

**DC CROSS-PART COLLABORATIVE  
2013  
HIV QUALITY MANAGEMENT PLAN**



PREPARED BY:  
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## INTRODUCTION

The Health, Resources and Services Administration (HRSA) of the HIV/AIDS Bureau (HAB) sponsored the development of the DC Eligible Metropolitan Area (DC EMA) Quality Management (QM) Cross-Part Collaborative (the Collaborative) in January 2011 to strengthen the regional capacity for collaboration across Ryan White (RW) HIV/AIDS Program Parts (Parts A, B, C, D and F). Under the leadership of the National Quality Center (NQC) the Collaborative worked for alignment of QM goals to jointly meet the RW HIV/AIDS Program legislative mandates, and to implement quality improvement (QI) activities to jointly advance the quality of care for people living with HIV/AIDS (PLWHA) across jurisdictions within the Area DC EMA and to coordinate HIV services seamlessly across Parts. Since May 2012, HAB and NQC have endorsed the work of the Collaborative to continue under guidance of the Response Team, HAHSTA, and the participating administrative agents.

The various Parts were created by HRSA, each with a specific grant structure and reporting requirements in response to the Ryan White HIV/AIDS Treatment Modernization Act of 2009. Grantees, administrative agents, HIV care providers, and consumers representing each of the Parts and other stakeholders from the DC EMA came together to form the Collaborative. A complete listing of the Collaborative membership and their affiliation with the RW Program Parts can be found in Appendix A. The Parts and their grantees within the DC EMA are listed below.

### **PART A: Grants to Eligible Metropolitan Areas and Transitional Grant Areas**

Part A provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. Part A funds are used for PLWHA who are uninsured, underinsured or underserved to ensure access to core medical and support health services that enhance access to care; maintain clients in care, particularly primary care services; and ensure continuity of care.

The DC EMA, the District's Department of Health (DOH) HIV/AIDS, Hepatitis, STD and TB Administration's (HAHSTA) Care Bureau is the designated DC EMA grantee. HAHSTA provides oversight to DC and West Virginia (WV) providers directly. In Suburban Maryland (MD) and North Virginia (NOVA), HAHSTA contracts with the Suburban Maryland and Administrative Agency (SMAA) within the Prince George's County Health Department and the Northern Virginia Regional Commission (NVRC) respectively to provide oversight to providers serving their jurisdictions. Providers offering Outpatient/Ambulatory Medical Care (Medical Care) and Medical Case Management (MCM) services throughout the DC EMA were invited to attend the Collaborative. DC, West VA, Suburban MD and Northern VA are currently represented.

### **PART B: Grants to States and Territories**

Part B provides grants including a base grant to supplement core medical and support services, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants and grants to States for Emerging Communities (EC). The DOHs within each of the four jurisdictions of the DC EMA are the grantees for their State/District's Part B funds which include the counties, cities and the District within the DC EMA. Each DOH receives a base grant, ADAP and ADAP supplemental grants. In Maryland, their ADAP is known as MADAP. West Virginia also receives EC grant. The grantees can choose to provide services

directly through their local health departments or a consortium. All four State/Territory Health Departments are participating in the Collaborative along with some of their Medical Care Providers.

In addition, Minority AIDS Initiative (MAI) grants are provided to address HIV/AIDS care needs under Parts A, B, C and D to address the HIV/AIDS care needs of African Americans and other disproportionately impacted communities. In the DC EMA, MAI funds are provided to the grantees under Parts A and B to DC, MD and VA.

### **PART C: Early Intervention Services**

Part C provides grants directly to service providers such as ambulatory medical clinics to support outpatient Early Intervention Services (EIS) and ambulatory care for services at their facility location. The Part C grantees participating in the Collaborative represent federally qualified health centers (FQHCs), community-based organizations (CBOs), other medical clinics and a research institute.

### **PART D: Services for Women, Infants, Children, Youth and Families**

Part D provides grants for family-centered primary medical care involving outpatient or ambulatory care (directly, through contracts or through memoranda of understanding) for women, infants, children, and youth with HIV/AIDS. Part D funds primary medical care, treatment and support services to improve access to health care. Two (2) Part D grantees, Children's National Medical Center (CNMC) located in DC and Inova Juniper Program in NVa are participating in the Collaborative.

### **PART F: AIDS Education and Training Centers Program and Dental Reimbursement Program & Special Programs of National Significance (SPNS)**

Part F provides grants to support the AIDS Education and Training Centers (AETC) Program and the Dental Reimbursement Program (DRP). The AETC conducts targeted, multidisciplinary education and training programs for health care providers treating PLWHA. The Pennsylvania/Mid-Atlantic (PA/MA) AETC serves Delaware, DC, MD, Ohio, Pennsylvania, VA, and WV. Currently, the VA and DC Local Performance Sites (LPS) of the PA/MA AETC are participating in the Collaborative. The MD site has been invited, but has not joined.

The DRP funds institutions that have dental or dental hygiene education programs to improve access to oral health care services for PLWHA. The DRP simultaneously educates dental hygiene students and residents about comprehensive care specific to HIV/AIDS. Only Howard University's Dental Program in the District receives DRP funds to serve the DC EMA.

SPNS Programs support the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Programs. There is one SPNS initiative in the EMA currently. The George Washington University YES Center provides technical assistance, training, guidance and evaluative services to eight demonstration sites around the country working with young men of color who have sex with men. The sites are participants in Outreach, Care and Prevention to Engage HIV Seropositive

Young MSM of Color, a Special Projects of National Significance (SPNS) Initiative of the federal Health Resources and Services Administration.

## **Demographics of the Population in the DC EMA:**

### General:

The general population is racially, ethnically and linguistically diverse. The following number posted in the document is population data estimations based on 2011 US Census Data. The total population of the DC region is 5,703,948 with 48.2% Non-Hispanic White, 25.3% Black or African American, 14.1% Hispanic or Latino, 9.3% Asian and Other Pacific Islanders, and Mixed and Other comprising the remaining 3.1%. Nearly 22% of the DC region population is foreign-born, and 39% have limited English proficiency according to census data from the 2011 American Community Survey. This region has significant numbers of people moving here for its economic opportunities.

The DC EMA operations are composed of four separate jurisdictions. The four (4) jurisdictions are identified as the four quadrants of Washington DC, five counties located in Suburban Maryland, eleven counties and six cities located in Northern Virginia, and two counties located in West Virginia.

### HIV/AIDS:

Of the 5,703,948 people living in the DC region, 30,797 people were diagnosed living with HIV/AIDS as of December 31, 2010, according to the CDC 2011 HIV Surveillance report published in February 2012. When including the CDC estimate of 18% of those that do not know their status an estimated 36,340 people are living with HIV/AIDS. This represented 0.64% of the region's residents. People of color are disproportionately impacted by HIV/AIDS in the DC region.

