance data are helpful for:

- **Problem identification.** Reviewing data helps to verify assumptions and anecdotes about the nature of existing problems.
- **Planning and goal setting.** Performance measurement data can be used in developing the QM plan and for identifying the annual quality goals and activities.
- **Focus**. Data help to focus the efforts of quality improvement activities and can help the committee to identify what to address first.
- **Buy-in.** A preliminary look at the existing level of performance can make problems visible and establish the need for change.

Data that are already available provide a quick and easy way to get started. Once existing data have been reviewed, determine the areas in need of improvement and include these in your QM plan and action plan.

If existing data are not available or adequate, then baseline data should be collected. Depending on the program's information systems, these data can be collected using your existing data systems. If the committee decides that existing data systems do not capture what is needed for the quality improvement work, then data need to be collected manually using newly defined indicators. To collect project data, three key steps are identified: defining measures for performance measurement, collecting representative statewide data, and analyzing the available data.

Possible Data Sources:

- ADAP Database
- Ryan White CAREWare Database
- HIVQUAL
- Ryan White HIV/AIDS Program Data Report
- HIV Reporting System (HARS)
- Vital Statistics (mortality)
- Medicaid
- Surveillance
- Subgrantees
- Unmet Need Assessments

Real World Example: Florida Gains Access to Medicaid Data

A priority for Florida was to gain access to multiple data systems in order to obtain the data necessary to facilitate improvements. Obtaining access to Medicaid data was an important part of this process.

This was not the first time the Department of Health sought to work with Medicaid. Over the years, various data sharing agreements had been proposed by either the Department of Health or Medicaid. The Medicaid representative on the QM committee, which over the course of the effort was three different individuals, focused initially on synthesizing into a single agreement the multiple data sharing agreements that had been proposed over time. The new agreement emphasized the QM committee's priorities. This agreement was then reviewed by lawyers from the Department of Health and Medicaid. Once this process was initiated, it took about 6 months to obtain a signed agreement.

Key to the success of this effort was a focus on mutual benefit—Medicaid will not enter into a data sharing agreement unless it derives specific benefits from the exchange. The QM committee proposed to share data that could be useful to both agencies—matching HARS and ADAP data to Medicaid data. As a result of this match, Medicaid and the Part B program could identify if they were covering the same clients, which saves both programs money.

The turnover of the Medicaid representative on the QM committee turned out to have some advantages. The QM committee maintained a relationship with each successive individual, providing greater access to the Agency. This helped to further cement the relationship between the QM committee and Medicaid.

The initial agreement between the Department of Health and Medicaid was for 1 year. When it came time to renew the agreement, the process was very smooth and took approximately 1 month. Both agencies were eager to maintain the agreement.

Defining Performance Measures for the Statewide HIV Quality Program

A challenge in making quality improvements in Part B programs is to select specific quality of care indicators that are relevant to a statewide program and can be captured accurately and efficiently. A quality of care indicator is a carefully defined measure of a specific aspect of the program. A broad representation of staff and leaders should participate in the process of selecting indicators as this ensures transparency and long-term buy-in.

For the final selection of indicators, all measures should be prioritized for each indicator based on the following four measurement criteria:

- **Relevance.** Does the indicator relate to a condition that occurs frequently or has a great impact on the program?
- **Measurability**. Can the indicator realistically and efficiently be measured given the program's finite resources? Will the indicator show the impact of changes?

- **Accuracy**. Is the indicator based on accepted guidelines or developed through formal group-decision making methods?
- **Improvability**. Can the performance rate associated with the indicator realistically be improved given the limitations of the program?

If those who are responsible for the selection process answer "no" to any of these questions, the indicator is either too difficult to measure or less than critical to program outcomes. On the other hand, if the team answers "yes" to all of the questions, they have most likely found a viable indicator. At times, more than one indicator is selected to best assess and to balance the core aspect under review.

Once a list of potential indicators has been identified, they need to be further defined. This is accomplished by writing the indicator in the form of a question (e.g., 'Was the CD4 count measured and the result documented in the medical record in the past four months?') to which there are a certain range of responses based on patient documentation (e.g., 'yes', 'no', 'NA'). At this step, it is important to define the measure by clearly documenting the 'yes' and 'no' responses. Further indicator descriptions can explain either allowable data sources (e.g., lab results, self-reported) or further action steps (e.g., hard copy of results shared with patient).

The following should be considered:

- Complete definitions of indicators that are based on current guidelines or commonly agreed standards.
- Frequency of data collection (e.g., monthly, bi-monthly).
- Efficiency of data collection.
- Quality of existing data.

Real-World Tips: Beg, Borrow, and Steal Indicators

The following websites include HIV-specific indicators for your quality program:

- HAB clinical core indicators (hab.hrsa.gov/special/habmeasures.htm)
- National HIVQUAL Project (www.HIVQUAL.org)
- National Quality Center (NationalQualityCenter.org)
- New York State Department of Health AIDS Institute (www.hivguidelines.org)
- National Quality Measures Clearinghouse (www.qualitymeasures.ahrq.gov)

HAB has developed the HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents. These measures can be used by all programs funded by the Ryan White HIV/AIDS Program and can be used either at the provider or system level. Group 1, which represents the first five core clinical performance measures that are deemed critical for HIV programs to monitor, was released in January 2008. These performance measures are included in Appendix D.

More information on the HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents is available on the HIV/AIDS Bureau website at: hab.hrsa.gov/special/habmeasures.htm

Toolbox: Examples from the Part B Collaborative Measures

TOPIC	INDICATOR	TYPE
ADAP Enrollment	Percent of ADAP applicants approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application	Process
ADAP Recertification	Percent of ADAP enrollees recertified for ADAP eligibility criteria every 6 months	Process
HIV Reporting with AIDS Diagnosis	Percent of individuals newly reported with HIV infection who also have AIDS diagnosis	Outcome
AIDS Progression Rate	Percent of individuals newly reported with HIV infection (not AIDS) who progress to AIDS diagnosis within 12 months of HIV diagnosis	Outcome
HIV Death Rate	Ratio of individuals who die within 12 months of HIV diagnosis to the number of individuals newly reported with HIV infection	Outcome
HIV Medical Visit	Percentage of all HIV-infected clientes who had 2 or more CD4 T-cell counts performed in the measurement year.	Outcome
HIV Monitoring	Percent of individuals with at least two lab tests (CD4 or VL) in the last 12 months with at least one lab test in the first six months and at least one identical lab test in the second six months of the same 12 month period	Outcome

For more indicator details and definitions, see Appendix E.

Collecting Performance Data

Data collection methods and collection tools need to be identified or developed to measure the current level of performance. Committee members will need to find the most efficient way to collect information and to determine who will collect the data.

- **Construct a population sample.** Data sampling allows for inferences about a total patient population based on observations of a smaller subset of that group (the sample), saving both time and resources during data collection. To select a sample population, the larger eligible population (measurement population) must first be identified. Defining this measurement population requires identifying those patients who are eligible to be selected for the sample based on pre-established criteria (e.g., patients with two medical visits during the year). Visit the New York State Department of Health website at www.HIVQUAL.org for detailed description of sampling strategies, including the number of patients to be minimally reviewed and how to effectively randomize.
- **Design a data collection tool.** Based on selected indicators to assess the performance level, a data collection tool is created to assist and facilitate the data collection process.
- **Train data collectors.** Those who are assigned to collect data should be given an opportunity to review the measurement process. They should also be instructed on how data collection will contribute to the QM program.
- **Collect data.** Clinical data abstraction, the process of gleaning data from a larger data set, is achieved through record review and/or administrative review. With record review, a designated data collector directly collects data manually from individual medical records, whereas with administrative review, the individual gathers information from data previously collected in the facility's administrative database or log.
- **Validate results.** Performance measurement data are only as good as the process from which they are collected. Steps should be taken to ensure the process works by assessing its reliability and effectiveness.

Real World Tips: Keep Data Measurement Simple

Keep in mind the following practices in reviewing performance measurement data:

- Use only as much data as necessary; more is not necessarily better.
- Train staff in data collection processes and address any data interpretation issues.
- Realize that there is no 'perfect indicator' and agree early on the best indicator.
- Limit data analysis to the achievement of the identified indicators.
- Performance measurement is only the first step—use your data for quality improvement.
- Communicate project data early on; don't wait to get perfect results.

Real World Example: Cross-Part Data Collection in Missouri

When it comes to HIV services, Missouri has a longstanding history of collaboration across Ryan White grantees and providers in the state. It also has been a longstanding goal of the Department of Health to have a single, statewide HIV case management database that would allow for client-level tracking.

The process of moving toward a single database was incremental. St. Louis, a Part A grantee, established a database to track its case management services, which utilized FACTORS software. St. Louis and the Part B program used the same contractor to provide their claims adjudication and data management services. Once the contractor had developed the database, the Part B program was able to adopt the system, with the only expense being the purchase of software licenses.

Since there are statewide case management standards already in place, all Ryan White HIV/AIDS Program grantees collect the same core data. Most importantly, HIV providers in Missouri had already agreed on the use of a single unique identifier throughout the state, which is also the state Medicaid number, making it easier to unduplicate data and to track consumers as they access services and change providers throughout the state. Support from key administrators within agencies, as well as champions at all levels, was important in moving forward with the database. The Part A grantee in Kansas City had already implemented data tracking software but after some convincing, converted to FACTORS.

Gradually, providers from Parts C and D who also had contracts for Part A and B case management services began using the FACTORS software to track their clinical outcomes data. Once again, cost was a major incentive as providers only had to purchase the software licenses and not a whole system. Providers also share the costs of maintaining the database—another economy.

Besides the cost savings, there have been other significant benefits. The system provides real-time access to all data collected by all Ryan White HIV/AIDS Program-funded grantees across the state. Data on enrollment time, referral time, and payers can be generated instantly for all consumers, instead of relying on data from a sample of consumers that is collected from charts. Individual grantees can also run their own reports and compare their performance to that of other grantees.

Implementing the system with case managers presented a few challenges, some of which are ongoing. There are varying levels of computer skills among staff. In addition to an initial training, it has been necessary to conduct group, individual, and web-based trainings on an ongoing basis. In order to deal with this ongoing training, not only for the database but also for adherence to standards, additional funds have been used to support three educators/trainers who are shared throughout the state.

While the system automated the generation of reports—a significant time saver for administrative staff—in some ways it is more time consuming for those who do data entry and are responsible for updating files. Staff is held accountable on a day-to-day basis for the accuracy of the data in 100 percent of their electronic charts and are asked to make corrections—this burden was significantly less when representative samples were used to evaluate individual charts.

While there were challenges along the way, and some resistance to change, the many benefits have won over most users. As one early champion of the system put it, "If anyone complains, just tell them to go back to paper."

Real World Tips: Working with Data Management Staff

- **Involve data staff early in the process.** Involving data staff from the very beginning (i.e., during the goal-setting phase) is critical. This will provide them with an understanding of the big picture so that they can see how their role fits in overall effort. Providing an orientation for data staff can help them understand their role since most likely, QM will be new for them.
- **Find a data "translator."** Identify a member of the data staff that can clearly communicate concepts to the non-data staff. This can greatly facilitate interactions and limit misunderstandings.
- **Link to the field.** Consider partnering data staff with a direct service provider as a resource. The service provider can explain how things work at the provider level and how data can be collected and used.
- **Work with IT staff.** It is important to have IT staff that are knowledgeable about data management software and IT staff are key in making data available to staff. As in other areas, a glossary of terms can be helpful in making sure everyone is speaking the same language.

Real World Example: Ohio-Take Time to Create the Best Data Collection Tools That You Can

In 2005, HIV CARE Services (HCS) at the Ohio Department of Health (ODH) began the process of updating its statewide Case Management Outcome Measurement tool. The tool is part of HCS' web-based Case Management Information System (CMIS). ODH, through its Office of Management Information Systems (OMIS), routinely produces, deploys, maintains and updates software applications, including online data collection systems such as CMIS.

To initiate the process of improving the data collection process, HCS sought input from program researchers prior to contacting coding experts (computer programmers). This strategy, which was designed and led by the HCS Quality Management Researcher and included participation of case management staff, involved much more than developing a list of concerns to be taken to the programmers. The multistage process included the following steps.

1. The existing version of the paper form, which case managers used to collect data from their clients and then key that data into CMIS, was used as a starting point. Through face-to-face meetings and telephone conference calls involving carefully selected case managers, clients and ODH staff, feedback was obtained and an updated form, called Version 1 Questionnaire (V1Q), was developed.
2. The usefulness of V1Q was tested through a pilot study (PS1). The number of case management agencies selected was small, by design. The purpose of the test was to determine if the updated form could be mailed or handed to consumers for them to complete on their own. Case managers were given written instructions which guaranteed that they would have no control over which client did or did not participate in the study. Furthermore, depending on the order in which clients came in, the case managers were asked to assist one client in completing the form but not to assist the next one, and to identify the forms accordingly. The data collected were analyzed to determine the usefulness of the questions on the form. V1Q was revised to produce V2Q, and to a new pilot study we called PS2.
3. By design, the number of case managers and clients participating in the second pilot study was larger and more representative than had been the case for PS1. Also, the selection process was designed to ensure that a client or case manager who had participated in PS1 would not be asked to participate in PS2. This was done to avoid putting a heavier burden on study partici pants than was absolutely necessary. Based on the results of this second analysis and further deliberations involving case managers, consumers and ODH staff, the final version of the tool, labeled Case Management Outcome Measures (CMOM), was produced and eventually submitted to the programmers.

The primary value of the data collected from participating consumers was to inform the revision process on the usefulness of the questions on CMOM. Were the right questions being asked? Were the questions appropriately phrased? Was the language used appropriate to the target population? Was anything overlooked? Would the data entered into CMIS lend itself to appropriate analysis? After HCS was satisfied with the answers to these questions, they took the CMOM to computer programmers.

HCS realized several benefits by going to their researcher prior to coding:

- Cost and time savings. Updating electronic data collection systems can be very expensive and time consuming. Designing a system that will not need to be updated frequently results in cost and time savings, in the long run.
- Improvements in quality of data. The quality of the form used to collect the data determines the quality of the data that will eventually be entered into the electronic system, whether online or offline. If frequently updating a data collection system, new data fields are created in the database and data values collected under changing contexts will be

added to values in existing fields. This constant shift in the structure and meaning of the data causes nightmares to data analysts and frustrations to data users. HCS avoided some of these challenges by ensuring that the paper form on which the electronic tool is based is as good a product as it can be at the outset.

- Facilitating the task of data analysis. Conducting pre-test analysis on data collected using the form under revision helped ensure the usefulness of the data to be collected in the electronic system.
- Getting critical input from the people in the field. Involving case managers and consumers in the revision process meant getting critical input that cannot be obtained from researchers, programmers or administrators.
- Setting up data collection systems that are accepted by all stakeholders. Getting buy-in from stakeholders was one of the keys to success.

Real World Example: Oregon Making it Easy for IT Staff to Collect Data

Oregon has developed a Data Request Form that is sent to IT staff on a quarterly basis. IT staff pull necessary data from various databases (HARS, ADAP and CAREWare).

2007 Oregon HIV Care & Treatment Quality Management Data Report

Data Source: CARE Assist database
Date Due: Quarterly: the 15th of each month after the end of the quarter – 4/15; 7/15; 10/15; 1/15

Question #1: How many clients are in "pending" status in CARE Assist for longer than 4 weeks?
Numerator = total number of clients who have been in "pending" status more than four weeks by the end of the previous quarter ("start" date minus the date the report is run). Please run this with client ID numbers attached so we can do more evaluation.
Denominator = total number of clients assigned "pending" status in the quarter.
Numerator = Denominator =

Question #2: How many clients who entered the "Bridge" program successfully enrolled in CARE Assist?
Numerator = Number of clients who were in the "Bridge" program in the previous quarter and are enrolled in CARE Assist by the end of the current quarter. (do not include "rejected" from Bridge)
Denominator = Total number of clients who were in the "Bridge" program in the previous quarter.
Numerator = Denominator =

Question #3: Do new/returning CARE Assist applicants receive status notification (letter, email or phone call) within 30 days of receipt of their application?
Numerator = Number of newly enrolled clients who have a notification activity and date documented in their data file within 30 days of "Application Received" date (by month).
Denominator = Total number of newly enrolled clients in the previous quarter (by month).
Numerator = Denominator =

Toolbox – Results from the Part B Collaborative

INDICATOR	MEDIAN RATE (START OF COLLABORATIVE)	MEDIAN RATE (END OF COLLABORATIVE)
ADAP Enrollment	88%	97%
ADAP Recertification	82%	92%
HIV Reporting with AIDS Diagnosis	23%	28%
AIDS Progression Rate	18%	25%
HIV Death Rate	5%	5%
HIV Medical Visit	65%	42%
HIV Monitoring	52%	30%

The following limitations apply to this data set:

- Clarifications were provided throughout the Collaborative to refine the indicator definitions (e.g., medical visit).
- Different data sources were used by various Part B teams, limiting the comparability of data over time.
- Some indicator data were not available at the beginning of the Collaborative and/or were not easily being matched suggesting underreporting of some indicators.
- The early focus of some teams was on data collection; improvement activities were reported later in the life cycle of the collaborative.

