2024

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

FISCAL YEAR 2024

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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 _____ 4/1/2024 _____

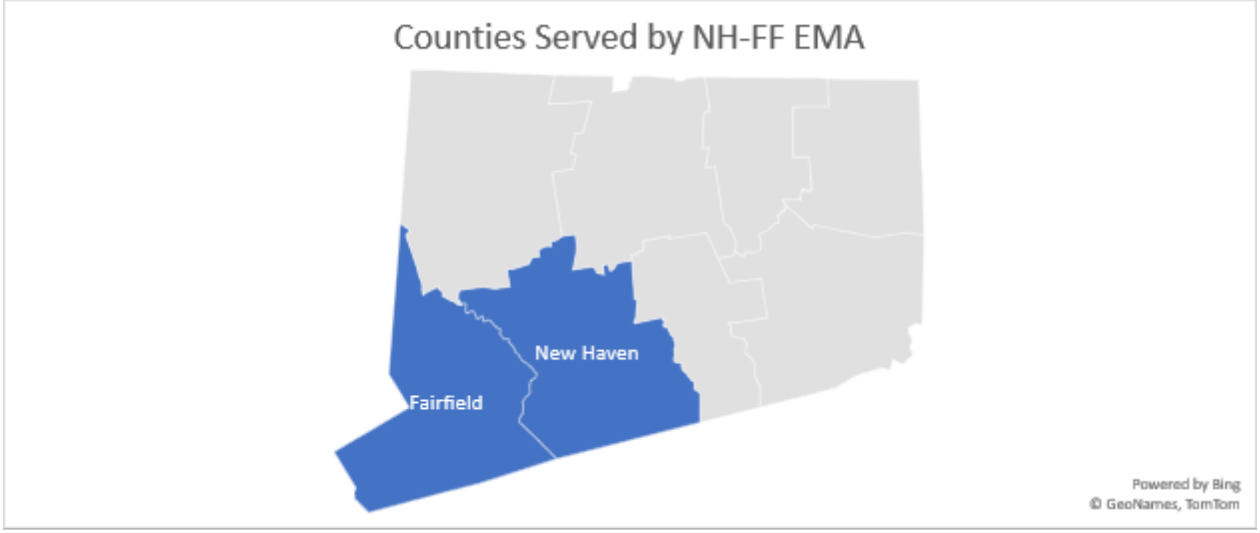
Thomas Butcher
Program Director
RWHAP Part A Office

Date

Introduction

Since 1993, the New Haven-Fairfield Counties, Connecticut Eligible Metropolitan Area (EMA) has used RWHAP Part A grant funding to deliver high-quality care and treatment to people living with HIV (PLWH). As of November 30, 2023, a total of 1,687 PLWH were enrolled in RWHAP Part A in the New Haven – Fairfield Eligible Metropolitan Area (NH-FF EMA). Looking at the demographics of those enrolled, minority groups make up the largest share of clients, with Black/African Americans representing 46% (n=783) and Hispanic/Latinx 36% (n=606) being the most prevalent groups. This translates to 84% of the program's clients identifying as a racial or ethnic minority. Males continue to be the majority of clients served, accounting for 59% (n=994) of those enrolled. When it comes to age, the largest proportion of clients are 45 years old or older at 73% (n=1,229). Heterosexual contact is the most common risk factor reported by clients in the EMA's RWHAP Part A program, making up 50% (n=845) of cases. Men who have Sex with Men (MSM) account for 29% (n=492) of clients, followed by injection drug use (IDU) at 17% (n=282). Understanding these demographics is crucial for ensuring the program effectively meets the needs of the community it serves.

