2021

New Haven-Fairfield EMA Ryan White Part A Program Clinical Quality Management Plan

FISCAL YEAR 2021

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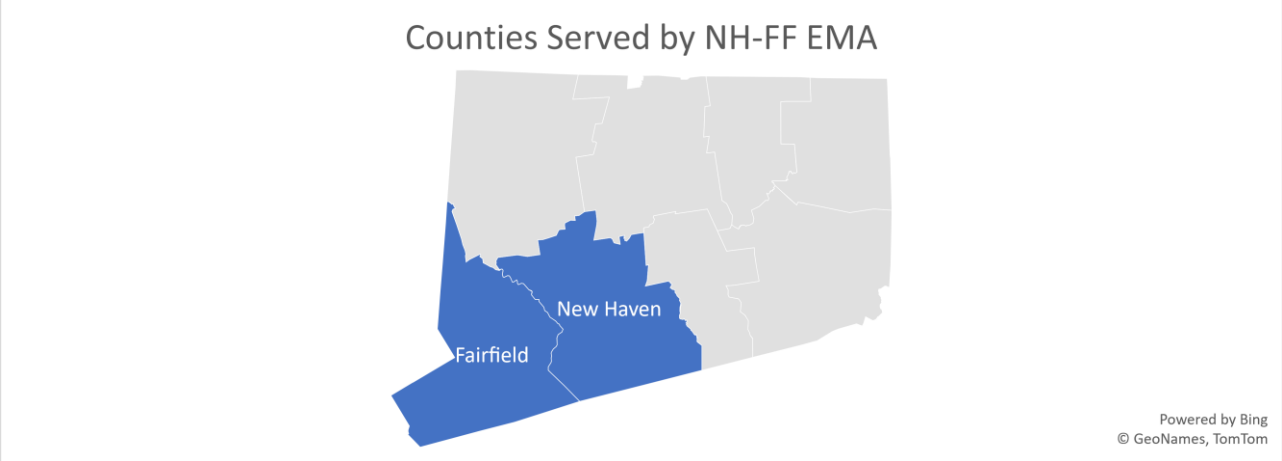
Introduction

The New Haven-Fairfield Counties, CT EMA has provided high-quality care and treatment for PLWH utilizing RWHAP Part A grant funds since 1993. As of December 31, 2019, a total of 5,964 persons were reported to be living with HIV and/or AIDS (PLWH, unless specifically indicated, incorporates all persons living with HIV and persons living with AIDS as total prevalence) in New Haven Fairfield Counties, EMA. Minorities present the largest disparity given their proportion to the general population in that 71% (n=4,291) of the total prevalence for PLWH are minorities with dominant representation of African Americans and Hispanics, yet these same races/ethnicities comprise only 34% of the general population in the EMA. For PLWH prevalence, African Americans comprise 38% of the total, with 32% Hispanic. Males continue to dominate PLWH prevalence with 66% of the cases, and persons over age 45 comprising 74% of PLWH. MSM comprise 31% PLWH, heterosexuals 29% and IDU are 25% of PLWH prevalence. Similarly, minorities command AIDS prevalence, with 37% African American PLWA and 33% Hispanics in relation to their proportion in the general population of 14% and 20% respectively. PLWA males comprise 66% of the total AIDS prevalence, with 85% of PLWA being over the age of 45. Among those PLWA, IDU comprise 31% of all cases, heterosexuals 30%, and MSM 26%.

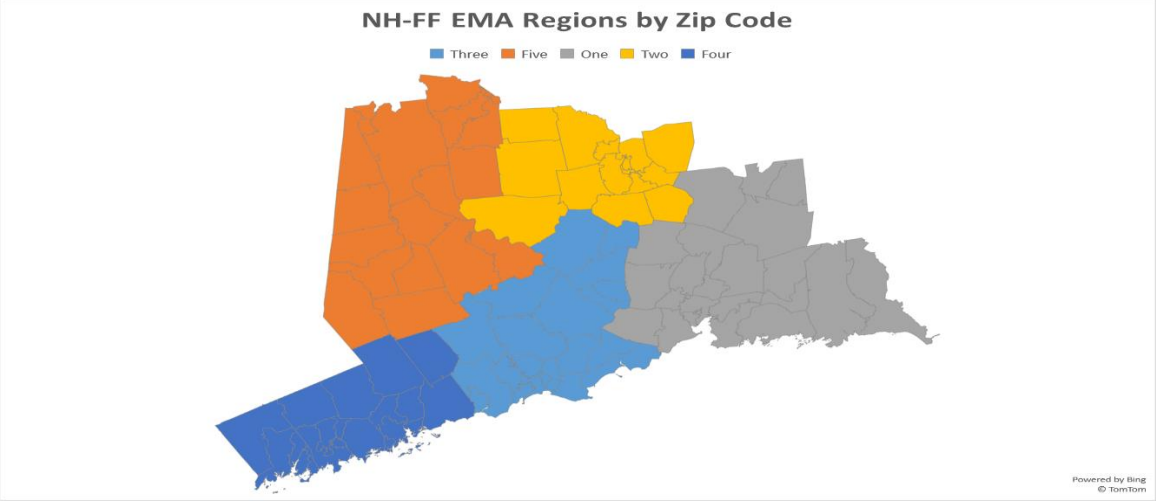
The Clinical Quality Management Plan provides a coordinated approach to addressing quality assessment and improvement of the HIV/AIDS medical and support services in the New Haven-Fairfield Counties Eligible Metropolitan Area (NH-FF EMA). The CQM Program maintains a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to People Living with HIV (PLWH) throughout the EMA. The City of New Haven Ryan White Part A Office assists with developing strategies to ensure that the delivery of services to all RWHAP eligible PLWH is equitable and adheres to current HRSA and clinical practice standards.



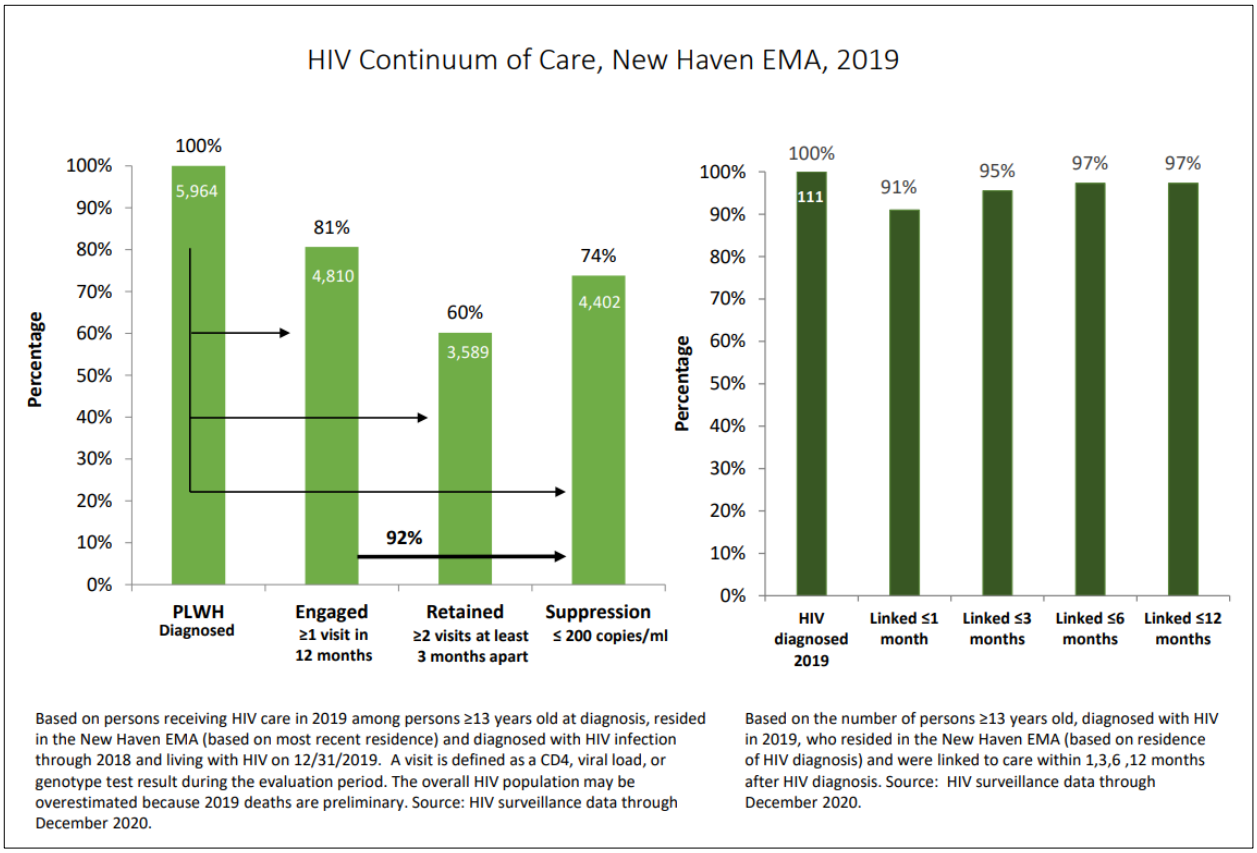
Service Delivery Areas

The New Haven-Fairfield Counties EMA functions in a regional structure whereby provision of accessible, comprehensive quality health care and support service delivery to Ryan White eligible clients is prioritized. The regional divisions are:

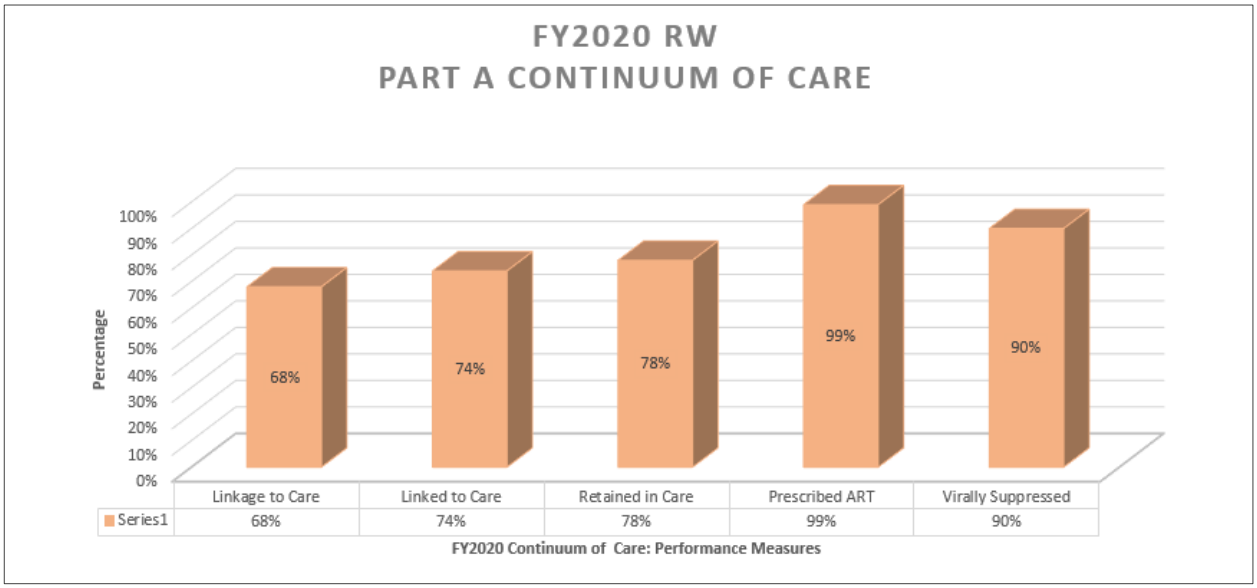
Region 1: Greater New Haven
Region 2: Waterbury, Meriden, and the Naugatuck Valley
Region 3: Greater Bridgeport
Region 4: Norwalk and Stamford
Region 5: Greater Danbury



The New Haven-Fairfield EMA HIV Continuum of Care chart, shown below, is used to assist in determining areas of need and thereby plays a role in guiding CQM efforts.



Similarly, the RWHAP Part A HIV Continuum of Care, shown below, is used to identify disparities within the Part A system of care and determine areas in need of CQM interventions.



It is evident from this that in the RWHAP Part A care system PLWH are achieving higher viral suppression rates and are retained in medical care at higher rates than the general PLWH population in the EMA. This data is reflective of the CQM efforts in the community by sub-recipients to reduce

barriers to care for PLWH entering the RWHAP system of care. The Part A program continues to enhance their CQM plan to further reduce barriers and increase viral suppression among PLWH, with an emphasis on populations who are disproportionately affected.

Structure of the CQM Plan

This plan outlines how the Clinical Quality Management (CQM) Program for Ryan White Part A funded services in the NH-FF EMA is structured and implemented and offers a framework for ongoing improvement. It uses three methods to manage quality of the service delivery system**:**

1. **Outcome evaluation:** This examines the effectiveness of a service or program in achieving its intended results. It assists Ryan White HIV/AIDS Program (RWHAP) subrecipients with determining if they are making a difference in the lives of PLWH. Outcome documentation can be used to ensure and improve service quality, help guide program planning, set priorities, and allocate resources.
2. **Quality assurance**: These are strategies that measure the extent to which the minimum requirements or established standards are met.
3. **Quality improvement:** Strategies that identify problem areas and aim to solve them through implementation of activities to correct the problem, creation of new processes, ongoing analysis of the results, and continuous evaluation until identified problem areas are resolved.

The CQM Program directs activities intended to improve patient care, health outcomes, and patient experience. This CQM Plan lays out:

- Health outcome goals.
- Identified leadership and support for the program.
- Accountability for CQM activities.
- Dedicated resources.
- Use of data and measurable outcomes to determine progress and implement improvements to achieve the aims cited above.

The CQM Plan includes:

- Methods to identify Continuous Quality Improvement (CQI) strategies.
- Monitoring adherence to local and federal HIV service standards.
- Facilitating active involvement of subrecipients in quality improvement projects.
- Promoting communication regarding performance improvement between the Recipient, CQM Committee, subrecipients, Ryan White Planning Council, and consumers.

Prior Year Goals

Prior year goals of the CQM program were as follows:

1. Increase linkage to HIV care in newly diagnosed persons.
    a. Objective: Increase linkage to HIV care in newly diagnosed persons from 64% to 75%.
2. Improve health outcomes for PLWH
    a. Objective: Increase viral load suppression among persons in HIV medical care from 90% to 93%;
3. Reduce HIV related disparities and health inequities.

a. Objective 1: Increase viral load suppression among black women, transgender women of color, and young MSM of color by 5%.
b. Objective 2: Have at least 90% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.

4. Achieve a more coordinated statewide response to the HIV epidemic.
    a. Objective: Strengthen collaboration between HIV prevention and care partners.

Quality Statement

It is the mission of the New Haven-Fairfield Counties' Ryan White Part A Eligible Metropolitan Area (EMA) to improve the quality and delivery of HIV core and support services provided to people living with HIV through systematic monitoring, evaluation and enhancement of the Quality Management Program. Through collaborative efforts with its subrecipients and community partners, NH-FF EMA works to ensure that HIV care and treatment align with the four 2021-2025 National Strategic Plan's primary goals: (1) prevent new HIV infections, (2) improve HIV-related health outcomes of people with HIV, (3) reduce HIV-related disparities and health inequities, and (4) achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders.

Annual Quality Goals

The Connecticut Getting to Zero Report shows that the rate of HIV among MSM of color, Black women, and transgender women is increasing, particularly in Hartford, Waterbury, New Haven, Bridgeport and Stamford. Similarly, data collected from the Part A CAREWare database on newly diagnosed clients showed stark disparities in HIV incidence by age, gender, ethnicity, and sexual orientation. Young MSM of Color and Black/African American women are most at risk of acquiring HIV compared to other demographic groups. The data demonstrated that of those newly enrolled in Ryan White Part A services in FY2019, 47% were Black or African American and 35% identified as Hispanic. Males consisted of 79% of all newly enrolled clients and nearly 65% identified as MSM. The data further showed the median age of newly diagnosed clients to be 32.5 years. As a result, the NH-FF EMA will prioritize activities designed to reduce health disparities in these populations.

The current goals of the CQM Program are as follows:

1. Increase linkage to HIV care in newly diagnosed persons.
    - Objective: Increase linkage to HIV care in newly diagnosed persons from 68% to 72%
2. Improve health outcomes for People Living with HIV.
    - Objective: By the end of FY2021, increase viral load suppression among persons in HIV medical care from 90% to 93%.
3. Reduce HIV-related disparities and health inequities.
    - Objective 1: In the EMA, 135 clients were non-virally suppressed (NVLS) in FY 20. 112 or 83% were Black, Indigenous, and other People of Color (BIPOC). By the end of FY 2021 we aim to improve the viral suppression rate among non-virally suppressed BIPOC by 3% (83% of NVLS to 80%).
    - Objective 2: In FY2021, At least 92% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in

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

4. Achieve a more coordinated statewide response to the HIV epidemic.
    - Strengthen collaboration between HIV prevention and care partners.

Quality Infrastructure

The CQM Program is responsible for EMA CQM initiatives which include assessment, coordination, evaluation, and improvement of RWHAP funded core medical and support services. The QI program is conducted through the combined efforts of the Recipient, its Quality Management staff, and the Planning Council Quality Improvement Committee. The CQM plan is written by the Quality Assurance Manager and updated annually. It is reviewed and approved by the Ryan White Part A Program Director.

CQM Committee Leadership

The Clinical Quality Management Committee: This is comprised of the RWHAP Part A Office Program Director, the RWHAP Part A Office Quality Assurance Manager, the RWHAP Data Processing Project Coordinator, leadership from each region within the EMA, and regional data coordinators. The CQM Committee also includes a member of the Planning Council Quality Improvement Committee, who contributes input between the CQM Committee and the Quality Improvement Committee. The RWHAP Part A Office Quality Assurance Manager chairs the CQM program and facilitates CQM meetings, which are held quarterly.

The Quality Improvement Committee of the NH-FF EMA Planning Council: This committee is responsible for reviewing the data request made by the SPA committee annually for unduplicated client count by service category by region, which is used in the Priority Setting & Resource Allocation (PSRA) process. Additionally, the QI committee reviews the regional site visit findings annually in June/September to identify any areas of improvement that may be needed in the EMA. The QI Committee may also review the service standards and update them accordingly to help improve the areas identified during site visits. It uses service standard-specific performance measures that align with HRSA HAB measures, as well as EMA-specific measures, to guide QI projects. The Committee includes consumer and stakeholder representation.

Stakeholders: These include subrecipients, sub-sub-recipients, Ryan White Part B, C, D, community partners, and State partners. Subrecipients have MOUs with community partners for prevention and linkage to care services in the field.

