RWHAP CQM Listserv

Responses to Question about Sub-Recipient Monitoring
September 2021

Question

I was wondering to what extent you monitor your sub-recipient. We are pretty new in this CQM journey. I have attended some trainings on the subject already. But I am looking for wording you put in your CQM Plan/Work plan for monitoring sub-recipients and to what extent you monitor their CQM Plan/Work plan. We are a Part B fee for service program with one sub-recipient across the state that provides the case management services along with other support services. Any suggestions or help would be greatly appreciated.

Responses

Orange County Health Services Department

For the Orlando EMA we require that all subrecipients implement a QM Program that is in compliance with PCN 15-02 additionally the following are required:

1) Their Plan must be submitted annually by the end of March to the RWHAP Part A Office and it is reviewed for compliance with PCN 15-02 – feedback is provided within 30-days if deficiencies are noted or the subrecipient is notified that their Plan has been accepted. If deficiencies are identified, they are asked to revise the Plan if possible or submit an Action Plan pertaining to how and when they expect the deficiencies to be cleared up.
2) On an annual basis they are required to complete the National Quality Center's (NQC) "Organizational Assessment Tool for RWHAP –funded Part C and D Recipients" as part of their evaluation of their QM Program – the completed tool is required to be submitted to the RWHAP Part A Office by the end of January. Feedback is provided and if any area scores less than a "3" they are required to submit an Action Plan within 30-days of the feedback regarding how they plan to improve the items to at least a "3" , once the plan has been accepted/approved by the RWHAP Part A office, they are required to include in their QM Plan that is due at the end of March.
3) CQM monitoring is also included in our subrecipients annual programmatic & fiscal monitoring for all subrecipients (included in their contract) using the attached tool. Findings are identified with recommendations to fix the findings in their monitoring report and a CAP must be submitted within 30-days of receipt of the monitoring report. The CAP is reviewed and approved by the RWHAP Part A Office and discussed during regular monthly calls with the subrecipient.

Alelia Munroe, MPH (She, Her, Hers)
Health Planner/CQM Coordinator, Orange County Health Services Department
Ryan White Part A Office
2002A E. Michigan Street
Orlando, FL 32806-4941
Phone: (407) 836-8107, Cell: (407) 619-1816, Fax: (407) 836-2870

Seattle TGA

Every agency must have a representative on the TGA Quality Management Advisory Committee (QMAC).

Within 30 days of the beginning of a contract/grant period, each agency is required to submit an annual CQM Plan, using a template created by the Ryan White program. The template has four components.

1) Infrastructure, which includes information about the agency CQM committee and a request to determine what method they will use for quality improvement (i.e. LEAN, PSDA)
2) Client voice and involvement, including client satisfaction surveys or a focus group. The results of the survey or focus group are due at the end of the contract/grant period
3) Performance Measures as determined by QMAC. Currently those are Viral Suppression and Annual Retention in Care
4) Quality Improvement. This can be selected by the agency, however, we also can assign a Quality Improvement project to the agency.

Agencies must submit a CQM progress report quarterly using the template provided by Ryan White. The template has the same four components that the plan template contains.
We also monitor CQM activities as part of our Annual Site Visits.
I've attached both of the templates as well as the guide that was developed this year for sub-recipient agencies.
I realize much of this is specific to our TGA, but wanted to share. As they say, share selflessly, steal shamelessly! I hope you find this helpful!

D. Mark Baker (he/him)
Ryan White Part A CQM Program Manager
Desk: (206) 477-4301

Public Health
Seattle & King County
HIV / STD Program

Ryan White Part A
Seattle Transitional Grant Area
Clinical Quality Management
Agency Guidance

Table of Contents

Terms 3
Overview 4
Introduction 5
Before you get started 6
Section One: Infrastructure 7
Your Team 7
Resources 9
Defined Approach for Improvement 9
Model for Improvement 10
Lean 10
Section Two: Client Voice and Involvement 11
Section Three: Performance Measures 13
Viral Suppression 14
Annual Retention in Care 14
Section Four: Your Quality Improvement Project 15
Choosing your Quality Improvement Activity 16
Quality Improvement Options 17
Quarterly Reports 18

Terms

Client Care (Client Services) refers to the prevention, treatment, and management of illness and the preservation of physical and mental well-being through services offered by health professionals.

Client Satisfaction is the degree to which a client's expectations about a health encounter were met.

Client Voice refers to any expression of the views, needs, experiences or outcomes of people who have lived experience of community services.

Clinical Quality Management is defined as the system-wide coordination of activities aimed at improving client care, health outcomes, and client satisfaction.

Defined Approach is a generally accepted method that leverages specific processes, procedures, techniques, and standards practices to achieve stated goals and desired outcomes.