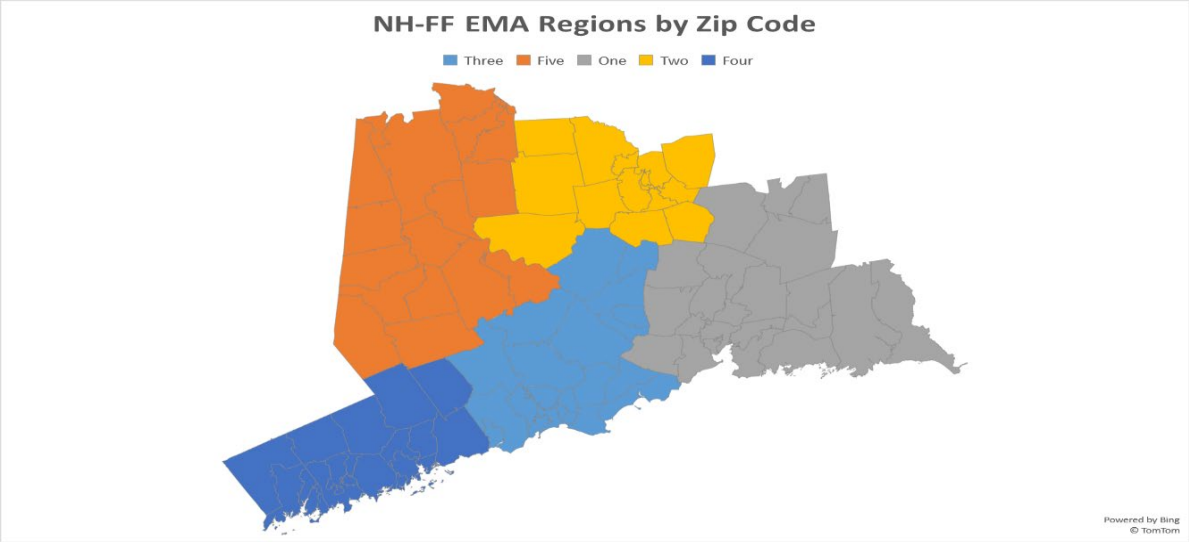
The Clinical Quality Management Program provides a coordinated approach in addressing quality assessment and improvement of the HIV/AIDS medical and support services in the New Haven-Fairfield (NH-FF) EMA. The CQM Program maintains a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to 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.



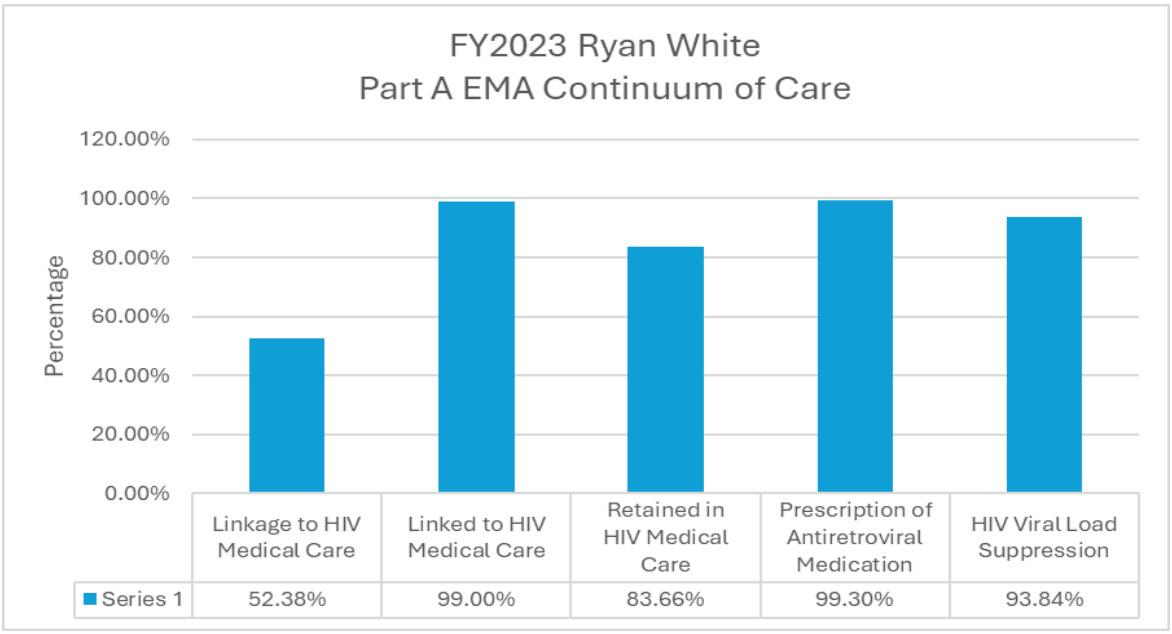
Service Delivery Areas

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 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.