Toolbox – Results from the Low Incidence Initiative

INDICATOR	MEDIAN RATE (START OF INITIATIVE)	MEDIAN RATE (END OF INITIATIVE)
CD 4 tests at least every six months	70%	81%
ADAP clients approved/denied within 2 weeks of application	97%	100%
At least 2 HIV medical care visits in last 12 months	72%	86%

The following limitations apply to this data set:

- Different data sources were used by various Part B teams, limiting the comparability of data over time.
- The early focus of teams was on developing and improving data collection efforts, which may be the cause of improved rates; improvement activities were reported later in the life cycle of the collaborative.

Real World Tips: Data Collection Techniques

- Data collection should be coordinated for multiple projects, with different projects using the same data—collect mutually beneficial data.
- Create a part-time data position to collect data from various efforts such as performance management, subgrantees, and client satisfaction surveys.
- Make the data gathering process formal, either through letters of agreement with agencies or through a contract that provides access to data.
- Engage clinicians and frontline staff through regular feedback on QM efforts.
- Demonstrate how poor data reporting from staff and subgranteess can misinform decisions; for example, show how incomplete forms submitted by clinicians can misrepresent who is being served and the services provided.
- Provide consistent training on data collection.

Sharing Performance Data Results

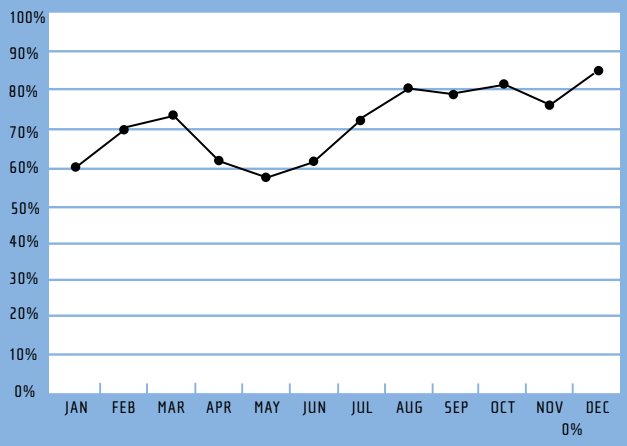
Communicating baseline data to the QM committee, staff, subgrantees, and stakeholders helps everyone to better understand the data collection process and the meaning of the data. Whenever possible, the summary of performance measurement data should include graphics such as tables or charts--graphic displays help to convey outcomes at a glance. Text should be used sparingly for background and/or explanatory information. The level of detail provided through graphics and text will generally depend on the target audience.

Commonly used charts to graphically present performance measurement data include:

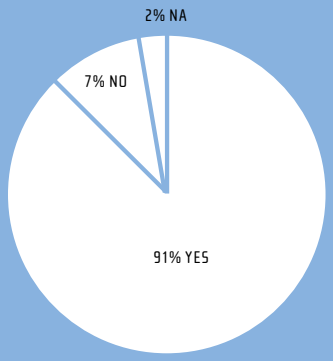
- **Run chart:** a graph showing measurements on the vertical axis against time on the horizontal axis.
- **Pie chart:** a circle divided into wedges to show relative proportions; the sum of all portions equal 100%.
- **Control chart:** a run chart with statistically determined upper and lower control lines drawn on either side of a process average; used to analyze different types of variations.
- **Histogram:** a bar graph that shows the distribution (variation) in a set of data, illustrating how often different values occur.

Toolbox:
Display of Measurement Data in Graphic Form

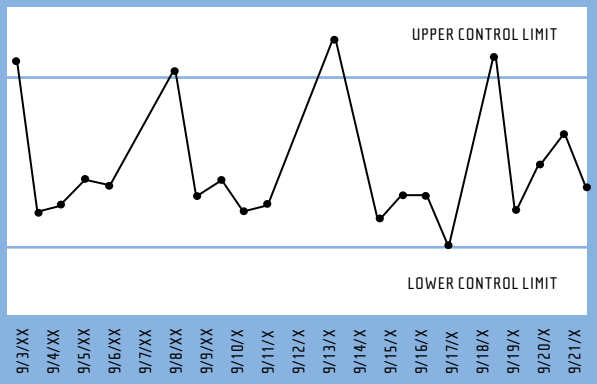
Run Chart: Annual PPD Rate



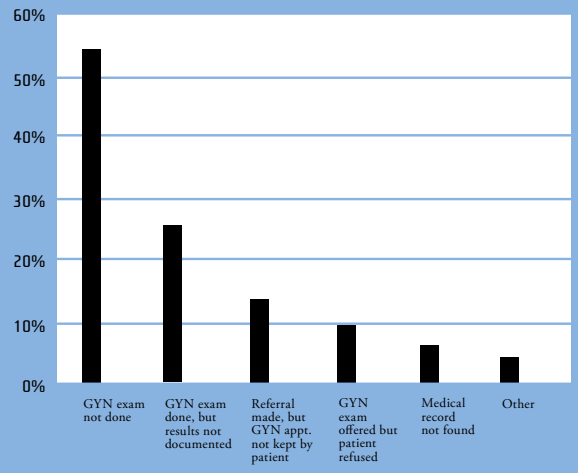
Pie Chart: Did patient receive PCP prophylaxis?



Control Chart: Waiting Time



Histogram: Reasons for No GYN Exam in Medical Record



Real World Example: Maine- Creating a Data "Feedback Loop"

With a relatively new QM program, Maine wanted to make sure processes were in place to train providers and their staff about QM, share data with stakeholders, and help providers use their data for their own quality improvement efforts.

- **Informing Frontline Staff how Data are Used.** In a time of shrinking resources, many of the frontline staff being asked to collect the data seemed resistant and did not understand why the data were being collected and how this data could be used for change. Two Part B program staff had been trained through the NQC's Training-of-Trainer (TOT) Program, but despite efforts to generate interest, providers and their staff were not receptive to attending formal trainings. In response, the Part B program found other ways to integrate information about QM efforts. Components of the TOT Program are now integrated into the bimonthly Part B Advisory Committee meeting, which is attended by a case manager from each subgrantee, representatives from consumer advisory boards, and clinicians. Components from the TOT Program have also been integrated into annual trainings for case managers. Infusing quality into other training opportunities has allowed the Part B program to increase understanding about quality-related activities at the provider level.
- **Using Data at the Subgrantee Level.** To foster a culture of quality at the provider level, Maine has sought to ensure that data collected by subgrantees are useful to them for their own quality improvement activities. In Maine, all grantees use CAREWare and report on the same measures on a quarterly basis. In selecting measures, the Part B program focuses on data of interest to subgrantees such as caseload, amount of time case managers devote to a client, core services provided, and successful referrals. In their FY08 contracts, subgrantees will be required to carry out a PDSA Cycle each quarter based on the data in their report. The Part B program also provides subgrantees feedback on how they mea sure up against state-level outcomes. Both these activities help subgrantees see the relevance of the data and identify areas for improvement.

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. Four tutorials, Tutorial 7 through 10, outline the various aspects of performance measurement in HIV care.
NationalQualityCenter.org

The guide, "Measuring Clinical Performance: A Guide for HIV Health Care Providers," details all necessary steps to collect data, from how to define an indicator, to set up data collection systems, and to analyze the data.
NationalQualityCenter.org

The HIVQUAL Group Learning Guide includes related exercises on how to conduct performance measurement activities. Review the document and choose the most relevant workshop topics for your program.
www.HIVQUAL.org

Section 5: Implementing and Assessing an HIV Quality Management Program

Implementation Steps

1. Develop an action plan to implement the written Part B QM plan
2. Assess your QM program against a standardized assessment tool
3. Respond to assessment findings and make adjustments accordingly

Developing a Statewide Action Plan to Implement the QM Plan

An annual action plan answers the questions of what, when, where, and how the Part-B QM plan is implemented and assists the Part B program in clearly documenting the necessary steps to implement the overall QM plan. This action plan benefits quality implementation efforts by:

- Assisting the committee to allocate the appropriate resources essential for quality activities, including project teams, staff training, data collection, and evaluation efforts.
- Effectively communicating quality activities to leadership, staff, subgrantees, and other stakeholders.
- Creating a template to monitor the implementation process of the QM plan, with roles, responsibilities and timelines.

What is the Difference between a QM Program, QM Plan, and Action Plan?

• **QM program:** encompasses all grantee-specific quality activities, including the formal organizational quality infrastructure (e.g., committee structures with stakeholders, subgrantees and consumer) and quality improvement-related activities (performance measurement, quality improvement project and quality improvement training activities).

• **QM plan:** a written document that outlines the grantee-wide QM 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.

• **Action plan:** a plan that identifies major quality goals, specific quality activities, responsibility for completing the activities, and sets completion dates over the course of a specific time period, usually one year.

Although there are different approaches to writing an action plan, it should include, at a minimum, the following categories:

- **Major quality goals:** a straightforward goal statement divides the action plan into categories under which several activities are identified to accomplish each goal.
- **Quality activities:** each activity is briefly explained; the documentation is informative and concise but should also be practical and user-friendly.
- **Responsibility:** a staff person or team is identified to oversee and report back on the implementation of each activity.
- **Date of completion:** the duration and/or date by which each activity is completed should be noted.

During the evaluation stage, the QM committee can use the action plan to assess its annual implementation efforts, comparing planned against actual activities. It also generates a template for future planning efforts.

Toolbox:
Gantt Chart

DESCRIPTION	• Graphically displays activities (including roles and responsibilities) in sequential order plotted over time • Depicts when each activity in a project must start and finish • Shows which activities can be accomplished concurrently • Shows the relative amount of time required to complete an activity • Presents the minimum time needed to complete an improvement project
USE	• To plan an improvement project • To monitor the progress of an improvement project
BASIC CONSTRUCTION	1. Identify all the activities that are necessary to complete an improvement project. (Note that these activities are not necessarily related.) 2. Identify the time required for each activity. 3. Identify the sequence of activities (e.g., which ones must be finished before another can begin and which can occur simultaneously). 4. Construct a horizontal timeline along the top axis; mark the appropriate scale for the project duration (e.g., days, weeks, or months). 5. List the project activities on the left vertical axis in order along with responsibility. 6. Mark the period of time from the planned beginning to the planned end for each activity.

Gantt Chart Example: Self-Management Program

Implementation Plan of a Self-Management Program to empower patients to become informed and active participants in our health care delivery system.

ACTIVITY	RESPONSIBILITY	WEEKS								
		1	2	3	4	5	6	7	8	9
Collect current written materials about self-management	Mary	X	X							
Prepare presentation and draft educational materials	Mary		X	X						
Discuss at quality improvement committee	Pat			X						
Discuss with consumer advisory board	Hal			X						
Establish team with providers and consumers	Pat			X	X					
Formulate clear objectives and staff expectations	Mary				X	X	X			
Present at staff meeting	Pat					X				
Implement self-management program with one provider	Jack					X	X	X	X	X
Establish indicator to measure performance	Mary							X	X	
Review new self-management program articles	Pat								X	X

Conduct an Organizational Assessment of the Part B Quality Management Program

At least annually, the Part B staff should take a step back to assess the statewide quality program, the written QM plan, and the annual action plan. This approach will guide the quality program and allows it to integrate its assessment findings into future planning.

Here are some key questions in the assessment:

- **Quality program infrastructure.** Was the committee effective in its efforts to improve the quality of Part B program activities? Does the quality infrastructure require any changes to improve how quality improvement work gets done?
- **Annual quality goals.** Were annual quality goals for quality improvement activities met? How effectively were the goals met? What were the strengths and limitations?
- **Performance measures.** Were the measures appropriate to assess Part B systems and programs? Are the results in the expected range of performance?
- **Staff and subgrantee involvement.** Did the appropriate staff and subgrantees participate in quality improvement activities? Were staff and subgrantees informed about ongoing quality activities and about quality improvement methodologies?
- **Annual action plan.** Did the implementation process go as planned? Did you meet established milestones? What were the strengths and limitations?

The Part B staff should decide which standardized organizational assessment tool to use to guide the assessment process. If your program has an existing assessment tool, see if it could be modified to help assess your QM program. Otherwise adapt the HAB/NQC Part B QM Assessment Tool which has been developed during the Part B Collaborative. By comparing the scores over time, the Part B staff can analyze the progress of the statewide QM program.

To ensure a range of perspectives are represented in the assessment, a cross-section of the Part B staff, QM committee members, subgrantees and other stakeholders should participate in the program assessment. Broad-based input provides a better picture to assess the entire QM program.

Real World Tips: Planning for the Assessment

Consider the following ideas to assess your HIV quality program:

- Dedicate a committee meeting to assess, review and discuss the assessment findings.
- Ask individuals to complete the assessment tool and compare the aggregate scores.
- Engage an external quality improvement expert to guide this process.
- Involve the voices of consumers to augment the assessment.

Learn from and Respond to Findings

Assessment results can help the Part B program to identify critical issues for adjustments and future planning. To maximize the lessons learned from assessment data, the Part B staff should review all available organizational assessment data to identify common themes or problems. Additional data (such as audit results or quality evaluations performed by external agencies) can be used to supplement the internal program assessment and may help to identify future improvement opportunities.

In reviewing the assessment data and linking them to overall program objectives, the Part B program assesses the impact and is able to compile a list of critical issues to be addressed during the upcoming annual planning process. The past performance is used to learn lessons for future quality activities and how to best adapt the quality infrastructure. Those steps can include changes to the existing quality program by adapting annual goals and performance measures or changes to the annual action plan. It is critical to immediately take action while the evaluation results are still fresh in the minds of the QM committee.

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. One tutorial, called 'Quality Management Infrastructure' – Tutorial 6, outlines how to assess your QM program.
NationalQualityCenter.org

The HIVQUAL Group Learning Guide includes related exercises how to evaluate and HIV-specific QM program. Review the document and choose the most relevant workshop topics for your program.
www.HIVQUAL.org

Section 6: Conducting Quality Improvement Activities

Implementation Steps

1. Select a key aspect for improvement for the Part B quality program
2. Set up a quality improvement team to carry out quality improvement activities
3. Conduct cycles of changes to improve the prioritized aspect of HIV care or service
4. Sustain improvements over time

Establishing a Quality Improvement Project

Improvement projects are the vehicle by which staff members address the quality goals set forth in the Part B QM plan by bringing together the skills, experiences, and insights of different staff into a team. Each team has a unique combination of people, improvement goals, and performance measures.

Successful outcomes of improvement projects result most often when a team has clear objectives to guide their activities, the necessary resources to complete project work, support of the committee, and the willingness of team members to learn from each other and maintain open communication with the committee, staff, and subgrantees.

Given finite resources, mainly in the form of time and manpower of the Part B program, the QM committee needs to prioritize which aspect of HIV care, service or program administration should be improved. To do this, the committee reviews recent performance data results and consults with subgrantees and consumers about their concerns. The following questions should be considered when prioritizing topics for quality improvement projects:

- **Relevance**. How large is the problem? How frequently does it occur? Are there data to support its relevance?
- **Resources**. Can this aspect of HIV care, service or program administration be efficiently measured and improved? Are resources available to tackle it?
- **Momentum**. Do subgrantees and/or consumers support the initiation of this activity? Does the Department of Health fully support this initiative?

The QM committee needs to create the basic framework to allow the teams to optimally perform and accomplish their goals. At a minimum, the following objectives should be established:

- **Define the quality goal for the project.** This basic information frames the scope of the project and helps improvement teams launch their efforts. For example, a QM committee might describe a project goal as, "improve patient adherence to ARV therapy to 85% using a 3-day self-report." The project team starts with this goal.

- **The QM committee decides who will be included on each quality improvement project team.** The QM committee selects the team leader and/or team facilitator and individual members to achieve a cross-functional representation.
- **Project deliverables.** Specifying deliverables clearly communicates the QM committee's expectations for a project and ensures that the committee and the improvement team are "on the same page."
- **Deadline for completion and any interim deadlines.** Clear deadlines for reporting back to the QM committee (such as weekly project updates and a final report in 3 months) allow an improvement team to efficiently plan project activities.

Toolbox: Quality Improvement Opportunities – Ideas for Change from the Part B Collaborative

The following four domains used for the Part B Collaborative provide a framework for identifying quality improvement opportunities; for more information about these domains, see Appendix A. Appendix F lists a wide range of ideas to kick off Part B QI initiatives.

Alignment Across Jurisdictions and Services, including ADAP

- Create a Single System of Care for All Parts: Continuum of Care
- Develop a Standard Data Collection, Reporting, and Monitoring Process for All Ryan White HIV/AIDS Program Grantees in the State (see Information Management for detail)
- Promote Statewide Collaboration to Improve Quality of Care and Services

Integration of Data and Information Systems

- Provide Administrative Oversight to Manage the Data at the System Level
- Develop State Level Outcome Measures at the Program and Client Level, and Across Agencies and Parts
- Reduce the Burden of Data Collection
- Establish a Case-level Data Structure
- Use Data to Promote Quality Improvement
- Provide Technical Assistance to Facilitate Collection of Client-Level Data at Point and Time of Service

Improving Access to Care and Retention of HIV/AIDS Clients

- Coordinate Care and Services Within and Across Agencies
- Involve Consumers
- Use Data to Define Need and Target Services
- Identify and Involve All Stakeholders to Improve Access and Retention
- Improve the Care Delivery System to be More Proactive and Responsive to Patient Need
- Provide Training and Technical Assistance for Provider and State Staff
- Standardize Processes at the System Level to Improve Access and Retention

Optimization and Management of Resources

- Contain Costs and Maximize Resources
- Follow Standards/Guidelines to Ascertain Eligibility and Reimbursement for Services
- Improve Staff Retention and Satisfaction

Setting Up Quality Improvement Teams

Typically, a cross-functional group of Department of Health representatives is assigned to each project, potentially including subgrantees and consumers from across the state. This helps to ensure that multiple viewpoints are represented in this improvement effort. To the degree possible, the team should include those staff members who influence the project goal as well as those impacted by the goal. A broad representation strengthens the team's ability to make informed decisions and signals that input from those staff members who are most impacted by the project work is valued. Some-

one who feels personally invested in a project is much more likely to actively seek its completion. If feasible, include staff members in the selection process.