PLWH Representation: The QI Committee has members who are PLWH. Regional CQM committees hold focus groups with PLWH, have members who are PLWH, or receive input from Consumer Advisory Boards.

Roles and Responsibilities

Name	Title	Agency	Role/Responsibility
Dionne Kotey	Quality Assurance Manager	Part A Office	Chairs CQM committee, facilitates quarterly CQM meeting, reports back to the NHFFEMA Planning Council, reviews regional CQM plans.
Thomas Butcher	Program Director	Part A Office	Approves NHFFEMA CQM plan, under the supervision of Health Director Maritza Bond, MPH.
Arvil Alicea	Data Processing Project Coordinator	Part A Office	Extracts and analyzes NHFFEMA CAREWare data.
Margaret Fikrig (end 6.30.2021) **Michael Virata, MD**	Region 1 CQM Lead	Yale Infectious Diseases Center, YNHH	Attends Quarterly CQM meetings. Conducts and oversees Region 1 quality management program.
Tequetta Valeriano	Region 1 Data Specialist	Yale University AIDS Program	Extracts and analyzes clinical data. Provides support to the Region 1 CQM Lead on quality improvement projects.
Kathyleen Pitner	Region 2 CQM Lead	StayWell Health Center	Attends quarterly CQM meetings. Conducts and oversees Region 2 quality management program.
Maria Prieto	Region 3 CQM Lead	GBAPP	Attends quarterly Part A CQM meetings. Oversees Region 3 quality management program.
Yirley "Gigi" Chaux	Region 4 CQM Lead	Family Centers	Attends quarterly Part A CQM meetings. Conducts and oversees Region 4 clinical quality management program. Extracts and analyzes clinical data.
Albana Lame	Region 5 CQM Lead and Planning Council QI Committee Co-Chair	Apex Community Care	Attends quarterly Part A CQM meetings. Conducts and oversees Region 5 clinical quality management program. Provides feedback (where appropriate) to the NHFFEMA's Planning Council QI Committee, as the QI Committee Co-Chair.

Performance Measurement

Performance measurement involves the collection, analysis, and reporting of quantitative data regarding patient care and health outcomes, as well as qualitative data regarding patient experience. According to HRSA policy, CQM Programs should identify the number of CQM performance measures for each RWHAP service category based on the proportion of the EMA's unique consumers that receive at least one unit of service from that RWHAP service category based on the table below. This applies to any services funded by direct RWHAP funds, rebates, and/or program income.

Percent of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service	Minimum number of performance measures to be selected
>=50%	2
>15% to <50%	1
<=15%	0

The NH-FF EMA used the following FY 2020 information to determine the number of CQM performance measures needed for each service category in FY2021. The selected performance measures for FY 2021 are described in the table below.

Service Category	FY2020 Clients Served (Percentage of Clients Served)	# of Performance Measures Required	Performance Measures
Outpatient Ambulatory Health Services	537 (31%)	1	Percentage of clients with HIV infection whose last viral load in the measurement year is less than 200 copies/viral load suppression.
Medical Case Management	1123 (64%)	2	Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated every 6 months in the measurement year.
			Percentage of HIV-infected medical case management clients enrolled into outpatient/ambulatory health services for HIV treatment as documented CD4/VL measurements or outpatient/ambulatory health services visit in an HIV care setting in the measurement year.
Food Bank/Home Delivered Meals	733 (42%)	1	Percentage of clients who receive food services enrolled into outpatient/ambulatory health services for HIV treatment as documented CD4/VL measurements or outpatient/ambulatory health services visit in an HIV care setting in the measurement year.

The NH-FF EMA has developed performance measures and utilizes clinical quality measures based on the most recent HRSA/HAB Quality Measures and the NH-FF EMA Service Standards for Ryan White funded programs. Performance indicators are monitored quarterly through analysis of data in CAREWare to identify areas needing improvement. Indicators directly pertaining to selected annual quality goals are given priority. The Quality Assurance Manager also collects and analyzes the data from subrecipients and examines stratified data from sources outside of QM activities. QM data and performance measure outcomes are reviewed and shared during quarterly CQM meetings. ***Please see Appendix A for a complete list of Outpatient Ambulatory Health Services Performance Measure descriptions.***

Core and Support services for the EMA are monitored through CAREWare and chart reviews, utilizing HRSA/HAB measures and the NH-FF EMA Service Standards. Outcomes are aggregated along each

service category performance measure indicator and are scored by performance measure outcome for each provider receiving funding for that service. The individual performance measure outcomes are then aggregated by HAB measure to determine the overall QI score for the goals identified by the EMA. Providers are able to review their individual performance measure scores as well as the overall HAB measure scores for the EMA. ***Please follow this link to view the most recently updated NH-FF EMA Service Standards:*** http://nhffryanwhitehivaidscare.org/standards-of-care.html

Data Collection

1. **CAREWare:** The CQM Program utilizes HRSA's CAREWare software for the collection of specific performance measure data for the EMA and is the main data source for the creation of the annual CQM Plan. CAREWare reports can be customized to retrieve data to show the impact of a QI plan on performance measures. Subrecipients are expected to utilize this data when creating QI plans and measuring the progress of specific QI plans.
2. **Department of Public Health**: The Connecticut Department of Public Health supplies the EMA with zip code-specific data for PLWH. The EMA uses this data to identify disparities of care, specifically PLWH who are out of care or not virally suppressed. The EMA continues to analyze this data to show the top zip codes by number of out-of-care individuals and shares the information with each region in order to enhance outreach, linkage, retention and engagement efforts.
3. **Electronic Medical Records:** Some regions utilize data from Electronic Medical Records to identify areas needing QI and measure outcomes.
4. **Patient Satisfaction Surveys/Focus groups:** Used to gather qualitative data in all Regions.

Quality Improvement

The recipient will conduct QI activities within each Ryan White Part A-funded service category. CQM performance measure data will be used to identify potential QI projects. Once the topics for QI projects are identified, QI strategies will be executed within the Model for Improvement framework that employs Plan-Do-Study-Act (PDSA) cycles.

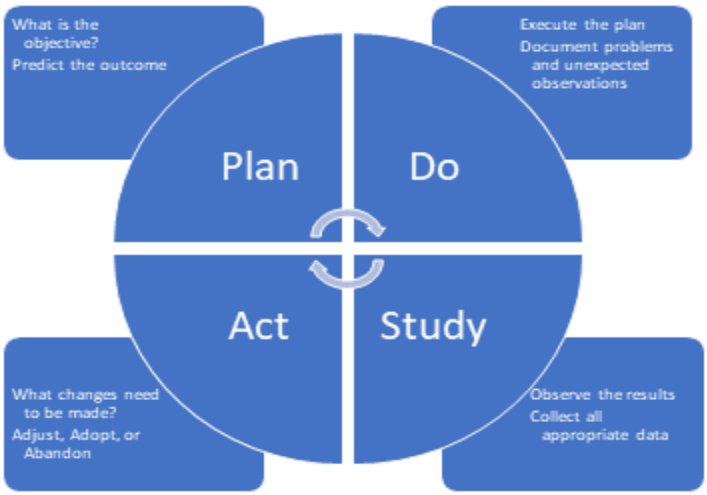
QI Methods

The primary QI Methodology used by the NH-FF EMA is The Model for Improvement, which is comprised of two parts:

1. Three Fundamental Questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

2. The Plan-Do-Study-Act Cycle: This is used to test and implement changes. It guides the test of a change to determine if the change is an improvement and will lead to achievement of identified goals.



The repeated use of PDSA cycles are data driven and begin with small-scale tests. The small-scale tests are modified and enhanced, lending themselves to both a wider-scale test of changes and to the final step of implementation. It is the responsibility of the CQM committee to assess the intervention and determine whether the change should be adopted or modified in the next planning phase, restarting the cycle from the beginning. The PDSA cycle ends when an intervention is adopted, which occurs upon the success of repeated intervention and the attainment of established goals. If the intervention is adopted, it becomes a key component of internal processes, and the committee will identify new intervention cycles. Quality Improvement projects are deemed complete when all targeted goals and objectives have been attained. Current regional QI projects include:

- Data Integrity
- STI Screening
- Viral Load Suppression by Demographics
- Oral Health Screening
- Hepatitis B Vaccination
- Improving MCM Care Plan compliance (every 6 months)
- Improving compliance with Lipid Panel Screenings

QI Documentation and Reporting

Subrecipients maintain customized spreadsheets for each QI project and create slideshows to report updates at quarterly CQM meetings. The recipient maintains a master spreadsheet, to collect data on active QI project activities and track progress toward goals. The CQM manager attends monthly regional CQM meetings, where she provides updates and technical assistance, and reports back to the Project Director. The RWHAP Part A Office Data Processing Project Coordinator also attends regional CQM meetings upon request to provide data-entry education and receive updates from subrecipients.

Subrecipient Engagement, Support, and Monitoring

The Part A Office requests, reviews and monitors regional CQM plans. When possible, the QA Manager attends regional CQM meetings, to provide feedback and technical assistance.

Through quarterly program reports and monthly data assessments in partnership with the Data Processing Project Coordinator, the Part A Office monitors regional performance measures and brings

attention to any that require improvement. At least one performance measure is assigned to each service category. Performance measures below 85% are discussed to determine the appropriate next steps. Additionally, the Project Director, Data Processing Project Coordinator and QA Manager discuss CAREWare data monthly to determine where improvements might be needed. Where appropriate, regions are supported to develop PDSAs to improve underperforming performance measures.

During quarterly Part A CQM meetings, regions share resources, request technical assistance and provide updates on active and retired PDSAs. This serves as another opportunity for the Part A office to provide any guidance needed for quality improvement. Selected performance measures are reviewed during the meeting to engage the regions in discussions around prospective QI projects to explore. ***Please see Appendix B for Regional CQM Plans.***

New regional CQM staff are offered an introduction to CQM and the NHFFEMA's CQM Program by the Part A Office to ensure smooth continuation of CQM initiatives.

QI Timeline

Activity	Responsible Party	Frequency/Date
Approval of CQM Plan	CQM Committee	Annually
Review of QI Activities	CQM Committee	Quarterly
Review of Performance Measures	Part A Team	Monthly
Review of Regional CQM Plans	Quality Assurance Manager	Annually

CQM Program Evaluation

The CQM Program will be evaluated annually using a standard format and with the input of the CQM Program's various stakeholder groups. The workplan will be used to track progress made toward achieving goals, objectives, and activities with subrecipients and stakeholders.
The following tools will also be used to evaluate the CQM Program:

- CQM Performance Measurement data, including patient experience data.
- Service Standards review results (chart reviews).
- Achievement of CQM Plan Work Plan tasks and hence Annual Quality Goals.
- Recipient-level HAB CQM Organizational Assessment.
- Subrecipient-level HAB CQM Organizational Assessment.
- Quality Improvement Project Results.

Where possible, quantifiable results will be used and converted into visuals to help stakeholders in processing information. Qualitative data collected through the CQM Program evaluation will be carefully coded for analysis or summarized as appropriate for the purpose of CQM Program stakeholder engagement and discussion. The results of the CQM Program evaluation will be made publicly accessible through a variety of channels.

Updates to the Plan

CQM staff will update the CQM Plan annually based on the most recent CQM Program evaluation and in collaboration with the other CQM committee members and the Planning Council's Quality Improvement Committee. The Planning Council QI committee will provide information on any changes in their responsibilities. Data will be reviewed during the first CQM meeting each year in April and will continue each quarter during the CQM meeting. The plan will be developed with each region's CQM plan in mind.

Approval of CQM Plan

This CQM plan has been reviewed and approved by the EMA RWHAP Part A Office Program Director, Thomas Butcher, under the leadership of Maritza Bond, MPH, Health Director.

Thomas Butcher

Date: June 21, 2021

Thomas Butcher, MEd
Program Director
RWHAP Part A Office

Attachment 1 – Work Plan

2021-2022 GOALS:			
NHEMA Goal 1: Increase linkage to HIV care in newly diagnosed persons			
OBJECTIVE: Increase linkage to HIV care in newly diagnosed persons from 68% to72%			
STRATEGIES	**ACTIVITIES/ INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
1. Promote and facilitate access to health care. 2. Strengthen access to care initiatives, including reengagement in care.	**Collaboration and Partnerships:** • NH-FF EMA Recipient to continue support for the ICM/MCM entry/re-entry into care program through assessment of quarterly reports and technical assistance as needed. • Renew Memorandum of Understanding (MOU) with existing prevention community partners. Create new MOUs with additional community partners. • Gather, compile, and disseminate list of HIV medication prescribers outside of the Ryan White system of care. Engage these providers to ensure that newly diagnosed clients under their care are aware of available services to assist them with overcoming barriers to remaining in medical care. • Conduct semi-annual review of compliance with utilization of most-up-to date ART by region. **Evidence-based, client-centered care:** • Work with community HIV providers to continue strategies in the Intensive Case Management (ICM) program that focuses on newly diagnosed and out-of-care priority populations to remove barriers to care and successfully link clients to care.	Recipient, Sub-recipients, sub-sub-recipients.	Newly diagnosed individuals
EVALUATIVE MEASURES: Increase linkage to HIV care by 4%. HAB measures for linkage to care will be used and can be run through CAREWare			

NHEMA Goal 2: Improve health outcomes for PLWH			
OBJECTIVE: By the end of FY2021, increase viral load suppression among persons in HIV medical care from 90% to 93%			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
1.Optimize and increase resources available to impact PLWH 2.Strengthen capacity to implement quality improvement initiatives.	**Evidence-based, client-centered care:** • Continue the Intensive Case Management (ICM) program through the Minority AIDS Initiative funding to prioritize enrollment of clients who are non-virally suppressed or non-adherent to treatment. • Within the ICM program, utilize evidence-based and evidence-informed interventions	Recipient, subrecipients, sub-subrecipients, intensive case managers.	Non-virally suppressed individuals

	that have shown to be effective at increasing viral suppression. (outlined below in Goal 3) **Collaboration and Partnerships:** • NH-FF EMA Recipient to continue support for the ICM/MCM entry/re-entry into care program. • Provide CQM training to all subrecipients and new QI staff. • Gather, compile, and disseminate list of HIV medication prescribers outside of the Ryan White system of care. Engage these providers to ensure that clients under their care are aware of available services to assist them with overcoming barriers to viral suppression. • Assess each Region's Treatment Adherence services and review data on viral suppression/retention rates. Use data to inform Regions and provide support for implementing or improving current practices. • Research pharmacy services that can assist with medication adherence support. • Collaborate with other programs or other states with similar programs on what methodologies they have implemented.		
NHEMA Goal 2: Improve health outcomes for PLWH (cont.)			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
	Use of Data • Utilize data to identify zip codes with low rates of viral suppression and demographic details of non-suppressed populations. Share information with each region for use in their ICM/MCM programs. Data from CAREWare to be reviewed quarterly for viral suppression. DPH data for each region will be requested for the grant application to use in this review as the baseline. Use strategies that align with Ending the Epidemic to support programs in each region. • Carry out regional PDSA cycles to increase viral load suppression among priority populations identified by the Planning Council		
Evaluative Measures: Increase viral suppression by 3%. HAB measures for viral suppression will be used and can be run through CAREWare.			

NHEMA Goal 3: Reduce HIV-related disparities and health inequities.			
OBJECTIVE 1: OBJECTIVE 1: By the end of FY 2021 improve the viral suppression rate among non-virally suppressed BIPOC by 3% (83% of NVLS to 80%).			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**

1.Analyze data sets by race/ethnicity and other factors relevant to social determinants of health. 2. Introduce and scale effective. Evidence Based Strategies to reach priority populations 3.Engage communities to inform the planning process.	**Improve Data Analytics and Meaningful Use** • Use data to identify priority prevention and care populations. • Update HIV epidemiological profiles and care cascades to display data in meaningful ways that inform issues on health equity. • Utilize DPH data to identify zip codes with low rates of viral suppression and high numbers of individuals in priority populations. Review CAREWare data for each region to analyze improvement efforts of ICM/MCM programs.	**Recipient, sub-recipients, sub-sub-recipients**	**Black/AA women, Transwomen of Color, and Young MSM of Color**
NHEMA Goal 3: Reduce HIV-related disparities and health inequities. (cont.)			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
	• Present data to regional lead agencies in a timely manner. • Regional PDSA cycles focused on increasing viral suppression in identified priority populations. • Hold client-focused virtual meetings and educational sessions in a manner that protects clients' identity. Utilize surveys and other methods for input from community to better understand and plan for improving health disparities and decrease health inequity. **Evidence-based, client-centered care:** • Continue the Intensive Case Management (ICM) program through the Minority AIDS Initiative funding to prioritize enrollment of clients who fall into priority populations. • Implement trauma-informed approach and care, as well as the ICM in all regions as applicable. Offer motivational interviewing training for ICM/MCM programs. • Continue HIV Care Coordination EBI – Continue workgroup meetings among 5 regions for ICM and MCM teams to share home- and field-based strategies for achieving engagement in care and viral suppression in priority populations. • Continue initiatives from Women Involved in Life Learning from		

	Other Women (WiLLOW) EBI for African American women in Region 3. • Continue initiatives from Region 1 for MSM , for example increasing access to at-home HIV tests, telehealth PrEP appointments, and revamping online outreach through social media.		
NHEMA Goal 3: Reduce HIV-related disparities and health inequities. (cont.)			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
	• Continuation of bi-weekly case conferences with clinical partners and ICMs in each region to educate and inform of ICM services. **Training and information-gathering:** • Continue training program to foster equity of knowledge among regional planning groups and communities. • Conduct listening sessions with priority populations.		
Evaluative Measures: Improve non-virally suppression rate in identified priority populations by 3%. HAB measures for new diagnoses and viral suppression will be used and can be run through CAREWARE. DPH incidence rates will also be used for new diagnoses.			

NHEMA Goal 4: Reduce HIV-related disparities and health inequities.			
OBJECTIVE 2: In FY2021 At least 92% of clients receiving medical case management services are actively engaged in medical care as documented by at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
1.Promote and facilitate access to health care. 2. Introduce and scale effective Evidence Based Strategies to reach priority populations	**Collaboration and Partnerships:** • NH-FF EMA Recipient to continue support for the ICM/MCM entry/re-entry into care program. **Evidence-based, client-centered care:** • Continue the Intensive Case Management (ICM) program through the Minority AIDS Initiative funding to prioritize enrollment of clients who are non-virally suppressed or non-adherent to treatment. • Within the ICM program, utilize evidence-based and evidence-informed interventions that have	**Recipient, subrecipients, sub-subrecipients, intensive case managers, medical case managers.**	**Black/AA women, Transwomen of Color, and Young MSM of Color. Clients enrolled in case management services.**

	shown to be effective at increasing viral suppression.		
NHEMA Goal 4: Reduce HIV-related disparities and health inequities.			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
	• Conduct PDSAs to address data integrity as it relates to compliance with timely care plan updates and development.		
Evaluative Measures: Increase in number of MCM clients attending at least one medical visit in each 6-month period of the 24-month measurement period to 92%. Use of CAREWare data for medical visits attended by medically case managed clients.			