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 program to further reduce barriers and increase viral suppression among PLWH, with an emphasis on populations who are disproportionately affected.

Quality Statement

It is the mission of the New Haven-Fairfield Counties' Ryan White Part A 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.

Structure of the CQM Program

The Clinical Quality Management (CQM) Program for Ryan White Part A funded services in the NH-FF EMA is structured and implemented to offer 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:** Systematic and continuous actions to lead to measurable improvement in health care services and health status for PLWH. Key principles with QI are a) working as systems and processes, b) focus on patients, c) focus on being part of a team, and d) focus on use of data.

The CQM Program directs activities intended to improve patient care, health outcomes, and patient experience. Components to the NH-FF EMA CQM Program are:

- 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, consumers, and other relevant stakeholders

Annual Quality Goals

The NH-FF EMA CQM program quality goals are discovered by first assessing performance data to identify strengths and weaknesses. The current HIV care being delivered, and demographics of patients served is also considered. Combining the assessment of performance data and the current care environment allows the CQM committee to generate a list of annual relevant goals. Once the goals are identified, they can be prioritized and restated in quantitative terms.

The current goals of the CQM Program are as follows and in the Work Plan in **Appendix D**:

Goal 1: Establish an Effective Clinical Quality Management Program.

Objective 1: By the end of FY24, provide comprehensive education on implementation of effective Clinical Quality Management Plans across all regions.

Objective 2: By the end of FY24, integrate using Organizational Assessment to help determine TA needs for each Region.

Goal 2: Improve Regional comprehension of Performance Measures.

Goal 3a (EMA-Wide): Improve Linkage to Care by 5% by the end of FY24.

Goal 3b: Increase viral suppression rates by 5% among Black/African Americans who are not virally suppressed receiving Intensive Case Management who reside in the zip code 06511.

Objective 1: Conduct Driver Diagram and Priority Matrix to identify source for conducting an intervention for Black/African Americans who are not virally and reside in zip code 06511 and implement PDSA with intervention.

Objective 2: Implement PDSA with intervention for non-virally suppressed Black/African Americans.

Quality Infrastructure

The CQM Program is responsible for EMA CQM initiatives which include assessment, coordination, evaluation, and improvement of 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: The CQM Committee 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 acts as a liaison 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. Contractors

may be utilized on an as-needed basis when staffing resources are limited and when Technical Assistance is needed. The Program Director supports and champions the CQM Program by assisting in areas of buy-in from sub-recipients and stakeholders, promotes process and policy change as necessary to enhance the CQM efforts, and elicits collaborative partnerships among other programs and agencies.

The Quality Improvement Committee of the NH-FF EMA Planning Council: The Planning Council's QI Committee is responsible for reviewing any data requests 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.

The Planning Council's QI Committee holds representation from consumers, stakeholders, and sub-recipients. Their responsibilities include conducting the annual Priority Setting and Resource Allocation process, reviewing monitoring outcomes, and reviewing of the service category service standards. Their review of these items work in tandem with identifying quality assurance opportunities that may promote systemic improvement measures that interlace between them.

Stakeholders: Stakeholders 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: Persons living with HIV offer their valuable lived experience in CQM improvement initiatives. The Planning Council's QI committee works in collaboration with the CQM committee to hold focus groups with PLWH or at Consumer Advisory Boards to elicit personal experiences specific to current goals and activities of quality improvement to identify gaps and strengths in care delivery.
Please refer to **Appendix A** for more details on the CQM Committee Roles and Responsibilities.

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 FY 2023 data to determine the number of CQM performance measures needed for each service category. The service utilization data can be found in **Appendix B** and the selected performance measures for FY 2024 are described in **Appendix C**.