All team members are responsible for the effective functioning of the team. At the beginning of the project, team members should take time to get acquainted with team members' roles and responsibilities and agree upon how the team will go about its work.

- **Team leader.** The team leader should have a firm understanding of HIV care delivery issues and Part B systems and programs. The person selected as team leader must also understand the entire breadth of the improvement project so he or she can effectively plan and lead team meetings.
- **Team facilitator.** Team leaders may wear two hats and also serve as the team facilitator. Generally, the facilitator assists the team leader in planning meetings and developing agendas. A facilitator also tends to the meeting process—ensuring that everyone participates and helping the team stay on track with the agenda and scheduled times.
- **Team members.** Team members reflect the range of functions and departments involved in the process being improved in order to build and maintain consensus from key individuals on the solutions to the problems. They should also have intimate knowledge of the process.

The QM committee can assign staff members to serve as the team leader and team facilitator for a quality improvement team while improvement team members can be selected by either the committee or by the team leader.

With Part B programs, team members may not all work in the same building, or even in the same city. This may necessitate conducting team meetings via conference calls. While opportunities to conduct face-to-face meetings, or at least one face-to-face meeting, should be explored, teams can be equally effective if meetings are held via telephone.

In the initial phase of an improvement project, the team leader serves as the driving force in building effective relationships between team members and ensuring everyone understands the team's assignment. During this phase, the team leader should:

- Ensure team members know each other and recognize how members can complement each other through their expertise and perspectives.
- Provide any necessary training to successfully start the improvement project.
- Establish ground rules to govern the interactions of the team.

Toolbox: Team Roles for an Improvement Project

TEAM RESPONSIBILITIES	TEAM LEADER	TEAM FACILITATOR	TEAM MEMBER
Provide direction and focus to team activities	X		
Ensure productive use of team members' time		X	
Represent team to clinic management and QM committee	X		
Ensure balanced participation by all team members		X	
Provide feedback and support to team leader		X	
Suggest problem-solving tools and techniques			
Offer perspective and ideas and participate actively	X	X	X
Adhere to meeting ground rules	X	X	X
Complete assignments on time	X	X	X
Support implementation of recommendations	X	X	X
Keep up-to-date on QI training, research and methods	X	X	
Manage the team's time	X	X	
Take and distribute minutes of meetings			X

Real World Tips: Launching the Team

Whether an improvement project is small or large, simple or complex, the following suggestions can help a team complete a project:

- Include a QM committee member on the team.
- Involve additional staff who are willing to participate—ask for volunteers.
- Rotate functions of the team.
- Start with a presentation of a successful quality improvement project.
- Generate enthusiasm and excitement at the first team meeting by explaining why the work is important and how staff, subgrantees, and consumers will benefit.
- Explain the potential for change and limitations early in the process.
- Include subgrantees and consumers on the team.
- Rotate the role of recorder and timekeeper among team members.

Writing an Improvement Project Memo

An improvement project memo serves as a blueprint for the improvement project. Teams develop memos to help ensure that all members work toward the same goals according to a single set of operational guidelines. An improvement project memo should:

- Clarify and focus the team's direction and scope of work.
- Serve to communicate what the project is, what it intends to accomplish, when it is likely to be completed, and who is responsible for the project implementation.
- Direct team efforts and refocus the team if it gets stuck on a specific issue.
- Orient new team members coming on board during the project cycle.

An improvement project memo typically includes:

- **Project problem statement.** A problem statement describes the problem to be addressed. It should be stated in concrete terms—terms that clearly describe the problem to be addressed, include quantifiable numbers that indicate the current level of performance (e.g., "currently 60 percent of women in our state receive annual GYN exams"), and are relevant to Part B processes and systems.
- **Project improvement goal.** Effective teams need clearly defined goals. How high to set the goal—an achievable, realistic, or a "stretch" goal—is up to the QM committee and the team. A basic guideline in setting goals is to set the goal and then continue making changes until the level is reached at which the effort expended is too great for the gain. In other words, the value of meeting the goal should exceed the cost of doing so. A good project goal is both measurable and achievable.
- **Team members.** All members of the team are listed to have a complete record of those involved in the project.
- **Additional project components.** This section of the memo outlines the necessary resources available to the team, the frequency of reporting to the QM committee and establishes ground rules and other logistical matters.

Real World Tips: Adopt Effective Team Ground Rules

- Meetings will start and end on time.
- All opinions will be considered with respect.
- Meetings will last no longer than one hour (or the specified time).
- Meetings will be conducted in a way to encourage all team members to share their opinions.
- Team members will complete their assigned tasks on time.
- All team members will participate in meetings on a regular basis.
- Team members will inform other team members in advance in the event of an unavoidable absence.

Toolbox: Example of an Improvement Project Memo

Completion Date	April 21, 2007
Project Start Date	August 21, 2007
Indicator	PCP prophylaxis
Problem Statement	Currently, only 75% of patients with CD4 count less than 200 receive appropriate PCP prophylaxis, compared to the nationwide average of 92%. In the last year the performance rate declined by 15%.
Improvement Goal	The team will work to improve the statewide performance on this important prevention measure. The team should focus on increasing the number of patients with CD4 count less than 200 receiving appropriate PCP prophylaxis to 95% and above.
Team Members	Ann Cavanaugh, C.S.W. (team leader) Peter Brown Paul Sabo, M.D. Santiago Rodriguez Helen Kearney Cheryl March, R.N.
Other (Resources, Authority, Frequency of Reporting, and Ground Rules)	Team will be given time to meet. There's money for supplies or other similar expenses, but not for additional staff. Mac Martin (MIS department) will be available to help with data analysis. Team members should give a verbal report at the next QM committee meeting, September 15. All team members should be on time and no excuses.

Conducting Improvement Activities

Improvement changes are tried through many cycles of changes or pilot tests on a small-scale before committing valuable time and resources to system-wide implementation. Pilot tests are often described as Plan-Do-Study-Act (PDSA) Cycles. Selecting and planning pilot tests and evaluating test results are probably the most critical activities in quality improvement projects. Because not all changes tested in pilots result in improvements, a project team identifies promising ideas for changes, tests them on a small-scale and assesses the impact on the programmatic aspects under review. Teams plan the implementation of pilot tests to better orchestrate and guide their efforts. A planning approach increases the likelihood of task completion. Team members should strategize the following areas:

- **Scope of change.** What is the working hypothesis for the change? For how long do you want to test your changes before implementation?
- **Timetable.** What are the necessary steps and when are they completed?
- **Accountability for change.** Who will measure and follow-up on results? Who will report results?
- **Measurement.** How do you measure the success? What indicators are identified?
- **Sample size.** What is the size of the sample? How many subgrantees should be involved?

Cycles of changes allow team members to assess the effectiveness of various solutions before program-wide implementation. A pilot test is intended to be a small-scale trial of a potential solution. The team should consider the following strategies for successful pilot tests:

- **Simplicity of changes.** Keep initial changes simple and emphasize the following point: conducting additional changes allows more opportunities for learning.
- **Series of pilot tests.** Allow for multiple changes and build on the success of previous changes.
- **Short-time approach.** Reduce the test intervals to a minimum while increasingtesting cycles.
- **Clear accountability.** Ensure that the responsibilities for conducting changes are clearly defined and communicated.

Real World Tips: Conduct Successful Tests

- Quick turnaround is key—plan on conducting a series of tests.
- Always plan two or three pilot tests ahead.
- React right away—if an improvement is very obvious, make a quick decision to implement.
- Find opportunities for all staff to participate in the pilot tests.
- Reward successes of quality activities.

Team members compile data collected during the cycles of changes and compare the overall results against the goals outlined in the improvement project memo. Based on these findings, the team reaches an agreement on how to best move forward. The team should ask the following questions:

- Did the changes help us reach our improvement project goal?
- Are additional pilot tests indicated?
- Are there other changes that can be implemented to exceed our goal?

Once a decision is made that the overall results are satisfactory, the team wraps up the project and shares the findings with the QM committee.

Toolbox: The PDSA Cycle

The PDSA Cycle was developed by Walter A. Shewhart and represents a "trial-and-learning" method to test changes before system-wide implementation. Four steps are included in the PDSA Cycle:

- **Plan (Plan a change).** The team identifies a change and plans its implementation; including the number of records, timeframe, responsibilities, and predictions of results.
- **Do (Try it out on a small-scale)**. Team members test the proposed change to see whether it results in an improvement and document the expected and unexpected results.
- **Study (Observe the results).** Once the results are analyzed and reviewed, the team will need to find answers to the following questions: Did we meet our goal? What worked and what didn't? Do we need additional test cycles?
- **Act (Refine the change as necessary).** The team maximizes the impact of successful changes by increasing the sample size involving subgrantees and expanding the test cycles.

The goal of the initial PDSA Cycles is to keep the tests as small as possible. The shorter the test cycles, the more tests can be conducted and therefore, more opportunities for learning will emerge. The completion of each PDSA Cycle leads directly into the start of the next cycle. A team learns from the test and uses the new knowledge to plan the next tests. The team continues linking PDSA Cycles. Once confident of its success, the team scales up the scope of the test to increase its impact. Often, a team will test more than one change at a time, each change aimed at achieving the ultimate goal of the entire quality improvement project.

The following example should illustrate the process of the Plan-Do-Study-Act Cycle:
A project team that is charged to improve the progression rate from HIV to AIDS of newly infected individuals decides to pilot test a new flowchart that hopefully better documents new infected individuals. The team predicts a 20% increase. Initially, the team revises the clinical flow sheet and asks just one subgrantee to test the revised flow sheet during one clinic session. Once feedback is received, the flowchart is revised and tested again with three subgrantees over the course of the following week. The results are studied and more changes are made to the new flow sheet. After one more testing cycle, the revised flow sheet is implemented system-wide, ready for all subgrantees for all clinic sessions.

Toolbox: PDSA Worksheet

Organization Name:_____

Date: _____ Initiated by:_____ Cycle # _____

Purpose of this cycle:_____

PLAN: the change, prediction(s) and data collection.	
THE CHANGE:	
What are we testing?	
On whom are we testing the change?	
PREDICTION(s):	
What data do we need to collect?	
Who will collect the data?	
When will the data be collected?	
Where will data be collected?	
DO: Carry out the change/test, collect data, and begin analysis.	
What was actually tested?	
What happened?	
Observations:	
Problems:	
STUDY: Complete analysis of data. Summarize what was learned and compare to prediction.	
ACT: Take a step back and decide how to move forward.	
What adjustments to the change or method of test should we make before the next cycle?	
Are we ready to implement the change we tested?	

Real World Example: Oregon's PDSA on Communication and Information Provided to Physicians when they Report a Positive HIV Test

Part B Collaborative Demonstration Project Testing Change (PDSA) Worksheet

Date: 6/21/05 **Cycle #**: 1
Began: 6/21/05 **Completed**: 6/28/05

PLAN

What is purpose of this cycle? This cycle is the beginning of our work on one of our AIM goals (To increase the number of clients enrolling in ADAP earlier in their disease progression by 10%) and addresses the communication and information provided to physicians when they report a positive HIV test. This cycle is an assessment of the current process and will attempt to answer the following questions: (1) Is any information currently sent to physicians by Oregon's Data & Evaluation (Surveillance) staff? (2) If information is sent, what is included? (3) What ideas does the Surveillance staff have about sending information to physicians with a positive test report? (4) Do physicians treating PLWH/A know about Oregon's ADAP (CAREAssist) so they can refer their clients immediately to a payer for HIV treatment?

What additional information will we need to take action? Three things will be required: (1) A copy of the information package sent to physicians (if it is sent); (2) a meeting time to talk to the staff in Data and Evaluation; and, (3) the results of the most current CAREAssist (ADAP) provider satisfaction survey which gives us the baseline for how many physicians know about CAREAssist.

Details: Who, What, Where, When, How
Veda and Vic:
Meet with Data & Evaluation staff on 6/27/05. Veda: Get copy of package (if it is used) by 6/28/05. Donna & Annick: Review "2005 CAREAssist Case Manager and Medical Provider Satisfaction Survey" that was released on 6/22/05.

What do we expect (predict) will be the effect or outcome of the change?

- Find out what information about CAREAssist, if any, is being given to physicians for clients who test positive.
- Establish the baseline (physician knowledge of CAREAssist) for change.

If our expectation (prediction) is on target, what will be our next test/cycle or action?

- Information for physicians will be created (or revised).
- Establish a protocol to get a package of information and a CAREAssist "Quick Referral" form out to every physician in conjunction with an HIV positive test.

DO and STUDY

Was the test/cycle carried out as we planned? YES

What did we observe that was not part of our plan?
Data & Evaluation staff identified a problem with sending out packages of information to physicians, primarily that by the time the test result is reported, the window of opportunity to give a referral package to the client has passed. Also, there was a sense that they sent lots of packages to the same physicians and never saw any evidence that these packages were being given to clients. Additionally, almost half of the physicians treating PLWH/A in the state did not know about Oregon's ADAP program (even though they were identified by their clients in CAREAssist).

How did we study and understand the result? A meeting with Data & Evaluation staff and review of the provider satisfaction survey results.

How did or didn't the outcome of this test/cycle agree with our expectation (prediction)?

- Physicians aren't getting referral information about CAREAssist to newly diagnosed clients.
- There are some very good reasons why information packages are no longer sent to physicians.

- Even physicians of clients who are actively participating in CAREAssist are not familiar with CAREAssist.

What did we learn from this test/cycle? Physicians are not receiving referral information about paying for HIV treatment to give to their clients testing HIV positive and almost half of the physicians currently treating PLWH/A have not heard of CAREAssist. Data & Evaluation has tried to send information packages to physicians to give to their clients but it didn't work. No information has been gathered about why the physicians didn't use the packages previously sent.

ACT

Given the above understanding and learning, what are we going to do now?

- Perform some key information phone interviews with physicians and/or their key office staff to determine what would work and be appropriate in getting information to clients who test positive for HIV.
- Create an information package for physicians based on information received in interviews.
- Establish a protocol to get a package of information and a CAREAssist "Quick Referral" form out to every physician in conjunction with an HIV positive test.
- Include a question in the CAREAssist application about where the client heard about ADAP as another way to test the change.
- Work with AETC to include more comprehensive information about CAREAssist in their provider trainings.
- Do semi-annual mailings with information about CAREAssist to all physicians identified by clients in the CAREAssist database.

Are there forces in our organization that will help or hinder these changes? Data & Evaluation staff will need to be involved in the development of the physician referral package and protocol in order to minimize resistance to incorporating this activity into their regular response to positive reports. The Data & Evaluation staff may think that this is a waste of time because it was attempted before and apparently didn't work. Getting physicians to participate will be the primary challenge. The new Epidemiology Physician being hired by the program could provide some assistance in communicating with physicians.

Sustaining Improvements Over Time

Documenting Results

To gain buy-in from representatives with the Department of Health, subgrantees and consumers, results from improvement projects should be widely shared. Communicating this information provides a feedback mechanism on the team's work and lays the groundwork for getting "buy-in" on how best to spread and systematize changes. Use every opportunity to share these successes with internal and external stakeholders. This will also help to build future support for quality improvement activities.

Real World Tips: Secrets of Effective Communication

Use the "Four Cs" to present your project results:

Clear - Use terms that QM committee members and staff understand and relate to.

Concise - Be short and to the point.

Complete - Include all relevant information.

Correct - Ensure that all data are accurate.

Various documentation strategies can be used. Two effective strategies include:

Final project report. The final project write-up documents the improvement project results. It discusses how problems in current processes have been addressed and what results have been achieved. Typically, this write-up includes baseline data and pilot test results—both of which can be effectively conveyed through graphic displays, such as charts and

tables. The choice of report format, length, and sophistication may vary.

Storyboards. Storyboards can help teams communicate the highlights of an improvement project in a visual manner—a logical progression of boxed information that leads the reader through the main points and steps of the improvement project. It uses descriptive pictures and graphics more than words.

Real World Tips: Making your Storyboard

- Construct the storyboard as a logical progression of "boxed information."
- Lead the reader through the main points and steps of the improvement project.
- Communicate with descriptive pictures and graphics more than words.
- Use color and keep any text simple.
- Present the storyboard to the leaders with the Department of Health.
- Present the storyboard to subgrantees and consumers.

Systematize Changes

Before the team completes its project work, it is important to take the time to systematize the changes the team has meticulously tested and implemented. The goal is to institutionalize successful improvements so that they become the new "status quo" and that the gains are sustained over time.