NHEMA Goal 5: Achieve a more coordinated statewide response to the HIV epidemic			
OBJECTIVE: Strengthen collaboration between HIV prevention and care partners.			
STRATEGIES	**ACTIVITIES/INTERVENTIONS**	**RESPONSIBLE PARTIES**	**PRIORITY POPULATIONS**
1. Enhance communications and information sharing between stakeholders	**Collaboration and Partnerships** • Reassess ICM/MCM workflows for program and quality assurance methodologies continuously for improvement and introduce additional EBI/EIIs to improve entry/re-entry into care. • Identify any protocols/processes that need technical assistance and/or refinement. • Conduct at least two (2) meetings for Regional Leads and CQM Committees to review data, assess the effectiveness of the ICM services, determine additional strategies to address any deficiencies in the delivery of ICM services. Identify best approaches to facilitate warm hand offs from ICM to MCM for clients who achieve linkage and retention. • Renew MOUs with existing prevention community partners and create additional MOUs with new community partners. Engage community partners in CQM process and regional CQM meetings.	**Recipient, Germane Solutions.**	**All**
Evaluative Measures: Was ICM/MCM workflow assessed? Were processes/protocols needing technical assistance identified and refined? Did the 2 meetings occur? Were new MOUs created? How many? How many regional CQM meetings did community partners attend?			

Appendix B: New Haven-Fairfield EMA Regional Clinical Quality Management Plans

Region 1- (New Haven) Clinical Quality Management Plan

March 1, 2021 – February 28, 2022

I. General Information

Grant Recipient: Ryan White Part A Office

Lead Agency: Yale University

Last Approved: 05/12/21

II. Quality Statement:

The goal of the Region 1 Continuum (R1C) Clinical Quality Management Plan (QMP) is to systematically monitor, evaluate, and continuously promote the improvement of quality HIV care and services to all People Living with HIV (PLWH) in Region 1, through the combined efforts of all R1C service providers and by using the US Department of Health and Human Services Guidelines to set benchmarks, establish uniform measurements, and monitor performance measure data to promote best practices among the stakeholders, and to disseminate tools that promote high quality and cost-effective care for the PLWH in Region 1.

III. Annual Quality Goals

The following goals address a region-wide process for planning, designing, measuring, assessing, and improving performance. The SARS-CoV-2 pandemic has continued to force the delay of appointments or video/telephone appointments with consequent decrease in laboratory draws. The duration of the pandemic is unknown at this time, but the QM team will continue to monitor performance measures and adjust time points for PDSA's as the pandemic progresses.

A. Goal 1: The CQM, the RW Consumer Subcommittee and the CT AIDS Education Training Center developed in 2020-2021 an educational curriculum about the CQM's quality management measures and goals and will continue to present this curriculum to PLWH at least twice a year.

Objectives:

i. Educate the R1C members and PLWH about quality principles, methods, and standards of care.
ii. Assess delivery of the services provided within Region 1 through surveys and/or focus groups.

B. Goal 2: Improve viral suppression rates among special populations to 95%. African-American men have the lowest viral suppression rate in the R1C at 92.5%. We will use the same techniques used in our PDSA for viral suppression in African-American women, as we increased that rate to 95%.

C. Goal 3: Utilize HAB performance measures and goals selected to improve PLWHA progress along the HIV continuum. Any performance measures under national benchmarks will be monitored by the individual clinics and reviewed at monthly regional QM meetings until numbers improve to meet or exceed benchmarks.

D. Goal 4: Utilize Plan, Do, Study, Act (PDSA) as a quality improvement tool to develop and implement strategies to address variances in the provision of care and services, as well as to prevent health disparities among various sub-populations of PLWH. PDSA cycle will be repeated or altered until the goal percentage is met for that performance measure.

IV. Quality Improvement Infrastructure

- The purpose of the Quality Management team is to review the quality of patient care and patient services and to implement changes to improve patient care and services.
- The QMC for R1C meets monthly, on the second Wednesday of the month. In March after RSR is submitted, the committee reviews the results and designates areas that need further attention. PDSAs are created to address specific areas needing improvement. Performance measures are reviewed quarterly, updates from the continuum and client satisfaction surveys are discussed. Note that due to COVID19, members have been working remotely, so the QM team will meet virtually via Zoom.
- The R1C QM program progress and performance measure reports will be on the agenda and presented at the monthly R1C meetings. The committee will develop the Quality Improvement (QI) work plan annually and monitor its progress quarterly. The plan will be approved by the Quality committee co-chairs, Dr. Fikrig and Dr. Barnes. On an annual basis, the committee will review the QM infrastructure and identify areas where more resources should be allocated or changed.

The Quality Management Committee (QMC) is comprised of stakeholders from the R1C and PLWH. The current R1C QMC includes.

Name	Title	Role/Responsibility
Dr. Margaret Fikrig Yale Infectious Diseases Center, YNHH As of July 1, 2021: Dr Michael Virata Yale Infectious Diseases Center, YNHH	Co-Chair	Facilitate CQM meeting. Responsible for the implementation of the CQM Program and implements PDSA studies at Yale Infectious Diseases Center, YNHH
Dr. Arti Barnes Cornell Scott-Hill Health Center	Co-Chair	Reports CQM efforts to the Region 1 continuum and brings updates from continuum back to the committee. Work with R1C Consumer Subcommittee representative and AETC representative to draft QM curriculum for consumer education. Responsible for the implementation of the CQM Program and PDSA studies at Cornell Scott Hill Health Center.
Wynnett Stewart Yale Infectious Diseases Center, YNHH	Registered Nurse	Responsible for Yale Infectious Diseases Center, YNHH data collection and performance measures. Implements PDSA studies at Haelen Center.
Wendy Cusick Fair Haven Community Health Center	Registered Nurse	Responsible for Fair Haven Community Health Center data collection and performance measures. Implements PDSA studies at Fair Haven Community Health Center.
Nitza Agosto Cornell Scott-Hill Health Center	Department Manager	Responsible for Cornell Scott Hill Health Center data collection and performance measures. Implements PDSA studies at Cornell Scott Hill Health Center.
Tequetta Valeriano Yale Infectious Diseases Center, Yale University	Ryan White Statistical and Data Coordinator	Responsible for Region 1 data collection, reporting, and performance measures.
Gary S. Consumer Representative	Consumer	Responsible for discussing patient barriers to care, ways to improve services, and provide feedback on client satisfaction surveys. Work with QMC co-chair and AETC representative to develop QM curriculum to educate consumers. Attend monthly QI meetings.
Sandra Gossart-Walker Yale Child Study Center	Assistant Clinical Professor	Sub-contractor representative from mental health agency

Jennifer Loschiavo Recovery Network of Programs, Inc	Coordinator of Special Population Department	Sub-contractor representative from inpatient/outpatient substance use treatment organization
Jocelyn Antunes New Reach Inc	Supportive Housing Program Manager	Sub-contractor representative from housing, emergency financial assistance and MCM support organization
Nick Boshnack, MSW A Place to Nourish Health	Director of Client Services	Sub-contractor representative from HIV health agency
Robert Sideleau New England AIDS Education and Training Program	Registered Nurse, BSN	Responsible for drafting QM education curriculum for consumers and presenting to the information to consumer groups.

- All Ryan White Clinics in New Haven have representation in our committee.
- All sub-contractors have been invited to participate in the monthly meeting of the R1C QMC, those available at the meeting time participate.
- A representative from the Quality Committee attends the Quarterly Clinical Quality Management meetings held by the Part A office, and Planning Council meetings.
- The Part A office provides guidance on quality management efforts and PDSAs.
- In March, at the end of the fiscal year, the committee meets to review the annual goals set for that year and determine whether those goals were met and discuss ways to improve areas that still need improvement.

V. Performance Measurement

The following HAB – domain wide performance measures will continue to be measured where applicable. For agencies such as CSHHC which also provides non-primary care services such as oral health and dental services, agency wide measures will apply to avoid double counting of services across multiple sites. The below performance measures are selected based on HRSA Primary Care Service Standards and areas that need improvement in Region 1. These measures are selected with the aim of monitoring and keeping PLWH connected with and engaged in their HIV care, screening for and treatment of sexually transmitted infections, and prevention of other co-morbidities. This year the goal is to examine and report on HAB data for Part A eligible clients entered into the CAREWare database to ensure quality care for all PLWH. On a quarterly basis, each agency will review selected performance HAB measures to make sure the agency is on the right track and identify what can be done to improve performance if necessary.

The performance measures listed below will be evaluated every 3 months during our monthly QI meeting.

PTADW01	2 HIV Primary Care visits in the measurement year
PTADW02	Viral Suppression
PTADW03	ART prescription
PTADW08	2 viral load tests per year, at least 3 months apart
PTADW09	Cervical PAP screening in the measurement year
PTADW10	Syphilis screening
PTADW 14/15	Chlamydia and Gonorrhea screening
PTADW16	Lipid screening in the measurement year
HABDW09	Hepatitis C screening
HABDW19	Influenza Vaccination rates

- The performance measures described above are evaluated every 3 months.
- A 10% decrease in a performance measure will open a conversation about creating a quality improvement plan and implementing interventions at the clinics. The next section describes our Quality Improvements Projects planned for implementation in 2021.
- Health disparities will be assessed by reviewing performance measures that have lower rates than desired by breaking them down into demographic subgroups. If numbers for certain demographics are lower than the overall numbers, then a health disparity is identified and should be addressed (via PDSA etc.)
- Our efforts are presented in a PowerPoint Presentation at the Quarterly Clinical Quality Management Meetings and guidance regarding next steps is provided by the Part A office and the rest of the Quality Committee representatives from other regions in the EMA.

VI. Quality Improvement

- The committee will conduct at least 2 Quality Improvement activities per year. These will be identified based on performance measures being monitored identified in Section V above. PDSAs will be developed and implemented for performance measure improvement. During the committee's March QI meeting, the data, the QM plan and activities will be assessed. This will facilitate discussion and planning of future quality improvement plans/activities for the following year. We will determine whether goals have been achieved and evaluate barriers, resources and collaborations. Additionally, we will evaluate data and consumer feedback to determine and implement the study of any other issues beyond HAB measures which need to be addressed by PDSAs.
- Quality improvement will be done using the PDSA model which is Plan, Do, Study, Act. Running performance measures, audit reports, etc. serve to identify certain clinical outcomes that need to be addressed to improve quality of care for our clients. The committee then creates a study strategy (Plan) explaining what will be done from data collection (Do), analysis (Study), and then an intervention that will be implemented (Act).
- On a quarterly basis, each agency will review selected performance HAB measures to make sure the agency is achieving the target goal and identify what can be done to improve performance if necessary. Any performance measure or PDSA not reaching its goal will be discussed with the Part A office and/or other regions' QM teams to share information on problem solving techniques between regions.

Proposed QI Projects

1. Sexually Transmitted Infections Screening:
    a. This year we will continue our R1C STI project to improve screening rates for Syphilis, Chlamydia and Gonorrhea. The PDSA in progress was reported to the Part A office at the Clinical Quality Management Meeting in January and showed a decrease in STI screening rates, partly due to labs not being obtained during the Covid pandemic. We did however, reach our goal of >80% screening by the end of the RW fiscal year of February 28, 2021 with 83.7% of clients screened for STI's. Our goal is to reach 90% for all STI screenings by the end of the year 2021.
2. Client Satisfaction Surveys:
    a. Client satisfaction surveys were not administered during the pandemic as patient care methods were constantly in flux.

3. Cervical PAP/cancer screening:
    a. The cervical cancer screening rate for Region 1 on 12/31/20 was 21.35%. We believe this mostly reflects that the performance measure denominator still stipulates annual cervical cancer screening, whereas the DHHS guidelines for cervical cancer screening in women with HIV has decreased to every 3 years if results are normal, so this will affect a decline in annual screening monitored by the current performance measurement. Our goal is to reach 90% cervical cancer screening as performed by the DHHS guidelines, by the end of this fiscal year, February 2022. Individual clinics' QMC representative will monitor this performance measure and ensure that women are being scheduled for their screening when due and report to the QMC at the quarterly PM review meeting.
4. Retention in Care:
    a. The quality committee will focus on making sure that retention in care numbers remain around 90% or higher. The clinic staff will consistently work with the data managers on updating "out of care" client lists and contacting those clients to bring them back to clinic. Following the 90:90:90 World HIV Goals, 90% retention in care is our goal. Individual clinics' QMC at the quarterly PM review meeting.
5. Hepatitis C Screening and Treatment:
    a. Yale has obtained a HRSA grant (HRSA 047) entitled "Curing HCV in Persons of Color Living with HIV" which uses a Data to Care approach to improve HCV treatment outcomes. Three of the Region 1 clinics are participating in this grant. One clinic has achieved an 86% cure rate of those eligible for treatment, and the two other clinics have 71% cure rate of those eligible for treatment. We will continue to participate in this grant to reach the goal of 100% cured.
6. Quality of Data:
    a. The quality committee will focus on improving the quality of data by decreasing the percent data error and shortening the data entry lag onto CAREWare. All Region 1's clinics have recently acquired an electronic bridge between their lab provider and CAREWare, which should improve accuracy and speed of data entry. All clinics, however, have encountered glitches in transmission of certain labs that are being addressed.
7. Viral Suppression:

a. The committee completed the PDSA on improving viral suppression rates in our African American female patients, as the rate increased to 95% by 12/31/20. We will now do a similar PDSA for African American men whose rate of viral suppression was 92.5% on 12/31/20, to get their rate to 95% as well. Individual clinics' QMC representative will provide updates on progress at monthly QMC meetings.

8. CAREWare Share Information Requests
    a. The R1 QMC performed a SWOT analysis this year for our ambulatory clinics and all subcontractors. We identified that many participants were unaware of the utility of Share Requests and how to generate one and grant one. The quality committee will work to increase the use of Share Requests and improve the response rate to grant Share Requests as this will enhance the care of our clients.

The QI projects for Region 1 are documented in a quarterly table format by clinic and by entire region. The rates are reviewed every quarter, and the committee discusses ways to achieve goal rates over the next quarter. The co-chair keeps a binder of all agendas, minutes, performance measure reports, and PDSA reports. The Region 1 QM Committee will actively participate in the upcoming quarterly clinical QM meetings organized by the RW Part A Office. Region 1 QI projects are also documented at the CQM Quarterly meetings. QI projects are selected based on Quality Committee discussion and input from the Part A office during Clinical Quality Management quarterly meetings.

VII. Work Plan

Quality Improvement Plan Quality Management Committee (QMC)

Ryan White Region 1

March 1, 2021 – February 28, 2022

Objectives	Activity	Timeline	Responsible Person	Outcome
1. Quality Committee Governance	• The QMC will continue to meet monthly to ensure the implementation and monitoring of the QI plan • Minutes will be maintained at all meetings and members will share this responsibility on a rotating basis.	March 1, 2021-February 28, 2022	The Co-Chairs of the QMC will inform the agenda for the meetings with input from members and report back to the Region 1 Continuum (R1C)	• Agenda, attendance, and minutes recorded at each of the meetings and shared with the R1C. • Data collected and assembled for Quarterly reports to be presented to R1C. • Committee list, attendance at meetings.

	• The QMC will maintain communication with data management team members to ensure continuity and accuracy of data entry and extraction. • The QMC will work with the Quality Management Committee of the Lead Agencies and RW Part A Office/Planning Council QMC to determine its structure, focus and quality planning activities moving forward. • A consumer was identified to participate in monthly QMC meetings. • Subcontractors were invited to designate someone to participate in the QMC monthly meeting.			• A consumer has agreed to participate in the QMC monthly meetings, and their input is sought on all discussions. Subcontractors agreed to have a representative from their agency at monthly QMC meetings. • Attendance at meetings and recorded minutes and quality plan.
2. Ensure Quality HIV Care in Region 1: Monitoring HAB Performance Measures	The performance measures below will be addressed: • HIV Care and Outcomes: -2 Primary Care visits PTADW01 -2 Viral Load tests PTADW08 - Viral Suppression PTADW02 - ART Prescription PTADW03 • Sexually Transmitted Infections: -PTADW 10, 14, 15 • Prevention Co-morbidities: - Influenza vaccination HABDW19 - Lipid Screening PTADW16 - Cervical PAP screening PTADW09 - Hepatitis C Screening HABDW09 • All data will be entered and extracted by the data coordinators in each of the respective clinics comparing respective quarterly results to same	Quarterly between March 1, 2021-February 28, 2022	Data managers from each clinic run the performance measure report quarterly and send to Part A CQM lead data manager to create Region 1 Quarterly Performance Measure table.	• Quarterly reporting and examining Part A Domain Wide numbers for trends in HAB measures specifically in response to PDSA and reporting to R1C. • Quarterly Performance Measure table is analyzed and plans for improvement are made. • Review and analyze patient information and develop PDSA's.

	quarter of the prior year and forwarded to the Co-chairs on a quarterly basis.			
3. Ensure Quality Service Delivery	• Client Satisfaction Surveys • Quality In-services for: -Providers: each individual clinic representative will review quality measures and standards of care for Ryan White HIV care at regular intervals through established meetings. - Consumers: QMC members will conduct upon request Quality training for Consumer Committee to review quality measure and screening guidelines. • Conduct patient focus groups to gather more meaningful information from patients and to combat patient survey overload.	Twice a year between March 1, 2021-February 28, 2022	All committee members	Due to the Covid-19 pandemic and constantly changing modes of patient care, client satisfaction surveys will not be administered during this monitoring year. • PM's are discussed at clinics' provider meetings and plans for improvements discussed at those meetings. • A consumer QM education forum was held and was well received by those in attendance, generating information and ideas they could bring back to the Consumer Committee. • Another consumer QM education initiative is being planned.
4. Develop and Implement Quality Improvement Projects	• Plan, Do, Study, Act (PDSAs) for Performance Measures <80% STI (ongoing)-Region Wide Lipid Screening- (ongoing)-Region Wide Influenza vaccination (ongoing)-individual clinics Cervical PAP screening-(ongoing)- • Viral Suppression PDSA: Each clinic will provide data from the custom CAREWare report created by Avril which looks at gender. race, ethnicity, age, and HIV risk factor. • Tobacco Cessation Counseling PDSA- clinics will determine which Part A clients have not been counseled and implement measures to improve the rate of counseling. • Data collection for the HRSA 047 HIV/HCV study	Quarterly between March 1, 2021-February 28, 2022	All committee members	• Monitor HAB measures quarterly for trends in response to PDSAs. • Results of PDSA will be reviewed and analyzed to determine what we will do with the findings. Based on findings we will adapt, adopt, or abandon the PDSA cycle. • Year-end 2021 data from each clinic will be compared to 2020 data. Results will be reviewed and analyzed to determine what we will do with the findings. Based on findings we will adapt, adopt, or abandon the PDSA cycle. • Review of data provided. By the research team • Curriculum for educating consumers currently includes: 1. Screening tests for lipids 2. Screening for cervical cancer 3. Screening for STIs 4. Screening for viral suppression.