In addition to the above, the NH-FF EMA also tracks additional performance measures as found below as they apply to the 2022-2025 National HIV/AIDS Strategy. As mentioned in the introduction, minority populations and sub-groups such as Young (age 13-24) MSM of Color, Black/African American women, and Hispanic MSM are disproportionately affected by HIV in the NH-FF EMA. Specific attention is directed toward these sub-populations when addressing these performance measures.

1. Prevent New HIV infections
   - Objective: Increase collaboration with prevention partners
2. Improve health outcomes for People Living with HIV
   - Objective/Performance Measure: Increase linkage to HIV care in newly diagnosed persons of each prioritized population by 5% by the end of FY23
3. Reduce HIV-related disparities and health inequities.
   - Objective/Performance Measure: By the end of FY23, increase viral load suppression among Black/African American men who reside in zip code 06511 by 5%
4. Achieve a more coordinated statewide response to the HIV epidemic
   - Objective/Performance Measure: Conduct Ishikawa Diagram and Priority Matrix to identify source for conducting an intervention for Black/African Americans who are not virally suppressed receiving Ryan White Part A IMCM and reside in zip code 06511 and implement PDSA with intervention
   - Objective/Performance Measure: Develop or promote tailored U=U campaign with Black Faith Community, providers, non-traditional agencies who reside or deliver services in zip code 06511

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 NHEMA Recipient office also collects and analyzes the data from subrecipients and examines stratified data from sources outside of QM activities. Data and performance measure outcomes are reviewed and shared during quarterly CQM meetings.

Data Collection

1. **CAREWare:** The CQM Program utilizes HRSA's CAREWare software for the collection of specific performance measure data for the EMA. 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 running Unduplicated Client Count data by service category to identify the number of Performance Measures to track and ultimately, the Performance Measure data that has been selected per service category.

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 improve upon goals and activities selected in the CQM Program and the identified lower performing performance measures.
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:** Patient Satisfaction surveys and focus groups are used to gather qualitative data in all Regions that correlate with performance measures so that the CQM Committee may address and respond to issues found that can be changed within the CQM program.

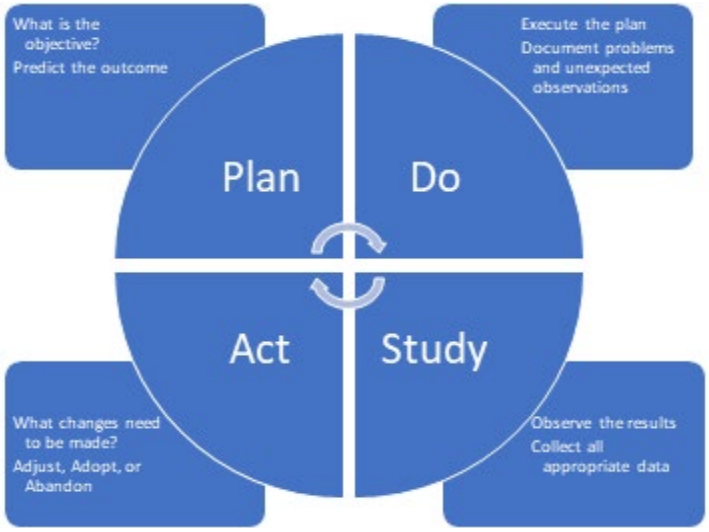
Quality Improvement

CQM performance measure data will be one source used to identify potential QI projects. Additionally, QI projects will be identified as they relate to the CQM Program components: Infrastructure, Quality Improvement, Performance Measures, and the Work Plan. Once 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 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.

The regional QI projects for FY23 are:

- Improve Linkage to Care.

Specific details on current regional QI projects can be found in the Work Plan in **Appendix D.**

QI Work Plan

Quality Improvement project updates and outcomes are stored in the Work Plan (see **Appendix D**), which is then shared and discussed during the quarterly CQM Committee meetings. During the meetings, each region will also share their updates and outcomes on individual QI projects as well as collective EMA-wide projects. The workplan will be used to track progress made toward achieving goals, objectives, and activities with subrecipients and stakeholders. When necessary, ad-hoc committee meetings will be convened to address specific areas pertaining to projects. Sharing of processes and progress is made possible through distributing the Work Plan via email to all CQM committee, Planning Council QI members, subrecipients, and other partnering agencies or programs within the NH-FF EMA.