The project team members most familiar with the processes, along with Part B program staff and subgrantees as appropriate, should work together on identifying how to sustain the new level of performance. The following elements are helpful to maintain long-term effects of implemented gains:

- **Identify a champion of change.** A staff person who has intimate knowledge of the improvements can serve as the champion of change. Staff or consumers can contact this person to ask follow-up questions or clarify certain details. The champion becomes the "human face" of the new status quo and a visual reminder to sustain changes.
- **Communicate the changes.** Steps taken to ensure the ownership of changes help make the improvement part of the fabric of the Part B program. Every opportunity should be used to promote the new status quo to individuals either at meetings, through storyboards in hallways or in mini-presentations. Changes are also clearly communicated to new staff members to integrate these improvements in their daily work. These activities send a clear message that quality activities are everyone's responsibility to keep the momentum of change going.
- **Re-measure performance level**. Key project indicators are re-measured routinely to ensure that gains have been maintained over time. The remeasurement of data should be integrated into the program's quality program and become part of the routine performance measurement process. The team should also decide on any necessary thresholds to trigger the attention of the QM committee or to reconvene the project team.
- **Educate staff to support improvements.** Some level of training will be necessary to ensure that staff under stands new tools and process changes, as well as their new roles and responsibilities in implementing the planned improvements. The scope of implemented changes dictates the type of training that is appropriate. For example, a printed worksheet of instructions or a laminated checklist hung near a workstation may suffice. Improvements that require more critical knowl edge-based tasks or complex skills may require training incorporating some degree of problem-solving and decision-making.
- **Review and/or revision of existing policies**. The project team should review and revise, if neces sary, the program's policies and procedures to ensure that new processes are documented. The team may also consider screening job descriptions of staff involved and making appropriate changes.

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. Various tutorials, Tutorial 2, 11, 12, 13, 14 and 15, outline all key areas to conduct quality improvement activities.
NationalQualityCenter/QualityAcademy/

The HIVQUAL Group Learning Guide includes several related exercises how to carry out HIV-specific quality improvement activities. Review the document and choose the most relevant workshop topics for your program.
www.HIVQUAL.org

Section 7: Building Capacity for Quality Improvement

Implementation Steps

1. Routinely train Part B staff on quality improvement
2. Develop a statewide training plan for subgrantees and other HIV providers to increase their knowledge of quality improvement
3. Widely communicate about quality improvement with all stakeholders and reach out to new stakeholders
4. Recognize individual efforts and demonstrate program successes

As State Health Departments, Part B grantees play the dual role of sponsoring their own QM program and of championing quality improvement for subgrantees and other HIV providers in the state. Therefore, the Part B quality program acts on two levels: to champion quality program within their respective HIV/AIDS program, and to build capacity for quality improvement within the HIV provider community across the entire state. The Part B program should assume the role of facilitator and promote quality improvement among HIV providers across the state.

The Part B program can serve as the driving force to align all Ryan White HIV/AIDS Program-funded providers within the jurisdiction. With the involvement of all stakeholders, including Part B staff, representatives from the Department of Health, subgrantees and consumers, a statewide "culture of quality" can be created and sustained.

Training of Part B Staff on Quality Improvement

Quality improvement has its own body of knowledge and skills that are necessary in completing project work and implementing QM strategies. Routine updates in the quality improvement field, ever changing quality expectations for the Part B program and staff turnover require routine quality improvement trainings of all Part B staff. In order to provide quality improvement training and support to subgrantees and other HIV providers, Part B staff need to be trained on how to provide effective trainings.

Core training topics may include: quality improvement principles and methodologies, how to establish an HIV-specific quality improvement structure, how to write a QM plan, data collection strategies, indicator development, how to conduct a quality improvement project, importance of leadership, and how consumers can be involved in quality improvement activities.

Real World Example: Texas Getting Staff on Board the QM Bandwagon

The Texas HIV Medication Program (THMP), the state's ADAP, plays an important role in the Part B program's overall QM efforts. QM has been incorporated into the program so that it is clear to staff that it is a priority—and an integral part of their work.

Including QM in Performance Evaluation. Including QM in the performance evaluation process sends a clear message to staff that QM is a priority for the program. Knowing that their performance review is tied to their participation and the quality of their efforts can serve as a strong motivator. Each year, staff are reviewed based on four performance standards and two optional standards, one of which is participation in QM activities. Staff can participate in QM activities in various ways, by serving on the ADAP QM committee, developing measures, or compiling data. Their participation in these activities then serves as the basis on which their performance is evaluated in this area.

Bringing Staff Up to Speed. While some staff, especially nurses, are well versed in quality, many staff needed training in the basics of QM—the major objectives, basic processes, and terminology. This was especially true for clerical and support staff who had not previously been exposed to QM concepts. In 2006, THMP conducted a Quality 101 training for staff that focused on QM basics and dispelling some of the misconceptions related to QM efforts. Once staff understood the basics, a second meeting was held that focused on gaining staff input and brainstorming about the most appropriate QM activities. Staff considered the main goals for the THMP program and what was important in terms of the provision of services to consumers—the consumer is always the ultimate focus of the program.

Toolbox - Key Quality Improvement Training Resources

- **NQC Quality Academy.** A no-cost online training course with more than 20 quality improvement tutorials, developed by the National Quality Center. Accessible via: NationalQualityCenter.org/Quality Academy
- **NQC Training-of-Trainer Program.** A training program for trainers in quality improvement, developed by the National Quality Center. For more information, contact Info@NationalQualityCenter.org or call 212/417-4730
- **HIVQUAL Workbook:** Guide for Quality Improvement in HIV Care, developed by the National HIVQUAL Project and updated 2006. Accessible via: www.hivqual.org
- **HIVQUAL Group Learning Guide: Interactive Quality Improvement Exercises for HIV Health Care Providers,** developed by the National HIVQUAL Project and updated in 2006. Accessible via: www.hivqual.org
- **Measuring Clinical Performance: A Guide for HIV Health Care Providers,** developed by the National HIVQUAL Project and updated 2006. Accessible via: www.hivqual.org
- **NQC Game Guide: Interactive Exercises for Trainers to Teach Quality Improvement in HIV Care,** developed by the National Quality Center in 2006. Accessible via: NationalQualityCenter.org
- **Quality Management:** Technical Assistance Manual, developed by HRSA/HAB. Accessible via: www.hab.hrsa.gov/tools/QM

Building Statewide Capacity for Quality Improvement

In recognition of the critical role of the Part B program to work with HIV providers across the entire state, the Part B staff needs to develop a statewide approach to build capacity for quality improvement.

The audiences include:

- HIV clinical and non-clinical providers
- Subgrantees
- QM committee members
- Representatives from the Department of Health who intersect with the Part B program (e.g., Medicaid, Epidemiology)
- Representatives across Ryan White HIV/AIDS Program Parts
- Consumers
- Funders

Real World Tips: Keeping Part B Staff Up to Speed on Quality

Informed staff members are better participants in quality activities. The following strategies can be used to keep staff informed:

- Review at regular staff meetings individual online Quality Academy tutorials.
- Invite speakers from other Part B programs to present their quality approaches at internal quality committee meetings or staff meetings.
- Routinely share available TA resources with staff.
- Include information about the QM program in new employee orientation and training and keep staff posted on new statewide quality initiatives.
- Provide a copy of this book and/or the HIVQUAL Workbook to all staff.
- Organize an annual 1-day quality training day for staff.
- Establish a 'Journal Club' to review the latest articles or successes in quality improvement.

Different strategies are required to reach each of these audiences. Main strategies to build capacity include:

- **Offerings of quality improvement trainings:** Quality improvement trainings need to be offered on a regular basis as new members join the QM committee and due to staff turnover in HIV providers and subgrantees. These trainings provide the opportunity to develop a common language and understanding of quality. A statewide training plan should be developed to ensure that all audiences are routinely educated around quality improvement.
- **On-site consultation:** To individualize TA to the unique challenges of subgrantees and other providers, the Part B program should develop an on-site TA approach. Depending on the available resources, the program may use available staff time or contract with expert consultants to provide on-site consultation.
- **Include quality improvement language in contracts with subgrantees:** Revisit the various contracts with HIV providers across the state and include specific language clearly outlining quality expectations and requirements. During site visits, Part B staff should review the existing quality infrastructure against these contractual expectations.

Real World Example: New York Quality Program Standards

The following Quality Program Standards were developed by the New York State Department of Health AIDS Institute to outline expectations to develop a sound quality program. This language is being introduced into various state-issued contracts.

'A formal quality of care program that embraces quality improvement (QI) philosophy should be developed and implemented, as part of the HIV service delivery program. The components of the HIV quality program are the following:'

A) Infrastructure for HIV Quality Program: 'The infrastructure of the quality program should be fully described in the quality plan, with a clear indication of responsibilities and accountability, and elaboration of processes for ongoing evaluation and assessment.' Discussion: Each HIV quality program should have a comprehensive 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 infrastructure 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 followup on HIV quality findings, and d) link the HIV quality program to institution's overall quality program. The HIV program should 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.

B) Staff Involvement in Quality Improvement Activities 'Staff should be actively involved in the HIV Quality Program and its quality improvement activities. The participation in the quality program should be part of job expectations. Provisions should be made for ongoing education of staff about quality improvement.' Discussion: The involvement of staff in the quality program should be integrated into job expectations and descriptions. The objectives, progress, and results of quality activities should be routinely communicated to staff to increase participation in the HIV quality program. Members of different professional disciplines and programmatic backgrounds should be included in the quality committee membership. At a minimum, annual education about quality improvement principles, HIV quality program goals and objectives, and performance measurement indicators and results should be provided to staff.

C) Performance Measurement 'Performance measurement should include clearly defined indicators that address clinical, case management and other services as prioritized by the program. A plan for follow-up of results should be outlined.' Discussion: 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 review results in quality committees. An action plan for follow-up should include implementation steps and timetable. Performance data results should be shared with staff, patients, and key stakeholders.

D) Quality Improvement Projects 'Quality Improvement activities should be conducted based on performance data results. Specific quality improvement projects should be undertaken which include action steps and a mechanism for integrating change into routine activities. Quality improvement teams should include cross-functional representation.' Discussion: The process of selection and prioritization of quality improvement activities should be clearly outlined and respond to external expectations and internal priorities. Staff should be involved in the selection of quality initiatives. A process of reviewing results of internal quality initiatives and external audits should be integrated into the HIV quality program. The quality committee should oversee and provide feedback to quality improvement projects. 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, shared among staff, and used for future planning.

E) Consumer Involvement 'Consumers should be included in quality-related activities.' Discussion: The quality program should routinely assess patients' needs and/or satisfaction, and integrate consumer feedback into the quality program. Consumers such as patients, family members, advocates, etc. should participate in the quality program.

Real World Example: New York Supports Providers through Learning Networks

The New York State (NYS) Department of Health AIDS Institute coordinates HIV Quality Learning Networks with the New York City EMA, which provide structured environments for group learning and focused quality improvement activities. The Networks are designed for HIV care providers who share a commitment to improving the quality of the care they deliver. They provide an opportunity for quality-related technical assistance TA and a rich environment for peer learning and sharing successes. This model is applicable to other jurisdictions looking to support the quality-related efforts of local service providers.

Learning Networks are designed for providers with similar circumstances and needs. For example, in New York, Learning Networks have been set up for Part A subgrantees in New York City, community health centers funded through Part C, and for addiction treatment providers funded through Part B. By focusing the Networks on a certain type of provider, technical assistance can be highly tailored to their needs, participants can engage in group projects, and the exchange of information across participants is more relevant.

The program is designed to be ongoing, with three to four face-to-face meetings per year and regular conference calls between the meetings. Participating providers are encouraged to send more than one person to the meetings, so that more than one staff person can bring skills and, as important, the commitment to quality, back to the providers. Administrators, clinicians, and quality management staff often attend as part of the providers' team.

In putting together networks, the location of providers is an important consideration as participants must be able to attend the meetings on a regular basis. If participating providers are located too far apart, it becomes less likely that their staff will attend the meetings. TA is provided at various levels through the Networks. Experienced quality improvement consultants provide both group and individual consultation as needed. An annual organizational quality assessment is conducted with staff from each participating provider program to identify quality goals for the year. Between Network meetings, quality consultants provide support and coaching in undertaking quality improvement activities and in developing the quality management infrastructure. Coaching may include areas such as conducting team meetings, the role of senior leadership, and assistance with use of specific quality improvement methods and tools.

A key aspect of the Networks is the exchange of information across peers. By bringing together similar providers, participants in the Network can share their experiences and learn from each other. Working together on a quality improvement project provides additional learning opportunities.

The whole purpose of the Networks is to bring together providers with similar experiences so that, as the name implies, a "Learning Network" ensues and the exchange of TA and experiences can continue to take place outside of meetings.

In initiating and maintaining the Networks, a strong commitment from the leadership within participating providers is necessary. From the beginning, it is important to gain a commitment from leadership to make time available to staff to participate. In maintaining this support, regular communication with provider leadership is necessary. The Learning Networks send regular updates to leadership within participating providers.

Receiving regular feedback from participants, both on the content and the logistics of the Networks, is key to ensuring that the program is meeting their needs. The AIDS Institute uses Survey Monkey, a tool for creating Web-based surveys, to obtain input. Surveys are used to identify topics of interest, update contact information, and to schedule meetings and conference calls.

Real World Tips: Planning Your Cross-Part Meeting

- Use existing cross-Part meetings to initiate discussion around QM.
- Consider the use of an external facilitator with expertise in QM for your first meeting.
- Form a planning group/coordinating group with representatives from each Part to develop the goals of meeting and to set the agenda and continue momentum after the meeting.
- Develop common QM goals, a cross-Part written QM plan and an implementation plan with assigned roles and a timeline to ensure momentum is put into action.
- Develop a final product/outcome from your initial meeting (i.e., an action plan) and use workgroups/ breakout groups during meeting to get work done.
- Have all Parts sign off on shared documents created.
- Include senior leaders from each Part to make the decision-making process easier.
- Engage important providers of HIV care who are not funded by the Ryan White HIV/AIDS Program in the QM effort in order to make it a truly statewide improvement effort.
- Include consumer input in the statewide QM effort to strengthen efforts.

Real World Example: Michigan- Using Your Statewide Meetings for Cross-Part Alignment on Quality

In January 2007, Michigan used their annual statewide meeting to align QM goals across Ryan White HIV/AIDS Program-funded Parts in the state and to develop and a comprehensive cross-Part QM plan. As previous statewide all Part meetings did not have a QM focus, NQC Technical Assistance (TA) was requested to help facilitate the planning process and the meeting.

Planning the Meeting

With the help of NQC consultants, a planning committee was formed consisting of representatives from Part A, B, and D programs. The planning committee reviewed previous statewide meetings, which helped to provide context to the development of goals. Three specific goals for the meeting were identified by the planning committee:

- Gain an understanding of each other's QM programs
- Reach agreement on key areas to improve coordination/ share work
- Propose a work plan for collaboration

NQC helped to facilitate the meeting, and to assist in the agenda development as well as create an indicator matrix to display, side-by-side performance measures that each of the programs were currently collecting data on.

The group expressed a strong desire to move beyond sharing information to making practical steps to align efforts and reduce confusion and duplication of effort for their contracted providers and for their QM teams. Priorities identified were: performance measurement, consistency/alignment, and coordinated capacity building.

Meeting Highlights

- Introduction and Review of Quality Principles. The Part D program manager, who had recently returned from the NQC TOT, led a 45 minute brief review of quality principles for the group using materials from the TOT, including definitions of quality, HRSA expectations, quality assurance vs. quality improvement, and the meaning of "indicator" and "measure."
- Identifying Commonalities and Differences The participants then self-divided into two work groups, one to focus on performance measurement and data, and one on capacity building and collaboration. Each group had an `assigned series of focus questions to be answered.

Performance Measurement and Data Work Group:
The Data Work Group reviewed the indicator matrix and identified the common indicators across Parts. Of these, the group then identified which indicators HRSA was likely to require and for which indicators all participating agencies could collect data. Finally, the group selected three candidate measures to focus on and use jointly for the coming year and several others that were promising but needed further development. The group noted that all programs were already working on Pap improvement programs, and that these strategies should be shared across Parts.

First Priority Measures:

- HIV monitoring – CD 4 test every 6 months
- Annual Pap test for women
- Adherence

Capacity Development, TA and Training Group
The group began by identifying which provider/subcontractors were common to the EMA and the Part B, C and D systems and existing opportunities for training of provider staff were listed. The group then identified training topics they suspected providers were in need of and brainstormed and prioritized a list of opportunities for collaboration and alignment. Two training topics the group felt were obviously needed and they prioritized in the coming year were QM 101 and using CAREware and other data systems for quality.

Training Needs:

- Knowledge: QM 101, i.e., quality language, quality assurance vs. quality improvement, using data
- Skills: Choosing an improvement project, communicating about QM within an organization, collecting and using data, constructing QM queries in CAREware and other data systems, practical examples of PDSA Cycles
- Attitude: QM "buy-in"

Cross-Part TA and Collaboration Opportunities

- Create/adapt cross-Part QM training needs assessment and a list of available training resources, such as on-line curricula, to be disseminated to all providers.
- From the needs assessment and training resource inventory, identify what is both needed and not currently available, and develop cross-Part QM trainings to be delivered jointly to providers from any Part.
- Develop similar/identical quality language across Parts for use in RFPs, contracts, and report formats.

For the future:

- Develop unified Standards of Care

Big Picture Synthesis
The whole group reassembled to review the small group discussions and decide which opportunities to work on in the coming year. Each small group's conclusions were discussed and agreed to by the group of the whole. Detailed work plans to accomplish the goals for this year were developed and reviewed by the group as a whole. The group agreed to reconvene six months later to continue discussions.

Real World Example: Educating Frontline Staff about Quality in Iowa

In 2001, Iowa's Part B program initiated the process of developing statewide case management standards. Initially, subgrantees were resistant to the process-they preferred to utilize their existing processes. By soliciting input from frontline case managers and educating them about the importance and usefulness of QM activities, the Part B program was able to move the process forward. The statewide standards became effective in April 2004. Since then, standardized forms have been developed and are now in use.