HAB The HIV/AIDS Bureau (HAB) administers the Ryan White HIV/AIDS Program, which provides a comprehensive system of care for people living with HIV.

Health Outcomes are changes in health that result from measures or specific health care investments or interventions.

HRSA The Health Resources and Services Administration (HRSA), an agency of the US Department of Health and Human Services, which supports the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery.

Infrastructure is the entire system consisting of the policies, framework, personnel, resources, and practices needed to support and enhance the quality management program.

Performance Measures are indications of an organization's performance in relation to specified processes or outcomes. The HAB Performance Measures were developed to help Ryan White HIV/AIDS Program agencies monitor and improve the quality of care they deliver.

Process Improvement is the practice of identifying, analyzing and improving processes to optimize performance, meet best practice standards, and/or improve quality of care and experience for clients.

Quality Assurance is defined as the activities designed to ensure compliance with minimum quality standards. Quality Assurance is conducted within the Ryan White program at Public Health Seattle & King County.

Quality Improvement refers to an organization's approach to improving the quality of care and services using a specified set of principles and methodologies.

Quality is defined by HAB as the degree to which a health or social service meets or exceeds established professional standards and client expectations.

Quality Management Plan is a written plan outlining the sub-recipient agency's quality management program that includes the infrastructure, client voice, Performance Measures, and quality improvement project.

Overview

As established under the Ryan White HIV/AIDS Treatment Modernization Act of 2006, all Ryan White HIV/AIDS Program recipients are required to implement a Clinical Quality Management Program to:

- Assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV and related opportunistic infections.
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

Clinical quality management activities should be continuous and fit within and support the framework of grant administration functions. Components of a clinical quality management program include infrastructure, performance measurement, and quality improvement. Each of these have a distinct role in the overall Clinical Quality Management program.

To be effective, a Clinical Quality Management program requires:

- Specific aims based in health outcomes.
- Support by leadership.
- Accountability.
- Dedicated resources.
- And use of data and measurable outcomes to determine progress toward improved health outcomes.

In the Seattle Ryan White Transitional Grant Area, each sub-recipient agency is required to develop, implement, and evaluate a Clinical Quality Management Plan. The four primary expectations for each sub-recipient quality management plan in the Seattle TGA are broken down into:

- Infrastructure – providing the resources and methods needed to design, implement, and assess a sustainable CQM Plan and monitoring endeavors.
- Client Involvement/Voice – incorporating client concerns into your plan to respond to client needs.
- Performance Measurement – collecting, analyzing, and reporting data on client care and health outcomes.
- Quality Improvement – developing and implementing initiatives to improve the quality of client care and health outcomes.

The following pages will go into further detail on each of the four primary activities and expectations of contracted agencies in the Ryan White Seattle Transitional Grant Area (TGA).

Introduction

This purpose of this document is to provide information and support for all contracted agencies in the Ryan White Seattle Transitional Grant Area (TGA). Each section directly correlates with the required sections of the Quality Management Plan and Quality Management Progress Report templates provided to your agency. We also hope to energize your thought process and approach to Quality Management and to improve care for clients in the TGA.

Each funded agency in the TGA will create a Quality Management Plan for each funded service category and submit a quarterly progress report on each plan. Your Quality Management Plan will include all the elements outlined in this document. Each agency will determine the Infrastructure, Client Involvement, and Quality Improvement components of their respective plans. Agencies are allowed and encouraged to stratify the Quality Improvement activities, that is to use one improvement activity across multiple funded categories. The Performance Measures are determined by the Seattle TGA.

How to use this Guide

This document is broken into four sections. Each section aligns with the Seattle TGA templates for your Quality Management Plan and Quality Management Quarterly Report. In each section, we will review requirements that you must include in your plan and quarterly reports. In addition, we will explore different options, ideas, and innovative approaches to quality management that you may want to deploy at your agency.

As mentioned earlier, the four sections of your Quality Management Plan are:

- Infrastructure
- Client Involvement/Voice
- Quality Measures
- Quality Improvement

This document will review each of these sections. At the end of each section, there will be a high-level summary for quick reference. This summary will also identify contractually required elements for that section.

Finally, we will provide some tips and planning suggestions to ensure your success in improving care for our clients. While some of the tips and tricks are not mandatory, we hope to offer a framework that informs and supports your decision-making related to quality management.

Before you get started

Before you get started, we strongly encourage you to develop a strategy for your planning process. Even the best Quality Management Plan will struggle unless you are proactive in laying the groundwork for success. Below are some programmatic fundamentals to ensure the best chance for success.

Data, Data, Data

"If you can't measure it, you can't improve it." – *Peter Drucker*

When you think about this quote, it should immediately become apparent how true it is. Because, if you can't measure something and know the results, you can't possibly get better at it. Makes sense, right?