	• The QMC will work with Ryan White Consumer Subcommittee and the CT AIDS Education and Training Center to create a curriculum to educate consumers on various Quality Management issues and have one of their members attend QMC meetings.			5. Screening for diabetes. 6. Screening for influenza vaccination Specific dates and times for future educational opportunities will be determined through communication between the QMC co-chair representative to the Continuum, the consumer subcommittee representative to the QM committee, and Robert Sideleau from CT AETC. One representative from the QMC will attend the monthly consumer meetings when trainings are being presented. The goal will be to have at least two consumer education forums per fiscal year. The QMC "Continuum" co-chair will review the curriculum at the start of each RW fiscal year and make any necessary changes and educate the RW Consumer Subcommittee representative about the changes.

The work plan and activities conducted by the QM committee will be reported to the Ryan White continuum, Ryan White Part A office, PLWH, clinic staff, community agencies, and other grant recipients. Each committee member presents the data and work plan from the Region 1 Quality Management team at their individual clinic team meetings.

Ryan White and Prevention Clinical Quality Management Plan 2021

Clinical Quality Management Plan

Effective Date: 01.31.2019	**Last Review Date**: 01.20.2021	**Revised Date:** 06.05.2021

I. PURPOSE OF THE PLAN

Ryan White HIV/AIDS legislation requires clinical quality management (QM) programs as a condition of grant awards. The purpose of this QM plan is to guide the StayWell Health Center HIV Care and Prevention Quality Management (QM) program and related activities. Although StayWell and HIV service providers have been conducting QM activities for many years, this plan formalizes these activities and provides an important structure for ongoing and future work. It articulates the goals of the QM program, identifies key roles, establishes annual goals and objectives (including priority performance measures), and recommends additional goals, objectives, and activities for subsequent years (to be re-assessed at the end of the first year). Lastly, the plan provides a timeline for key activities to facilitate progress toward the goals and objectives.

II. CLINICAL QUALITY MANAGEMENT INFRASTRUCTURE

The CQM committee has been established in accordance to "Title XXVI of the Public Health Service Act" as stated in the *Clinical Quality Management Policy Clarification Notice* (PCN) (No. 15-02). The establishment of the committee serves to assess and develop CQM strategies that will improve the accessibility to and the delivery of health care and ancillary services, which are consistent with the guidelines of the *U. S. Department of Health and Human Services* (HHS).

Under the leadership of the Quality Assurance Director (QAD), the committee collaborates on a monthly basis and comprises professionals of multiple disciplines, representing the sectors of health care, public health, and human services (see Table 1). The multidisciplinary committee is responsible for the planning, direction, and coordination of all CQM activities that are evaluated and approved against empirical data and evidence-based interventions.

Table 1. Clinical Quality Committee

Name	***Title***	***Role/Responsibility***
Tess Lombard, MD	Chief Medical Officer	CQM advisor
Kathyleen Pitner	Program Director	Presider and CQM director - Oversees data processes and writes/updates CQM/QI plans
TBD	Client Advocate	Provides input in behalf of clients.
Elie Helou, MD	Primary Care and Infectious Disease Specialist	QAD, establishes quality and reliability standards; Infectious Disease expert
Zife Krosi, MD	Primary Care and Infectious Disease Specialist	Subject-matter expert on clinical care and requirements
Lindsey Marr, APRN	Nurse Practitioner	Subject-matter expert on clinical care and requirements
Susan Alward, CM	Midwife, OB-GYN	Subject-matter expert on clinical care and requirements
Claudia Denze, LPN	Licensed Practical Nurse	Subject-matter expert on basic nursing practices
Samuel Smith, RDN	Dietician	Subject-matter expert on nutrition
Jacqueline Davis	Assistant Director of Behavioral Health	Subject-matter expert on mental health and substance abuse
NormaMarie Martinez	Supervisor, Dental	Subject-matter expert on office administration, dental
Elda Martinez	Supervisor, Medical Case Management	Subject-matter expert on case management
Kathy Bonilla	Intensive Medical Case Manager	Engages hard to reach patients, non-virally suppressed, into care.
Keith Taylor	PrEP Navigator	Subject-matter expert on PrEP, conducts outreach activities
Juliana Mantey	TA/QI Nurse, RN	Subject-matter expert on nursing and QI practices
Joshua Jordan	Institutional Research Specialist	Data integrity
Griffin Suter	Community Resource, Walgreens Pharmacy	Resource for medication and vaccine administration
Scott Nelson	Subcontractor, MCCA Waterbury Director of Waterbury Outpatient Services	Expert on behavioral health and substance abuse diagnoses

Jennifer Loschiavo	Subcontractor, RNP Coordinator Special Population Department	Expert on behavioral health and substance abuse diagnoses

CQM Committee Leadership. The key roles and responsibilities are specific to the leadership of the CQM committee by whom the quality management activities are commissioned and guided:

CQM Advisor

Advises on and ensures that all aspects of clinical services—as it relates to CQM practices—are administered in accordance with generally accepted professional standards, reviewing cases, and addressing all matters of quality control and performance protocols. The incumbent also appropriates resources and manages any issues or concerns of CQM stakeholders to sustain a positive team culture.

Quality Assurance Director

Reviews clinical data and establishes quality standards, processes, and systems by which all CQM activities are executed in the pipeline of its development, providing leadership and direction to committee members that will promote growth and development and quality improvement practices within the infrastructure of CQM operations.

Program Director

Acts as liaison to both the HRSA/HAB project officer and the Planning Council Quality Committee (as an executive board member) and conveys HRSA/HAB *priorities* to members of the CQM committee. Ultimately, the vision, scope, and mission of performance improvement management are effectively communicated to help develop quality improvement programs and support long-term goals. Hence, the establishment of quality improvement initiatives rest with the incumbent who assumes the responsibility of ensuring that data-driven performance management and quality improvement programs are designed and implemented to align with the CQM program's strategy. It is also the ongoing collaboration with the Clinical Informatics Director and Institutional Research Specialist that information is gleaned, assessed, and reported to members for feedback and informational purposes. Also, the program director collaborates with the QAD to ensure that the CQM plan has been reviewed, updated, and approved by the CQM committee.

The ability of leadership to work in harness with other stakeholders will influence performance measurement practices—a key process of the QI plan and its improvement strategies. Leadership shares QM/QI findings and reports with stakeholders. Stakeholders include the Connecticut HIV Planning Consortium (CHPC), and the New Haven/Fairfield HIV Planning Council, The City of New Haven Ryan White (Part A), HRSA (Part C), CT DPH (Prevention) and Community Health Association of Connecticut (Part D).

III. QUALITY STATEMENT

StayWell Health Center (SHC) serves *people living with the human immunodeficiency virus (HIV)* (PLWH) within the medically underserved Greater Waterbury community, providing comprehensive services (that are funded by Parts A, C, D of the *Health Resources and Services Administration's* (HRSA) Ryan White HIV/AIDS Program and Expanded Testing Initiative (ETI) of the Center for Disease Control HIV Prevention Program) with a holistic approach to health care. SHC—through collaborative efforts with its subcontractors— works to ensure HIV care and treatment align with the ***four National Strategy primary goals:*** (1) prevent new HIV infections, (2) improve HIV-Related Health Outcomes of People with HIV, (3) reduce HIV-related disparities and health inequities, and

(4) achieve integrated, coordinated efforts that address the HIV epidemic amount all partners and stakeholders. These efforts are aligned with the center's vision to minimize the burden of disease through health promotion and disease prevention strategies. To that end, SHC continues to make great strides in the treatment and management of emerging and reemerging infectious diseases along its care continuum of interdisciplinarity and cultural diversity. And it is through the provisions of the *Ryan White HIV/AIDS Program Legislation* and the resources of the Connecticut Department of Health AIDS Institute that decisions and quality are respectively guided and implemented.

IV. PERFORMANCE MEASUREMENT

Performance measurement is vital to the CQM process, which is facilitated by the creation and criteria of HAB measures—assessment tools that not only allows for trends in clinical performance but also predictions of viral load suppression outcomes/success rates. Hence, HAB measures are tools on which the CQM committee primarily relies to inform and to guide decision-making.

Selection of performance measures. Performance measures are selected based on relevancy, measurability, eligibility, and the efficacy of meeting a desired outcome. In addition to these criteria, performance measures of the Eligible Metropolitan Area (EMA) will be considered in accordance to StayWell's coordination and collaboration with the Part A office and its quality improvement program. Additionally, CHCACT Part D and DPH HIV Prevention quality improvement programs, will be included in QI activities. Moreover, performance measures are selected based on the criteria set forth in the *Policy Clarification Notice* (No. 15-02):

- ≥ 50% of clients with at least one unit of service | *two* (2) performance measures
- > 15% but < 50% of clients with at least one unit of service | *one* (1) performance measure
- < 15% of clients with at least one unit of service | *zero* (0) performance measures

Additionally, social determinants of health will be used in the selection of performance measures. Screening clients for unmet health-related social needs, such as housing instability, interpersonal violence, food instability, and transportation needs ensure bridging of gaps in care. This will ultimately promote health equity and reduce health disparities.

Data collection and sharing. Data are routinely extracted from electronic databases for weekly, monthly, quarterly, and annual review and reporting. The extraction process is facilitated through structured, systematic, and scientific methods that drive quality improvement projects within the CQM program:

- *CAREWare*: "An electronic health and social support services information system [(i.e., database)]" that not only contains modules of clearly defined performance measures but also contains mechanisms that support the "tracking [of] demographics, services, medications, laboratory test results, immunization history, diagnoses…and referrals to outside agencies" (https://hab.hrsa.gov/program-grants-management/careware). This database is a medium that is often used to generate and customize reports (with an option to include graphs).
- *Intergy*: An electronic health records (EHR) system that supports SHC's ambulatory platform, providing "clinical, regulatory, and revenue support to [automate and] streamline the [organization's] workflows" (https://www.greenwayhealth.com/intergy). Hence, the EHR stores complete records of patient encounters, allowing the abstraction of medical charts, notes, and laboratory results.

- Pre-PARE Group: A small group of consumers who are educated on research outcomes relating to social and health & wellness issues, providing feedback on educational material and in-house services.
- Consumer Advisory Board (CAB): A consumer constituency who will advise and collaborate on matters related to in-house services and surveyed health and social outcomes. The group's feedback will facilitate decision-making, pinpointing areas in need of improvement that support patient care and retention. *The board, however, is in the process of being developed and will convene on a quarterly basis.*
- Patient satisfaction surveys and activities

All pertinent and impactful information (including that from the Part A office, Part D and DPH HIV Prevention) is disseminated throughout the agency in public areas for educational and informative purposes and is both shared and discussed with members of the monthly CQM and consortium meetings (that include consumers, community providers, and a small percentage of [Part A] subrecipients). Moreover, information is conveyed through quarterly reporting and PowerPoint presentations to the Part A office, Part D and DPH Prevention. on a trimonthly basis.

Data analytics. The practice of analytics empowers CQM stakeholders to improve performance on all levels of patient care. Raw data are analyzed and translated into useful information, giving insight into the health of StayWell's subpopulations and its conformity to the reporting requirements of the Ryan White HIV/AIDS Program (and other value-based incentive programs). Manual and automated methods are respectively employed via:

- An *excel spreadsheet* that is customized with all sexually transmitted infection (STI) screenings (opportunistic infections) and immunizations. The accuracy and correctness of data are compared to *CAREWare* and *Intergy* on a weekly basis but submitted to the ID physicians at the end of each month for validation, reliability, and quality control.
- *Practice Analytics*, which is a reporting and analytics tool that tracks value-based performances, identifies gaps in care (based on diagnoses, lab results, vitals, patient visits, and risk levels), analyzes obscure and or nonstandard measures, and supports all EHR-based measures.

Performance measure categories. The table below **(Table 2)** depicts calendar year 2021 goals for HAB Core Performance Measures, definitions and previous year's outcomes.

Table 2. Performance Measures of Funded Categories

Category	Performance Measure	Numerator	Denominator	Measurement Period Data Collection (Frequency)	Data Collection (Method)
Outpatient/ Medical Care	Tuberculosis (TB) Screening **HAB14**: HIV-infected clients who received testing for latent TB infection since HIV diagnosis.	Numerator: Number of clients in denominator who have received screenings (using Quantiferon, PPD, IGRA, or TST) for latent TB infection across providers within the measurement year.	HIV-infected clients without history of TB disease or infection with at least one medical visit within the measurement year.	12 months Monthly and quarterly Target: 50% Baseline: 18.75%	Record and administrative reviews
	Syphilis Screening **HAB13**: Percentage of adult patients with a diagnosis of HIV who had a test for syphilis	Number of patients with a diagnosis of HIV who had a serologic test for syphilis performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *1)* Were >18 years old in the measurement year[1] or had a history	12 months Monthly and quarterly Target: 85%	Record and administrative reviews

	performed within the measurement year.		of sexual activity <18 years, and *2)* Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	Baseline: 69.53%	
	Chlamydia Screening **HAB15**: Percentage of adult patients with a diagnosis of HIV who had a test for Chlamydia Screening performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for Chlamydia performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *3)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	12 months Monthly and quarterly Target: 85% Baseline: 80%	Record and administrative reviews
	Gonorrhea Screening **HAB16**: Percentage of adult patients with a diagnosis of HIV who had a test for Gonorrhea Screening performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for Gonorrhea performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *4)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	12 months Monthly and quarterly Target: 85% Baseline: 80%	Record and administrative reviews
	Annual Retention in Care **PTA04**: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.	Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters need to be a medical visit with a provider with prescribing privileges.	Number of patients, with a diagnosis of HIV who had at least one HIV medical encounter within the 12-month measurement year. An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test. Exclusions: Patients who died at any time during the measurement year.	12 Months Quarterly Target: 85% Baseline: 78.81%	
	Linkage to Care **PTA 17**: Percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis	Number of patients who attended a routine HIV medical care visit within 1 month of HIV diagnosis	: Number of patients, regardless of age, with an HIV diagnosis in the 12-month measurement year	12 Months Quarterly Target: 100% Baseline: 85.71%	
	Viral Load Suppression **CORE01**: Percentage of [patients] or clients with HIV infection whose last viral load in the measurement year is less than 200 copies.	Number of [patients] or clients whose last viral load in the measurement year is less than 200 copies.	Number of HIV-infected [patients] or clients with at least one medical visit in the measurement year.	12 Months Quarterly Target: 90% Baseline: 87.75%	Administrative review

Oral Health Care	Oral Exam **HAB12**: Percentage of HIV-infected clients who received an oral health exam in measurement year.	Clients in denominator who had an oral exam or were referred for an oral health care exam.	HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	12 months Monthly and quarterly Target: 70% Baseline: 23.44%	Record and administrative reviews
Category	Performance Measure	Numerator	Denominator	Measurement Period Data Collection (Frequency)	Data Collection (Method)
Outpatient/ Medical Care	Tuberculosis (TB) Screening **HAB14**: HIV-infected clients who received testing for latent TB infection since HIV diagnosis.	Numerator: Number of clients in denominator who have received screenings (using Quantiferon, PPD, IGRA, or TST) for latent TB infection across providers within the measurement year.	HIV-infected clients without history of TB disease or infection with at least one medical visit within the measurement year.	12 months Monthly and quarterly Target: 50% Baseline: 18.75%	Record and administrative reviews
	Syphilis Screening **HAB13**: Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for syphilis performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *5)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and *6)* Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	12 months Monthly and quarterly Target: 85% Baseline: 69.53%	Record and administrative reviews
	Chlamydia Screening **HAB15**: Percentage of adult patients with a diagnosis of HIV who had a test for Chlamydia Screening performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for Chlamydia performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *7)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	12 months Monthly and quarterly Target: 85% Baseline: 80%	Record and administrative reviews
	Gonorrhea Screening **HAB16**: Percentage of adult patients with a diagnosis of HIV who had a test for Gonorrhea Screening performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for Gonorrhea performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *8)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	12 months Monthly and quarterly Target: 85% Baseline: 80%	Record and administrative reviews

	Annual Retention in Care **PTA04**: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.	Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters need to be a medical visit with a provider with prescribing privileges.	Number of patients, with a diagnosis of HIV who had at least one HIV medical encounter within the 12-month measurement year. An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test. Exclusions: Patients who died at any time during the measurement year.	12 Months Quarterly Target: 85% Baseline: 78.81%	
	Linkage to Care **PTA 17**: Percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis	Number of patients who attended a routine HIV medical care visit within 1 month of HIV diagnosis	: Number of patients, regardless of age, with an HIV diagnosis in the 12-month measurement year	12 Months Quarterly Target: 100% Baseline: 85.71%	
	Viral Load Suppression **CORE01**: Percentage of [patients] or clients with HIV infection whose last viral load in the measurement year is less than 200 copies.	Number of [patients] or clients whose last viral load in the measurement year is less than 200 copies.	Number of HIV-infected [patients] or clients with at least one medical visit in the measurement year.	12 Months Quarterly Target: 90% Baseline: 87.75%	Administrative review
Oral Health Care	Oral Exam **HAB12**: Percentage of HIV-infected clients who received an oral health exam in measurement year.	Clients in denominator who had an oral exam or were referred for an oral health care exam.	HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	12 months Monthly and quarterly Target: 70% Baseline: 23.44%	Record and administrative reviews

[1]Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.
[2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe antiretroviral therapy.

V. CLINICAL QUALTIY MANAGEMENT (CQM)

The Clinical Quality Management (CQM) committee is focused to meet or exceed the expectations of the HIV/AIDS Bureau's (HAB) performance measures—measurable goals that will be facilitated through capacity building activities and the existent monitoring and management of data. Based on the 2021 Calendar year HAB Performance Data Report and input from the QM Team, screenings, medical case management (includes Intensive Medical Case Management), and coordinated services have been targeted for quality Improvement.