- Racial and ethnic minorities make up 51.8% (N=2,040,403) of region's residents, yet they account for an astounding 80.1% of the estimated living HIV/AIDS cases.
- Blacks account for only 27.6% (N=1,574,290) of the region's population, but they comprise over 69.2% (N=20,361) of the estimated living HIV/AIDS cases in the region.
- The top four (4) reported exposure categories among the cumulative HIV/AIDS diagnoses were male to male sex 37.4%, heterosexual transmission 26.7%; risk either not reported or not identified 20.5%, and injection drug use 12.3%.
- Although residents of Washington DC only represent 10.9% (N= 617,996) of the total DC region's population, they accounted for 47.1% (N=14,359) of known HIV/AIDS cases.
- The nation's capital continues to be the epicenter of the epidemic in the region. Though the prevalence estimate dropped from 3.2% at the end of 2008 to 2.7% at the end of 2010, this was largely because it does not include 2,041 code-based HIV cases in the overall number of living cases due to a mature name-based system. .

The DC Cross-Part Collaborative's HIV QM Plan reflects a continuous process which improves, evaluates and informs the delivery system of measurable outcomes and demonstrates a commitment to quality services for consumers served within the DC EMA's RW Program Parts' (A,B,C,D, and F) provider network. A timeline for annual implementation, revision, and evaluation of the plan is included in this document.

### Structure of the HIV QM Plan

The overall purpose of the Quality Management plan is to have a unified document which grantees, each jurisdictional agency, and RW sub-grantees can use to build and strengthen their systems and program services to ultimately improve quality of care to clients. To accomplish this, the DC Cross-Part Collaborative QM Response Team has identified the following areas that must be addressed in the development of the QM Plan:

- A. Quality Statement;  
Vision, Purpose, AIMS
- B. Definitions of Quality
- C. Quality Management Infrastructure;
- D. Goals and Implementation Plan;
- E. Capacity Building
- F. Performance Measurements;
- G. Participation and Communication with Stakeholders;
- H. Quality Management Plan;
- I. QMP Work Plan  
Process to Update the QM Plan; and
- J. Communication Processes.
- K. Limitations

This QM Plan was originally prepared in 2011 by a Sub-committee of the DC Cross-Part Response Team under the leadership of Safere Diawara, QM Coordinator with the Virginia Department of Health (VDH). It was updated in 2013 by the HIV QM Plan sub-committee under the direction of Response Team Co-Lead Justin Britanik. The HIV QM Plan sub-committee is an interdisciplinary team who has been reviewing literature and samples of QM Plans and conferring for several months to develop drafts of the QM Plan. The drafts were reviewed and discussed at different levels of the Collaborative before final approval for publication. This final approved document will be shared with all stakeholders and healthcare providers who care for PLWHA in the DC EMA. The Plan is available in print and on the following websites:

- <http://nationalqualitycenter.org/index.cfm/17112/38159>
- [www.doh.dc.gov/dcqc](http://www.doh.dc.gov/dcqc)
- <https://nationalqualitycenter.glasscubes.com>
- <http://www.novaregion.org/DocumentCenter/Home/View/2249>

## **The DC Cross-Part Collaborative Quality Management Plan**

### **A. QUALITY STATEMENT**

#### **VISION:**

The Collaborative's well-defined Ryan White network of community partners and resources will build capacity to provide quality HIV-related care and services for all persons living with HIV/AIDS in the DC EMA.

#### **PURPOSE:**

The Collaborative will systematically monitor, evaluate and continuously improve the quality of HIV care and services provided to all RW consumers in the DC EMA through the collaborative efforts of community partners and key stakeholders from all HIV/AIDS Program Parts. All comprehensive HIV care must be provided according to the HHS guidelines for the treatment of HIV disease and related opportunistic infections, formerly the Public Health Service (PHS) guidelines. The key focus of the Collaborative is on changes that demonstrate and improve measurable outcomes of clinical performances.

**AIMS:**

Due to the efforts of this Collaborative, the following have been achieved and will continue to be sustained:

- Strengthened partnerships across all RW Parts in the DC EMA as evidenced by established communication strategies for the purpose of collaboration for QM; region-wide QM priorities; and joint training opportunities.
- Expanded consumer involvement in quality activities to lead to increased patient engagement and improved health outcomes.
- Collection and synthesis of a portfolio of performance measures that reflect the required HAB measures will be used for the coordination of QI activities, development of best practices and standards, and the implementation of key activities that will minimize and/or eliminate barriers of impeded communication between regional providers and consumers.
- The unified, regional DC Cross-Part Collaborative's HIV QM Plan for all RW funded providers, will be re-developed with an updated workplan by September 2013 will be rolled out to providers and stakeholders throughout the DC EMA;
- The Collaborative Quality Improvement Project Team will focus on Retention in Care and each sub-grantee will contribute to the success by submitting quarterly data, and trialing interventions in their agency.
  - The framework of the project will be the [\*Patient Engagement Model\*](#).
  - The Retention Measure has been defined as the NQC In+Care Campaign Viral Load Suppression measure.
- Project objectives will be updated at least annually.

**B. DEFINITION OF QUALITY**

The following definitions can be found in the QM Technical Assistance (TA) manuals developed by HRSA and the NQC.

**a. Indicator:**

A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or the level of quality achieved. Indicators serve as an interim step toward achieving a performance measure and are also referred to as activities.

**b. Performance Measure:**

Performance measure is a quantitative tool that provides an indication of the quality of a service or process. It is a number assigned to an object or event that quantifies the actual output and quality of work performed.

**c. Plan-Do-Study-Act (PDSA) Cycles:**

The Collaborative QI process is based on the PDSA Cycle methodology. This model for performance improvement will be used for all QI activities:

- **PLAN** – Identify and analyze what you intend to improve, looking for areas that hold opportunities for change;
- **DO** – Carry out the change or test on a small scale (if possible);
- **STUDY** – What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?; and
- **ACT** – Adopt the change, abandon it, or run through the cycle again.

**d. Quality:**

Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider: the quality of the inputs, the quality of the service delivery process, and the quality of life outcomes.

**e. Quality Assurance (QA):**

QA refers to a broad spectrum of ongoing/continuous evaluation activities design to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent HHS guidelines for the treatment of HIV disease and related opportunistic infections, and adherence to grantee, and federal, state and local laws, rules, and regulations.

**f. Quality Improvement (QI):**

QI is generally used to describe the ongoing monitoring, evaluation, and improvement process. It includes a client/consumer-driven philosophy and process that focuses on preventing problems and maximizing quality of care. This focus is a means for measuring improvement to access and the quality of HIV services.

**g. Quality Management (QM):**

QM is a larger concept, encompassing continuous QI activities and the management of systems that foster such activities: communication, education, and commitment of resources. The integration of quality throughout the organization of the agency is referred to as QM. The QM Program embraces QA and QI functions.