Your Quality Management Plan must be data driven. You will use data to determine projects and to measure progress and improvement. Therefore, you should focus on data from the start.

First, you need to identify what data you will use, what you need for reporting, and what your program needs to conduct internal monitoring and evaluation. It is also important to consider how and where the data will be stored and documented. Once identified, use standard language for your data elements for reporting and internal communication. This will be beneficial for ongoing information sharing regarding your Quality Management Plan.

Next, determine how you will collect and leverage the data for reporting and to inform your program decisions. This is imperative to evaluate your program, identify gaps, and strengthen planning efforts.

Finally, you will want to create procedures to examine your data to ensure validity, reliability, completeness, timeliness, integrity, and confidentiality. These procedures can include communication and training as well as system checks and routine data quality improvement activities.

Remember the essentials to data: collect it; manage it; report it; and use it.

Training

Train every team member that will be part of the process. This includes your committee (more on this later), administrative support, everyone working with your clients, and any other people in your agency that will participate in quality management. Provide clear and concise expectations, along with the tools and resources to achieve the goals.

Participation

Find ways to get key stakeholders at all levels in your agency involved in your quality management planning process. An effective Quality Management Plan will require Executive leadership support. Take the time to inform those that are responsible for the data entry and direct work with clients about the Quality Management Plan. Explain the purpose; then allow

those stakeholders to help develop the goals to get their buy-in. If everyone understands your Quality Management Plan and the 'why', you will have much more success.

Communication

Share progress along the way and celebrate successes. As you get close to a benchmark, make sure everyone understands how well the project is going and what you need to accomplish to realize your goal. Be open and transparent about your annual plan and quarterly progress reports.

Make quality management processes standard work

Listen to the team and address obstacles. If you learn of barriers to your plan, make sure to take the time to listen and address those obstacles. Quality management should become standard operating procedure without creating extra work. You may want to consider a standard work checklist to get you started.

Section One: Infrastructure

Introduction

In this section, we will review the Infrastructure of your Quality Management Plan. The Infrastructure may be the most important component. It will determine the success of your plan and efforts. We strongly encourage you to develop and implement a strong infrastructure to sustain an effective Quality Management Plan.

What is the Infrastructure?

This is the backbone of the plan that will continue to manage, measure, and influence your program. While each agency will determine the scope and needs of the agency's specific plan, an ideal infrastructure consists of the following elements:

- An internal team to develop, implement, and monitor the Quality Management Plan
- Resources dedicated to training, data collections, and evaluation
- A defined approach to quality improvement

Your Team

To be effective, you will need a committee to develop the quality management program and related activities. A committee that devotes time and energy to your Quality Management Plan activities and records meeting minutes is a requirement of Ryan White Part A. The committee may be a part of a larger committee, group, or standing meeting, depending on available resources and the size of your agency.

For example, at a smaller agency, the committee could be a dedicated portion of time of a management meeting, team meeting, or leadership meeting. However, to influence the quality management program, a larger agency might want a dedicated team solely focused on the Quality Management Plan due to the scope of the plan. If your organization has an existing

quality management program that you intend to leverage, please ensure those activities comply with Ryan White Part A requirements.

This team will study data to find opportunities for improvement, and to design, write, implement, and oversee the agency Quality Management Plan. In addition, the team will meet at least quarterly to review the plan, address barriers, and assess progress. The Committee will need to assign a committee member to submit the Quality Management Quarterly Report. The committee will also communicate to the agency to ensure understanding of the plan, expectations, and progress. The committee must also record meeting minutes, which may be requested by Ryan White during the contract year as part of a Programmatic/Clinical Quality Management site visit.

There are certain roles you need on your committee. Include individuals on your committee who fill the roles listed below. It is possible that members hold more than one role in your agency. At least one of these individuals needs to be knowledgeable about the funded services in the TGA. You also will need a committee member from leadership who has the authority to make decisions at your agency.

In addition to the above requirements, these three roles are the minimum you must have on your committee:

- A **committee chair**, or lead, to organize and drive the ongoing work and measurement of the Quality Management Plan. The person in this role needs to possess knowledge and understanding of quality management concepts. They will need to understand performance measures and how to develop and implement quality improvement activities. The chair will set the agenda for meetings, facilitate meetings, and recruit committee members. This person needs to be able to work effectively with management and members of the quality management committee. The committee chair also serves as the “key contact” responsible for coordinating communication on the progress of Quality Management Plan to the overall organization and to Ryan White program staff.

- A **data specialist** who provides and analyzes data. The person selected does not necessarily need to work in a specific department or hold a specific title as long as he or she is well-versed in quality improvement concepts and tools and has the ability to access and analyze agency data. This person might be responsible for creating internal reports to evaluate the success of the program and to identify opportunities for Quality Improvement initiatives. It is a good idea to have a backup person so that reporting is not interrupted for vacations, illnesses, or other unexpected events.