A. Quality Management Work Plan

- The QM plan includes a "living" Work Plan that is updated at least quarterly.
- The Work Plan specifies objectives and strategies for QM plan goals listed below in Continuous Quality Assurance and further detailed in the Work Plan included in **Appendix B.**

B. Continuous Quality Assurance (CQA) 2020 Goals and Objectives

Goals:

1. Continuously implement a quality Management plan, which is updated at least annually, to monitor and improve the quality of services that includes the participation of providers, consumers, and stakeholders.
2. Improve efficiency of HIV care services with Region 2 that meets the U.S. Public Health Service (PHS) Guidelines, Clinical Practice Guidelines and Standards of Care.
3. Improve patient linkage, retention, and medication adherence that will result in viral load suppression.
4. Ensure individuals who meet the criteria for Intensive Case Management services are identified and linked to services.
5. Improve Data Accuracy and inputs in Intergy and CAREWare.

Objectives:

Progress toward achieving the objectives listed below will be monitored by the QM Committee and will be modified as needed during annual updates to this plan. To facilitate implementation, all objectives are SMART (specific, measurable, achievable, realistic, and time phased).

GOAL 1: Continuously implement a quality Management plan, which is updated at least annually, to monitor and improve the quality of services that includes the participation of providers, consumers, and stakeholders.

Objectives include:

1.1. By December 1, 2021, provide quality improvement (QI)/quality management (QM) training workshops based on identified need.

1.2. By August 1, 2021, implement at least one other activity (e.g., satisfaction survey, focus group, or other effort) to gather additional data on quality of services provided and complement other data collection activities.

1.3. By December 31, 2021, assure that subcontractors conduct a least one quality improvement project each year.

1.4. Throughout 2021, monitor implementation of the QM Plan and evaluate and revise it by December 31, 2021.

GOAL 2: Improve efficiency of HIV care services with Region 2 that meets the U.S. Public Health Service (PHS) Guidelines, Clinical Practice Guidelines and Standards of Care.

Objectives include:

2.1. Beginning January 1, 2021, Monitor the priority performance measures for Outpatient Ambulatory Care Services (identified in Table 2).

2.2. Beginning May 1, 2021, review data of subrecipients and internal data sets (i.e., labs & screenings) to assess quality of care.

2.3. The percentage of HIV infected new or established patients receiving an annual Tuberculosis screening will be at or greater than 50%.

2.4. The percentage of HIV infected new or established patients reporting an annual oral exam will be greater than 70%.

2.5. The percentage of HIV infected new and established patients receving a STI screening (to include gonorreha and Chlamydia and syphilis), will be at or greater than 85%

GOAL 3: Improve patient linkage, retention, and medication adherence that will result in viral load suppression.

Objectives include:

3.1. Beginning January 1, 2021, conduct a bi-monthly review on patients that are out-of-care within a 6 to 12-month period.

3.2. The percent of HIV-infected Latino and African American MSM youth, African American cisgender and transgender women achieving viral load suppression will be 85% or greater.

3.3. Monitor, assess, and improve systems of care for HIV infected clients.

3.4. Design CQI Projects with the aim to increase Consumer involvement.

3.5. Monitor medical visit frequency among Ryan White program participants and maintain at least 2 medical visits within 12 months.

3.6. Monitor client recertifications by due date to prevent delays in services.

3.7. Design CQI projects to analyze impact on medical visits, patient adherence and patient engagement in services before and after COVID 19.

Goal 4: Ensure individuals who meet the criteria for Intensive Case Management services are identified and linked to services.

Objectives include:

4.1. By June 1, 2021, inform staff IMCM services criteria, and monitor compliance with MAI program requirements.

4.2. By April 1, 2021, Monitor appropriateness of clients of IMCM/MAI services.

4.3. Continually monitor the Acuity Scale.

4.4 By February 28, 2022 individuals will achieve at least 2 clinic visits in a 12-month period and will achieve VL suppression <200.

Goal 5: Improve Data Accuracy and inputs in Intergy and CAREWare.

Objectives include:

5.1 By May 1, 2021, implement PDSA to monitor improvement in data integrity (input, collection, and analysis) to ensure accuracy of data.

5.2 Monitor data performance on a monthly basis to identify barriers, challenges, and success.

5.3 Review of data will be conducted during CQC meetings and review of monthly submission reports with sub-recipients.

5.4 By February 28, 2022, improve data accuracy and inputs by 90% of baseline data (n=102).

C. Quality Management Timeline

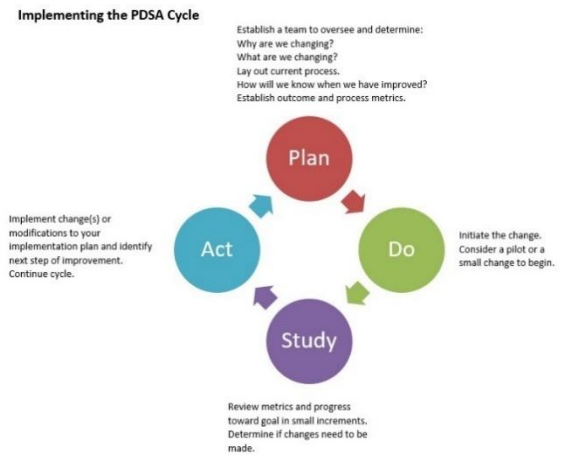
- The QM plan includes a timeline to ensure annual revision of the QM plan.
- The timeline incorporates development, implementation, and revision of the plan based on grant and calendar year.
- The timeline includes quarterly QM Core Team meetings and progress reports.

VI. QUALITY IMPROVEMENT

"Quality improvement," according to the Agency for Healthcare Research and Quality (AHRQ), "is the framework…to systematically improve the ways care is delivered to patients"

(https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod4.html).

Quality Improvement (QI) initiatives will be effectively managed and implemented by stakeholders of the CQM committee. Possessing clearly defined roles and responsibilities, each member is a valuable resource who will offer unique perspectives and skills to all phases of the QI plan, which will be reviewed and revised annually.



The QI initiatives will be driven by well-defined goals, empowering the committee to produce consistent and measurable results:

Grounded in the understanding of *quality improvement* (QI), it is the ambitious design of the CQM committee to implement sustained QI activities, which require the proper application of data, analytics, and implementation of evidence-based interventions that will ultimately reduce variations within its internal processes and effect better health outcomes within its community.

However, QI activities must be strategically implemented; therefore, QI strategies will be executed within the *Model for Improvement* framework that employs *Plan-Do-Study-Act* (PDSA) cycles.

Diagram: Implementation of PDSA Cycles

Model for Improvement. The model emphasizes three fundamental questions reported by Provost (2018), which are addressed by the established goals, aims, and interventions of the CQM committee:

1. **What are we trying to accomplish?** This question establishes the aim for improvement efforts and ensures that collected data [are] related to patients' perception of quality.
2. **How will we know that a change is an improvement?** This question sets up the criteria for determining when [a] change results in sustainable improvement.
3. **What changes can we make that will result in improvement?** This question leads to the PDSA cycle, which tests small scale changes or interventions to see their effect on outcomes. (https://www.healthcatalyst.com/insights/quality-improvement-healthcare-5-guiding-principles)

PDSA Cycles. PDSA cycles (see *Diagram: Implementation of PDSA Cycles*) are seemingly "simplistic [when] compared to other methodologies; [however], the PDSA cycle, in a repeated application, is the backbone of quality improvement." Moreover, PDSA cycles are proven methods for testing the validity of interventions (using process, outcome, and structural measures) and identifying variations in data, ergo, are effective solutions to quality improvement (https://www.healthcatalyst.com/insights/quality-improvement-healthcare-5-guiding-principles):

The repeated use of PDSA cycles are data driven and begin with *small-scale tests*. Small-scale tests are *fine-tuned*, lending themselves to both a *wider-scale test of changes* and to the final step of *implementation at scale*. It is the responsibility of the CQM committee to assess the intervention and determine whether the change should be adopted or modified in the next planning phase, restarting the

cycle from the beginning. The PDSA cycle ends when an intervention is adopted; adoption occurs upon the success of repeated intervention cycles (at either a one-month, three-month, or six-month interval) and the attainment of goals, which result from the improvement of health and statistical outcomes and or human behavior. If the intervention is adopted, then it will become a key component of internal processes, and the committee will advance to a new intervention cycle. And the quality improvement project will be deemed complete when all targeted goals and objectives have been attained.
(For more information on the PDSA model, please visit:
http://tutorials.nqcqualityacademy.org/QI_tutorial/.)

VII. ACTION PLANS, WORK PLANS AND SELECTED PROJECTS AND MONITORING

Action plans and work plans. A customized spreadsheet of performance measures will be employed to direct the strategic methods of meeting the committee's goals/objectives and to track and document QI projects, which will be identified in accordance with the committee's selection process (see *Selection of performance measures*) and by areas of deficiency (see *CQA Goals and Objectives 2020*). The customized spreadsheet, which is populated and maintained by the program director, is a monthly representation of data and intervention outcomes; therefore, it will be used in lieu of the action plan (see Appendix A) as a stand-alone document (since the size of the committee and the manageability of the spreadsheet renders this approach feasible). All relative discussions and decisions will be captured in the minutes of CQM meetings. However, the action plan will be a format used to capture decisions and intervention outcomes of QI activities that are specific to PDSA implementation.

The work plan (**see Appendix B**), on the other hand, will be used to capture annual quality management goals of the CQM program, giving credence to the mission of StayWell's HIV Care and Prevention program and promoting efficiency, accountability, focus, and insight that will help result in the manifestation of the committee's vision. To that end, the detailed plan will be distributed in writing to all members and discussed at monthly meetings to solicit feedback and updates, ensure the feasibility of timelines and due dates, and recognize accomplishments.

Selected projects. SHC seeks to eliminate all paper charts and, therefore, has instituted the practice of data migration to *Intergy* through established parameters. New electronic templates have also been implemented in *Intergy* for the creation of care plans for clients/patients. These projects support the centralization of data collection and accessibility to all providers and ancillary staff, allowing staff to better coordinate schedules and identify health care needs of consumers—hence, minimizing "no-shows" and lapse in care.

Appendices

APPENDIX A – 2020 QUALITY MANAGEMENT PLAN AUDIT LOG

Planned Quality Review Date	Activity Reviewed	Issue(s)	Resolution
12/26/2019	CQM Member resignation	CQM Member resigned from position at agency	▪ Removal of Member. No longer an employee of StayWell
03/18/2020	Review and Revision of CQM Plan	Evaluation of year performance, identify new PDSA projects,	▪ Revised annual goals and outlined objectives. **Included**: ▪ Integration of HIV care and Prevention performance measures. ▪ Table of Contents ▪ Quality Terminology ▪ Performance Measure Results form ▪ CQI Update form ▪ Quality Plan Audit log ▪ Revision history ▪ Intensive Medical Case management
03/31/2020	Impact of COVID 19 on Health systems	How to continue CQM activities due to CQC team limited access to each other.	▪ Identified tools, such as ZOOM that can be leveraged to transition from conventional, onsite monitoring to remote. ▪ Staff are equipment with laptops that have remote access, via VPN to data systems used to collect,

			evaluate, and monitor service delivery and outcomes (Intergy, CAREWare)
04/10/2020	Addition of Data Integrity – Goal number 5 to goals for 2021; and update of percentages for target performance measures; Update of Appendix B workplan.	None	None

APPENDIX B: CLINICAL QUALITY MANAGEMENT PROGRAM WORK PLAN 2021

Goal 1: *Continuously implement a quality Management plan, which is updated at least annually, to monitor and improve the quality of services that includes the participation of providers, consumers, and stakeholders.*

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
1.1 Provide quality improvement (QI)/quality management (QM) training workshops based on identified need.	1.1a. Provide at least three QM training (PDSA, performance measures) for CQM members, staff and consumers, based on identified need. 1.1.b So not to disrupt clinical services, we will use webinars to share best practices and provide QM training. 1.1.c. SHC will collaborate with partners to implement clinical and/or case management training based on identified needs. 1.1.d Participate in Integrated Planning efforts	PD, K Pitner QAD, Dr. Helou	HIV Qual Consultant AETC/YALE	1.1a.TBD 1.1.b. As needed 1.1.c. As needed 1.1.d. Ongoing	1.1a-1.1d we were not able to conduct the CQM trainings for year 2020. Going forward for 2021 we will work with AETC to develop at least 2 trainings geared toward teaching staff QA and importance on service utililzation.
1.2 implement at least one other activity (e.g., satisfaction survey, focus group, or other effort) to gather additional data on	1.2.a. Complete satisfaction survey for HIV services. 1.2.b. Design an assessment tool specifically for HIV primary care sites covering special services—case management, substance use, mental health, women's health, and dental.	PD, K Pitner, E. Martinez, MCM Supervisor	QM Team PrEPARED Group	1.2.a 08.2021 1.2.b. 06.2021 1.2.c. 07.2021	1.2a Satisfaction survey completed. 2021 will update satisfaction survey to include service delivery during the time of COVID.

quality of services provided and complement other data collection activities.	1.2.c. Provde tool to RW staff in the Region to disseminate to patients. 1.2.d. Analzye data and share with stakeholders.		Region 2 MCM Network Group Subcontractors (MCCA, RNP) Access to Care Coordinator, Crystal Lizardi	1.2.d. Annually	1.2b-d: CQM Team and Network will continue to focus on these strategies, was unable to address strategies.
1.3 Assure that subcontractors conduct a least one quality improvement project each year.	1.3.a. Review subcontractor CQI projects and provide technical assistance (TA). 1.3.b. Monitor funded agencies quarterly QM reports for CQI and best practices. 1.3.c. Showcase CQI best practices during CQM meetings. 1.3.d. Share updates and solicit input from QM Team regarding statewide improvement efforts.	PD, K Pitner, E Martinez, MCM Supervisor S Nelson, MCCA	CQM Team Training materials and assessment tools CHPC	1.3.a. Quarterly 1.3.b. Quarterly 1.3.c TBD 1.3.d. Quarterly	1.3a-d: will be refocused specifically to mental health and substance abuse services (outpatient and inpatients) this objective and strategies will address new goal of data accuracy and inputs.

		J Loschiavo, RNP	NH/FF Qualtiy Committee		
1.4 Throughout 2020-2021, monitor implementation of the QM Plan and evaluate and revise it by December 31, 2021.	1.4.a. Revise work plan quarterly. 1.4.b. Share QM Plan with SHC Leadership, RW Part's A, C, and D offices, RW staff and subcontractors 1.4.c. Place revised QM plan on common drive.	PD, K Pitner	CQM Advisor Dr. Tess Lombard, QM Team QAD, Dr. Helou	1.4.a. Quarterly 1.4.b. Annually 1.4.c. Annually	1.4a-c: was accomplished, and will continue as a staple for 2021.

GOAL 2: *Improve efficiency of HIV care services with Region 2 that meets the U.S. Public Health Service (PHS) Guidelines, Clinical Practice Guidelines and Standards of Care.*

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
2.1. Monitor the priority performance measures for Outpatient Ambulatory Care Services (identified in Table 2).	2.1.a. Include HAB measures in monitoring tools, chart reviews, and QM plan. 2.1.b. Extract and analyze performance measures data for ambulatory outpatient care every 3 months and give feedback to providers within one month of extraction. 2.1.c. Generate quarterly reports from CAREWare on the HAB PMs and share with HIV staff and QM team.	PD, K Pitner	QM Team HRSA/HAB CAREWare RW Part A Office CHCACT – Part D Institutional Research	2.1.a. As needed 2.1.b. Quarterly 2.1.c. monthly 2.1.d. As needed	2.1 was accomplished, and will continue as a staple for 2021

	2.1.d. Request technical assistance from RW Part A, and CHCACT, as needed, to improve the accuracy of CAREWare HAB Measure data and reports. 2.1.e. Conduct clinical and MCM/IMCM chart reviews. 2.2.f. Review RW patient who are not adhering to at least 2 visits for routine HIV medical care in 12 months, and who are not virally suppressed.		Specialist J Jordan	2.1.e. Quarterly 2.1.f. monthly	
2.2. Review adherence practices to the recommended clinical guidelines.	2.2.a. Provide medication adherence training to MCM/IMCM staff. 2.2.b. Communicate with pharmacies to collect data on client's picking up perscriptions. 2.2.c. Provide access to current updates of HIV and related medication guidelines and resources for MCM/IMCM and providers.	PD, K Pitner QAD, Dr. Helou	CQM Advsior Dr. Tess Lomard Curant Pharamacy G. Suter Walgreens Pharmacist YALE/AETC APRN K. Turmillo and B. Sidelou	2.2.a. As needed 2.2.b. Monthly 2.2.c ongoing	2.2 a-c: Will continue with the objective. Staff received training from APRN K. Turmillo on medications and medication compliance. Pharmacy partners attend regional meetings and CQM to ensure coordinated care.