**h. Outcomes:**

Results achieved for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, conditions or health status.

**i. Outcome Indicator:**

These are the specific measurement of information to track a program's success (or failure) of health care outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.

## **C. QUALITY MANAGEMENT INFRASTRUCTURE**

### **a. The development of the Collaborative was initiated by NQC and HRSA HAB.**

The NQC, with support from HAB, has helped to guide the efforts of the Collaborative. The Collaborative has become self-sustaining under the leadership of the Response Team with assistance from HAHSTA.

HAHSTA responsibilities over the course of the Collaborative:

- Hosting Response Team meetings & calls
- Providing logistical support for Learning Sessions
- Coordinating with Response Team to dovetail Part A & DC Part B data collection and initiatives

NQC's ongoing responsibilities to the Collaborative:

- Help facilitate Learning Sessions and/or Regional Quality Summit(s);
- Maintain Glasscubes workspace
- Contribute NQC materials and expertise

### **b. The leadership of the Collaborative comes from the Response Team.**

Membership on the Response Team is optional and open to anyone in the Collaborative. The Response Team provides oversight and support of the Collaborative and works with other Collaborative members to set the goals for the QM Plan, determine priorities and provide technical support necessary to implement identified quality initiatives. In addition, the Response Team will collaborate on a regular basis to ensure that clinical QM activities and actions are integrated appropriately throughout the DC EMA. Each member of the Response Team will perform different roles in the development, implementation, training, evaluation, and support of the HIV QM Plan and written Work Plan over the next 12-18 months.

#### **Response Team Responsibilities:**

- Define the structure and framework for QM and performance monitoring activities within the Collaborative;
- Oversee the implementation of the HIV QM Plan;
- Ensure that adequate resources are made readily available to successfully implement the annual Work Plan;
- Oversee and approve quality initiatives from a planning, monitoring, analysis, identification of recommendations and implementation perspective;
- Ensure that consumers are represented in all Collaborative activities;
- Engage key stakeholders in the QI activities;
- Identify and prioritize key QI project measure indicators;
- Oversee the data analysis and reporting activities for the Collaborative;
- Provide expertise for the development of learning sessions for Collaborative members;
- Participate in monthly face-to-face meetings, conference calls, and quarterly Collaborative-wide meetings.

## **Sub-committees**

The Response Team will accomplish its work through close and constant interaction with other Collaborative members through a sub-committee structure. The following standing Sub-committees have been established for the Response Team.

### 1. QI Projects Sub-committee

#### Responsibilities:

- Lead the Collaborative in dialogue regarding project improvement activities;
- Provide TA and other supports around those activities;
- Set Collaborative goals for each improvement project; and
- Manage the effective communication of best practices related to the project among Collaborative members.

### 2. Data Management Sub-committee

#### Responsibilities:

- Assist the Collaborative with identifying potential data improvement projects;
- Advise the Collaborative on the development of improvements to the data collection system and performance monitoring initiatives;
- Review data over time for trends in program outputs and data validity;
- Request performance measures data from providers per schedule;
- Develop recommendations on how to improve data; and
- Share findings with stakeholders.

### 3. HIV QM Plan Sub-committee

#### Responsibilities:

- Develop and implement the HIV QM Plan and gathering needed information from various sources;
- Review the HIV QM Plan, for promoting collaboration among all participants;
- Establish shared measures and standards whenever possible; and
- Report the HIV QM Plan implementation outcomes to both the Response Team and to the stakeholders in a feedback mechanism that, not only holds the DC EMA accountable for implementing the plan, but provides good input and advice from the entire region across all Parts.

### 4. Provider Capacity Development Sub-committee

#### Responsibilities:

- Support the development of DC Cross-Part QI activities by linking training and TA to all stakeholders;

- Develop and implement QM training opportunities based on identified needs; and
- Facilitate providers and consumers ability to conduct QM activities as well as their knowledge about QI concepts.

5. Consumer Capacity Development Sub-committee (Now Advocates for Quality – A4Q)

Responsibilities:

- Providing an effective means of QI communication to the consumers;
- Serving in an advisory capacity and making recommendations to the Response Team and stakeholders;
- Providing QI 101 trainings to consumers, and trainings for providers to integrate consumers into agency quality initiatives; and
- Increasing public awareness of the Collaborative activities; and providing input into identified QM Programs.

Membership on the Response Team is open to all members of the collaborative. Participating members who wish to serve on the response team must submit a letter of interest and Response Team Membership Application form to the Response Team Chairperson. The Response Team will review all applications and selections will be made based on availability and experience. Applications to join the response team can be submitted each month for review at their meetings. A copy of the form is included as Appendix A.

c. **The Collaborative is a group of internal stakeholders made up of grantees, RW providers, and consumers.**

**Grantees and DC EMA RW Providers:**

The grantees and RW providers are a network of administrators and HIV healthcare providers that include physicians, mid-level practitioners, dieticians, dentists, nurses, phlebotomists, pharmacists, mental health counselors, medical case managers, quality managers, data managers, and others who are awarded RW funding directly or through a sub-contract to monitor and/or provide HIV-related services to PLWHA in the DC EMA.

Someone with signatory authority from each grantee and RW provider agency will be asked to review and agree to implementation of this HIV QM Plan within their specific program to achieve the vision of the Collaborative. Throughout the process, they will need to conduct internal QM processes related to joint QI projects; monitor and report on specific outcomes quarterly and participate in the regularly scheduled meetings.

**Consumers:**

Consumers are equal partners in the QI process and as such are sought as active members of any QI initiative related to the Collaborative. Because consumers of all HIV-related services are the primary driving force behind the need for continual monitoring, re-evaluations and improvement of those services, the Collaborative includes consumer representation to advise other members on QI processes. Meaningful consumer involvement reflects an integrated process rather than parallel consumer improvement activities. To that end, the Collaborative felt the need and saw value in the inclusion of consumer representation from the inception of

the Collaborative and moving forward. In fact, because of Collaborative efforts the consumer capacity team was able to develop into a fully-fledged funded agency to lead a consumer-driven effort emphasizing the perspective of HIV-positive consumers as invaluable to the design and execution of quality improvement activities,

**External Stakeholders:**

External stakeholders are interested in seeing the quality efforts of the Collaborative succeed but may not be actively participating in the activities of the Collaborative. External stakeholders may include caregivers; Advocacy groups, AIDS or health care focused policy committees, the Metropolitan Washington Regional HIV Health Services Planning Council, the Regional Advisory Committees; non-Ryan White providers of HIV Care in the DC EMA; and other funders, such as medical insurers (Medicaid, Medicare, and the Veterans Administration, etc). They should be kept informed of the Collaborative’s efforts and called upon as needed to support the work of the Collaborative.