During the development process, it was important to educate frontline staff about the importance of QM. They needed an understanding of the "big picture"— how the statewide standards would fit into overall QM activities — and the benefits that could result from such activities. It was important that these discussions with case managers were a two-way process. While they learned about QM, they also provided feedback to the Part B program about the proposed standards and their implementation.

The interactions with case managers took two forms. During annual site visits to subgrantees, the Part B program coordinator met with both administrators and case management staff. In these visits, QM was discussed, as were ways that subgrantees could carry out quality improvement efforts. The visits provided an opportunity to acknowledge existing efforts, identify strengths and weaknesses, and suggest areas for improvement. Putting QM in this context helped frontline staff move past some of their negative perceptions related to QM.

The informal training during site visits was complemented by annual capacity building meetings for case managers. The meetings are mandatory for case managers and at least one administrator from each subgrantee must attend. QM became a regular item on the meeting agenda. Presentations at the meetings ensured that everyone received key information and team building activities helped ensure that attendees processed the information.

On an ongoing basis, staff turnover presents a training challenge. To address this, the QM subcommittee of Iowa's joint prevention and care planning committee holds a 1-day training once a year for new case managers and administrators. The training focuses on the Ryan White HIV/AIDS Program and incorporates basics on QM.

Creating Communication Pathways

An open flow of communication between all stakeholders involved in the quality program, including Part B staff, QM committee members and subgrantees, helps to ensure steady progress toward established goals. There are a variety of ways to maintain the flow of information. These include newsletters (both email and hardcopy), listservs, and reports. It is important to remember when communicating that we are all constantly inundated with information. Look for ways to make it as relevant as possible to the target audience and keep it as short, and to the point as possible.

Real World Example: Keeping People Informed of QM Efforts in Oregon

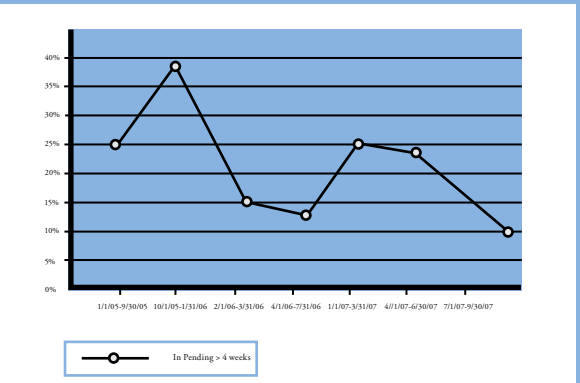
Oregon's HIV Care and Treatment Program keeps stakeholders informed of quality-related efforts through various methods. These efforts are integral for maintaining interest in quality activities.

CAREAssist (ADAP) quality improvement staff receive updates every couple of months. Information on a few key measurements is provided since staff members do not have time to read a long report. Over the course of a year, staff members eventually receive information on all measures.

Subject Header: QI? Eeek!
To: The CAREAssist Staff
From: Donna Yutzy, Consultant
Date: 7/28/08
Re: HOW ARE WE DOING? Glad you asked....

1. **Pending More than 4 Weeks:** There has been a marked improvement in the number of clients in "pending" status more than 4 weeks.

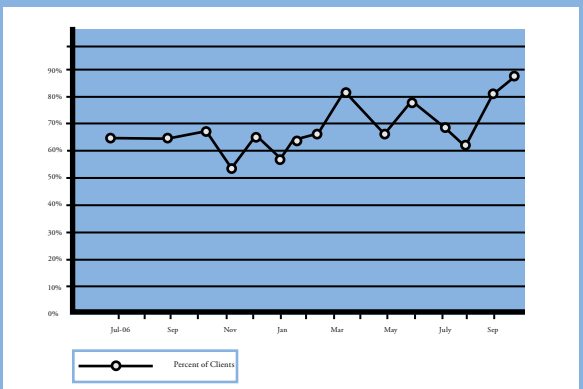
Graph #1: Percent of new applicants in pending status more than 4 weeks



Comments: This is primarily impacted by delays in clients getting signed up with OMIP. Staff has been more closely following clients in "pending" status and are intervening more frequently to help reduce the amount of time before activation in the program. Significant improvement in this area is noted.
QI Goal: 10% or less

2. **Processing New Applications Within Two Weeks:** This data also shows significant improvement. Here are the results: Graph #5: Percent of new applicants' status noted in database within 2 weeks of CAREAssist receiving application.

Graph #5: Percent of new applicants' status noted in database within 2 weeks of CAREAssist receiving application.



Comments: This measurement looks strictly at the length of time between the date the application was received and when anything is next entered in the database for that client. It does not measure length of time before a client and/or case manager have received communication (email, telephone or mail). HRSA's outcome goal for this measure is 80%. This area shows great improvement in the past two months. Staff has been really focusing on improving in this area.
QI Goal: 80%

Incorporating New Stakeholders in QM Activities

Over time, membership on the QM committee will change as old members leave to take on new positions and new members join to take their place. As the committee's work evolves and priorities shift, consider reaching out and involving new stakeholders. These can include consumer groups, prevention programs, other infectious disease such as hepatitis or tuberculosis, and providers of key support services, such as addiction treatment. QM activities can also be expanded to other aspects of the Part B program, such as ADAP.

Real World Example: New York State - Putting Your Consumer Advisory Committee to Work

The New York State Quality of Care Consumer Advisory Committee was formed in July 2002. The Committee provides a vehicle for consumers to communicate their ideas and concerns about quality of care in New York State to the AIDS Institute. It is composed of up to 25 HIV-infected and affected consumers representing diverse communities affected by the HIV epidemic in New York State. Special considerations are given to geography, gender, age, race/ethnicity, and exposure category.

The Consumer Advisory Committee plays an active role in the Part B program's quality-related activities. Quality-related issues are discussed during quarterly meetings or conference calls as needed. Key areas where the Consumer Advisory Committee provides input are discussed below.

Assist in Development and Refinement of Clinical Indicators

Committee members review clinical indicators from a consumer perspective. An example of the nature of their input is changes that were made to an indicator on mental health. The consumers argued for the importance of this measure and outlined key elements which were incorporated when defining the mental health indicator.

Review of Clinical Guidelines

At least two consumers review any clinical guidelines before they are released. Usually their input focuses on making the guidelines more consumer friendly (e.g., modifying language to make easier to understand) or to help clinicians be more sensitive in their interactions with patients. Providing clinicians with guidance when they raise sensitive issues such as mental health or secondary prevention can aid clinicians as they address these with their patients.

Provide HIV Quality of Care Training and Technical Assistance to Peers

Members of the consumer advisory committee have been trained to deliver a 3-hour workshop entitled "Making Sure Your HIV Care Is the It Best Can Be" to educate their peers about HIV quality of care. The purpose of the workshop is to allow consumers to identify what is most important to them in their HIV health care, judge the quality of care they are receiving, appreciate what their peers consider to be the most important qualities of HIV care, describe measures used to evaluate the quality of HIV clinical care, develop an understanding of the potential uses and limitations of quantitative performance measures as an aid to assessing quality HIV care, and to develop an individual action plan that will help consumers improve the quality of HIV care they receive. Find this resource at NationalQualityCenter.org.

Address Regional Issues

Consumers who are active in the state's regional consortia are recruited to serve on the statewide Consumer Advisory Committee. Their involvement in consortia helps members stay in touch with other consumers in their region. Members serve as a link to what is going on at the local level and can bring issues to the attention of the Part B program. For example, there was a perception that HIV-related mortality was increasing in upstate New York. The Committee brought this to the attention of the Part B program and an AIDS Mortality Workgroup including providers and consumers was established in the Rochester region. The workgroup found that co-morbidities were responsible for the increase and not the quality of HIV care or another factor.

Address the Needs of Emerging Populations

The Committee can help to bring the needs of specific populations to the attention of the Part B program and providers. For example, the Committee recommended that more information was necessary on the needs of young people (ages 16 to 24) living with HIV. To gain the input of young people, a discussion group was held in February 2008 that included approximately 30 people. The group provided insight into the care and support needs of this population. Committee members helped to recruit participants for the discussion group.

General Consumer Committee Goals

- Engage Committee members in discussions about quality of care issues that can effectively empower consumers in their relationships with providers.
- Provide input into the AIDS Institute's Quality of Care Program, including, but not limited to, performance measurement, quality improvement projects, quality infrastructure requirements, and targeted consumer and provider initiatives.

- Inform and educate committee members and their represented groups about current and future quality initiatives of the AIDS Institute's HIV Quality of Care Program.
- Identify Committee representatives for AIDS Institute's Quality of Care Advisory Committees who will voice the ideas and concerns of the Committee.

Celebrating Success

Be sure to celebrate your successes! Letting stakeholders, subgrantees, and frontline staff know about your successes can help sustain QM efforts and maintain interest. It can also convey the importance of QM activities and how they ultimately improve the quality of care received by consumers.

While it is important to let stakeholders and others know about how your efforts have improved the quality of HIV care in your state, it is also important to celebrate the success of those involved in QM efforts—whether it is the development of your first QM plan, 100 percent submission of requested data by frontline staff, or recognizing the contribution of QM committee members as they cycle off the committee.

Real World Tips: Celebrate Success

- Build excitement for quality by publicizing success stories in internal newsletters and journals.
- Mount success storyboards openly so that providers and patients can see them.
- Establish annual awards for quality improvement.
- Report successes to funders and in reports to internal and external councils.

QM Resource Section:

The NQC Quality Academy is a no-cost online training course on quality improvement. This resource can be used to teach staff and providers around quality. NationalQualityCenter.org/QualityAcademy/

The HIVQUAL Group Learning Guide includes the relevant training content for more than 20 quality improvement workshops. www.HIVQUAL.org

A Guide to Consumer Involvement: Improving the Quality of Ambulatory HIV Programs was developed by the New York State DOH AIDS Institute with the New York State Quality Consumer Advisory Committee. It contains best practices collected from New York on engaging consumers in quality efforts and is available at NationalQualityCenter.org.

Appendix A: Part B Collaborative Demonstration Project

The Part B Collaborative Demonstration Project: Improving Care for People Living with HIV Disease involved eight states working together intensely for 18 months. During this time, Collaborative participants developed and implemented QM plans. Support was provided by the NQC through three Learning Sessions and by facilitating continual contact between the participants and the collaborative leadership team and faculty members through email, a dedicated website, and conference calls. Participating states included: Alabama, Georgia, Florida, Michigan, Missouri, Ohio, Oregon, and Washington, DC.

Part B Collaborative Domains

Many opportunities exist to improve the complex systems of care integral to the provision of comprehensive HIV/AIDS services. The multifaceted nature of the Part B environment often results in less than optimal coordination and collaboration among grantees in local communities. To focus on improving these complex relationships, a Vanguard Group of leaders and experts in the Part B community was convened on November 30, 2004 in Washington D.C. The group held a dialogue on the major issues facing Part B grantees with respect to QM. The following four core themes emerged as priorities:

- Alignment across jurisdictions and services to support a common vision of service delivery and quality of services;
- Data and information systems (including understanding outcomes and linking these to data management);
- Access to services and retention of clients; and
- Cost containment and managing resources.

Focusing on the above four themes, also called domains, the overarching purpose of the Collaborative was to improve the quality of care for people living with HIV in the state or jurisdiction. Through creating an effective and actionable quality management plan, and assuming a direct role in support of quality improvement activities in the state or jurisdiction, Collaborative participants conceptualized and implemented a quality management program, and developed a supporting infrastructure across the defined service area that was consistent with legislative requirements and guidance expectations for Part B. The domains are described below.

Alignment Across Jurisdictions and Services:

The nature of the Ryan White HIV/AIDS Program creates an environment where there are different grants awarded under the various Parts, each with their own structure and reporting requirements. Despite these differences, however, the overarching goal for clients is the same: seamless access that incorporates all essential services. The ideal care system would have no gaps in services, smooth handoffs between service providers and would be without redundancy or waste, achieving optimization of available resources. The problem can be articulated:

- How can program services, expectations, roles and responsibilities be aligned to provide seamless care for the client?
- How can measurements and reporting requirements be structured to encourage coordination of high quality services without duplication of effort?

Numerous opportunities to better align the many elements of the care environment exist. These include efforts to work across Parts to engage all stakeholders, thus achieving buy-in to care improvement and quality management strategies. This alignment could occur at many levels; for example, local level contractor buy-in leading to meaningful linkage agreements among providers for service referrals and a uniform process for obtaining client consent for sharing information among providers. Providers and insurers might be convened by the State Health Department to address important care and systems issues. These efforts to visualize a more effective and integrated health care system and to better align services under different jurisdictions could ultimately have a positive effect on quality of care at the point of service.

Integration of Data and Information Systems:

The lack of alignment in the environment and the complexity of the players are mirrored by disparate information systems. Sharing of key data elements and information poses substantial challenges. At a clinical practice level this is manifested in the lack of shared information relevant to the care of a patient between different care teams and case managers. At the broader level, population data are not commonly shared among communities and among strategic partners that would lead to improved clinical service delivery while safeguarding precious resources. An opportunity exists to create coordinated data sharing within states and jurisdictions, and across Parts and health care.

The interpretation and use of outcome data is critical to any improvement initiative, and inextricably linked to improved data and information systems. At present there is no consensus about critical measures that can be used to drive improvement across communities. Linking data to feedback on performance is a key principle in performance improvement. The lack of alignment of measures within grant programs and across funding entities (including philanthropic) contributes to the fragmentation. An opportunity exists for coordinated outcomes assessment and achieving a consensus as to useful and appropriate measures that lead to improved performance.

Improving Access to Care and Retention of Clients:

Access to care is a prerequisite for providing care that reflects standards of care. Lack of timely access to HIV/AIDS screening contributes both to increased burden of disease at the time of diagnosis and to spread of infection. Inadequate access results in delayed receipt of preventive and therapeutic services. This delay further contributes to morbidity and mortality attributable to HIV and to the cost of care. Waiting lists for drug assistance programs and issues unique to rural settings require special focus to ensure equal access among all groups of people with HIV. Opportunities to share best practices to improve access to HIV screening, primary health care services, and essential medications should be maximized.

Retention of clients is a major issue in most communities and is consistently identified by providers as a major priority area of focus to improve care. Many factors contribute to sporadic care, including economic status of clients, changing eligibility criteria for entitlement programs, perceived stigma, and inadequate supportive services such as transportation and housing. Many communities lack tracking systems for clients or have not implemented systems to proactively reach out to clients who are not fully engaged in care. Missed visits result in diminished continuity of care, and result in poor adherence to treatment, which leads in turn to poor health outcomes and can lead to increased community prevalence of HIV drug-resistant strains. Changes in this area would not only improve quality, but also improve client satisfaction and lead to more efficient use of limited resources.

Optimization and Management of Resources:

All systems and organizations are faced with challenges managing resources in an environment of cost reduction and constrained budgets. At the same time, innovations in idealized design, lean thinking and care delivery redesign provide opportunities to assist systems with managing their business case more effectively. In addition, personnel are among the most valuable and expensive resources in any system or organization. Improved management of human resources represents a huge opportunity to contain costs and also improve staff and client satisfaction. One example in particular is to more efficiently recruit and retain personnel. Best practices in workforce management link to productivity and the quality of the care delivery system. An opportunity exists to create a learning community where these best practices can be shared to improve services while managing with fewer resources.

Detailed descriptions of the Part B Collaborative measures can be found in Appendix E.

Appendix B: Low Incidence Initiative Demonstration Project

The multifaceted nature of Part B environments along with limited resources and other unique challenges faced by states with lower HIV incidence often result in less than optimal coordination and collaboration among grantees in local communities. To better understand the needs and challenges that these states face in developing QM programs, a meeting was convened with representatives from 16 low incidence states (LIS), HAB representatives and NQC staff on June 26-27, 2006 in Washington DC. The group held a dialogue on the major barriers faced with respect to QM in these states, brainstormed possible solutions and made recommendations to HAB and NQC for supporting their QM efforts. A report was developed to summarize the meeting outcomes and recommendations and used to develop an appropriate response to assist LIS in developing and sustaining their QM programs.

Methods

In March 2007, 17 LIS Part B programs joined a 12-month initiative to develop or refine QM programs in accordance with the Ryan White HIV/AIDS Program legislation. Participating states included: Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

Participating states committed to the following outcomes:

- Completion of a comprehensive written quality management plan.
- Development and/or strengthening of a quality management committee within their state/jurisdiction.
- Ability to regularly collect, trend and report quality data.
- Initiation of at least one improvement project within the 12-month period.
- Improvement in the quality management program core criteria self-assessment.

During the initiative, participating teams took part in one face-to-face meeting and maintained continual contact with each other and faculty members through conference/web-conference calls, listserv discussions, and email. Participants used these opportunities to discuss common issues and share ideas and best practices.

Low Incidence Initiative Measures

There are 3 Required Measures for all states participating in the Low Incidence Initiative. Two other measures must be chosen from the Optional Measures listed below for a total of 5 measures that each state will report on bi-monthly. The 2 Optional Measures cannot be from the same category (i.e., both ADAP, Case Management, or clinical).

Required Measures

REQUIRED #1:

Percent of Ryan White funded clients who have a CD4+ test done at least every six months.

Numerator:
Then number of clients with CD4+ tests measured at least twice in the past 12 months, at least 6 months apart.

Denominator:
All active clients who have received a Ryan White funded service within the past 12 months from the reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the total number active, living clients within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least two 2 CD4+ tests, at least 6 months apart (N). Finally divide N by D and multiply the result by 100%.