2.3. review data of subcontractors and internal data sets (i.e., labs & screenings) to assess quality of care	2.3.a Complete audit of all active client files during site visit of sub-contracting agencies. 2.3.b. Subcontractors will share data and QI projects with QM Team during CQM meetings.	PD, K Pitner	Subcontractors (MCCA, RNP)	2.3.a. Annually 2.3.b. semiannually	2.3a-b: continue with objective.
2.4. The percentage of HIV infected new or established patients receiving an annual Tuberculosis screening will be greater than 70%.	2.4.a. As part of the RW Program clinical chart review, assess management of HIV-infected patients being screened for TB. 2.4.b. Create quarterly report card from the CAREWare summarizing findings.	PD, K Pitner QAD, Dr. Helou MCM Supervisor, E Martinez	QM Team HRSA/HAB CAREWare Intergy Institutional Research Specialist J Jordan	2.4.a. monthly, quarterly 2.4.b. August 2021	2.4a-b: Did not achieve target of 70%. Will continue with objective.
2.5. The percentage of HIV infected new or established patients reporting an annual oral	2.5.a. Complete a PDSA geared out client annually oral health visits, including those self-reported by clients not receiving oral health services on site.	PD, K Pitner	QM Team HRSA/HAB	2.5.a. February 2021	2.5a-d: ongoing

exam will be greater than 70%.	2.5.b. As part of the RW Program clinical chart review, assess management of HIV-infected patients being screened for annual oral exam by SHC provider or client self-report. 2.5.c. Work with Clinical Informatics team to add additional features to the EHR that will allow providers to document self-reported oral health screenings as well as reports that will allow staff to capture and analyze data. 2.5.d. Create quarterly report card from the CAREWare summarizing findings.	Supervisor, Dental N Martinez MCM Supervisor, E Martinez	CAREWare Intergy Institutional Research Specialist J Jordan Clinical Informatics Director, A. Herrrick	2.5.b. monthly, quarterly 2.5.c. July 2021 2.5.d. June 2021	
2.6.The percentage of HIV infected new and established patients receving a STI screening (to include gonorreha and Chlamydia and syphilis), will be greater than 80%	2.6.a. Complete a PDSA geared out client annually oral health visits, including those self-reported by clients not receiving oral health services on site 2.6.b. As part of the RW Program clinical chart review, assess management of HIV-infected patients being screened for STIs. 2.6.c. Create quarterly report card from the CAREWare summarizing findings.	PD, K Pitner QAD, Dr. Helou MCM Supervisor, E Martinez	QM Team HRSA/HAB CAREWare Intergy Institutional Research	2.6.a. February 2021 2.6.b. monthly, quarterly 2.6.c. July 2021	2.6a-c: Continue with objective- PDSA focused

			Specialist J Jordan		

GOAL 3: *Improve patient linkage, retention, and medication adherence that will result in viral load suppression*

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
3.1. Conduct a bi-monthly review on patients that are out-of-care within a 6	3.1.a. Create quarterly report using data from the CAREWare and Intergy database 3.1.b. Utilize the reports to communicate with the providers, and RW staff.	E Martinez MCM supervisor IMCM Kathy Bonilla	CAREWare Part A Office IMCM staff MCM supervisor Medical Providers	3.1.a. Ongoing 3.1.b. Ongoing	3.1a-b: Ongoing
3.2. The percent of HIV-infected Latino and African-American MSM youth, African-American cisgender and	3.2.a. Create quarterly report using data from the CAREWare and Intergy database 3.2.b. Utilize the reports to communicate with the providers, and RW staff.	PD, K Pitner E Martinez MCM supervisor	RW Part A Office Institutional Research	3.2.a. 7/1/2021 3.2.b. ongoing	3.2a: Completed-CQM monitoring 3.2b-d: continue with objective.

transgender women achieving & maintaining viral load suppression at 85% or greater.	3.2.c. Review IMCM clients who adhere to at least 2 visits for routine HIV medical care in 12 months 3.2.d. Share finding with SHC QM, Part's A, C, D and Prevention.	IMCM Kathy Bonilla	Specialist J Jordan IMCM K Bonilla	3.2.c. monthly 3.2.d. quarterly	
3.3. Monitor, assess and improve systems of care for HIV infected clients.	3.3.a. Develop an Access to Care Working Group to meet and identify socioeconomic issues that affect HIV positive patients within the region and develop recommendations for systemic improvement. 3.3.b. Collaborate with each provider organization in the region to strengthen the enrollment of case management services patients that are HIIV positive and demonstrate need for service.	PD, K Pitner Access to Care Coordinator, Rosette Molnar	QM Team PrEPARED Group Region 2 MCM Network Group Subcontractors (MCCA, RNP) Access to Care Coordinator,	3.3.a. Ongoing 3.3.b. Ongoing	3.3a-b: Ongoing

			Rosette Molnar City of Waterbury Health Dept. Waterbury and St. Mary's Hospital		
3.4. Design CQI Projects with the aim to increase Consumer involvement in SHC QM committee.	3.4.a. Complete PDSA cycle geared at consumer Involvement. agencies. 3.4.b. Research models to increase consumer involvement. 3.4.c. Showcase best practices to increase consumer involvement in Region 2 RW Program. 3.4.d. Enlist support and technical assistance from AETC and HIVQUal. 3.4.e. Collect data on consumer involvement and recruiting initiatives. 3.4.f. Report on project at quarterly QM Team meetings.	PD, K Pitner	QM Team RW MCM's HRSA/HAB Center for Quality Improvement and Innovation	3.4.a. Ongoing 3.4.b. 6/1/2021 3.4.c. Annually 3.4.d. As needed 3.4.e. Semiannually 3.4.f. Quarterly	Continue with objective. We were only able to hold one CQM meeting for 2021, in April. No client was identified to participate in CQM activities in 2020. In 2021 there was one CAB meeting in which 5 clients participated and agreed to restructure CAB to increase consumer involvement in CQM

	3.4.g. Attend the Part A Planning Council and QM Committee.				
3.5. Monitor medical visit frequency among Ryan White program participants and maintain at least 2 medical visits within 12 months.	3.5.a. Monitor medical visits within 12-month period. 3.5.b. Create quarterly report from CAREWare monitoring medical visit frequency among Ryan White program participants. 3.5.c. Share findings and solicit input from QM Core Team regarding improvement efforts if needed. 3.5.d. Utilize report to communicate with QM staff and subcontractors regarding client's medical visit frequency	PD, K Pitner E Martinez, MCM Supervisor	CAREWare Intergy MCM Supervisor QAD Dr. Helou	3.5.a. Monthly, 3.5.b. Monthly, Quarterly 3.5.c. Quarterly 3.5.d. quaterly	Ongoing.
3.6. Monitor client recertifications by due date to prevent delays in services.	3.6.a. Generate monthly reports to monitor this objective and share quarterly with the QM committee and SHC MCM staff. 3.6.b. Utilize reports to communicate with MCM staff and MCM supervisor regarding clients' recertification status.	E Martinez, MCM Supervisor	CAREWare MCM Supervisor MCM staff	3.6.a. Monthly, 3.6.b. Monthly, Quarterly	Ongoing.
3.7. Design CQI projects to analyze impact on medical visits, patient	3.7.a. Complete PDSA cycle geared at patient engagement during and after COVID 19.	PD, K Pitner	CQM Advisor	3.7.a 12/31/2021	Ongoing

adherence and patient engagement in services before and after COVID 19.	3.7.b. Collect data on ART adherence, Viral load suppression, and medical visit (Telehealth) show rates. 3.3.c. Report on project at quarterly QM Team meetings.	CQM Advisor QAD	MCM staff MCM Supervisor QAD	3.7.b. Monthly, 3.7.c. Monthly, Quarterly	

Goal 4: *Ensure individuals who meet the criteria for Intensive Case Management services are identified and linked to services.*

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
4.1. Informed staff of IMCM services criteria and monitor compliance with MAI program requirements.	4.1.a. Develop processes to improve compliance with RW Program Part A IMCM, and MAI program requirements for eligible patients. 4.1.b. Update internal chart audit tools for case management services in accordance with the IMCM/MAI program requirements.	PD, K Pitner E Martinez MCM supervisor	MCM Supervisor, E Thomas PD, K Pitner RW Part A Office Collabortive Research	4.1a. 3/1/2021 4.1.b 4/1/2021, Ongoing	Ongoing.

4.2. Monitor appropriateness of clients of IMCM/MAI services	4.2.a. Extract and analyze performance data of client population using eligibility criteria to identify patients for ICM services. 4.2.b. Generate monthly reports to monitor this objective and share quarterly with the QM team, NH/FF Planning Council QA, and RW Part A Office	PD, K Pitner, E Martinez, MCM Supervior	CAREWare RW Part A Office	4.2.a. Monthly, quarterly 4.2.b. Monthly, quarterly	Ongoing
4.3. Continually monitor the Acuity Scale.	4.3.a. Conduct CM Chart Reviews	E.Martinez, K Pitner	Intergy CAREWare	4.3.a Quarterly	Ongoing

Goal 5: Improve Data Accuracy and Inputs in Intergy and CAREWare

Objectives	Strategies	Lead	Staff Resources	Timeline	Progress Notes
5.1 implement PDSA to monitor improvement in data integrity (Input, collection and analysis) to ensure	5.1.a. Develop PDSA for data integrity 5.1.b. Review the billed and unbilled encounters to ensure no services provided were missed, that should have been entered into CAREWare. 5.1.c. Encounter Reports generated from sub-subrecipient EMR and match those encounters to those in CAREWare, within 48 hours of receipt of Encounter Report.	Lead – Kpitner	QM Team Subcontractors (MCCA, RNP) Access to Care Coordinator,	5.1a. 2/1/2021 5.1.b, Ongoing	

accuracy of data.	5.1.d. Quality Checks: At the end of the month, run report out of the EMR (SAMS) M and make sure that all of the outpatient services have been entered into CAREWare. 5.1e.Running and cross checking of inpatient billing report to make sure that all of clients' services have been entered. If anything has been missed, then it will be entered at that point.				
5.2 Review of Data will be conducted during CQC meetings and review of monthly submission reports with sub-subrecipients.	5.2a.Monitor encounters monthly to ensure timely input of data and accuracy of services to reflect what's in EMR and CAREWARE. 5.2b.CQC will work to identify and implement new interventions that will address issues with entry of services. 5.2.c. Lead will work with sub-subrecipient to ensure there are quality check plans in place.	Lead K Pitner, E Martinez MCM Supervior	CAREWare *CAREware, EMR's (Intergy, CareLogic, SAMMS).* QM Team Subcontractors (MCCA, RNP)	5.2.a. Monthly, quarterly 5.2.b. Monthly, quarterly	

			Access to Care Coordinator,		
5.3 By February 28, 2022 *Improve data Accuracy and inputs by 90% of baseline data (n = 102).*	5.3a Monitor that all encounters provided in the previous month, are entered into CAREWare by the 5th of the current month. Services entered into CAREWare will reflect what is in the EMR. 5.3b. Report on project at quarterly QM Team meetings.	Lead K Pitner, E Martinez MCM Supervior	QM Team Subcontractors (MCCA, RNP) Access to Care Coordinator,	5.3.a. Monthly, quarterly 5.2.b. Monthly, quarterly	

APPENDIX E: QUALITY IMPROVEMENT PROJECT TEMPLATE (PDSA)

QUALITY IMPROVEMENT PROJECT TEMPLATE

Date: _____ Cycle#: _____ Began: _____ Completed: _____ Team: _____

PROJECT INFORMATION

Project Title:
Center's Mentor: Dr. Tess Lombard
Location:

PLANNING

PROJECT PROPOSAL/PROBLEM STATEMENT

Why are you doing this project? What is the problem you are addressing? What are the goals of the project? Consider aligning the project goals with one or more of the center's six dimension of quality: safe, effective, patient-centers, timely, efficient, and equitable.

***Problem**:*

***Goal**:*

AIM STATEMENT: What are you trying to accomplish?

What are the aims of this project? What do you hope to accomplish by doing this project?

Aims:

TEAM MEMBERS

Who are the appropriate team members for this project?

BACKGROUND

What background knowledge or literature is relevant to the project? What evidence is available to guide planning?

CURRENT STATE/IDEAL STATE

What is the current state of the system under study? How do you know improvement is needed? What features of the current system are contributing to the problem?

ESTABLISHING MEASURES

TESTING CHANGES

PLAN
What is the objective of this particular test of change? What do you think will happen and why? How, when, and by whom will the change be tested? What data will you collect?

DO
What happened as you conducted the test? What did you observe? What problems or unexpected observation were encountered?

STUDY
What data was collected? What does the data show? How does it compare to your predictions? Is the quality of the data adequate? What did you learn? Include a graph or chart of your data, if possible?

A**CT**
Given the above understanding and learning, what are we going to do now? Are there forces in our organization that will help or hinder these changes? If the test did not show improvement, what modifications should be made to your change?

PROJECT SUMMARY

Region 3 – Bridgeport
Ryan White Part A

Quality Improvement Plan for FY 2021
Date Last Approved: 4/8/2021
Date Last Updated: 6/8/2021

QUALITY STATEMENT

The Ryan White Part A Continuum operating in the Bridgeport Region systematically monitors, evaluates, and continuously strives to improve the quality and delivery of HIV care and services provided to Ryan White Part A consumers. The Quality Improvement (QI) Plan is updated annually and ensures access to the highest quality HIV services within the Bridgeport Region.

Mission

The Lead, GBAPP, Inc. will work with sub recipients to continuously improve the quality of care and health outcomes among People Living with HIV (PLWH) in Region 3 with a particular achievement and maintenance of HIV viral suppression.

Vision

The Quality Improvement Plan will improve patient care, health outcomes, and patient satisfaction for PLWH throughout the Bridgeport Region. To achieve this vision, all funded staff will hold itself to the highest standards to support a service delivery system that provides the high-quality care.

The commitment is to:

1. Utilize all available data sources in an effort to best understand the service population.
2. Consider and value the input of all stakeholders, especially consumers of HIV services.
3. Integrate quality management activities within Client Services and Planning Council activities.
4. Recognize the importance of a comprehensive continuum of care, including a combination of core medical and support services.
5. Identify emerging needs and barriers to care in order to facilitate response.
6. Educate sub recipients, consumers, and the community about quality improvement.
7. Facilitate quality improvement activities including performance-based site visits, monthly desk audits.
8. Develop community mobilizing strategies, designed to engage and galvanize community members to take action towards achieving a common goal of reducing stigma.
9. Work in partnership with the local Getting to Zero Coalition to ensure all PLWH are in care.
10. Further develop strategies with reduce transmission to the three identified target populations, Young Black/Latin/MSM, Heterosexual Black Women, and Transgender Women.
11. Introduce trauma-informed practices into our system of care.
12. Develop training schedule for all Ryan White funded positions.

ANNUAL QUALITY IMPROVEMENT GOALS

There are four distinct QI goals for FY 2021:

1. **<u>To Improve the Hepatitis B vaccine rate among the Outpatient Ambulatory clients in Region Three</u>**

Total Number of Outpatient Ambulatory Clients 4/1/2020-3/31/2021	Total Number of Outpatient Ambulatory Clients in the Denominator	Outpatient Clients in the Numerator	Percentage that met Performance Measure	Target Goal
115	88	53	60%	70% by 2/28/2022

2. **<u>To improve the percentage of Medical Case Management Clients that receive a Care Plan Update across Region 3</u>:**

Performance Measure 1: Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated every 6 months in the measurement year.				
				Target Goal
# of Clients Served in the Past 12 Months	# of Clients Meeting Performance Measure	% of Clients Meeting Performance Measure	Reporting Period Beginning and End Dates (Rolling 12 Month Period)	We hope to have 90% of our MCM clients to have two service plan updates by 2/28/2022.
214	177	83%	4/1/2020-3/31/2021	

3. **<u>To Improve Syphilis, Chlamydia and Gonorrhea Screening across Region 3:</u>**
   To increase the number of Part A Outpatient Ambulatory Clients in Region Three who have Chlamydia (HAB 14), Gonorrhea (HAB 15), and Syphilis (HAB 10) screenings yearly. Between 4/1/2020-3/31/2021 81% of patients completed Gonorrhea screenings and 82% completed Chlamydia screenings. The goal is to increase these rates to 85%. 84% of clients received Syphilis screenings during this time period. The goal is to increase this rate to 90%.
4. **<u>To Improve the Viral Suppression Rate of Heterosexual African American Women in Region 3:</u>**
   To increase the viral suppression of Heterosexual African American Women as documented in CAREWare. As of 3/31/2021 9% (45/482) clients are non-virally suppressed. 12 of the 45 clients are African American females.

QUALITY INFRASTRUCTURE

The QI program is conducted through the combined efforts of the Ryan White Project Director and QI staff, the Bridgeport Lead Agency/Project Coordinator (GBAPP) and its subcontracted providers.

The QI committee consists of

Nancy Kingwood	GBAPP,INC.	Executive Director
Maria Prieto	GBAPP,INC.	Director of Programs
Jean Brown	GBAPP,INC.	HIV Team Lead

Sara Burns	GBAPP,INC.	Data Quality Assurance Specialist
Clunie Figaro	Southwest Community Health Center	Infectious Disease Program Director
Charlene Lee	Liberation Program, INC.	Health Educator
Jennifer Loschiavo	Recovery Network of Programs	Coordinator of Special Populations
Johanna Cruz	Optimus Health Care Inc.	Head Medical Case Manager
Jose Latorre	Optimus Health Care Inc.	Associate Medical Director

The Quality Improvement Plan is written, reviewed, updated, and approved by the Bridgeport/Lead Project Coordinator and Data/Quality Improvement Specialist. PLWH and Stakeholders are involved in the development of the Quality Improvement Plan through the use of data collected from CAREWare and from barriers and concerns that are discussed in monthly Continuum meetings. CAREWare data helps show the committee key target populations in the Region that may need additional support with their care or individuals that can independently maintain their HIV care.

Evaluation

Progress toward achievement of the annual goals is evaluated at the Bridgeport Region 3 monthly Continuum meetings and quarterly QI meetings. The work plans below detail each activity that corresponds to the goal statement. These work plans serve as a checklist and facilitate review of progress at each meeting. A year-end report will summarize findings and recommendations based on work plan activities. The year-end report helps the Bridgeport Region to identify new goals for the coming fiscal year. During the year, the program is evaluated by engaging with our partners with their challenges in achieving the goals of the Quality Improvement Plan. Partners are encouraged to share the barriers they face in quarterly Quality Improvement meeting when data is shared with them. We work together as a Region to over these obstacles and meet our goals. Communication among all stakeholders is essential to provide quality care to all our clients.

Process to Update QI Plan

The Quality Management Plan is reviewed and updated annually (April) by the Region Lead and Subcontractors. The Lead agency follows the Ryan White Part A Project Director (Grantee), and Planning Council recommendations and drafts annual plan, which is further refined and approved by the collaborative partners (subcontractors) of the Ryan White Part A program in the Bridgeport Region.

Key responsibilities for the Quality Improvement program team include:

- Bridgeport Lead Agency/Project Coordinator (GBAPP) - Liaison with Ryan White Part A Office Project Director and QI Staff; facilitates monthly Continuum meetings and quarterly QI meetings with sub-contracted providers and consumers to review quantity and quality of services provided in the region; leads QI projects on annual basis for Ryan White Part A partners in Bridgeport Region. The lead agency (GBAPP) and

subcontractors will discuss Quality Improvement data more frequently if the Lead Agency determines that there is a need for all partners to convene about the Quality Improvement Project.

- Program Director – Maria Prieto is the Project Director for Region Three. She will facilitate the quarterly Quality Assurance Meetings and will act as the liaison to the subcontractors to fulfill their duties of the Quality Assurance Team. She will also attend the quarterly Quality Assurance meetings at the Recipient's Office.
- Data/Quality Assurance Specialist - Sara Burns will be responsible for running the data reports monthly and quarterly of clients that are not meeting the performance measures. She will also attend the Quality Assurance meetings planned by the Recipient's Office.
- Sub-contracted providers – Serve as 'experts' for development/review/updating/ improvement of quality in service delivery for Bridgeport Region. Subcontracted agencies in the Part A program include: Liberation Programs, Optimus Health Care, Recovery Network of Programs, and Southwest Community Health Center
- Consumers –The Continuum recognizes the criticality of consumer participation and welcomes their experience and input. As key stakeholders, consumers will participate in the face-to-face strategic planning for developing and refining service quality improvement projects for the region, providing first-hand information of how services are received in the field, describing patient barriers and challenges to care, and provide insight into quality improvement strategies and interventions.