Subrecipient Engagement, Support, and Monitoring

The Part A Recipient Office requests, reviews, and monitors regional CQM plans. When possible, the Part A Office staff 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. Additionally, the Project Director and Data Processing Project Coordinator 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 E** 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.

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 following tools will also be used to evaluate the CQM Program, as applicable:

- 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.

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.

APPENDIX A

NH-EMA CQM Committee Roles & Responsibilities		
Title	**Agency**	**Role/Responsibility**
Quality Assurance Manager	Part A Office	Chairs CQM committee, facilitates quarterly CQM meeting, reports back to the NHFFEMA Planning Council, reviews regional CQM plans
Data Processing Coordinator	Part A Office	Extracts, stratifies, and analyzes NHFFEMA CAREWare data Program Director Part A Office Approves NHFFEMA CQM plan, champions and promotes buy-in with sub-recipients and stakeholders, promotes process and policy changes
Program Director	Part A Office	Approves NHFFEMA CQM plan, champions and promotes buy-in with sub-recipients and stakeholders, promotes process and policy changes.
Region 1 CQM Lead	Yale ID Center	Attends Quarterly CQM meetings; Conducts and oversees Region 1 quality management program and projects
Region 2 CQM Lead	Staywell Health Center	Attends Quarterly CQM meetings; Conducts and oversees Region 2 quality management program and projects
Region 3 CQM Lead	GBAPP	Attends Quarterly CQM meetings; Conducts and oversees Region 3 quality management program and projects
Region 4 CQM Lead	Family Centers	Attends Quarterly CQM meetings; Conducts and oversees Region 4 quality management program and projects
Region 5 CQM Lead	Apex Community Care	Attends Quarterly CQM meetings; Conducts and oversees Region 5 quality management program and projects

APPENDIX B

FY23 Service Category Utilization		
Total EMA Unduplicated Client Count for FY23 – 1,687 Clients		
Service Category	**FY23 Total Clients Served**	**FY23 Service Utilization** Clients Served / Total Clients (%)
Outpatient/Ambulatory Health Services (OAHS)	521	31%
Oral Health Care	301	18%
Intensive Medical Case Management (ICM)	137	8%
Health Insurance Program (HIP)	108	6%
Mental Health	245	14%
Medical Case Management (MCM)	1021	61%
Substance Use- Outpatient	267	16%
Emergency Financial Assistance (EFA)	323	19%
Food Bank / Home Delivered Meals	741	44%
Housing	186	11%
Medical Transportation	499	30%
Substance Use – Inpatient	65 (intakes)	4%

APPENDIX C

Service Category	FY2023 Clients Served (%)	# of Performance Measures Chosen	Performance Measures
Outpatient Ambulatory Health Services	521/1687 (31%)	3	***Linkage to Care:*** Percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis
			Chlamydia Screening: Percentage of patients with a diagnosis of HIV at risk for sexually transmitted infections (STI) who had a test for chlamydia within the measurement year.
			Gonorrhea Screening: Percentage of patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year.
Medical Case Management	1021/1687 (61%)	2	***Care Plan***: 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.
			Gap in HIV medical visits: Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.
Oral Health	301/1687 (18%)	1	***Oral Exam:*** Percentage of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year
Substance Use Outpatient	267/1687 (16%)	1	***Viral Load Suppression****:* Percentage of patients who received outpatient substance use, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.
Food Bank / Home Delivered Meals	741/1687 (44%)	1	***Annual Retention in Care:*** Percentage of patients who received a food bank service, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.
Medical Transportation	499/1687 (30%)	1	***Annual Retention in Care:*** Percentage of patients who received medical transportation service, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.
Emergency Financial Assistance	323/1687 (19%)	1	***Annual Retention in Care:*** Percentage of patients who received EFA service, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.