**Membership:**

The attached Appendix B provides information about the current and potential membership of the DC Cross-Part Collaborative.

**Meeting schedule:**

The Collaborative is expected to continually work together. Ongoing communication with Response Team members and Collaborative participants is maintained utilizing Glasscubes, a web-based portal for project and content management of the Collaborative hosted by NQC. The Collaborative will meet quarterly at a centralized location to be determined by the Response Team and shared with the broader Collaborative membership with as much notice as possible. Members of the Response Team are expected to also participate in monthly face-to-face meetings and/or conference calls to review performance and QI project data, as well as discuss consumer activities. Other ad hoc calls and meetings will take place, as needed.

**d. Resources:**

QM resources provided by the following organizations are consulted frequently:

- HRSA HAB  
(<http://hab.hrsa.gov/special/qualitycare.htm/>)
- NQC (<http://nationalqualitycenter.org/QualityAcademy/>)
- Institute for Healthcare Improvement (<http://www.ihl.org/IHI/Topics/HIVAIDS/>)
- Target Center (<https://careacttarget.org/category/topics/quality-management>)

**D. GOALS AND IMPLEMENTATION PLAN**

Health outcome goals are based on HAB’s HIV Performance Measures for Core Clinical, ADAP and Pediatric Services. Additionally, the Collaborative will select an optional goal as the focus of the joint QI Project.

QA/process evaluation goals include:

1. Strengthening the existing HIV QM Infrastructure within RW Programs across all Parts to support QI activities throughout the DC EMA;
2. The development and implementation of the DC Cross-Part Collaborative HIV QM Plan;
3. Assuring QM alignment and integration throughout the DC EMA at the local levels;
4. The development and implementation of outcome and performance measures;
5. Providing TA and training on an ongoing basis;
6. Ensuring that ambulatory/outpatient centers, primary care and health-related support services adhere to the most recent HHS guidelines, as well as federal, state, local and grantee regulations;
7. Developing, implementing, and reporting on identified specific QI projects;
8. Facilitating the active involvement of provider agencies in the implementation of multidisciplinary data driven QI projects; and
9. Ensuring that the goals for consumer involvement include the participation of a diverse group of PLWHA in QI activities, including but not limited to:
  - a. Providing consumer perspectives, outreach, and as community liaisons;
  - b. Helping with needs assessments for QM and identifying service barriers;
  - c. Functioning as trainers for QM; and
  - d. Acting as a resource pool for various skill sets needed at agencies for QM.

### **Implementation Timeline (2013-2015):**

#### **Year Three - 2013:**

- Continue collection, synthesis and analysis of the Collaborative's performance measures, including retention measure;
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA
- Support Advocates for Quality (A4Q – formerly QPAC)
- Implement new retention QI project
- Add In+Care Viral Load suppression measure to indicator portfolio ; and
- Set project goal for Year Four & Five focus across the DC EMA.

#### **Year Four - 2014:**

- Continue collection, synthesis and analysis of the Collaborative's performance measures, including retention measure;
- Continue to work with and help further the initiatives of A4Q. Align Collaborative and A4Q activities for training consumers and developing consumer capacity at each agency
- Full implementation of retention/patient engagement project
- Look at overhaul of portfolio of measures given the pending revision of the portfolio of HAB HRSA performance measures
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA; and set project goal for Year Five focus across the DC EMA

### **Year Five - 2015:**

- Continue collection, synthesis and analysis of the Collaborative's performance measures, including retention measure;
- Begin evaluation of retention/patient engagement project;
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA; and
- Set project goal for Year Six focus across the DC EMA

The attached Appendix C provides information about the three-year strategic plan.

### **Quality Management Program Work Plan, 2013 – 2014**

GOALS include:

1. Continue Implementation of the DC Cross-Part Collaborative HIV Quality Management Plan. Key activities include;
  - Regional QM Summit
  - Increased Communication – quarterly newsletter and updates via GlassCubes
  - New training opportunities for consumers in conjunction with A4Q
  - Continued quarterly learning sessions
  - Continued quarterly data submission and summary reports
2. The development and implementation of measurable outcomes and performance measures at all levels.
  - New performance measure - Viral Load Suppression Retention Measure
  - Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/m at last viral load test during the measurement year
3. To provide ongoing TA and trainings, when necessary.
4. Encourage Collaborative participants to achieve goals for each QI Project.
  - Increase the percentage of HIV patients who are retained in primary HIV healthcare within the measurement year across Collaborative participants to a mutually agreed upon goal to be determined.

The attached Appendix D provides information about the implementation/work plan.

Accomplishing the activities within this plan will require coordinated teamwork efforts throughout the DC EMA. All RW programs should become an integral component in conducting activities to accomplish the comprehensive QM Plan objectives and key activities.

### **E. CAPACITY BUILDING**

The Collaborative will continue to build QI capacity through providing training, TA, and technology transfer. Capacity building needs will be determined through organizational assessments, QM surveys and focus groups.

Training will involve the development and delivery of curriculum and the coordination of training activities to increase the knowledge, skills and abilities of trainers, HIV service providers and consumers. Collaborative members trained by NQC, or trainers from LPS of PA/MA AETC and HAHSTA will provide QM training opportunities for members of the Collaborative as well as the DC EMA.

TA will be provided or facilitated through culturally relevant and expert programmatic and technical advice (mentoring/coaching) with support from the NQC. TA is also provided in areas such as organizational infrastructure development, program implementation, QI, and evaluation via self-study QM tutorial through the NQC's Quality Academy:  
<http://nationalqualitycenter.org/index.cfm/5847/8860>.

Information exchange will occur when innovations are diffused among HIV providers to improve effectiveness and are translated into programs and practice. Newsletters and a Consumer Information Training Program will be utilized in this process.

The attached Appendix E provides information about the planned capacity building activities.

## **F. PERFORMANCE MEASUREMENT**

The attached Appendix F provides information about the current available data that is being tracked and reported for selected clinical services in the DC EMA to address HAB's Performance Measures. The Collaborative chose some of the Core Clinical Measures to focus on for their QI projects. Data will be collected from a variety of sources and, to the extent possible, existing data sources will be utilized including Electronic Medical Records (EMR) such as eClinical Works, Epic, Athena, or General Electric (GE) Centricity, as well as reporting utilities such as Virginia Client Reporting System (VACRS), CAREWare, custom agency databases in Access or Excel, and other transportable data sources.

By design, data will be shared across agencies un-blinded to facilitate sharing across agencies of best practices and for accountability among participating agencies. Findings for QM activities will be reported only in the aggregate. Client-level data will not be reported or made available. Program-specific data reports may be directly provided to each provider and A4Q for the purpose of enhancing their QM Program.