- A **client-facing team member**, such as a Non-Medical Case Manager, Peer, or Client Coordinator. Because they understand client needs, service standards, and workflows, this person is a critical member of the committee. This role is crucial to assessing and implementing quality improvement projects and addressing barriers in client care. This

committee member works regularly with those clients whose care is directly affected by quality improvement and measures efforts. This should be an individual who is well-respected and influential among the client-facing team(s), works well with management, understands your agency's service delivery, and is open to change and new approaches.

These three roles (not people) outlined above, knowledge of services in the TGA, and involvement of a decision-maker are required representation within the committee members. Remember, persons on your committee may have more than one role in your agency. For example, the person who chairs the committee may also have strong knowledge of funded activities in the TGA or, the data specialist could be the committee chair.

Adding a client to your quality committee is highly encouraged. Other roles you may want to consider for your committee include a medical provider, community leaders, or other roles from within your agency for the committee.

Resources

It is imperative that the agency dedicate the needed resources to ensure the viability of the program. As you think about what resources you may need, think about what the committee may need, staff training, data collection, and tools for performance measurement just to name a few.

- At minimum, you should select a dedicated team member to oversee and evaluate the plan. This could be a consultant or dedicated staff; both are allowable costs. To reduce the administrative burden, this could be one of your committee members.
- You will also need a method for data analysis and a comprehensive data integrity review.
- It is advisable to think about what additional resources would be needed for training and education for everyone involved in the Quality Management Plan.

Please remember that in our TGA, there may be funds available from Ryan White to help with these expenses. Please contact the Clinical Quality Management Program Manager or your Contract Monitor to learn more about the availability and allowable uses of these funds.

Defined Approach for Improvement

Process improvement is the practice of finding ways to make processes faster, more efficient, and more reliable. There are many different widely accepted defined approaches to process improvement.

For the purposes of your Quality Management Plan, you must identify the process improvement method you will utilize at your agency. This is a contract requirement.

There are several standard process improvement models available for you to select from. Which you choose will depend on the resources you dedicate to your quality program, the complexity of your improvement activities, and the size of your program. Below is a brief explanation of two defined approaches you may want to consider.

Model for Improvement

The Model for Improvement (also called Plan, Do, Study, Act, or Continuous Improvement) is a simple yet powerful tool for accelerating improvement. The model is not meant to replace or change improvement models that organizations may already be using, but rather to accelerate improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions, which can be addressed in any order.
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.
  - Plan – With available data and information that indicates an opportunity for improvement, plan an intervention based on your theory.
  - Do – Carry out and implement your test on a small scale (if possible).
  - Study – Evaluate the data outcomes to see if the theory was effective. What was learned? What went wrong?
  - Act – Restart the cycle whether you adopt the change, adjust the change, or abandon it for a new intervention.

You can find more information about the Model for Improvement here - www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx.

Lean

A popular misconception is that lean is suited only for manufacturing. Not true. Lean applies in every business and every process. It is not a tactic or a cost reduction program, but a way of thinking and acting for an entire organization.

Businesses in all industries and services, including healthcare and governments, are using lean principles as the way they think and implement. Lean is not a program or short-term cost reduction program, but the way an organization operates. It takes a long-term perspective and perseverance.

The characteristics of a lean organization and supply chain are described in *Lean Thinking*, by Womack and Jones, founders of the Lean Enterprise Institute and the Lean Enterprise Academy (UK), respectively. While there are many very good books about lean techniques, *Lean Thinking* remains one of the best resources for understanding "what is lean" because it describes the *thought process,* the overarching key principles that must guide your actions when applying lean techniques and tools.

Find more information about Lean here - https://www.lean.org/whatslean/

There are many more defined approaches to quality improvement. You should select the one most appropriate for your agency. No matter which system you choose, be sure to document your decision. This will be included in your Clinical Quality Management Plan.

Section Review and Contract Requirements

In the Infrastructure section, we reviewed the importance of creating an infrastructure to ensure a sustainable and effective program. There are three elements to a strong infrastructure – a committee, dedicated resources, and a defined approach to process improvement. We also reviewed the contract requirements.

There are two requirements in this section.

1. Develop and implement a committee. Identify and recruit the three required roles (Chair, Client-Facing, Data Specialist) for the committee. You must also have a decision maker and someone knowledgeable of the services in the TGA on your committee. The committee may be part of a larger regularly scheduled meeting or stand-alone committee dedicated to quality management.
2. Determine the defined approach to process improvement your agency will leverage for your Quality Management Plan.

Section Two: Client Voice and Involvement

Introduction

Gaining your clients' voice and input is crucial as you design your Quality Management Plan and improve on your Performance Measures and Quality Improvement activities. By involving clients who reflect the population your agency serves, you ensure your plan addresses the needs of your clients. Utilizing your clients' voice and input for your quality management program is a requirement of Ryan White.