PERFORMANCE MEASUREMENT

STI and Hepatitis B screenings were chosen because of its importance in the monitoring of all clients are receiving these tests as part of their medical care. These two performance measures will be reviewed monthly at the GBHCC meetings and sub-contractor meeting as needed. All data will be collected from CAREWare custom reports. The Hepatitis B screenings were a finding in our latest audit, therefore we wanted to make sure that all clients were offered both tests at our two subrecipient's two health centers. When CAREWare reports were run for these HAB measures it was important to be reassured that it was not a data entry issue. Assumptions include, clients receiving these tests but their data not documented in CAREWare. We want to be confident that the data in CAREWare is reflective of the medical records kept by our providers and services received. Once this issue is verified and resolved, Region Three Providers will be able to develop techniques that can motivate clients to be screened annually. Hepatitis B and STI screening will be measured from clients that received a Part A medical visit in Region 3.

Region Three continues to examine the service plan update rate of Medical Case Management clients. It is a requirement of all clients to be updated twice a year and we hope to continue to increase it to 95% of clients.

When examining the viral suppression rate of Region Three clients we saw that African American women comprised the greatest component clients of the three target populations in the Getting to Zero Campaign. We hope to conduct a needs assessment of African American women and determine their needs in order to become virally suppressed.

Data Collection

The primary source of data for measuring the progress of all goals is the CAREWare data reports. The guidelines and training workshops will have products completed. Meetings with the quality infrastructure team will be documented through attendance forms and meeting summary notes. Performance Measures are chosen and reviewed in Region Three through CAREWare data to determine the areas of improvement that will benefit the clients and other Stakeholders in Bridgeport. Data will be collected from CAREWare by the Data/Quality Improvement Specialist and shared to the subcontractors in the quarterly QI meetings. CAREWare data can be separated by medical care providers and by gender, race, or ethnicity. The Quality Improvement Team can determine whether a specific group of clients requires attention in an area to improve their care.

QUALITY IMPROVEMENT

- **Recipients are expected to implement quality improvement (QI) activities using a defined approach or methodology (e.g., PDSA/model for improvement, Lean, etc.).-**
  All members of the Quality Improvement team will use the Plan Do Study Act methodology. This allows for the team to reevaluate the previous activities and determine the successes and areas of improvement.
- **Recipients should conduct QI activities within at least one funded service category at any given time. (QI project may span multiple service categories.)-**
  Region Three have chosen performance measures that focus on the Outpatient Ambulatory and Medical case Management service categories.

- **Describe the QI approach or methodology used (e.g. Model for improvement/PDSA, Lean, etc.)-**Every quarter the Data/Quality Assurance Specialist will calculate the percentage of clients meeting each performance measure and will compare it the previous quarter. Then the QI committee will observe the improvement in a specific performance measure over a period of time. The main approach to Region 3's QI goals was a reflection of our areas of success, as well as the areas that needed improvement. It also encouraged us to become more data driven in our system of care. The four Quality Improvement goals were determined because we viewed them as major areas of improvement when we analyzed CAREWare data.

- **Describe how QI priorities or projects are selected; if known, state the QI priorities or projects for current year**

- **Describe how QI projects are documented**

QI projects are documented quarterly at the Quality Improvement Meetings. QI activities will be documented through meeting minutes but through emails that are sent out to members of the committee when the Quality Assurance Specialist runs data reports. Executive Directors will also be copied on emails sent to providers in reference to Quality Improvement activities.

- **Describe how subrecipients are engaged, supported, and monitored with respect to QI**- The subrecipients are engaged consistently by the Region Three Lead with providing information about their clients that are not meeting the chosen performance measures. They are provided monthly lists and are required to refer clients to the

Intensive Medical Case Manager to get the clients back into care. Subrecipients' engagement will be monitored by checking the number of clients referred to Intensive Medical Case Management. In addition the Lead Agency meets monthly with the Region 2 Medical Case Managers to review and become aware of the successes and obstacles they encounter with clients.

WORK PLAN

The Work Plan will be shared with subcontractors and other stakeholders in quarterly QI meetings and local Continuum Meetings.

1. *To Improve the Hepatitis B vaccine rate among the Outpatient Ambulatory clients in Region Three*

Activities	Measurement	Timeframe	Responsible Persons
1. Track critical HAB measures via CAREWare 2. Run custom reports and distribute quarterly to subcontractors 3. Review outcomes and discuss QI on a quarterly basis	1. CAREWare report completed on a quarterly basis for specific year-end dates 2. Report documentation 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors (sign in sheet and summary of meeting) 4. Performance Measures will be monitored every three months. We hope to have a HEP B rate of 62% by 8/31/2021 and 65% by 11/30/2021. 5. We hope achieve a HEP B vaccine rate of 70% by 2/28/2022.	1. HAB Report start: March 2020 2. Custom report to subcontractors start: June 2021 3. Report review start: Monthly Continuum Meeting: June 2021 Quarterly QI Meeting: June 2021 4. Report review End: Monthly Continuum Meeting: February 2022 Quarterly QI Meeting: February 2022	1. QI steering committee: Nancy Kingwood (GBAPP), Sara Burns (GBAPP), Charlene Lee (Liberation Programs), Johanna Cruz, (Optimus Health Care), Jennifer Loschiavo (RNP), Clunie Figaro (SWCHC) 2. Sara Burns (GBAPP), Nancy Kingwood (GBAPP), Maria Prieto (GBAPP) 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors

Goal 2: To improve the percentage of Medical Case Management Clients that receives a Care Plan Update across Region 3:

Activities	Measurement	Timeframe	Responsible Persons

1. Run custom reports and distribute to subcontractors quarterly 2. Review outcomes and discuss QI on a quarterly basis	1. Quarterly review of Data Sharing requests and accepts in CAREWare 2. Quarterly report documentation 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors (sign in sheet and summary of meeting) 4. Performance Measures will be monitored every three months. We hope to have a MCM Service rate of 85% by 8/31/2021 and 87% by 11/30/2021. 5. We will attain a MCM service plan update rate of 95% by 2/28/2022	1. Data Sharing report start: March 2021 2. Custom report to subcontractors start: March 2021 3. Report review start: Monthly Continuum Meeting: March 2021 Quarterly QI Meeting: June 2021 4. Report review End: Monthly Continuum Meeting: February 2022 5. Quarterly QI Meeting: February 2022	1. QI steering committee: Nancy Kingwood (GBAPP), Sara Burns (GBAPP), Charlene Lee (Liberation Programs), Johanna Cruz (Optimus Health Care), Jennifer Loschiavo (RNP), Clunie Figaro (SWCHC) 2. Sara Burns (GBAPP), Nancy Kingwood (GBAPP) 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors

Goal 3: To Improve Syphilis, Chlamydia and Gonorrhea Screening across Region 3:

Activities	Measurement	Timeframe	Responsible Persons

1. Run custom reports and distribute to subcontractors quarterly 2. Review outcomes and discuss QI on a quarterly basis	1. Quarterly review of Data Sharing requests and accepts in CAREWare 2. Quarterly report documentation 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors (sign in sheet and summary of meeting)	1. Data Sharing report start: March 2020 2. Custom report to subcontractors start: March 2021 3. Report review start: Monthly Continuum Meeting: March 2021 Quarterly QI Meeting: June 2021 4. Report review End: Monthly Continuum Meeting: February 2022 Quarterly QI Meeting: February 2022	1. QI steering committee: Nancy Kingwood (GBAPP), Sara Burns (GBAPP), Charlene Lee (Liberation Programs), Johanna Cruz (Optimus Health Care), Jennifer Loschiavo (RNP), Clunie Figaro (SWCHC) 2. Sara Burns (GBAPP), Nancy Kingwood (GBAPP), Maria Prieto (GBAPP) 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors

Goal 4: To Improve the number of clients that are documented in care across Region 3:

Activities	Measurement	Timeframe	Responsible Persons
1. Run custom reports and distribute to subcontractors quarterly 2. Review outcomes and discuss QI on a quarterly basis	1. Quarterly review of Data Sharing requests and accepts in CAREWare 2. Quarterly report documentation 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors (sign in sheet and summary of meeting)	1. Data Sharing report start: March 2021 2. Custom report to subcontractors start: March 2021 3. Report review start: Monthly Continuum Meeting: March 2021 Quarterly QI Meeting: June 2021 4. Report review End: Monthly Continuum Meeting: February 2022 Quarterly QI Meeting: February 2022	1. QI steering committee: Nancy Kingwood (GBAPP), Sara Burns (GBAPP), Charlene Lee (Liberation Programs), Johanna Cruz (Optimus Health Care), Jennifer Loschiavo (RNP), Clunie Figaro (SWCHC) 2. Sara Burns (GBAPP), Nancy Kingwood (GBAPP), Maria Prieto (GBAPP) 3. Monthly Continuum Meetings: Lead agency, Subcontractors Quarterly QI Meetings: Lead agency, Subcontractors

Region IV (Stamford/Norwalk)

Clinical Quality Management Plan

FY2021

General Information

Lead Agency: Family Centers Inc.
Last updated: June 8, 2021

Quality Statement

Region IV is committed to providing all clients with the highest possible quality of HIV care. The region achieves this by focusing on quality indicators, accomplishing quality goals, proactively creating, revising quality indicators, and goals to achieve a level of care worthy of our clients.

Region IV Annual Quality Management Plan is designed to be the region's specific description of efforts that follow the HRSA Clinical Quality Management Policy Clarification Notice 15-02.

Annual Goals

2021 Priorities:

Ongoing

1. **Increase the number of STI screenings to 80%:**
   Actively monitoring and implementing strategies to bring up rate from 73% to 80%.

Objectives:

   i. Identify clients who are not receiving their STI screenings/test (Syphilis, Gonorrhea and Chlamydia) on a yearly basis.
   ii. Keep STI screening rates above 80% for the clients we serve.

2. **Ensure data integrity in CAREWare:**
   Monthly monitoring of Region's performance data and the timeliness of entering data.

Objectives:

   i. Identify missing/erroneous data and do monthly spot checks to ensure improvement.
   ii. Monitor data monthly consistency and accuracy in CAREWare.
   iii. Identify where data integrity gaps improve the accuracy of the data by running reports and locating areas of missing data, late data, or entry errors and reporting this information to each sub-sub to address and correct.
   iv. Inform staff on why data integrity is important and how it reflects on their own work and may affect regional funding decisions.

v. Ensure that every client inside of the Ryan White network is set up for data sharing. This allows everyone to have direct access to clinical, eligibility and service data.

3. **Identify those individuals who have not achieved viral suppression**:
Actively Monitoring and implementing strategies to bring rate up from 86% to 90%.

Objectives:

i. Monitor viral suppression among determined demographic groups for disproportionate outcomes.
ii. Increase rates of viral suppression by finding out from clients what their barriers are, seeing if there are any trends, and figuring out how each program can address the barriers.

Quality Infrastructure

The Clinical Quality Management Committee is tasked with overseeing Region IV clinical and operational quality of care for all clients. The CQM Committee is chaired by the Program Coordinator of Family Centers (lead agency) and consists of other critical program staff, consumers, and stakeholders. The Committee guides, endorses, and champions quality of services provided. The committee does all of this by choosing annual goals, creating, and executing the PDSA's and advocating for continuous quality. The committee will choose different standards to review and improve each quarter. In addition to the committee choosing annual goals, staff members and/or consumer can forward any quality concerns to the Chair who will review the concern with the rest of the CQM Committee.

The Committee consists of:

- Yirley Chaux- Program Manager Stamford CARES (chair)
- Stuart Lane- Executive Director – MFAP
- Mindy Garcia – Patient Eligibility Specialist – NCHC
- Jennifer McBride – Clinician Behavioral Health -FCA
- Anaica Quao – APRN – Stamford Hospital
- Krystle Moore – Health Educator – Liberation Programs
- Consumers
- Stakeholders

Representatives are responsible for taking instruction from the committee and doing the work of relevant PDSA's to their agency.

The CQM Committee meets monthly to review the Quality Plan, performance on Quality Indicators, progress towards the annual work plan, and progress on Quality Improvement Activities.

The Clinical Quality Management Committee is responsible for:

- Outlining the tasks of the CQM Committee in the coming year in relation to the CQM Plan.
- Completing an annual evaluation and recommending changes if needed, to Quality Indicators used to gauge progress towards the selected quality goals.

- Reviewing annually and recommending changes if needed, to the Regional Quality Management Plan.
- Creating and recommending quality improvement activities/corrective actions in response to quality measurement findings.
- Auditing charts and records as necessary.
- Conducting, analyzing, and reporting on Consumer Feedback obtained through surveys, focus groups and ongoing community input.

The Program Coordinator is responsible for:

- Creating, implementing, reviewing, updating, and approving the Clinical Quality Management Plan annually.
- Administering all procedural aspects of the committee including soliciting agenda items, recording, and archiving signed and approved meeting minutes.
- Reporting on the work of the CQM committee to the Ryan White Part A office.

PLWHA are involved in the CQM process so that the committee reflects the population that is being served and ensures that the needs of PLWHA are being addressed by CQM activities. The meeting times and dates are given to clients who are interested in attending. PLWHA are also included in the PDSA work and encouraged to be a part of quality improvement from the ground up.

Sub-Recipients are involved in the CQM process by working with the Program Manager and CQM Committee to work through and complete the various PDSA cycles.

Stakeholders are other community agencies besides sub-contractors (whose work impacts the clients served by Ryan White) have the opportunity to be involved and provide input on CQM activities addressed or undertaken. When appropriate or necessary they will also be included in the work of a PDSA. To ensure the utmost improvement of our care system sometimes community partners and stakeholders need to be involved and they will be included when suitable.

Evaluation: Evaluating the effectiveness of the CQM program ensures that the CQM activities are making changes that positively affect outcomes. Evaluation of the CQM activities happens regularly in order to maximize the impact of the program. Evaluation provides the opportunity to learn the processes and resources needed in implementing CQM activities through the collection of detailed information. Evaluation also identifies effective improvement strategies that can be scaled up or implemented in other facets within a system of care.

The CQM Committee itself, the Ryan White Office, and the EMA Wide CQM Continuum conduct evaluation. The CQM Committee conducts evaluation of performance annually and the EMA wide CQM Continuum provides feedback that is more ongoing quarterly. All feedback is integrated into the CQM process where practicable and aims to improve effectiveness.

Performance Measurement

The Clinical Quality Management Committee analyzes performance measure data to assess quality of care and health disparities and uses the performance measure data to inform quality

improvement activities. The CQM committee runs the performance measure reports monthly in CAREWare for each agency to identify any areas of concern.

The CQM Committee runs and tracks all clinical performance measures and retires measures when they meet 80% or better. Reports will be run regularly for each performance measure, retired or not.

HRSA/HAB Performance Measure	Responsibility	Goal
Clients are Virally Suppressed	Documentation that the client is virally suppressed within as evidenced by the last viral load test within the measurement year (<200 copies/mL) at last test of the measurement year as documented by the medical case manager.	90%
Client had annual screening for syphilis.	Documentation of annual syphilis screening evident in client chart.	80%
Client had annual screening for chlamydia.	Documentation of annual screening for chlamydia evident in client chart.	80%
Client had annual screening for gonorrhea.	Documentation of annual screening for gonorrhea evident in client chart.	80%
Client had viral load test performed at least every 3 – 6 months.	Documentation of viral load test outcomes evident in client chart.	100%

Quality Improvement

The CQM Committee uses the Plan, Do, Study, Act (PDSA) model to facilitate program improvement.

Plan –

1. Clarify your objective.
2. Make a prediction.
3. What is to be done (who, what, where, when, how)

Do

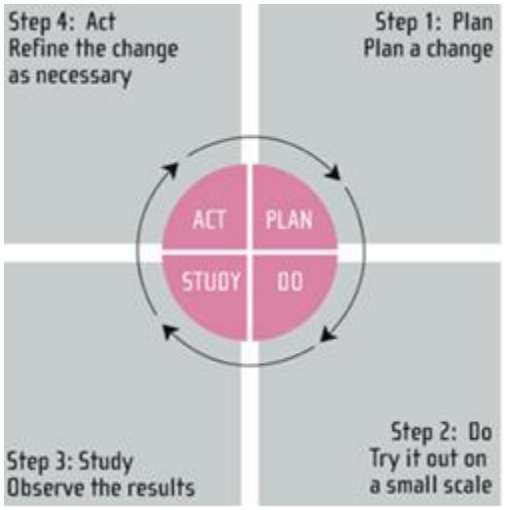
1. Carry out the plan.
2. Document your observations.
3. Begin analysis.

Study

1. Look at the test.
2. Complete the analysis of the data.
3. Compare it to your theory and predictions.
4. Summarize what you have learned.

Act

1. Make any adjustments.
2. New cycles



The CQM committee addresses issues identified through running performance measure reports in CAREWare or those issues brought to the EMA wide CQM consortium. Sub-recipients and other stakeholders are engaged when the project involves services that they provide. In addition, they are supported by the CQM committee to implement the PDSA cycle. The Program Manager follows up and provides ongoing support and monitoring.

QI projects are documented in this Plan and in PowerPoint form to be presented at the EMA wide meetings.

STI Work Plan – Ongoing

Objective	Timeline	Responsible Staff	Outcomes
Identify clients who are not receiving their STI screenings/test, specifically Syphilis, Gonorrhea and Chlamydia on a yearly basis.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	Remain above 80% for all three screenings.
Plan			
Monitor data input and lab work requests from private doctors. Educate clients to advocate for their own testing.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	Remain above 80% for all three screenings.

Utilize city STI clinic doctors in cases where private doctors refuse to increase screening rates.			
Do			
Continue to carry out action steps in all past PDSA cycles because they have all yielded success. Continue to monitor any percentages drop and if there are any problems or unexpected findings to address the issue in a timely manner.			
Study			
Review STI performance measures periodically to ensure they are above 80%. The team will see if they need to bring back STI as an active PDSA if percentages ever drop.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	
Act			
The Quality Improvement Committee will make every effort to search and apply best practices that will help increase and maintain STI rate.	3/1/2021-2/28/2022 (Quarterly)	Region IV CQM Committee / SNARP	-Re-run the PDSA as needed

Will reinitiate quarterly consumer forums to promote health empowerment and health screenings. Lead and MCM's will periodically reach out to private providers to remind them of required screenings. Quality Improvement Committee will continue to monitor CAREWare with client labs to make sure all reports are up to date and accurate.			