REQUIRED #2:

Percent of applying state ADAP clients approved/denied for ADAP services within two weeks of ADAP receiving a complete application.

Numerator:
The number of ADAP applicants who were approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application.

Denominator:
The number of complete applications that the ADAP received during the 2-month reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of complete applications that the state ADAP received during those 2 months CDJ. Then from this group, count the number of ADAP clients that were approved or denied for ADAP services within two weeks of the state ADAP receiving their application CNJ. Finally divide N by D and multiply the result by 100%.

REQUIRED #3:

Percent of clients with at least two general HIV medical care visits in the last 12 months who are enrolled in Case Management (CM).

Numerator:
The number of clients with 2 general HIV medical care visits in the last 12 months who are enrolled in CM.

Denominator:
The number of clients actively enrolled in case management within the last twelve months.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of clients actively enrolled in CM within the last twelve months i.e. their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least 2 general HIV medical care visits in the last 12 months (N). Finally divide N by D and multiply the result by 100%.

Optional Measures: ADAP

OPTIONAL ADAP #1:

Percent of ADAP enrollees re-certified for ADAP eligibility criteria at least every six months.

Numerator:
Number of all ADAP clients who were due for re-certification and that have been re-certified.

Denominator:
Total number of ADAP clients who were due for their six-month re-certification within the reporting months.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of ADAP enrollees who were due for their six-month re-certification within the 2 reporting months (D). Then from this group, count the number who have been re-certified (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL ADAP #2:

Percent of active clients who are inappropriately enrolled in both Medicaid and ADAP.

Numerator:
The number of active clients who are inappropriately enrolled in both Medicaid and ADAP.

Denominator:
The number of active clients who are enrolled in both the Medicaid and ADAP databases.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of active clients who are enrolled in both the Medicaid and ADAP databases. Then from this group, count the clients who are inappropriately enrolled in both. Finally divide N by D and multiply the result by 100%.

OPTIONAL ADAP #3:

Percent of active adolescent and adult clients in ADAP with AIDS who are prescribed HAART.

Numerator:
The number of active adolescent and adult clients in ADAP with AIDS who are prescribed HAART.

Denominator:
The number of active adolescent and adult clients in ADAP with AIDS.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of active adolescent and adult clients in ADAP with AIDS (D). Then from this group count the number who are prescribed HAART CNJ. Finally divide N by D and multiply the result by 100%.

Optical Measures: Case Management

OPTIONAL Case Management #1:

Percentage of case managed clients with HIV infection who have a Case Management Care Plan documented and updated at least every 6 months.

Numerator:
Number of active case managed clients whose Care Plan was due for a 6-month review and had documentation of a Case Management Care Plan being reviewed.

Denominator:
Number of active clients in case managed whose Care Plan is due for a 6-month review.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of active CM clients who are due for a 6-month review of their Care Plan (D). Then from this group count the number of CM clients whose Care Plan was reviewed and

updated (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Case Management #2:

The percent of active case management clients with HIV infection who have a CD4+ test done at least every 6 months.

Numerator:
The number of active case management clients who had at least 2 CD4+ test done within the last 12 months.

Denominator:
The number of active case management clients enrolled in the past 12 months.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of clients actively enrolled in CM within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients with at least 2 general CD4+ tests done in the last 12 months (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Case Management #3:

The percent of case management enrollees re-certified for case management eligibility criteria at least annually.

Numerator:
The total number of clients whose 12 month anniversary falls within the 2-month reporting period, who have documentation of eligibility recertification.

Denominator:
The total number of clients actively enrolled in case management in the past 12 months.(ie., if their 12-month anniversary falls in the 2 month reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of active CM clients whose 12 month anniversary appears during the reporting months (D). Then from this group count the number of CM clients with current eligibility documented (N). Finally divide N by D and multiply the result by 100%.

Optional Measures: Clinical

OPTIONAL Clinical #1:

Percentage of Ryan White funded clients who have a medical visit in an HIV care setting at least every 6 months.

Numerator:
Number of clients who were seen by an MD, PA or advanced practice nurse in an HIV care setting at least twice in the past 12 months, <6 months apart.

Denominator:
Number of clients with a Ryan White service who were seen within the past 12 months from the reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the number of clients, with at least one Ryan White service, seen within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients who were seen by an MD, PA or advanced practice nurse in an HIV care setting at least twice in the past 12 months, <6 months apart (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical #2:

Percentage of Ryan White funded clients with a CD4+ **count below 200/µL** who were prescribed PCP prophylaxis.

Numerator:
Number of clients who were prescribed PCP prophylaxis at the time when the CD4+ count was below 200/µL.

Denominator:
Number of clients who have received a Ryan White funded service in the past 12 months, and had a CD4+ count below 200/µL.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of active clients within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months with a CD4+ count less than 200/µL (D). Then from this group, count the number of clients who were prescribed PCP prophylaxis at the time when the CD4+ count was below 200/µL (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical #3:

Percentage of Ryan White funded adolescent and adult clients with AIDS who are prescribed HAART.

Numerator:
Number of clients who were prescribed a HAART regimen within the past 12 months.

Denominator:
Number of adolescent and adult clients who have a diagnosis of AIDS (history of a CD4+ count below 200/µL or other AIDS-defining condition), and were seen within the past 12 months from the reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of adolescent and adult clients with a diagnosis of AIDS who were seen within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of clients who were prescribed a HAART regimen within the past 12 months (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical #4:

Percentage of pregnant women with HIV infection who are on antiretroviral therapy.

Numerator:
Number of pregnant clients who were placed on an appropriate antiretroviral therapy regimen during the antepartum period.

Denominator:
Number of pregnant clients who were seen within the past 12 months of the reporting period.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of pregnant clients who were seen within the last twelve months, i.e., their 12-month anniversaries appear within the 2 reporting months (D). Then from this group, count the number of pregnant clients who were placed on an appropriate antiretroviral therapy regimen during the antepartum period. (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical #5:

Percent of individuals newly reported with HIV infection who also have AIDS.

Numerator:
The number of individuals newly reported with HIV infection who also have an AIDS diagnosis.

Denominator:
The number of individuals newly reported with HIV infection.

Sampling Plan:
At the end of the 2-month reporting period, count the total

number of individuals newly reported with HIV infection for the reporting period (D). Then from this group count the number who have an AIDS diagnosis (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical #6:

Percent of individuals newly reported with HIV infection (not AIDS) who progress to AIDS diagnosis within 12 months of HIV diagnosis.

Numerator:
The number of individuals who progress to AIDS diagnosis within 12 months of HIV diagnosis.

Denominator:
The number of individuals newly reported with HIV infection (not AIDS).

Sampling Plan:
At the end of the 2-month reporting period, count the total number of individuals newly reported with HIV infection (not AIDS) that are twelve months from diagnosis (D); then from this group count the number of individuals who progressed to AIDS diagnosis within 12 months (N). Finally divide N by D and multiply the result by 100%.

OPTIONAL Clinical # 7:

Ratio of individuals who die within 12 months of HIV diagnosis to the number of individuals newly reported with HIV infection.

Numerator:
The number of individuals who die within 12 months of HIV diagnosis.

Denominator:
The number of individuals newly reported with HIV infection.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of clients newly reported with HIV infection that are twelve months from diagnosis (D). Then count the number of clients who die within 12 months of HIV diagnosis: (N). Finally divide N by D.

OPTIONAL Clinical #8 :

Percent clients with at least two general HIV medical care visits in the last 12 months with at least one visit in the first six months and at least one visit in the second six months of the 12 month period.

Numerator:
The number of clients with at least one HIV medical care visit in the first six months and at least one in the second six months of the last 12 months.

Denominator:
The number of clients with at least one visit within the last twelve months.

Sampling Plan:
At the end of the 2-month reporting period, count the total number of clients with at least one visit within the last twelve months (D). Then from this group count the number of clients with at least two general HIV medical care visits in the last 12 months. Then from this group count the number of individuals with at least one medical care visit in the first six months and one in the second six months (N). Finally divide N by D; multiply by 100%.

OPTIONAL Clinical #9:

Percent of clients with at least two lab tests (CD4 or VL) in the last 12 month with at least one lab test in the first six months and at least one identical lab test in the second six months of the same 12 month period.

Numerator:
The number of clients with at least one lab test (CD4 or VL) in the first six months and at least one identical lab test in the second six months of the last 12 months.

Denominator:

The number of clients with at least one visit within the last twelve months.

Sampling Plan:

At the end of the 2-month reporting period, count the total number of clients with at least one visit within the last twelve months (D). Then from this group count the number of clients with at least two identical lab tests (either two or more CD4 or two or more VL) in the last 12 months. Then from this group count the number of individuals with at least one of the identical lab tests (CD4 or VL) in the first six months of the year and one of the same lab tests in the second six months of the year (N). Finally divide N by D and multiply the result by 100%.

Appendix C: Quality Management 2008 Part B Guidance

Quality Management Section, 2008 Part B Guidance

The following is language from the 2008 application guidance for Part B grantees. It is reflective of HAB's quality-related requirements for Part B grantees.

Clinical Quality Management

The purpose of this section is to describe the State's/Territory's overall clinical quality management program for Part B (including ADAP) and to describe how the results of the State's/Territory's clinical quality management activities are being or have been used to improve service delivery in the State/Territory.

Clinical Quality Management (CQM) data play a critical role in helping to identify needs and gaps in services as well as in helping to ensure the delivery of quality services to clients. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the State/Territory's planning process and ongoing assessment of progress toward achieving program goals and objectives. It should also be used by the grantee to examine and refine processes for administering the grant at the programmatic and fiscal level.

HAB has established the following minimum expectations of Ryan White HIV/AIDS Program grantees regarding clinical quality management. At a minimum, grantees must have:

1. Established and implemented a clinical quality management plan;
2. Established processes for ensuring that services are provided in accordance with DHHS treatment guidelines and standards of care (as outlined by the State/Territory); and
3. Incorporated quality-related expectations into Requests for Proposals (RFPs) and State/Territory contracts, including contractors/subcontractors at the consortia level.

Note: HRSA's expectations of Ryan White HIV/AIDS Program grantees with respect to improving the quality of care and establishing clinical quality management programs may be found online at: http://hab.hrsa.gov/special/qualitycare.htm. HRSA technical assistance in selecting appropriate service- and client-level outcomes is also available online at: http://hab.hrsa.gov/tools.htm or http://careacttarget.org.

a. Description of Clinical Quality Management Program

i. Provide a narrative of the State's/Territory's overall clinical quality management program including descriptions of the following:

- CQM program structure;

- Overall vision/mission and goals of the clinical quality management program;
- What percentage of FY 2007 Part B funds were allocated to clinical quality management;
- Roles and responsibilities of staff members or committees overseeing and managing the quality management activities, including the allocation of resources; and
- Process that has been established to evaluate the quality management program and activities that have been implemented to assess the quality of services provided by providers and/or subcontractors.

• Specific indicators that are being monitored for core medical services, including how these indicators are measured; and
• Data collection strategy including how data are collected, what data have been collected to date, and the results.

ii. Describe how the data have been used to improve or change service delivery in the State. Include the following:

• Discussion of quality improvement activities that have been undertaken to improve service delivery and what improvements have been shown, and
• How have clinical quality efforts been used by planning bodies in the priority setting and resource allocation process within the State.

b. Planned Quality Activities

i. Describe goals and objectives for FY 2008 and any plans for improvements to the State/Territory's clinical quality management activities or ADAP quality management program.

c. Description of ADAP Quality Management Program:

i. Describe how the data collected have been used to improve or change service delivery in the State/Territory. Include the following:

• How the ADAP Advisory Committee utilizes the information;
• How does the State/Territory make decisions; to add new FDA approved drugs while ensuring that ADAP funds are not depleted before the end of the year. Please describe us of any tools used to make these decisions.
• How the ADAP Advisory Committee develops Standard of Care and/or best practices, for the medication distribution component. The ADAP Advisory Committee should work in the creation of by-laws to govern the Committee, as well to establish a schedule for meetings; and
• How the Grantee works closely with the AETC (AIDS Education Training Center) to develop continuing medical education program(s) for all health care practitioners to ensure that clients receive medication therapies with the current DHHS Treatment Guidelines.

Appendix D: HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

Performance Measure: ARV Therapy for Pregnant Women	**OPR Measure:** #17
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy	
Numerator:	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester
Denominator:	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year
Patient Exclusions:	1. Patients whose pregnancy is terminated 2. Pregnant patients who are in the 1st trimester and newly enrolled in care during last three months of the measurement year
Data Element:	1. Is the client HIV-infected? (Y/N) 2. If yes, is the client female? (Y/N) 3. If yes, was she pregnant during the reporting period? (Y/N)
Data Sources:	• Program Data Report, Section 5, Item 53 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic database • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.
Outcome Measures for Consideration:	• Rate of perinatal transmission in the measurement year • Number of events of perinatal transmission in the measurement year

Basis for Selection and Placement in Group 1:

Treatment recommendations for pregnant women infected with HIV-1 have been based on the belief that therapies of known benefit to women should not be withheld during pregnancy unless there are known adverse effects on the mother, fetus, or infant and unless these adverse effects outweigh the benefit to the woman. Antiretroviral therapy can reduce perinatal HIV-1 transmission by nearly 70%.[2] Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Public Health Service Guidelines:

Health-care providers considering the use of antiretroviral agents for HIV-1 infected women during pregnancy must take into account two separate but related issues:

- Antiretroviral treatment of maternal HIV-1 infection, and
- Antiretroviral chemoprophylaxis to reduce the risk for perinatal HIV-1 transmission

The benefits of antiretroviral therapy for a pregnant woman must be weighed against the risk of adverse events to the woman, fetus, and newborn. Although ZDV chemoprophylaxis alone has substantially reduced the risk for perinatal transmission, antiretroviral monotherapy is now considered suboptimal for treatment of HIV-1 infection, and combination drug regimens are considered the standard of care for therapy. Initial evaluation of an infected pregnant woman should include an assessment of HIV-1 disease status and recommendations regarding antiretroviral treatment or alteration of her current antiretroviral regimen.

This assessment should include the following:

- Evaluation of the degree of existing immunodeficiency determined by CD4 T-cell count,
- Risk for disease progression as determined by the level of plasma RNA,
- History of prior or current antiretroviral therapy,
- Gestational age, and
- Supportive care needs.

Decisions regarding initiation of therapy should be the same for women who are not currently receiving antiretroviral therapy and for women who are not pregnant, with the additional consideration of the potential impact of such therapy on the fetus and infant. Further, use of ZDV alone should not be denied to a woman who wishes to minimize exposure of the fetus to other antiretroviral drugs and therefore, after counseling, chooses to receive only ZDV during pregnancy to reduce the risk for perinatal transmission.[1]

References/Notes:

[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.
[2] Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States (http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf)

Performance Measure: CD4 T-cell count | **OPR Measure:** #2

Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year

Numerator:	Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year
Data Element:	2. Is the client HIV-infected? (Y/N) 3. If yes, did the client have a CD4 count test conducted during the reporting period? (Y/N) a. If yes, list the quarters of these tests
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[2] National HIVQUAL Data: [3]

	2003	2004	2005	2006
Top 10%	87.2%	87.7%	90.3%	87.5%
Top 25%	74.2%	78.0%	76.6%	78.8%
Median*	61.0%	62.7%	63.9%	62.5%

Outcome Measures for Consideration	• Rate of opportunistic infections in the measurement year • Rate of clients with progression to AIDS in the measurement year • Mortality rates

Basis for Selection and Placement in Group 1:

The CD4 T-cell count plays a vital role in determining the staging of HIV disease and indicating the need for prophylaxis against opportunistic infections. It continues to be used in decisions regarding initiation or adjustment of antiretroviral treatment.

The most recent CD4 T-cell count is the strongest predictor of subsequent disease progression and survival, according to clinical trials and cohort studies data on patients receiving antiretroviral therapy.[4]

Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Public Health Service Guidelines:

"In general, CD4 T-cell count should be determined every three to six months to (1) determine when to start antiretroviral in patients who do not meet the criteria for initiation; (2) assess immunologic response to antiretroviral therapy; and (3) assess the need for initiating chemoprophylaxis for opportunistic infections." [3]

References/Notes:

Guidelines state that CD4 T-cell counts should be measured at least every 3-4 months depending on the stage of the disease. The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but can and should be measured at more frequent intervals if needed.