How can we get client input?

For the purposes of quality management in a Ryan White program, the 'gold standard' for client involvement would be to recruit a client for your Quality Management Committee to inform your quality activities. However, we recognize this is not always feasible, particularly for agencies with smaller caseloads or fewer resources.

With that said, there are several other ways you can involve client input and collect data and ensure your Quality Management Plan responds to the needs of your clients.

- A Client Advisory Board (CAB) can be an extremely powerful tool to help you ascertain client satisfaction and to garner input for your Quality Management Plan. CABs enable

organizations to hear directly from their clients about how they are fulfilling client expectations and about how the agency can improve. If you already have a CAB, you should consider tapping into this tremendous asset!

- Tapping into other committees or client groups (as appropriate of course) is another potential option to collect data and information from clients that access programs at your agency. Some examples might be support groups your agency hosts, client advocacy committees, or even social groups that may have stemmed from programs at your agency.
- If your agency leverages any other type of committee that includes elements of improvement on services based on input derived from client data or experience, this also could be a rich pool of information and data for your quality management activities.
- Client satisfaction surveys are a great way to gather data about your clients' experiences and satisfaction about the services they receive from your agency and Ryan White programs. If you are using Client Satisfaction surveys, be sure to send the same survey to measure outcomes so you are comparing "apples to apples". *(Note that while you are not required to use client satisfactions survey data for your Quality Management Plan, you are contractually required to conduct a client satisfaction survey each year and provide the results of the survey to Ryan White program staff at the end of the contract year.)*
- Focus Groups can also be a great source of data. Ensuring each focus group is managed similarly and consistently will garner solid data to include in your Quality Management Plan. If you leverage focus groups, keep in mind that you will need to use subsequent focus groups to measure your outcomes.
- Adding a question to Case Management activities (i.e. intake, assessment, or individualized service plan) is another way to collect client input. Be sure to train the entire team if you opt for this method to collect client input and document the data elements.

There are also a few client immersion methods you may want to think about. Client immersion is a process where staff - often those in leadership positions - experience their agency from a clients' perspective. Below are a few client immersion ideas for you to consider.

- Advice Interviews
  - This is a quick, low commitment approach to initial client immersion. Select three to four questions to ask a large number of clients. The questions should be focused on what advice they would provide to your agency or program. Be sure to document every response to ensure complete data collection.
- Contextual Interviews
  - Interviewing your clients while visiting your location offers an opportunity to have an in-context conversation with your clients. Often, this consists of a 'show and tell' experience that uncovers hidden insights. These are similar to Advice Interviews, but with a more in-depth conversation with a focus on a specific function or service.
- Ethnographic Observations

- This is the practice of observing clients at your location without interacting with them. By doing this, you may capture the habits and/or behaviors while at your location. You may uncover insights that would never have come up in an interview. For example, you may be able to document the number of clients that drop off paperwork, average wait times, or those visiting for social interaction.

Remember, no matter how you opt to incorporate the clients' voice into your program, projects and initiatives must be based on data and be measurable. If you are using the client voice for your Quality Improvement project, you will need data to determine the need, room for improvement, and to assess the progress on a quarterly basis throughout the contract and measurement period. For this reason, it is crucial that you document your data and data collection method.

Section review and requirements

In this section, we reviewed the importance of involving your clients voice in your quality management program. This ensures your plan is responding to the needs of your clients. We also offered a variety of options you may want to consider garnering input and advice from your clients.

There are two requirements in this section.

1. You must involve your clients' voice in your Quality Management Plan. This may be in your approach to improve Performance Measures or Quality Improvement, or as a method to determine your Quality Improvement project. You will report on your client involvement on a quarterly basis.
2. You must conduct an annual client satisfaction survey and provide Ryan White Part A the results of the survey at the end of the contract year.

Section Three: Performance Measures

Introduction

Performance Measures are developed by the HIV/AIDS Bureau (HAB) to monitor performance in relation to specified processes or outcomes. Performance Measures were developed by HAB to help Ryan White HIV/AIDS Program agencies monitor and improve the quality of care they deliver. As part of the larger Seattle TGA's Clinical Quality Management Plan, two HAB Performance Measures are imbedded in each agency Quality Management Plan

What Measures are included in my Quality Management Plan?

Two Performance Measures are incorporated into each agency plan. The Performance Measures are determined by Ryan White Part A and align with the National HIV Strategy. For

the 2022 contract year, we will continue measuring Viral Suppression and Annual Retention in Care in accordance with HAB's Core Performance Measures.

You may choose a third (or fourth) measure from HAB for your Quality Improvement activity if you would like. This is reviewed in the Quality Improvement section of this guide.