Performance measurement is a central component of the QM Program. The Collaborative will use performance measurement data to identify and prioritize QI projects, to routinely monitor the quality of care provided to consumers, and to evaluate the impact of changes made to improve the quality and systems of HIV care.

### **A. Data Collection**

To the extent possible, performance data will be collected from all RW funded agencies within the DC metropolitan area. Providers will use a standardized reporting template and submit their

aggregate data through the Collaborative's secured web-based portal, Glasscubes. The data collection efforts will:

- place as minimal a burden as possible on the sources;
- minimize any interference with the routine operations of provided services; and
- utilize existing data sources (including clinical chart abstraction and consumer interviews)

Persons involved with the collection of data will be bound by their provider, local, state, District and federal regulations regarding confidentiality. Individuals involved in the collection of data should receive appropriate training regarding their role, the confidentiality and security of data, and other ethical issues. No client level is intended to be shared or disseminated through this collaborative learning process.

Data collection will include:

- Data to assess the needs of PLWHA in the DC metropolitan area;
- Outcomes data developed for specific program areas;
- Client satisfaction data; and
- Other data as QM activities require or deem necessary.

### Strategies

In collaboration with the broader Response Team, the Data Team will coordinate the collection and analysis of data. The Data Sub-committee will:

- Develop and maintain a standardized data reporting template;
- Provide TA and training on data integrity, collection and use;
- Follow-up with non-participating providers to encourage participation,
- Compile and analyze the data,
- Develop and distribute jurisdiction and EMA-wide performance reports for each data submission, and
- Present the results to the Collaborative.

Data collection will be implemented utilizing appropriate sampling methodology and will include both concurrent and retrospective review. For each data collection activity scheduled in the QM work plan, a data collection plan will be developed that specifies:

- a. The purpose of the data collection activity;
- b. The measures and indicators to be collected;
- c. The instruments and methods to be used to collect the identified data;
- d. The analysis plan for the data;
- e. The methods for maintaining data security; and
- f. How and to whom the findings will be reported.

### Data sources

The Collaborative is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:

- Chart abstractions from client medical records (paper or electronic);
- Clinical databases;

- Demographic databases;
- Agency Reports;
- CAREWare;
- ADAP database;
- Administrative/Programmatic monitoring tools;
- Client satisfaction surveys/interviews;
- Focus group summaries; and
- Unmet Needs Assessments.

#### B. Reporting Mechanisms of Data

Findings for QM activities will be reported in aggregate format, and will not include client-level data. Program-specific data reports may be directly provided to each program for the purpose of enhancing their QM Program and to allow for comparison across the jurisdictions and DC EMA.

The Collaborative utilizes strategies outlined in the HAB's HIV/AIDS Performance Measures for Core Clinical (for Adults and Adolescents), ADAP and Pediatric Services to measure selected key performance indicators for HIV health care. RW grantees, sub-grantees, contractors and subcontractors will be required to report data on these selected key performance indicators. Compiled findings will be shared with HIV providers, the Response Team and HRSA faculty, consumers, grantees, and others, as deemed appropriate. The Response Team will be responsible for oversight and ensuring implementation of the established process.

#### G. PARTICIPATION OF STAKEHOLDERS

While HRSA and the NQC have concluded their formal activities with the Collaborative, several stakeholders are still currently involved in Collaborative activities.

Goals for Stakeholders are:

1. Make QM a part of the DC EMAs' RW care provision and a part of everyday work activities;
2. Given a clear understanding of their roles in the Cooperative, buy-in to participation in the Collaborative is a welcomed activity;
3. Replicate infrastructures and QM models that work in a similar geographic area and under similar conditions within their own program; and
4. Develop relationships and technical capacity to extract needed QM data.
5. Quality management program evaluation.

The goal of the QM Program evaluation is to determine whether or not programs made an improvement reflected in documented QI activities. The Collaborative requires providers to monitor and report on selected outcome measures bi-monthly.

The Collaborative will evaluate the QM Program on an annual basis, including rating the completeness of goals and key activities undertaken during the year. Results will be used to:

1. Determine the effectiveness of the QM Plan infrastructure and activities;

2. Review annual goals, identify those that have not been met the reasons for any shortcomings, and also assess possible strategies to meet them before the next review; and
3. Review the selected quality indicators for appropriateness and continued relevance in order to reach optimal care for consumers.

Based on the findings, the Response Team will refine strategies for the following year. Regular feedback regarding overall QI is critical in sustaining improvements over time. To obtain feedback from stakeholders:

- The Response Team will communicate findings and solicit feedback from key stakeholders on an ongoing basis and data presentations will be made during identified meetings.
- Written reports will be shared with stakeholders who will be given the opportunity to provide feedback on the reports.

## I. PROCESS TO UPDATE THE QUALITY MANAGEMENT PLAN

The HIV QM Plan Sub-committee will assess the QM Plan using the NQC Checklist for the Review of an HIV-Specific QM Plan. The NQC checklist will help identify opportunities for improvement to the QM Plan. The results will be shared with the Collaborative during one of the scheduled meetings. By consensus, the Collaborative will identify a new set of quality indicators, establish goals for the upcoming year, and identify and describe specific quality initiatives in the updated QM Plan. A revised QM Plan will be submitted to all the Collaborative's RW participants for approval on an annual basis.

Monitoring review of the implementation process will be conducted by the Response Team on a regular basis. The review will be planned and scheduled every quarter, with a report of progress to the Collaborative and other stakeholders. Monitoring the QM Plan will include reviewing the goals, the objectives and activities listed in the work plan. Frequent monitoring of the plan will allow for early recognition of possible barriers.

## **J. COMMUNICATION PLAN**

**Communication will be necessary with the following groups:**

- Contract and subcontract HIV service providers;
- Advocacy groups, AIDS or health care focused policy committees, RW leadership, Metropolitan Washington Regional HIV Health Services Planning Council, Regional Advisory Committees, the community at-large, and the press;
- NQC and HRSA staff ; and
- Consumers of RW services, Part A planning council/subcommittees.

**The forms of communication will depend upon the needs and preferences of the group and may include:**

- Email blasts
- Announcements and other posts via Glasscubes workspace
- Phone calls

- Face-to-face meetings
- Websites
- Webinars
- Posters
- Formal letters

**The purpose of communication will depend upon the needs/preferences of the group and may include:**

- Introduction to the work of the Collaborative;
- Routine meetings to encourage buy-in of non-participating providers to join and provide their data to feed quality measurements;
- Responding to requests for information;
- Data gathering;
- Responding to results of PDSA Cycle and to implementation of other quality processes;
- Press release style updates as the project progresses;
- Reports tied to output or outcomes more than process;
- Routine leadership communication, such as meeting minutes;
- Demonstration of the “process” of development of QM tools, consensus with brief introduction to the work of the Collaborative;
- Highly structured, polished, succinct reporting methods and tools;
- Outcomes of QI activities; and
- Written information for audiences of varying education levels and competencies.