[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.
[2]IHI Measure reads, "Percent of Patients/Clients with a CD4 Count Test in the Past 4 Months" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentof+patientswithaCD4countt estinthepast4months.htm)
[3]National HIVQUAL data looks at the percent of clients who have a CD4 T-cell count done every four months, not every six months.
(http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf)
[4]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

Performance Measure: HAART	**OPR Measure:** #12a
Percentage of clients with AIDS who are prescribed HAART	
Numerator:	Number of clients with AIDS who were prescribed a HAART regimen[1] within the measurement year
Denominator:	Number of clients who: • have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm^3 or other AIDS-defining condition[2]), and • had at least one medical visit with a provider with prescribing privileges[3], i.e., MD, • PA, NP in the measurement year.
Patient Exclusions:	1. Patients newly enrolled in care during last three months of the measurement year
Data Element:	1. Is the client diagnosed with CDC-defined AIDS? (Y/N) 2. If yes, was the client prescribed HAART during the reporting period? (Y/N)
Data Sources:	• Program Data Report, Section 2, Items 26 and 31 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base. • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	IHI Goal: 90%[4] CDC and HIVRN data consistent that 80% of those in care "eligible for ARVs" on tx. This includes CD4 < 350 and not just AIDS.[5,6] National HIVQUAL Data:[7,8]
Outcome Measures for Consideration:	• Rate of HIV-related hospitalizations in the measurement year • Rate of HIV-related emergency room visits in the measurement year • Rate of opportunistic infections in the measurement year • Mortality rates

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	100%	100%	100%	100%
Median*	100%	88.9%	95.7%	100%

Basis for Selection and Placement in Group 1:

Clinicians should schedule routine monitoring visits at least every 4 months for all HIV-infected patients who are clinically stable.[3,4]
Greater experience among primary care physicians in the care of persons with AIDS improves survival. [5]
Measure reflects important aspects of care that significantly impacts mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Public Health Service Guidelines:

"Antiretroviral therapy is recommended for all patients with history of an AIDS-defining illness or severe symptoms of HIV infection regardless of CD4 T-cell count." [10]

References/Notes:

[1] Many authorities recommend two baseline CD4 T-cell measurements before decisions are made to initiate antiretroviral therapy because of wide variations in results. The test should be repeated yet a third time if discordant results are seen. The optimal time to initiate antiretroviral therapy among asymptomatic patients with CD4 T-cell counts >200 cells/mm^3 is unknown. This measure focuses strictly on the subset of patients for whom antiretroviral therapy is unequivocally recommended—those with a CD4 T-cell count below 200 cells/mm3 or history of another AIDS-defining condition. Asymptomatic patients with CD4 T-cell counts of 201–350 cells/mm3 should be offered treatment. For asymptomatic patients with CD4 T-cell of >350 cells/mm3 and plasma HIV RNA >100,000 copies/ml most experienced clinicians defer therapy but some clinicians may consider initiating treatment. (See reference 8 below)

[2] AIDS Defining conditions are noted in CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR 1992;41(no. RR-17). (http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm)

[3] A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

[4] IHI Measure reads, "Percent of Patients with Appropriate ARV Therapy Management" http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAppropriateARVTherapyManagement.htm)

[5] Gebo, JAIDS January 2005, vol. 38, pp. 96-103.

[6] Teshale Abstract #167, CROI 2005.

[7] The National HIVQUAL data may not be directly comparable due to varying exclusions. Indicator definitions can be accessed at http://www.hivguidelines.org/Content.aspx?PageID=53. 8http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf

[9] "HAART, CD4<200" (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf)

[10] Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; p. 9. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

Performance Measure: Medical Visits	**OPR Measure:** #1
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement	
Numerator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP, in an HIV care setting[2] two or more times at least 3 months apart during the measurement year
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year
Data Element:	1. Is the client HIV-infected? (Y/N) 2. Did the client have medical visits in an HIV care setting during the reporting period? (Y/N) a. If yes, list the quarters of these visits
Data Sources:	• Program Data Report, Section 5, Items 42 and 43 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcome Measures for Consideration:	• Rate of opportunistic infections in the measurement year • Rate of HIV-related hospitalizations in the measurement year • Mortality rates
Basis for Selection and Placement in Group 1:	
"Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm[3.7,9] Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.	

US Public Health Service Guidelines:

In general, patients with early-stage disease are seen at 3-month intervals to undergo routine medical evaluation and monitoring of CD4 T-cell count, viral load and CBC. During the initial evaluation more frequent visits are common because there is so much information to transmit. Visits should also be more frequent when therapy is introduced and when the CD4 T-cell count is <200 cells/mm3 because complications are more likely.[6]

Multiple studies have demonstrated that better outcomes are achieved in patients cared for by a clinician with expertise. This has been shown in terms of mortality, rate of hospitalizations, compliance with guidelines, cost of care, and adherence to medications. The definition of expertise in these studies has varied, but most rely on the number of patients actively managed. Based on this observation, the Panel recommends HIV primary care by a clinician with at least 20 HIV-infected patients and preferably at least 50 HIV-infected patients. Many authoritative groups have combined the recommendation based on active patients, along with fulfilling ongoing CME requirements on HIV-related topics. [7]

References/Notes:

Guidelines state that routine monitoring of HIV-infected patients should occur at least every 3-4 months depending on the stage of the disease. 7 The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but CD4 T-cell counts can and should be measured at more frequent intervals if needed.

[1] A"provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

[2]An HIV care setting is one which received Ryan White HIV/AIDS Treatment Modernization Act of 2006 funding to provide HIV care and has a quality management program in place to monitor the quality of care addressing gaps in quality of HIV care.

[3]New York State Department of Health. Primary care approach to the HIV-infected patient. New York: New York State Department of Health; 2004. p. 8. http://www.hivguideliens.org/Content.aspx?pageID=257[Accessed November 27, 2007].

[4]AETC National Resource Center. Clinical Manual for Management of the HIV-Infected Adult http://www.aidsetc.org/pdf/AETC-CM_071007.pdf [Accessed November 27, 2007].

[5]Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. J Gen Intern Med. 2003 Feb;18(2):157-8.

[6]Bartlett JG, Cheever LW, Johnson MP, Paauw DS [eds]. A Guide to Primary Care of People with HIV/AIDS. Rockville(MD): US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2004, p. 167. http://hab.hrsa.gov/tools/primarycareguide/. [Accessed November 27, 2007].

[7]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

Appendix E: Measures from Part B Collaborative

Please note: 'N'= Numerator; 'D'= Denominator

Measurement Strategy
Part B Collaborative Demonstration Project

LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
ADAP Enrollment	Percent of ADAP applicants approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application.	N = the number of ADAP applicants that were approved or denied for ADAP enrollment within two weeks of the ADAP receiving a complete application. D = the number of complete applications that the ADAP received during the month [N / D] *100%	On the 15th of the current month, count the total number of complete applications that the ADAP received during the previous month (D). From this group, count the number of applicants that were approved or denied for ADAP enrollment within two weeks of the ADAP receiving them (N). Then, divide N by D and multiply the result by 100%. **Example:** On the 15th of July, count the total number of complete applications that the ADAP received during the month of June (D). Then from this group count the number of ADAP individuals that were approved or denied for ADAP services within two weeks of the ADAP receiving them for the month of June (N). Finally divide N by D and multiply the result by 100%. **Note:** 1. Data report is due the 20th of the month. For example, first data are due July 20th, 2005 for June 2005 data.

LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
ADAP Recertification	Percent of ADAP enrollees recertified for ADAP eligibility criteria at least annually.	N = the number of all ADAP enrollees who have reached their twelve month anniversary from date of enrollment that have been recertified D = the number of ADAP enrollees who have reached their twelve month anniversary from date of enrollment [N / D] *100%	At the end of the current month, count the total number of ADAP enrollees who reached (during the current month) their twelve-month anniversary from the date of their enrollment (D). Then from this group count the number who have been re-certified (N). Finally divide N by D and multiply the result by 100%. **Example:** On June 30th, 2005, count the total number of ADAP enrollees who reached (during the month of June, 2005) their twelve-month anniversary from the date of their enrollment (D). (These people would have enrolled in June 2004.) Then from this group count the number who have been re-certified (N). Finally divide N by D and multiply the result by 100%. **Note:** 1) Data report is due the 20th of the month. For example, first data are due July 20th, 2005 for June 2005 data.
LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
HIV Reporting with AIDS Diagnosis	Percent of individuals newly reported with HIV infection who also have AIDS	N = the number of individuals newly reported with HIV infection who also have an AIDS diagnosis D = number of individuals newly reported with HIV infection [N / D] * 100%	At the end of the quarter, count the total number of individuals newly reported with HIV infection for that quarter (D). Then from this group count the number who have an AIDS diagnosis (N). Finally divide N by D and multiply the result by 100%. **Example:** On June 30th, 2005, count the total number of individuals newly reported with HIV infection for April, May and June 2005 (D). Then from this group count the number who have an AIDS diagnosis (N). Finally divide N by D and multiply the result by 100%. **Note:** 1. Due to time lag in confirmed cases being added to the Surveillance Registry, when the data are analyzed for the quarter, please annotate period from which most infections were diagnosed. For example data are posted on Oct. 20th for the 3rd Quarter of 2005 (July, August, Sept of 2005), note that most of the reported infections occurred in Nov & Dec 2004.

LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
			(cont.) 2. Data report is due the 20th of the next month after end of quarter. For example, first data report is due October 20th, 2005 for third quarter (July August and September).
LABEL	**MEASURE**	**FORMULA**	**DATA COLLECTION PLAN**
AIDS Progression Rate	Percent of individuals newly reported with HIV infection (not AIDS) who progress to AIDS diagnosis within 12 months of HIV diagnosis	N = the number of individuals who progress to AIDS diagnosis within 12 months of HIV diagnosis D = the number of individuals newly reported with HIV infection (not AIDS) [N / D] * 100%	At the end of the quarter, count the total number of individuals newly reported with HIV infection (not AIDS) that are twelve months from diagnosis (D); then from this group count the number of individuals who progressed to AIDS diagnosis within 12 months (N). Finally divide N by D and multiply the result by 100%. **Example:** On June 30th, 2005 count the total number of individuals newly reported with HIV infection (not AIDS) for the quarter of April May and June of 2005 that are twelve months from diagnosis (D). Then from this group count the number of individuals who progressed to AIDS within 12 months of HIV diagnosis (N). Finally divide N by D and multiply the result by 100%. **Note:** 1. Data report is due the 20th of the next month after end of quarter. For example, first data report is due October 20th 2005 for third quarter (July, August and September).
LABEL	**MEASURE**	**FORMULA**	**DATA COLLECTION PLAN**
HIV Death Rate	Ratio of individuals who die within 12 months of HIV diagnosis to the number of individuals newly reported with HIV infection	N = the number of individuals who die within 12 months of HIV diagnosis D = the number of individuals newly reported with HIV infection [N / D] * 100	At the end of the quarter, count the total number of individuals newly reported with HIV infection that are twelve months from diagnosis (D). Then count the number of individuals who die within 12 months of HIV diagnosis (N). Finally divide N by D. **Example:** On June 30th, 2005, count the total number of individuals newly reported with HIV infection for the quarter of April May and June of 2005 that are twelve months from diagnosis (D). Then count the number of individuals who die within 12 months of HIV diagnosis (N). Finally divide N by D.

LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
			(Cont…) **Note:** 1. Due to time lag in confirmed cases being added to the Surveillance Registry, when the data are analyzed for the quarter, please annotate period from which most infections were diagnosed. For example data are posted on Oct. 20th for the 3rd Quarter of 2005 (July, August Sept of 2005), note that most of the reported infections occurred in Nov & Dec 2004. 2. Data report is due the 20th of the next month after end of quarter. For example, first data report is due October 20th 2005 for third quarter (July, August and September),
LABEL	**MEASURE**	**FORMULA**	**DATA COLLECTION PLAN**
HIV Medical Visit	Percent of individuals with at least two (2) general HIV medical care visits in the last 12 months with at least one visit in the first six months and at least one visit in the second six months of the 12 month period	N= the number of HIVAIDS individuals with at least one HIV medical care visit in the first six months and at least one in the second six months of the last 12 months D = the number of HIVAIDS individuals with at least one visit within the last twelve months [N / D] *100%	At the end of each quarter, count the total number of HIVAIDS individuals with at least one visit within the last twelve months (D). Then from this group count the number of HIVAIDS individuals with at least two (2) general HIV medical care visits in the last 12 months. Then from this group count the number of individuals with at least one medical care visit in the first six months and one in the second six months (N).Finally divide N by D; multiply by 100%. **Example:** On June 30th 2005, count the total number of HIVAIDS individuals with at least one visit within the last twelve months (D).Then from this group count the number of HIVAIDS individuals with at least two (2) general HIV medical care visits in the last 12 months. Then from this group count the number of individuals with at least one medical care visit in the first six months and one in the second six months (N). Finally divide N by D and multiply the result by 100%. **Note:** 1. These may arise from lab based surveillance reporting. 2. State Data System and Medicaid System are suggested databases from which to obtain data. 3. Data report is due the 20th of the next month after end of quarter. For example, first data report is due October 20th 2005 for third quarter (July, August & September).

LABEL	MEASURE	FORMULA	DATA COLLECTION PLAN
HIV Monitoring	Percent of individuals with at least two (2) lab tests (CD4 or VL)* in the last 12 month with at least one lab test in the first six months and at least one identical* lab test in the second six months of the same 12 month period *Both lab tests must be the same, either both CD4 or both VL	N = the number of HIVAIDS individuals with at least one lab test (CD4 or VL) in the first six months and at least one identical lab test* in the second six months of the last 12 months (*both lab tests must be alike) D = the number of HIVAIDS individuals with at least one visit within the last twelve months [N / D] *100%	At the end of each quarter, count the total number of HIVAIDS individuals with at least one visit within the last twelve months (D). Then from this group count the number of HIVAIDS individuals with at least two (2) identical lab tests (either two or more CD4 or two or more VL) in the last 12 months. Then from this group count the number of individuals with at least one of the identical lab tests (CD4 or VL) in the first six months of the year and one of the same lab tests in the second six months of the year (N). Finally divide N by D and multiply the result by 100%. **Example:** On June 30th, 2005, count the total number of HIV AIDS individuals with at least one visit within the last twelve months (D). Then from this group count the number of HIVAIDS individuals with at least two (2) identical lab tests (either two or more CD4 or two or more VL) in the last 12 months. Then from this group count the number of individuals with at least one of the identical lab tests (CD4 or VL) in the first six months of the year and one of the same lab tests in the second six months of the year (N). Finally divide N by D and multiply the result by 100%. **Note:** 1. State Data System and Medicaid System are suggested databases from which to obtain data. 2. Data report is due the 20th of the next month after end of quarter. For example, first data report is due October 20th, 2005 for third quarter (July August & September)

Appendix F: Suggested Quality Improvement Opportunities

The following list of ideas for change was generated by Part B teams participating in NQC collaboratives and group by the four main domains of the Part B Collaborative. Use these ideas as improvement opportunities to guide your quality improvement activities within your program.

Alignment Across Jurisdictions and Services, Including ADAP

1. **Create a Single System of Care for All Parts: Continuum of Care**
   - Engage all Ryan White HIV/AIDS Program grantees to participate in developing a standard continuum of services to reduce duplication of services and to address gaps in service.
   - Develop and adopt consistent standards of care across programs for all grantees in state
   - Develop a method to describe and depict this system and engage all clients in this single system of care
   - Develop uniform intake and/or standard eligibility process for patients to access any provider requiring only one point of access and eligibility determination
   - Develop a referral flow chart for all patients from community services, including counseling and testing, to primary medical care
   - Collect and analyze data to show all targeted subpopulations and potential barriers to and gaps in service provision
   - Outline the goals and objectives (priority initiatives) from HRSA, the state, the EMAs, local agencies and consortia to ensure alignment as part of the planning process
   - Link ADAP and other Ryan White programs that provide medication assistance services

2. **Develop a Standard Data Collection, Reporting, and Monitoring Process for All Ryan White HIV/AIDS Program Grantees in the State (see Information Management for detail)**
   - Develop consistent outcome and other core performance measures that are tracked across programs
   - Create standard measures to assess the continuity of care between HIV care, Case Management, and Specialty Care
   - Develop one centralized data management system per consortium that includes elements corresponding to quality improvement and outcome measures
   - Develop a database for all entities to warehouse enrollment and/or eligibility information
   - Administer the data system centrally
   - Coordinate data reporting systems and avoid duplication of efforts

- Develop data system to monitor coordination of care, i.e. movement within the continuum of care by clients
- Include written data-sharing agreements in every contract

3. **Promote Statewide Collaboration to Improve Quality of Care and Services**
   - Convene an annual state all-Parts meeting centered on common cross-cutting issues
   - Form a statewide quality improvement all-Parts collaborative
   - Conduct monthly phone calls to discuss important quality of care issues
   - Create a workgroup with the following state participants for quality improvement – Medicaid, ADAP, Epidemiology, Quality Management, Information Technology, and the Part B Program Director to focus on maximizing service information for the purpose of improving care
   - Use the Statewide Coordinated Statement of Need (SCSN) process as the foundation for more frequent statewide collaboration
   - Form a statewide planning consortium to address comprehensive planning, including representatives from all across the state
   - Convene all Ryan White HIV/AIDS Program grantees in a state for the purpose of identifying gaps in funding and establishing service priorities
   - Develop service specific task forces for substance abuse and mental health that includes representatives of all funding sources in state for these services
   - Seek joint funding/programming of services targeting co-morbidities from outside AIDS "silos" to maximize resources – e.g., substance abuse provider and AIDS service provider co-grantees on a grant from SAMHSA
   - Convene representative statewide group of consumers to advise state on policy and alignment of care and support systems

Intergration of Data and Information Systems

1. **Provide Administrative Oversight to Manage the Data at the System Level**
   - Assure that individuals/groups are established that are charged with management and interpretation of HIV statewide data; e.g.,
     - o Hire/train an epidemiologist data analyst who can manage and analyze data
     - o Assign an Information Technology (IT) expert, ideally with HIV care experience to oversee selection and implementation of HIV Management Information System (HMIS)
   - Establish new systems or adapt existing data systems, including Medicaid, surveillance and private insurer databases, to include measures to assess unmet need
   - Use methodologies to assess unmet need that have been developed by HAB as templates to build state systems for this analysis
   - In accordance with confidentiality laws, use consent forms that ease exchange of information among providers designated by patient/client
   - Clarify legal rules regarding exchange of patient information to create coordinated system
   - Develop state level measures that address care across the continuum of services
   - Develop standardized reporting mechanisms for common data elements
   - Develop information systems that report service and care utilization data
   - Administer the data system centrally
   - Allocate funds for data and information systems including technical assistance support to link and maintain databases