The required reports for these two measures in your plan are built into Provide. Note that the HAB measures do not look at a time period, rather a point in time for all clients within the reporting scope while the Washington (WA) measures look at a specific time period. For our purposes, you will need to run the HAB Performance Measures as your base line data and the Part A Performance Measures for the quarter you are reporting on for your quarterly Quality Management reports.

Below is the data description from HAB for each, along with how Provide looks at these data points to determine performance. You can find more information here: - https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Viral Suppression

Description: Percentage of patients, regardless of age, with a diagnosis of HIV and with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV and with at least one medical visit in the measurement year.

Patient Exclusions: None.

- **Data Elements**: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)
  - a. If yes, did the patient have at least one medical visit during the measurement year? (Y/N)

  i. If yes, did the patient have a HIV viral load test with a result?

Annual Retention in Care

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.

Numerator: 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.

Denominator: Number of patients, regardless of age, 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.

Patient Exclusions: Patients who died at any time during the measurement year.

- **Data Elements**: Does the patient, regardless of age, have a diagnosis of HIV? (Y/N)
    - a. If yes, did the patient have at least two medical care encounters during the measurement year? (Y/N)
    - i. If yes, did the patient have a HIV viral load test within the measurement year? (Y/N)
    - ii. If yes, did the patient have at least one additional medical visit encounter with a provider with prescribing privileges within the measurement year? (Y/N)

  iii. Or, did the patient have two medical visits with provider with prescribing privileges within the measurement year? (Y/N)

Section review and requirements

Performance Measures developed by HAB are used across the National Ryan White HIV/AIDS program as indicators of performance in specified areas. For the TGA, we include two of those measures in our collective quality management programs.

There are two requirements in this section.

1. To include the Viral Suppression and Annual Retention in Care measures in your plan
2. Report on these two Performance Measures in your quarterly report.

Section Four: Your Quality Improvement Project

Introduction

This is the section of your annual Quality Management Plan that allows the most creativity and flexibility. We hope this is exciting for each agency. Each agency will develop and implement at least one Quality Improvement activity. Depending on the size of your agency and the scope of services, you may be required to create more than one Quality Improvement project or activity. In the instance that your agency receives funding in multiple service categories, you are allowed, and encouraged, to stratify your improvement activities across funded service categories. Your Quality Improvement project(s) must be data driven and measurable and must improve client care, health outcomes, or client satisfaction. As discussed earlier, be sure to identify an improvement project that is meaningful to your team and your agency.

How do we choose a Quality Improvement Project?

Choosing your Quality Improvement Activity

There are several ways to choose your Quality Improvement (QI) project and many project areas to choose from, but no matter what project you choose, let the data be your guide. You will need to provide the baseline number and proposed improvement throughout the measurement period. Your projected improvement must be at least 10%.

We strongly encourage all agencies to align their Quality Improvement project or activity with either the National HIV Strategic Plan, the Ending the HIV Epidemic, the End AIDS Washington Initiative, or the Seattle Transitional Grant Area Clinical Quality Management Plan. Each of these documents contain evidence-based strategies to improve care for our clients and reduce HIV transmission in our community. Additionally, these all also seek to address health disparities in Black, Indigenous, and People of Color (BIPOC) communities, transgendered individuals, those living unhoused, people who inject drugs, and other social determinants of health.

A few tips before choosing your project.

Be sure that your project, or improvement area, occurs frequently enough to be able to measure and observe change in a reasonable amount of time. Your project must improve data by at least 10%. Here's where looking at your data can help you narrow your focus. What types of client concerns is your agency encountering most frequently? Which are likely to demonstrate room for improvement? How many of these opportunities for improvement happen in each day, week, month?

The right problem offers room for measuring and observing meaningful change. If you've decided to target a particular measure and find that compliance is already above 90%, ask yourself, "Is the juice worth the squeeze?" In other words, does it make sense to spend a great amount of time and resources to attempt an improvement of that already high rate of compliance? Use your data to choose an area that offers real room for improvement.

Your Quality Improvement project or activity must be data driven.

What do we mean by data driven? Data driven, or grounded in data, means that you need to have a static unit of measure. The initial unit of measure (baseline) must allow for improvement through a targeted activity or strategy. Further, the activity or strategy must continue to assess improvement using the same unit of measure and assess how your strategy has impacted that unit of measure.

Your agency has significant amounts of data that you may not have thought about. Where can you find data? As we discussed earlier, you may have good internal data from client satisfaction surveys, focus groups, or even client immersion practices. If you decide to use your internal data, be sure the data is collected and measurable throughout the contract and measurement period. Additionally, you can use data from Provide or the Washington State and King County Medical Monitoring Project.