Data Integrity Work Plan – Ongoing

Objective	Timeline	Responsible Staff	Outcomes
Monitor data consistency and accuracy in CAREWare. Identify data integrity gaps and initiate actions to fix them. Inform staff on why the accuracy of data is important and how it effects funding decisions. Ensure that every client inside our network is set up for data sharing.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	All data is real time and accurate
Plan			
Provide quarterly report to the "sub subs" and train them on how to run the data.	3/1/2021-2/28/2022 (Quarterly)	Region IV CQM Committee / SNARP	Regional staff understand importance of accuracy in data and know how to run their own performance reports.
Do			
Monthly reports will be run to discuss at SNARP meetings. Sub Subs will work on their data accuracy and on identified issues during SNARP.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	
Study			

Identify any trends or drastic changes on monthly reports.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	
Act			
-Subcontractors have until the 10th of the month following to enter all encounter data (by contract) Monthly reports are shared during SNARP meetings to identify any issues and progress towards performance goals Sub Subs have trained on CAREWare reporting and are given technical assistance as needed. Lead provides sub subs with data identified to be inaccurate or missing on an ongoing basis is not accurate when lead. Hosted a CAREWare training where we trained all new and existing staff on how to run their own reports so they can spot check their own data entry.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP	

Viral Suppression Work Plan – Ongoing

Objective	Timeline	Responsible Staff	Outcomes
Identify clients among determined demographic groups that are not virally suppressed.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP (Stamford CARES / MFAP)	Increase the number of clients receiving services through Part A who are virally suppressed.
Plan			
CQM Committee will determine if there are any disparities among demographic groups. If found, providers will implement program initiatives to address them.	3/1/2021-2/28/2022 (Monthly)	Region IV CQM Committee / SNARP (Stamford CARES / MFAP)	Increase the number of clients receiving services through Part A who are virally suppressed.
Do			
Conduct survey for all clients at MFAP and Stamford CARES who are not virally suppressed to identify any barriers. Work closely with providers to identify reasons why clients are not virally suppressed.	3/1/2021-2/28/2022 (Quarterly)	Region IV CQM Committee / SNARP (Stamford CARES / MFAP)	

Study			
Analyze responses from clients. Identify trend in any particular demographic group.	3/1/2021-2/28/2022 (Quarterly)	Region IV CQM Committee / SNARP (Stamford CARES / MFAP)	
Act			
Initiate any best practices or changes based on client's response to aid clients reach viral suppression. Work with Regional staff to collaborate with each other and help each client with barriers, if any.	3/1/2021-2/28/2022 (Quarterly)	Region IV CQM Committee / SNARP	-Reduce the number of people non virally suppressed

OAHS Standards of Care PDSA's

Oral Health Screening

Objective	Timeline	Responsible Staff	Outcome
Identify why standards had low rates: "Client received an oral exam by a dentist at least once during the measurement year based on client self-report" (79%)	3/22/2021-7/22/2021	Stamford Hospital / NCHC	Increase standards to 100%
Plan			
Identify why service standards are low and initiate an action plan to address any issue	3/22/2021-7/22/2021	Stamford Hospital / NCHC	Factors for low standards and action plan.
Do			
-Review current data collection processes at NCHC and SH.	3/22/2021-7/22/2021	Stamford Hospital / NCHC	Improve oral health data in client's record.

Ensure data is being collected and updated in EMR. Promote oral health screenings to clients.			Increase client's referral to oral health screenings.
Study			
Analyze data on quarterly reports and look for improvement of performance measures. Discuss findings with NCHC and SH to reexamine approach and appropriate changes.	3/22/2021 – 7/22/2021	Stamford Hospital / NCHC	
Act			
Work with NCHC and SH to ensure data is being collected. Will be discussed monthly at SNARP. Work with MCM's to get clients who have not seen a dentist to an appropriate dental provider.	3/22/2021 – 7/22/2021	Stamford Hospital / NCHC	Increase performance measures to 100%

Viral Load Test

Objective	Timeline	Responsible Staff	Outcome
Identify reasons why standards had low rates: "Clients had a viral load test performed every 3-6 month" (68%)	3/22/2021 - 7/22/2021	Stamford Hospital / NCHC	-Increase service standards to 100%
Plan			
Identify why service standards are low and initiate an action plan to address any issue.	3/22/2021 – 7/22/2021	Stamford Hospital / NCHC	-Factors for low standards and action plan.
Do			

-Review the current system that Stamford Hospital and NCHC have in place for scheduling and reminding clients of lab work.	3/22/2021 - 7/22/2021	Stamford Hospital / NCHC	-Improve client reminder system or increase number of people involved in getting the client to get lab work completed.
Study			
Analyze data on quarterly reports and look for improvement of performance measures. Discuss findings with NCHC and SH to reexamine approach and appropriate changes.	3/22/2021 - 7/22/2021	Stamford Hospital / NCHC	
Act			
Work with NCHC and SH individually to keep track of improvements and work with any gaps that need to be addressed. Work with MCM to ensure they are reminding clients of lab work. MCMs will also assist in making appointments for clients and request lab work before appointment.	3/22/2021 - 7/22/2021	Stamford Hospital / NCHC	Re-Run during next cycle to see if percentages improve

Region 5 (Danbury) Clinical Quality Management Plan

Apex Community Care, Inc.

CQM Quality Improvement Plan

Effective Date: 03/01/2018 **Last Review Date: 03/08/2020** **Revised Date: 06/05/2021**

I. QUALITY STATEMENT

Apex Community Care Inc. (ACC) serves *people living with the human immunodeficiency virus (HIV)* (PLWH) within the Danbury area. Apex is committed to providing core and support services to people living with HIV/AIDS and their loved ones, (that are funded by Parts A and B of the *Health Resources and Services Administration's* (HRSA) Ryan White HIV/AIDS Program). The mission of Apex CQM plan is to evaluate, measure, plan, and implement quality performance improvements in the delivery system and processes which affect the quality of care and services provided at Apex community center. The focus is emphasized on; (1) reduce new HIV infections, (2) increase access to care and improve health outcomes for PLWH, and (3) reduce HIV-related disparities and health inequities. These efforts are aligned with the center's vision to minimize the burden of disease through health promotion and disease prevention strategies.

II. ANNUAL QUALITY GOALS

The Clinical Quality Management (CQM) committee is purposed to meet or exceed the expectations of the HIV/AIDS Bureau's (HAB) performance measures—measurable goals that will be facilitated through capacity building activities and the existent monitoring and management of data. Hence, *screenings*, *medical case management*, and *coordinated services* have been targeted for quality improvement in the following areas* of HIV care as of calendar year (CY) 2020.

Care Indicators	Annual Goals	Baseline Data (%) CY2019
1) Annual syphilis serology	To obtain a screening rate of 90%	87.04% (94/108)
2) Lipid Screening	To obtain a screening rate of 85%	82.42% (75/91)
3) Care Plan updates	To obtain a completion rate of 100%	96.5% (84/87)
4) Viral Load Suppression*	To obtain completion rate of 95%	93.52% (101/108)

Goals

- To improve health outcomes and medical care across all funded categories for all the Ryan White grants as defined by U. S. Department of Health and Human Services (HHS) and HIV/AIDS Bureau.
- To improve quality services through the continuum of care and agencies vested in process.
- To promote retention into care and promote viral suppression.

III. CLINICAL QUALITY MANAGEMENT INFRASTRUCTURE

The clinical quality team is directed by the Program Director who authorizes the quality committee to plan; assess, measure, and implement performance improvements throughout the care continuum. Under the leadership of the quality assurance director (QAD), the committee collaborates on a monthly basis and comprises professionals of multiple disciplines, representing the sectors of health care, public health, and human services that are either employed by Apex, sub-recipients of Ryan White funding or consumer/s of services offered under the Ryan White services (see Table 1). The quality committee will have at least 10 scheduled meetings per year planned for the first Monday of each month from 12:00pm-1:00pm. Additional meetings may be called as needed. Minutes and attendance will be recorded and shared with all members of the committee and to all necessary agencies' committees and boards. The effectiveness of the program will be evaluated by the progression of PDSAs selected in reaching goals chosen, improvement of data deficiencies, and staying on target with work plan activities. Meeting will be facilitated by the presider (CQM Director) who will ensure information is being shared and discussed with stakeholders based on the annual work plan. CQM plan and work plan will be annually evaluated, and changes will be made based on agency's scope of care and HRSA requirements. The CQM plan is reviewed, updated, and approved by the CQM team.

Table 1. Clinical Quality Committee

Name	Title	Role/Responsibility
Roberta Stewart	Chief Executive Officer	Program Director
Albana Lame	Chief Operating Officer	Presider and CQM Director
Adam Shook PA	Primary Care and Infectious Disease Specialist/ Danbury Hospital	QAD, establishes quality and reliability standards; ID* expert
Katherine DeFiore	Assistant Director of Behavioral Health	Subject-matter expert on mental health and substance abuse
Josie Ossers	Supervisor, Medical Case Management	Subject-matter expert on case management
Jasmine Green	Intensive Medical Case Manager	Links target population patients to care and provides HIV counseling/education
Lisa Gluz	Consumer(s)	Provide advice and feedback on RW care and quality measures.
Anthony Archer	Consumer(s)	Provide advice and feedback on RW care and quality measures.

CQM Committee. Roles and responsibilities of staff accountable for developing and implementing the clinical quality management program and related activities:

CQM Director

Advises on and ensures that all aspects of clinical services—as it relates to CQM practices—are administered in accordance with generally accepted professional standards, reviewing cases, and addressing all matters of quality control and performance protocols. The incumbent also appropriates resources and manages any issues or concerns of CQM stakeholders to sustain a positive team culture.

Writes the CQM plan, reviews clinical data and establishes quality standards, processes, and systems by which all CQM activities are executed in the pipeline of its development, providing leadership and direction to committee members that will promote growth and development and quality improvement practices within the infrastructure of CQM operations.

Program Director

Acts as liaison to both the funders and conveys HRSA/HAB *priorities* to members of the CQM committee. Ultimately, the vision, scope, and mission of performance improvement management are effectively communicated to help develop quality improvement programs and support long-term goals.

The ability of leadership to work in harness with other stakeholders will influence performance measurement practices—a key process of the QI plan and its improvement strategies.

Consumer Advisory Board (CAB): APEX reviews the Quality Management Plan and progress at the monthly RW Consortium. Using data from APEX and sub-contractors with feedback from consumers the plan will be updated and adjusted in direct response to the needs of the community.

IV. PERFORMANCE MEASUREMENT

Selection of performance measures. Performance measures are selected based on the criteria set forth in the *Policy Clarification Notice* (No. 15-02):

- ≥ 50% of clients with at least one unit of service | *two* (2) performance measures
- > 15% but < 50% of clients with at least one unit of service | *one* (1) performance measure
- < 15% of clients with at least one unit of service | *zero* (0) performance measures

In addition to these criteria, performance measures of the Eligible Metropolitan Area (EMA) will be considered in accordance to Apex's coordination and collaboration with the Part A office and State of Connecticut Department of Public Health Part B office and its quality improvement program.

Data collection and sharing.

Data are routinely extracted from various systems such as electronic health record database, *CAREWare* and various spreadsheets that are utilized for monthly, quarterly, and annual review and reporting. These systems provide detailed performance measures that will help stratify the data that is collected and evaluated over a specific period of time. The collection of these data sources will be utilized for gaging the progression of PDSAs and meeting set goals. The extraction process is facilitated through structured, systematic, and scientific methods that drive quality improvement projects within the CQM program:

Case Conferences – conducted on a weekly basis with all providers from the care continuum.

RW Consortium- meets on a monthly basis and includes Danbury Hospital, APEX Care and Prevention Programs, as well as consumers. Consumer Advisory Board (CAB): APEX reviews the Quality Management Plan and progress at the monthly RW Consortium. Using data from APEX and sub-contractors with feedback from consumers the plan will be updated and adjusted in direct response to the needs of the community.

Interdisciplinary measures – APEX uses the HAB clinical performance measures to ensure achievements of clinical goals and improvement of clinical care.

Evaluation: Evaluation of all Quality Improvement activities occurs internally on a quarterly basis

Data analytics. The practice of analytics empowers CQM stakeholders to improve performance on all levels of patient care. Raw data are analyzed and translated into useful information, giving insight into the health of Apex's subpopulations and its conformity to the reporting requirements of the Ryan White HIV/AIDS Program (and other value-based incentive programs).

Performance measure categories. The following table (Table 1) identifies performance measures on which focused attention will be given for improvement:

Table 1. Performance Measures of Funded Categories

Category	Performance Measure	Numerator	Denominator	Data Collection (Frequency)	Data Collection (Method)
Primary Care Visits *≥ 50% (95.7%) of subpopulation (n = 246) receive at least one unit of service*	Tuberculosis (TB) Screening **HAB14**: HIV-infected clients who received testing for latent TB infection since HIV diagnosis.	Number of clients in denominator who have received screenings (using Quantiferon, PPD, IGRA, or TST) for latent TB infection across providers within the measurement year.	HIV-infected clients without history of TB disease or infection with at least one medical visit within the measurement year.	Monthly and quarterly	Record and administrative reviews
Syphilis Screening *>86% (84.9%)of subpopulation receive at least one unit of service*	Syphilis Screening **HAB13**: Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year.	Number of patients with a diagnosis of HIV who had a serologic test for syphilis performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who: *1)* Were >18 years old in the measurement year[1] or had a history of sexual activity <18 years, and *2)* Had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.	Monthly and quarterly	Record and administrative reviews
Oral Health Care > 15% but < 50% *(95.7%) of subpopulation receive at least one unit of service*	Oral Exam **HAB12**: Percentage of HIV-infected clients who received an oral health exam in measurement year.	Clients in denominator who had an oral exam or were referred for an oral health care exam.	HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	Monthly and quarterly	Record and administrative reviews
HIV Viral Load Suppression < 2 *(95.65%) of subpopulation receive at least one unit of service*	Viral Load Suppression **CORE01**: Percentage of [patients] or clients with HIV infection whose last viral load in the measurement year is less than 200 copies.	Number of [patients] or clients whose last viral load in the measurement year is less than 200 copies.	Number of HIV-infected [patients] or clients with at least one medical visit in the measurement year.	Quarterly	Administrative review
Lipid Screening <67.1% *(40.20%) of subpopulation receive at least one unit of service*	Lipid Screening HAB 11 Percentage of HIV-clients on HAART who received a fasting lipid panel in measurement year.	HIV-infected clients who had a medical visit with a provider with prescribing a fasting lipid panel once in the measurement year	Clients in denominator who had one medical visit with provider. Were >21 yrs. old in the measurement year	Quarterly	Record and administrative reviews
Mental Health < 15% *(13.8%) of subpopulation receive at least one unit of service*	N/A	-	-	-	-
Substance Abuse	N/A	-	-	-	-

< 15% (8.5%) of subpopulation receive at least one unit of service					

V. QUALITY IMPROVEMENT

"Quality improvement (QI) consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups. The Institute of Medicine (IOM), which is a recognized leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and populations." (https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf)
QI strategies will be executed within the *Model for Improvement* framework that employs the iterative process of *Plan-Do-Study-Act* (PDSA) cycles.

PDSA Cycles. PDSA cycles (see *Diagram: Implementation of PDSA Cycles*) are seemingly "simplistic [when] compared to other methodologies; [however], the PDSA cycle, in a repeated application, is the backbone of quality improvement." Moreover, PDSA cycles are proven methods for testing the validity of interventions (using process, outcome, and structural measures) and identifying variations in data, ergo, are effective solutions to quality improvement (https://www.healthcatalyst.com/insights/quality-improvement-healthcare-5-guiding-principles):

Diagram: Implementation of PDSA Cycles

Implementing the PDSA Cycle

***Source**:https://www.tha.org/THA-Foundation/Clinical-Initiatives-and-Quality/Initiatives/CAH-QI/CAHQI-Toolkits/PDSA-Cycle*

QI projects are selected based on the feedback received from consumers and/or unmet performamce measures. Small-scale tests are utilize to begin the process of the PDSA cycle and as they are fine-tuned, they become the mechanism of a wider-scale test and to the final step of implementation at scale. It is the responsibility of the CQM committee to assess the intervention and determine whether the change should be adopted or modified in the next planning phase, restarting the cycle from the beginning. The PDSA cycle ends when a desired outcome is achieved and the goal is met; adoption occurs upon the success of repeated intervention cycles (at either a one-month, three-month, or six-month interval) and the attainment of goals. If the intervention is adopted, then it will become a key component of internal processes, and the committee will advance to a new intervention cycle. And the quality improvement project will be deemed complete when all targeted goals and objectives have been attained. (For more information onthePDSA model, please visit: http://tutorials.nqcqualityacademy.org/QI_tutorial/.)

I. WORK PLANS AND SELECTED PROJECTS

A customized spreadsheet of performance measures will be utilized to track and document QI projects that have been identified in accordance with the committee's selection process and areas of deficiency. The spreadsheet will be analyzed monthly to track the progress of work completed and to identify any performance measures shortcoming.

The work plan, will be used to capture annual quality management goals of the CQM program, and promoting efficiency, accountability, focus, and insight that will help result in the demonstration of the committee's vision. The plan will be shared and discussed with stakehlders at monthly meetings to solicit feedback and updates, ensure the feasibility of timelines and due dates, and recognize accomplishments.

Work Plan (Year 2021)																
Ryan White Clinical Quality Management (CQM) Program											**Year3**					
Goals and Objectives	**Responsible Party**	**Status**	**1**	**2**	3	4	5	**6**	7	8	9	10	11	12		
Goal 1: Improve health outcomes and medical compliance																
Promote RW services of Apex to PLWH	All department and subcontractors	In progress														
Review and evaluate agency adherence to the recommended clinical measures	Medical (ID Physician and CQM director/MCM supervisor)	In progress														
Review external and internal data sets to assess quality of care provided	Apex (MCM supervisor/CQM director and Data Analyst)															
Goal 2: To promote patient linkage, retention, and medication adherence																
Chart Audit	All department	In progress														
Review patients who are out-of-care within a 24-month period	Apex (Data Analyst and MCM supervisor)	In progress														
Goal 3: To improve quality services through the agencies in the region																
Review, revise and monitor the CQM plan annually for the effective implementation	Apex (CQM Director/Data Analyst)	Completed														
Report CQM activities to key stakeholders	All departments	In progress														
Offer in-service training workshop: CME and CEU is used for all staff and departments as a requirement for their line of service.	All departments	In progress														