- Link data systems among health and human service providers, with appropriate security and confidentiality protections; e.g., link counseling and testing data systems with health care services
- Allocate time for planning and using data
- Specify in all contractual agreements that contractors meet standardized data reporting and quality management requirements. The data reporting requirement should specify both frequency and required variables

2. Develop State Level Outcome Measures at the Program and Client Level, and Across Agencies and Parts

- Plan how to align and link data to programmatic goals and objectives
- Be able to link pertinent outcome measures to quality improvement processes in order to identify issues and opportunities for improvement. Examples include: advanced disease at time of diagnosis; delay in accessing care after HIV + diagnosis; analyze testing history, CD4s and viral loads of newly diagnosed cases to determine how many and which patients are diagnosed late, and modify outreach and programs to reach sub-populations earlier.
  - o Provide training on how to use outcome data in program planning (linkage of data to performance improvement)
  - o Include outcome measures for supportive services
- Ensure that data systems capture outcome measures
- Develop a process for validation of outcome data such as medical record review
- Use logic models to select outcomes and evaluate successes
- Assure that outcome data serve multiple purposes such as quality improvement, grant reporting, and evaluation
- Convene consumers to obtain buy-in and develop measures
- Convene local experts to obtain buy-in and develop outcome measures
- Organize forum for the continual improvement of measures and reporting
- Require (use RW funds if necessary) client level data for outcomes measurement

3. Reduce the Burden of Data Collection

- Reduce duplicate data collection and entry
- Standardize data collection where vendors are using comparable data elements
- Use data from statewide systems, including surveillance, Medicaid and other databases to inform statewide quality improvement activities, and establish priorities for improvement

4. Establish a Case-level Data Structure

- Create an unduplicated client level database
- Use core data elements across systems that are coded consistently
- Create clear data ownership rules to facilitate data transfer across the system of care
- Develop open access to shared client information with appropriate security and confidentiality protections
- Create common data dictionary for all data elements
- Develop data agreements between systems and centers as part of infrastructure

5. Use Data to Promote Quality Improvement

- Develop system to use data for patient interventions: e.g., link ADAP use and adherence data with CD4 and VL – identify patients that need interventions
- Provide performance data back to stakeholders; celebrate successes
- Report aggregate data to senior staff in order to better target opportunities for improvements

- Use the data to test and measure specific service delivery interventions and to validate their successes or make necessary adjustments
- Develop core performance measures and compare across sites to identify best practices to share
- Promote mentoring of HIV programs with various levels of performance
- Collect data from providers to produce comparative performance reports that can be used to stimulate improvement activities
- Develop a plan to share data between case management and medical providers (e.g., increased self-management and increased CD4) and study how they work together (or not): promote joint quality improvement activities between providers to achieve improvements based on linked data
- Facilitate bringing teams together from different agencies to share information (team meetings)
- Assure that outcome data are immediately available for use to improve program services

6. Provide Technical Assistance to Facilitate Collection of Client-Level Data at Point and Time of Service

- Determine which providers in your state require technical assistance to implement an HMIS
- Provide time and training to develop data collection and data analysis skills at provider level
- Develop and coordinate a Technical Assistance office responsible for ensuring roll out and training in HMIS at provider level
- Provide training on outcomes/indicators to those who are responsible for data collection
- Provide technical assistance to help grantees understand how data can be collected and used to measure outcomes
- Educate providers and consumer communities about outcomes measurement

Improving Access to Care and Retention of HIV/AIDS Clients

1. Coordinate Care and Services Within and Across Agencies

- Use tracking database to identify patients who are using multiple agencies and generate reports to help reduce duplication of services, assure ongoing treatment and care
- Increase opportunities for Primary Care Providers and Case Managers to discuss common cases, share information with each other
- Limit the number of case managers (care/service coordinators) assigned to each client and develop a process for communication among those individuals working with a single client
- Link care and support services providers to reach out to patients and increase retention
- Improve linkages between Community Based Organizations and health care providers to get people in care/retained in care
- Provide technical assistance to regions/consortia/EMAs to assist with data linking, so that if a client accesses any service, they can be encouraged to get into care
- Sponsor training/learning collaboratives that cross the prevention/care cultural divide to improve coordination between these services, especially relating to partner notification and linkage to testing and care
- Work with correctional agencies and VA hospitals to coordinate patients' continuity of care
- Facilitate linkages to state prisons for easing transition of patients from prison to parole and immediately into care
- Develop working group between Medicaid, case management, and ADAP to identify who is in need and is not accessing ADAP
- Maximize all payment sources for care and ADAP to prevent gaps in insurance that prevent access

- Coordinate care for complex populations such as the dual or triply diagnosed
- Improve patient care by basing service package on acuity determination and the input of multi-disciplinary care team, including at a minimum nursing and social worker
- Improve/decrease length of time between diagnosis and first lab work/medical appointment by using a case manager/peer counselor first response team
- Develop a system for smooth and efficient referrals to specialty care
- Help patients address concrete needs – transporta--tion/child care to facilitate medical appointment-keeping, i.e., link service and care programs

2. Involve Consumers

- Create consumer initiatives to increase awareness of the importance of retention in care through booklets, campaign
- Improve patient self-management through training to improve show rate and adherence
- Ensure patients are aware of the full range of care services available in the community
- Train consumer as peer educators, focusing particularly on importance of knowing HIV status, receiving care and staying in care, and treatment adherence
- Promote peer-to-peer mentorships to educate and empower patients
- Ask consumers to identify barriers to care; provide services to overcome the barriers: e.g., transportation/child care
- Develop processes for obtaining consumer feedback on issues related to access, retention, and quality of care
- Conduct focus groups with populations not accessing service to determine cause
- Engage consumers to participate in quality improvement team activities to participate in quality improvement committee activities

3. Use Data to Define Need and Target Services

- Use data systems to identify populations accessing and not accessing care
- Review current ADAP HAART use and waiting list to address gaps in care
- Identify patients with a CD4 less than 200 who are not in care and address why they are not in care
- Examine hospital admission data for opportunistic infection diagnosis, determine if patients with opportunistic infections are linked to care, and develop a plan to identify them and link them to care if gaps in access exist
- Use unmet need data to target activities to promote access and retention
- Use data to examine disparities in the delivery of care and services, focusing on age, gender and race/ethnicity less than 200 who are not in care and address why they are not in care
- Examine hospital admission data for opportunistic infection diagnosis, determine if patients with opportunistic infections are linked to care, and develop a plan to identify them and link them to care if gaps in access exist
- Use unmet need data to target activities to promote access and retention
- Use data to examine disparities in the delivery of care and services, focusing on age, gender and race/ethnicity

4. Identify and Involve All Stakeholders to Improve Access and Retention

- Involve direct care providers in access and retention activities
- Identify existing providers, their current level of expertise, and ability/willingness to be Ryan White providers

- Require that all grantees must be working together in a state and agree to alignments
- Involve and work together with other state departmental units, e.g., corrections, mental health, substance abuse, and Vocational Rehab (see Alignment Domain)
- Include consumers at state level
- Include other stakeholders, such as representatives from Medicaid, Epidemiology, ADAP, information systems, to assess and improve access/retention

5. Improve the Care Delivery System to be More Proactive and Responsive to Patient Need

- Use strategies to decrease no-show rate
  - o Contact patients to remind them of appointments
  - o Test open access clinic
  - o Use peer support systems
  - o Introduce self-management concepts
  - o Close the visit carefully, explaining need for next visit and what will be done
  - o Use appointment scripts: "Will you call us if you need to cancel?"
  - o Test walk-in availability
- Use strategies to follow-up with patients
  - o Reimburse for staff efforts to contact patients
  - o Identify individuals to track clients who are lost to follow-up
  - o Develop a system to interview clients lost to care to understand their reasons for not accessing or staying in care
  - o Follow up with clients lost to care within two months of missed visit
  - o Follow-up to determine outcome of referral services
  - o Develop peer outreach program to help locate clients and re-engage them in care
  - o Schedule check-in calls with nurse, or case manager
  - o Create a registry for follow-up
  - o Update contact information with every visit
  - o Test non-traditional methods to follow-up such as nurse visits, group visits, telephone, or email
- Identify clients at highest risk who are most vulnerable and prioritize efforts to engage and retain them in care. Examples: co-morbidity and medical risk factors; psychosocial factors.
- Provide culturally competent care at the point of service:
  - o Provide cultural competency training for providers
  - o Improve retention of Hispanic clients in ADAP, by hiring a Spanish speaking "benefits counselor" at state level who contacts clients and is available on 800 number
  - o Hire interpreters, including those proficient in sign language;
  - o Create systems to assist hearing and visually impaired clients
- Decrease time from request and application for ADAP coverage to receipt of drugs by patient
- Decrease ADAP expiration by putting recertification date on face sheet for flow sheet clerk to check
- Provide the support systems that are needed to enable clients to access care, e.g., transportation, child care
- Cluster services as much as possible to reach high risk populations, e.g., health care at drug treatment sites [one-stop shopping model]
- Deliver testing and/or health care in non-traditional sites, such as mobile medical vans, storefronts, health fairs, and use incentives, such as radio promotion and giveaways, to reach high risk populations that may not seek such services
- Offer weekend service hours and extended hours of operation to accommodate people who work
- Share successful retention strategies across

state grantees
- Utilize existing statewide databases to analyze whether patients receive HIV care across multiple facilities
- Create strong tie with primary care provider
- Create strong tie between primary care provider and case manager so that they may work as a team to improve retention and follow-up

6. **Provide Training and Technical Assistance for Provider and State Staff**
   - Develop an on-line ADAP tutorial for new registration site staff to speed their training and reduce rejection of applications
   - Train case managers on client financial assistance programs
   - Train staff to elicit identified concerns that prevent patients from attending visits
   - Provider self-management training to staff so that they can in turn work with their clients to improve self-management

7. **Standardize Processes at the System Level to Improve Access and Retention**
   - Delineate expectations of client retention in standards of care (what steps to take, when it is ok to stop; define criteria for providers]
   - Increase access to health insurance; for example:
     - Hire a benefits specialist at the state level attached to ADAP to be available to clients and case managers
     - Make sure that case managers have pertinent information, including training and written materials on health insurance options
     - Utilize a Pharmacy Benefits Manager (PBM) to review list of medications dispensed, insurance premiums purchased and other charges on a monthly basis. Check monthly if enrolled individuals pick up their drugs, and work with the pharmacy and provider to resolve issues. Conduct site visits and chart reviews for customer satisfaction; consumer and provider complaints and suggestions
   - Utilize standardized policies that facilitate implementation of the Ryan White grant/laws and guidelines
   - Clarify sources of support for enabling services that help entry and retention
   - Standardize quality control for rapid testing in state; assist sites to incorporate through training and mentoring
   - Develop a single registration/eligibility process, including verification, across all the funded care providers in a region, for example core registration

Optimization and Management of Resources

1. **Contain Costs and Maximize Resources**
   - Seek joint funding/programming of services targeting co-morbidities and from outside AIDS "silos" to maximize resources – e.g., substance abuse provider and AIDS service provider co-grantees on a grant from SAMHSA
   - Combine buying power of like groups (ADAPs, state prison systems) both intra and inter state when negotiating drug prices and other purchases such as laboratory services and testing supplies
   - Participate in prime vendors program – ADAP
   - Perform an analysis to consider changing from 340b rebate to 340b direct purchase – ADAP
   - Negotiate with drug manufacturer for even lower drug prices than PHS
   - Create unit of service reimbursement for all services (including case management)
   - Negotiate best prices for services with all vendors
   - Obtain more flexible reimbursement for care provided outside of clinical settings (e.g., Medicaid approval for reimbursement of care provided in storefronts or on mobile medical vans) and out of network

2. Follow Standards/Guidelines to Ascertain Eligibility and Reimbursement for Services

- Develop clear policies and standards for eligibility to ensure their consistent application across the state
- Use eligibility criteria based on guidelines (e.g. CD4 <350) as a guide for accessing services, including ADAP
- Utilize acuity level or scale as one strategy to determine eligibility for services
- Ensure that funded services are clearly within RW grant guidelines

3. Improve Staff Retention and Satisfaction

- Standardize provider/client ratios based on client health and psycho-social status
- Share information among Ryan White (all Parts) grantees regarding human resources (i.e., number of case management full time equivalents each funds)
- Proactively plan for recruitment and retention of HIV/AIDS staff at both the state government and provider levels
- Create career ladders wherever possible
- Allocate funds to support dedicated Information Technology (IT) staff
- Provide statewide recognition of staff through commendations, awards
- Facilitate provision of continuing education opportunities at the state level
- Provide technical assistance/training on an ongoing basis to staff. Provide tuition reimbursement if possible
- Promote client self-management through staff training and protocol
- Assure sufficient support staff for HIV programs
- Create clear role expectations through effective job descriptions, assuring that staff are evaluated on time based on these role/job expectations

Appendix G: Quality Improvement Resources

Quality Management Publications:

- **A Guide to Consumer Involvement:** Improving the Quality of Ambulatory HIV Programs. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, 2006; www.hivqual.org
- **HIVQUAL Workbook**: Guide for Quality Improvement in HIV Care. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, Updated 2006; www.NationalQualityCenter.org
- **HIVQUAL Group Learning Guide**: Interactive Quality Improvement Exercises for HIV Health Care Providers. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, Updated 2006; www.hivqual.org
- **Making Sure Your HIV Care is the Best It Can Be:** A Consumer Quality of Care Training Workshop. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, Updated 2006; NationalQualityCenter.org
- **Measuring Clinical Performance:** A Guide for HIV Health Care Providers. A publication of the New York State Department of Health AIDS Institute, Updated 2006; www.NationalQualityCenter.org
- **NQC Game Guide**: Interactive Exercises for Trainers to Teach Quality Improvement in HIV Care. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, 2006; NationalQualityCenter.org
- **NQC Quality Academy.** A no-cost online training course on quality improvement. New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, 2007; NationalQualityCenter.org/QualityAcademy
- **NQC Training-of-Trainer Guide:** Facilitator Manual to Train HIV Providers on Quality Management. A publication of the New York State Department of Health AIDS Institute and the Health Resources and Services Administration HIV/AIDS Bureau, 2007; NationalQualityCenter.org
- **Patient Satisfaction Survey for HIV Ambulatory Care.** A publication of the New York State Department of Health AIDS Institute, 2002; www.NationalQualityCenter.org

HRSA Publications on Quality Management:

- **Improving Care for People Living with HIV/AIDS Disease.** Institute for Healthcare Improvement, HRSA/HAB. HIV/AIDS Bureau Collaborative. Order via the HRSA Information Center at www.ask.hrsa.gov or call 888-ASK-HRSA.

- **The Modular Quality Improvement Curriculum for Improving HIV Care.** Institute for Healthcare Improvement, HRSA/HAB, HIV/AIDS Bureau. www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Tools
- **Quality Management: Technical Assistance Manual.** HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA); www.hab.hrsa.gov/tools/QM

Books on Quality Management:

- Agresti, Alan. An Introduction to Categorical Data Analysis, Wiley Series in Probability and Statistics. Applied Probability and Statistics, May 1996.
- Brassard, M., Ritter, D., Rilter, D., Oddo, F. The Memory Jogger II. Goal /QPC, Lawrence MA; 1994.
- Carey, R.G., and Lloyd, R.C. Measuring Quality Improvement in Healthcare. New York: Quality Resources, 1995.
- Delbecq, A., Vand de Ven, A. and Gustafson, D. Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes. Middleton, WI: Green Briar Press, 1975/1986.
- Gerteis, M., Edgman-Levitan, S., Daley, J., Delbanco, T.L. Through the Patient's Eyes–Understanding and Promoting Patient-Centered Care. San Francisco, CA: Jossey-Bass; 1993.
- Graham, N. Quality in Health Care: Theory, Application, and Evolution. Gaithersburg, MD: Aspen Publications, 1995.
- Institute of Medicine Committee on Quality of Health Care in the US, Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century, National Academy Press, 2001.
- Langley Gerald J., Nolan, Kevin M., Nolan, Thomas W., Norman, Clifford L., and Provost, Lloyd P. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. San Francisco, CA: Jossey-Bass Publishers, 1996.
- Rogers, E. Diffusion of Innovation. New York: Free Press; 1995.
- Scholtes, Peter R., Joiner, Brian L. and Streibel, Barbara J. The Team Handbook. Second Edition. Madison, WI: Joiner Associates Inc., 1996.
- Swanson, Roger C. The Quality Improvement Handbook: Team Guide to Tools and Techniques. Delray Beach, FL: St. Lucie Press, 1995.

Websites on Quality Management:

- Agency for Healthcare Research and Quality (AHRQ) - www.ahrq.gov/qual
- HRSA Bureau of Primary Health Care Quality Center - www.bphc.hrsa.gov/quality
- HRSA Center on Quality - www.hrsa.gov/quality
- Institute for Healthcare Improvement (IHI) - www.ihi.org
- National HIVQUAL Project - www.hivqual.org
- National Quality Measures Clearinghouse - www.qualitymeasures.ahrq.gov
- New York State Department of Health AIDS Institute - www.hivguidelines.org
- National Quality Center - NationalQualityCenter.org

Building Capacity of Statewide Quality Management Programs
New York State Department of Health AIDS Institute
Health Resources and Services Administration HIV/AIDS Bureau
#9606