Every agency in the TGA enters data into Provide, the statewide database. Provide has robust Performance Measures reporting capabilities. Each Performance Measure is structured using HAB Performance Measures and you can easily create reports if you choose to select an additional HAB Performance Measure as your Quality Improvement initiative. For agencies that receive funding in multiple service categories, you are able to stratify data across multiple service categories to leverage each program to improve the upon your programs.

Quality Improvement Options

As mentioned earlier, each agency will select one or more Quality Improvement activities. For our TGA, there are three areas you may opt from: health outcomes; client satisfaction; and client care.

- **Client satisfaction** is about whether a client's expectations about a health encounter were met. You must have data to document client satisfaction, be able to improve upon that specific satisfaction point, and measure progress towards your stated goal. Your Client Satisfaction Survey is a great tool to garner information, determine your improvement goal, and measure success. This would require additional follow up with clients to measure progress for your quarterly reports.

- **Client care** (or client services) refers to the prevention, treatment, and management of illness and the preservation of physical and mental well-being through services offered by health professionals. To improve client care or client services, the data from your client voice and input is rich with opportunity. The information from your clients may demonstrate long wait times, confusing phone systems, or an opportunity to improve communication. You may choose your own measure in this category if you have the data, identify enough room for improvement, and you are able to utilize data to measure your progress.

- **Health outcomes** are changes in health that result from measures or specific health care investments or interventions. If you select a Health Outcome measure as your Quality Improvement activity, you have many options to choose from that can impact clients' health. Consider smoking cessation, vaccinations, or treatment adherence for just a few examples. You may also select an additional HAB Performance Measure. You can review the additional Performance Measure here - https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Finally, consider stratifying your data across all funded service categories to address health disparities for BIPOC, young men who have sex with men (MSM), or other disproportionally affected population. This could be a single Quality Improvement project across all funded service categories. These measures are available to you in Provide.

Summary

Every agency in the TGA has a unique place in the continuum of care and therefore have unique client needs. Think about your case load, programs, and capacity to measure the data and outcomes from the initiative(s) you select.

Once you determine your Quality Improvement initiative, you will need to determine and document the base line measurement, set your goal, and report your progress each quarter.

As you decide on your goal, spend time to refine a statement that clearly articulate your goal(s). This will be useful when completing your annual Quality Management plan.

Section Review and requirements

In this section, we reviewed the opportunities that your agency has available to determine how best to improve client care, services, or health outcomes. Additionally, earlier in this document, we talked about creative ways to involve your clients in selecting your Quality Improvement project and way to measure your outcomes.

There are three requirements in this section.

1. To determine a data driven improvement project that improves client care, client satisfaction, and/or health outcomes.
2. Measure your baseline data, propose your improvement project and goal for improvement in your Quality Management Plan
3. Report your progress on the quarterly report.

Quarterly Reports

Introduction

After you have developed your plan, using the Quality Management Plan template, you will submit the plan to the Quality Management Program Manager at Ryan White. Then, as outlined in your contract, you will submit quarterly reports using the Quality Management Plan Quarterly Report template provided in your contract. Both the Quality Management Plan and Quarterly Quality Management Plan Report templates align with the four sections of this document.

When you submit your quarterly reports, please report only on the measurement period. As you create your report, this should be reviewed by your quality committee to assess progress in all four areas of your plan, address barriers and adjust as needed.

Infrastructure

The infrastructure section of the quarterly report is where you will report on your quality committee activities and how you utilized your defined approached. In both instances, please

only provide information and activity during the reporting period. This is where you will furnish an overview of committee meetings, discussions, activity, and decisions. In this first section we also ask that you convey how your agency utilized your defined approach during the reporting period. Information in this section will vary depending on the defined approach you identified in your Quality Management Plan. For example, if you opted for a defined approach that impacts agency operations, you may want to share different aspects of implementation.

Client Involvement/Voice

Here is where you will share information about client involvement in your Quality Management Plan. Regardless of how you opt to include your clients input and voice for your Quality Management Plan, this is ongoing. We want to hear that you continue this practice and require that you report on that ongoing process.

Performance Measures

For the two required Performance Measures that Ryan White includes in your plan, run the WA Performance Measures report template in Provide. When selecting the parameters of the report, select the beginning and end date of the reporting period (quarter). Use the data from the report to populate these in your Quarterly QM Report.

Quality Improvement

Quality Improvement activities or projects in section four is where you furnish your progress on your Quality Improvement initiatives outlined in your plan. Be sure to include the stated goals, base line data, and improvement or progress toward your aim. This will not change throughout the contract year.

If you elected to stratify your Quality Improvement Project across programs at your agency, you will need to include that information on each service category report.

# # #

If you need more information

Please contact the Clinical Quality Management Program Manager at (206) 477-4301 or at markbaker@kingcounty.gov.