**The frequency of communication will depend upon the needs/preferences of the group and may occur:**

- On a routine basis, monthly or quarterly; more frequently during PDSA Cycles;
- Prior to new sub-grantees of Collaborative partners participating in their first collaborative meeting;
- Quarterly in the Collaborative newsletter;
- At local meetings as “news”;
- On a monthly routine basis to describe processes and outcomes, report successes and challenges, and respond to TA needs;
- As needed to share information on outcomes; and
- Quarterly for data submission and feedback.

### **Open Meetings**

Highly structured meetings such as the Collaborative Learning Sessions (LS) and QM Summit will be open to all RW providers, consumers and stakeholders and all are encouraged to participate.

### **K. LIMITATIONS**

- All stakeholders are at different levels of implementing QM Plans in their programs;
- This plan is only part of a multi-year process to improve outcome measurement;

- Information will not be used to compare providers for funding decisions;
- Many interventions can affect outcomes; and
- This document is based on beliefs, expectations and objectives in the current climate of the DC EMA. We realize that the Collaborative and its stakeholders are subject to possible unforeseen, substantive, changes that could cause actual results to be materially different.

## **ACRONYMS**

<b>A4Q</b>	Advocates for Quality (formerly QPAC)
<b>ADAP</b>	AIDS Drug Assistance Program
<b>AETC</b>	AIDS Education and Training Center
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>CBO</b>	Community Based Organization
<b>DC</b>	District of Columbia
<b>DC EMA</b>	DC Eligible Metropolitan Area
<b>DOH</b>	Department of Health
<b>DRP</b>	Dental Reimbursement Program
<b>EC</b>	Emerging Community
<b>EMA</b>	Eligible Metropolitan Area
<b>FMC</b>	Family Medical Center
<b>FPL</b>	Federal Poverty Level
<b>FQHC</b>	Federally Qualified Health Center
<b>GE Centricity</b>	General Electric Centricity
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HAB</b>	HIV/AIDS Bureau
<b>HAHSTA</b>	HIV/AIDS, Hepatitis, STD, and TB Administration
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRSA</b>	Health Resources and Services Administration
<b>LPS of the PA/MA AETC</b>	Local Performance Sites of the Pennsylvania/Mid-Atlantic AIDS Education & Training Center
<b>MADAP</b>	Maryland AIDS Pharmaceutical Program
<b>MAI</b>	Minority AIDS Initiative
<b>MD</b>	Maryland
<b>N</b>	Number
<b>NQC</b>	National Quality Center
<b>NOVA</b>	Northern Virginia
<b>NVRC</b>	Northern Virginia Regional Commission
<b>PDSA Cycle</b>	Plan-Do-Study-Act
<b>PLWHA</b>	People living with HIV/AIDS
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>QIP</b>	Quality Improvement Plan
<b>QIPS</b>	Quality Improvement Project Sub-committee
<b>QM</b>	Quality Management
<b>RW</b>	Ryan White
<b>RWPB</b>	Ryan White Part B
<b>SMAA</b>	Suburban Maryland Administrative Agency
<b>SPNS</b>	Special Programs of National Significance
<b>TA</b>	Technical Assistance
<b>TOT</b>	Training of Trainers
<b>VA</b>	Virginia
<b>VACRS</b>	Virginia Client Reporting System

**VDH  
WV  
XPRES**

Virginia Department of Health  
West Virginia  
Cross Program Reporting and Evaluation Systems

**ACKNOWLEDGEMENTS**

We would like to thank those who contributed to this document. First, we would like to acknowledge the **Response Team** for the subject matter and key contributions to this document.

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Next, we want to thank **NQC Staff** and **HRSA HAB faculty** for their involvement in the Collaborative. If it was not for the strong foundation laid in the first year the Collaborative could not have been sustained. Also, we want to thank all **the consumers, partners, and community members** who have patiently reviewed our early content and drafts.

And last but definitely not least, we would like to thank our **Ryan White leaders** for the opportunity they gave us to work on this project and their great feedback, kindness and specifically the time they spend guiding us successfully through the project.

The following individuals provided extensive time, effort and dedications to the development of this document.

<b><u>Tim Agar</u></b> <i>Federal Grants Contract Monitor Northern Virginia Regional Commission</i>	<b><u>Krystal M. Hilton, MPH</u></b> <i>Quality Management Coordinator Virginia Department of Health (VDH)</i>
<b><u>Justin Britanik</u></b> <i>Quality Management Specialist District of Columbia Department of Health Care, Housing and Support Services Bureau HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)</i>	<b><u>Lena Lago, MPH</u></b> <i>Monitoring and Evaluation Manager District of Columbia Department of Health Care, Housing and Support Services Bureau HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)</i>
<b><u>Denise Burke</u></b> <i>Quality Assurance Coordinator Prince George's County Health Department Suburban Maryland Administrative Agency</i>	<b><u>Rachel McLaughlin</u></b> <i>Director of Quality Improvement Whitman-Walker Health (WWH)</i>
<b><u>Mrs. Martha Sichone Cameron</u></b> <i>Community Health Worker Institute for Public Health Innovation</i>	<b><u>Keli E. Nibblins, RN, BSN</u></b> <i>Medical Case Coordinator Infectious Disease Associates Mary Washington Healthcare Physicians Group</i>
<b><u>Stephen Clark</u></b>	<b><u>Rachel Smith</u></b>

<i>Data and Quality Coordinator Fredericksburg Area HIV/Aids Support Services</i>	<i>Deputy Director University of Maryland Prevention Research Center</i>
<b><u>Safere Diawara, MPH</u></b> <i>Quality Management Coordinator Virginia Department of Health (VDH)</i>	<b><u>Khalil Hassam</u></b> <i>Data Manager MetroHealth (Formerly Carl Vogel Center)</i>
<b><u>Tarsha Harris Moore, MSW, LICSW</u></b> <i>Patient Support Services Manager Burgess Clinic, Family Connections, Special Immunology Services Children's National Medical Center</i>	

Appendix A: **DISTRICT OF COLUMBIA • ELIGIBLE METROPOLITAN AREA**

RYAN WHITE CROSS-PART QUALITY IMPROVEMENT COLLABORATIVE

**Response Team Membership**

The Response Team was assembled to coordinate the Collaborative’s activities. This Team is comprised of grantees, sub-grantees, and consumer representatives from the entire EMA. The Response Team accomplishes its work through constant interaction with the broader Collaborative membership via a sub-committee structure. The following standing sub-committees have been established for the Response Team:

**Data Management Team**

The Data Management Team is responsible for:

- Assisting the Collaborative with identifying potential data improvement projects;
- Advising the Collaborative on the development of improvements to the data collection system and performance monitoring initiatives;
- Reviewing data over time for trends in program outputs and data validity;
- Requesting performance measures data from providers per schedule;
- Developing recommendations on how to improve data; and
- Sharing findings with stakeholders.