Please note that Ryan White reserves to right to amend or change the Clinical Quality Management Plan each fiscal contract year. Each agency will receive notification of any changes. If you do not receive these notifications, please contact the Clinical Quality Management Program Manager, or the Ryan White Recipient and Program Manager.

EXHIBIT J
Ryan White Part A

Sub-Recipient Annual Quality Management Plan

Agency: _____ | Contact Person: _____ | Service Category: _____

1) Quality Infrastructure

List the members, job titles, and their required roles on your Quality Management Plan (QMP) committee. This is the group that reviews performance data, selects improvement goals, develops/selects/ implements/modifies improvement activities, reviews client satisfaction results, etc. Depending on the size or your agency, the committee may be part of a larger committee.

List the frequency and dates (if available) of the meetings held by your CQM committee. Programs must keep meeting minutes of these meetings/QMP discussions.

What defined approach will you use to advance your Quality Measures and Quality Improvement project during the measurement period?

2) Client Involvement

How will you involve clients in improving program services? *(Examples: client board representatives, client quality committee representatives, client advisory board, focus groups, surveys, etc.)*

How will you measure client satisfaction with program services during 2021-2022 and how will this information be used?

3) Quality Measures

Quality Measures are determined by Ryan White Part A and must be included in your Quality Plan.

Measure: Retention in HIV Medical Care

Performance/Outcome: **Clients demonstrate retention in HIV medical care during the measurement period.**	**90%**

Measure: Viral Suppression

Performance/Outcome: **Clients, regardless of age, have a viral load below 200 copies/ml at last test during the measurement period**	**75%**

4) Quality Improvement

Improvement goals must be grounded in and measured by data. Your plan must include the baseline measurement, have room for at least 10% improvement, and improve care for your clients with HIV.

Describe your Quality Improvement project

Be sure to include what area (Client Care, Client Satisfaction, Health Outcomes) you have selected and why.

What quantitative improvement will you achieve?

(example: "To increase the percentage of clients who have a service plan updated within the last 6 months from 76% to 90%.")

Please fill in the table below.

QI Goal:	______	
Numerator	*(example: Number of clients enrolled in the program for more than 12 months who had a service plan updated within the last 6 months.)* ______	
Denominator	*(example: Total number of clients enrolled in the program for more than 12 months)* ______	
Exclusion Criteria	______	
Data Source	______	
Baseline Data Result		______%
Goal/Benchmark		______%

Quarterly Report
FY2021

EXHIBIT K
Ryan White Part A

Quality Management Plan
Quarterly Progress Report

Service Category _____

Agency: _____ | Contact Person: _____ | Date: _____

Report Due Dates

___ **9/15/2021** ___ **12/14/2021** ___ 3/**14/2022**

1) Quality Infrastructure:

Provide a brief overview of your committee meeting, the date(s) the committee met to discuss quality management, and a brief overview of those conversations and any decisions made.

How did you leverage your defined approach advance your Quality Measures and Quality Improvement project during the reporting quarter?

2) Client Involvement:

Describe how you involved clients in assessing or improving the quality of program services during the reporting period.

3) Quality Measures

Measure: Annual Retention in Care

Performance/Outcome: **Clients demonstrate retention in HIV medical care during the measurement period.**	**90%**
Numerator (*Number of clients who met the performance benchmark)* **Number of HIV-positive clients in the denominator who had at least one medical visit during the measurement period**	______
Denominator (*Number of clients sampled)* **Number of HIV-positive clients who received a service during the measurement period**	______
How did you determine your denominator? *(e.g., entire client population, new clients only, etc.)*	
To what factors do you attribute your performance level?	
Plan for improvement (if applicable):	

Measure: Viral Suppression

Performance/Outcome: **Clients, regardless of age, have a viral load below 200 copies/ml at last test during the measurement period**	**75%**
Numerator (*Number of clients who met the performance benchmark)* **Number of HIV-positive clients in the denominator who had a viral load below 200 copies/ml at their last test during the measurement period**	______
Denominator (*Number of clients sampled)* **Number of HIV-positive clients who received a service during the measurement period**	______
How did you determine your denominator? *(e.g., entire client population, new clients only, etc.)*	
To what factors do you attribute your performance level?	
Plan for improvement (if applicable):	

4) Quality Improvement

Quarterly Performance on Quality Improvement Goal

QI Goal: *(As submitted in your annual QM plan)*

Baseline measurement (from your plan document): ______%

Goal/Benchmark (from your plan document): ______%

Date of most recent re-measurement: ______

Data Source: ______

Most recent re-measurement result: ______%

Narrative Comments:

Provide narrative comments related to the re-measurement result. This may include any trends, gaps, disparities or other concerns or "surprises" seen by your QM committee when reviewing the data.

Are there are any trainings or support you would like from the Ryan White program, please list them here.