**Quality Improvement Team**

The Quality Improvement Team is responsible for:

- Leading the Collaborative in dialogue regarding project improvement activities;
- Providing TA and other supports around those activities;
- Setting Collaborative goals for each improvement project; and
- Managing the effective communication of best practices related to the project among Collaborative members.

**Quality Management Plan Team**

The Quality Management Plan Team is responsible for:

- Developing and implementing the HIV QM Plan and gathering needed information from various sources;
- Reviewing the HIV QM Plan, for promoting collaboration among all participants;
- Establishing shared measures and standards whenever possible; and

- Reporting the HIV QM Plan implementation outcomes to both the Response Team and to the stakeholders in a feedback mechanism that, not only holds the DC metropolitan region accountable for implementing the plan, but provides good input and advice from the entire region across all Parts.

#### Provider Capacity Development Team

The Provider Capacity Development Team is responsible for:

- Supporting the development of DC Cross-Part QI activities by linking training and TA to all stakeholders;
- Developing and implementing QM training opportunities based on identified needs; and
- Facilitating providers and consumers ability to conduct QM activities as well as their knowledge about QI concepts.

#### Consumer Capacity Development Team

The Consumer Capacity Development Team will be responsible for:

- Providing an effective means of QI communication to the consumers;
- Serving in an advisory capacity and making recommendations to the Response Team and stakeholders; and
- Increasing public awareness of the status of the Collaborative activities; and providing input into identified QM Programs.

In addition to the subcommittees, there are opportunities to support the activities of the Response Team via the individual roles listed below:

#### Collaborative, Co-Leads

The Collaborative co-leads are responsible for:

- Interfacing with the NQC and HRSA faculty throughout the first 18-months of the project;
- Leading the Response Team in ascertaining and accomplishing goals;
- Identifying key priorities and milestones for the Collaborative; and
- Setting the agenda for the Response Team meetings.

#### Communicator

The Communicator is responsible for:

- Coordinating all email communication for the Collaborative participants;
- Formatting and editing all Collaborative products developed for distribution; and
- Developing webpage content.

#### Trainer

The Trainer is responsible for:

- Identifying the need for training;
- Developing in-person, webinar and conference call training agenda; and
- Identifying subject matter experts to address knowledge gaps.

#### Recorder

The Recorder is responsible for:

- Accurately capturing the ideas discussed and decisions of the Response Team meetings.

**Name:** \_\_\_\_\_  
**Organization:** \_\_\_\_\_  
**Email:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_

**I. Overview of Experience and Availability**

- Brief description of experience: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- List time constraints and availability:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**II. Committee and Role**

*Indicate the committee of interest and your willingness to take a leadership or support role*

<b>Leadership (L) or Support (S) Role</b>	<b>Committee / Team</b>
	Data Management
	Quality Improvement
	Quality Management Plan
	Provider Capacity Development
	Consumer Capacity Development
	Co-Lead
	Communicator
	Trainer

	Recorder
	Meetings Manager

**APPENDIX B: COLLABORATIVE MEMBERSHIP**

<b>Agency/Part</b>	<b>Participant and Response Team Role</b>	<b>Resource/Area of Expertise</b>
<b>Ryan White A</b>		
Northern Virginia Regional Commission (NVRC)	Participant <b><u>Tim Agar – Response Team</u></b>	Part A & Part B Administrative Agent
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)	Participant <b><u>Lena Lago – Response Team</u></b> <b><u>Justin Britanik – Response Team</u></b>	Part A Grantee/Administrative Agent
Prince George's County Health Department (PGCHD)	Participant	Suburban MD RW Part A Administrative Agent
AIDS Response Effort, Inc	Participant	Sub-recipient in NOVA providing Medical Care and MCM
Fredericksburg Area HIV/AIDS Support Services, Inc.	Participant	Sub-recipient in NOVA providing Medical Care and MCM
AIDS Healthcare Foundation	Participant	Sub-recipient in DC providing Medical Care and MCM
Andromeda Transcultural MHHC	Participant	Sub-recipient in DC providing Medical Care and MCM
Christ House	Participant	Sub-recipient in DC providing Medical Care and MCM
Community Family Life Services	Participant	Sub-recipient in DC providing MCM
La Clinica del Pueblo	Participant	Sub-recipient in DC providing Medical Care and MCM serving primarily a Latino/Hispanic population
Mary's Center for Maternal and Child Care	Participant	Sub-recipient in DC providing Medical Care
Regional Addiction Prevention	Participant	Sub-recipient in DC providing Medical Care and MCM
The Women's Collective	Participant	Sub-recipient in DC providing Medical Care
United Health Care	Participant	Sub-recipient in DC providing Medical Care and MCM
United Medical Center		
Us Helping Us	Participant	Sub-recipient in DC providing Medical Care
<b>Ryan White B</b>		
DC HAHSTA	Participant	ADAP agency

Maryland Department of Health and Mental Hygiene ( MD DHMH)	Participant	ADAP agency
Virginia Department of Health (VDH)	Participant <b><u>Safere Diawara – Response Team</u></b>	ADAP agency
West Virginia Department of Health & Human Resources (WV DHHR)	Participant	ADAP agency
Charles County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing MCM.
Frederick County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Alexandria Neighborhood Health Services	Participant	Part A and Part B sub-recipient in NOVA providing Medical Care and MCM.
Montgomery County Department of Health and Human Services	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Prince George’s County Department of Health	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Building Futures	Participant	Part B sub-recipient providing MCM services in DC
Damien Ministries	Participant	Part B sub-recipient providing MCM services in DC
Homes for Hope	Participant	Part B sub-recipient providing MCM services in DC
Joseph’s House	Participant	Part B sub-recipient providing MCM services in DC
Shenandoah Valley Medical Systems	Participant	Part B sub-recipient providing outpatient medical care and MCM services in WV, Part A sub-recipient in DCA EMA
<b>Ryan White C</b>		
Greater Baden Medical Services Inc.	Participant	Part A sub-recipient and Part C EIS program grantee in Suburban MD
Howard University Hospital Comprehensive Clinic	Participant Tammie Blair <b><u>Response Team</u></b>	Part A sub-recipient and Part C EIS program grantee
MetroHealth (formerly Carl Vogel Center)	Participant <b><u>Khalil Hassam– Response Team</u></b>	Part A sub-recipient and Part C EIS program grantee
Medstar Research Institute	Participant	Affiliated with Washington Hospital center, one of two Part C recipients in Suburban MD
Whitman-Walker Health	Participant <b><u>Rachel McLaughlin– Response Team</u></b> <b><u>Kovinsola Aladesuru – Data Team</u></b>	Part A sub-recipient and Part C EIS program grantee
Unity Healthcare	Participant	Part A sub-recipient and Part C EIS program grantee
Family and Medical Counseling Service	Participant	Part A sub-recipient and Part C EIS program grantee
Mary Washington Healthcare (formerly known as Medicorp)	Participant	Part A sub-recipient and Part C EIS program grantee in NOVA

<b>Ryan White D</b>		
Children's National Medical Center	Participant <b><u>Tarsha Moore – Response Team</u></b>	Part D Administrative agent, Part A, B, & C funding
Inova Juniper Program	Participant	Part D Administrative Agent and Part A, B & C Funding
<b>Ryan White F AIDS Education Training Center</b>		
Northern Virginia Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation
Washington, DC Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation
Maryland Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation
<b>Unaffiliated Consumers</b>		
Martha Cameron	<b><u>Martha Cameron – Response Team</u></b> Consumer Lead A4Q Lead	Consumer trained in Quality Management Principles
Debra Frazier	A4Q Member	
Daryl Williams Washington Healthcare	Consumer	Parts A & C
Joe Henson PG County Health Department	Consumer	
Harriet Odom FMCS	A4Q Member	
Corey Franks FMCS	A4Q Member	
Philip Bailey AIDS Response Effort	A4Q Member	
Doug Fogal AIDS Response Effort	A4Q Member	

**APPENDIX C: THREE-YEAR STRATEGIC PLAN: 2013-2015**

<b>Domain</b>	<b>Area</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Alignment</b>	<b>HIV QM Plan</b>	Evaluate, re-develop, update and, implement QM Plan, including a Work Plan.	Continue QM Plan implementation; revise as needed, Rewrite Work Plan annually.	Review QM Plan; revise as needed, Rewrite Work Plan annually.
	<b>QM Summit</b>	Hold RW "All grantees meeting" (which includes grantees and	Hold annual RW "All grantees meeting" (which includes grantees and	Recommend holding annual RW "All grantees meeting" (which includes grantees

		providers from all RW Parts) in July 2013.	providers from all RW Parts) in Summer 2014.	and providers from all RW Parts) in Summer 2015.
	<b>Newsletter</b>	Develop a template. Released 1 <sup>st</sup> Newsletter. Release new newsletter on a quarterly basis.	Revise and update the template. Release new newsletter on a quarterly basis.	Revise and update the template. Release new newsletter on a quarterly basis.
	<b>Expand the Collaborative to:</b>	Involve all committed RW grantees, providers, consumers and other key stakeholders.	Encourage participation of RW funded agencies in the DC region, that didn't participate in the first year's activities.	Encourage participation from non-RW funded providers who provide HIV care in the DC region. Continuously involve new people at key agencies who may not have been involved.
<b>Data</b>	<b>Data Management</b>	Continue to refine data collection process. Ensure more robust data submission.	Reduce missing data. Adapt data collection process for new CAREWare implementation in Maryland and DC.	Standardize data collection for accuracy and completeness. Ensure maintenance of data status.
		Select specific indicators to be tracked, analyzed, and reported.	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date. Guide transition to new data measures collected in new data systems	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date, relevant QI projects, common core indicators for monitoring HHS-funded HIV prevention, treatment, and care services, and new core HAB Measures
<b>QI Activities</b>	<b>QM Consultation, Training and Assistance</b>	Provide ongoing TA/consultations to providers in developing QI activities and projects.	Provide ongoing TA/consultations to providers in developing QI activities and projects.	Provide ongoing TA/consultations to providers in developing QI activities and projects.
	<b>Collaborative Activities</b>	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative
<b>QI Projects</b>	<b>Retention in Care</b>	Retention QM Measure defined as NQC In+Care Campaign Viral Load Measure	Monitor retention measure across Collaborative. Share best practices across Collaborative. Tap into national resources from NQC Campaign.	Evaluate retention project. Response team to assess the efficacy of the project.
	<b>Expand the QI Projects to other core services and</b>	Invite those delivering other core and support services to 2013 QM	Expand the QI Projects to other core services and support services, get them	

	<b>support services</b>	Summit	participating not necessarily submitting data	
	<b>Develop QM Training Team</b>	Develop QM Training Team to roll out activities as part of QI Plan.	Implement strategies and trainings devised by QM Training Team. These will be informed from the QIP Team about topics relating to, retention in care, Viral Load Suppression, and Patient engagement.	Assess impact of QM Training Team through measures such as participant satisfaction, and pre/post tests for knowledge retention.
<b>Capacity Building (Provider and Consumer)</b>	<b>Providers' QM Self-Assessment</b>	Examine results of self-assessment and data reports to determine most critical issues by agency and how performance can best be addressed and improved.	Complete self-assessment annually to measure impact by analyzing assessments and data reports. Perform on-going training and/or TA.	Complete self-assessment annually to measure impact by analyzing assessments and data reports. Perform on-going training and/or TA.
	<b>Developing Training Programs/Tools Accordingly</b>	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.



The following tables describe the program goals, objectives, and key action steps.

**APPENDIX D: IMPLEMENTATION/WORK PLAN FY2013-2014**

<b>Goal A: Continue Implementation of the DC Cross-Part Collaborative HIV Quality Management Plan</b>						
<b>Domain</b>	<b>Area</b>	<b>Objectives</b>	<b>Key Action Steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Timeline</b>	<b>Resources</b>
<b>Alignment</b>	Quality Management Plan	<b>Develop the DC Cross-Part HIV QM Plan and Work Plan for 2013-14.</b>	-Develop draft of the HIV QM Plan - Distribute draft to stakeholders for review - Review and revise Plan at response team meetings - Finalize plan and post on the different websites.	Response Team QM plan team All stakeholders.	May-August 2013	Previous QM Plans NQC /HRSA materials DOHs (in all four jurisdictions) websites
		<b>Implement DC HIV QM Plan across RW agencies in the DC EMA.</b>	- Provide training on QM principles including development of the QM Plan for providers.	QM Training Team All stakeholders	Ongoing	Work plans
		<b>Evaluate and update HIV QM Plan annually</b>	Utilize Cross-Part outcomes evaluation data/ information to update QM Plan	Collaborative All stakeholders	May 2013	Data/information from chart review, final year outcomes data report, HRSA and other federal mandates
	QM Summit Meeting	<b>Provide QM Training.</b>	Identify topics, dates, and locations for meetings and collaborate with all stakeholders to provide all-parts EMA training in July 2013.	NQC Response Team	Summer 2013	Written document, face-to-face, telephone, web, Glasscubes, and email
	Newsletter	<b>Spread information on Cross-Part activities.</b>	Identify interested parties, generate content, collect information, and release a new Newsletter on a quarterly basis.	Collaborative	Ongoing	Collaborative All other RW providers Other Consumers Any others

**Goal B: Strengthen the existing HIV QM Infrastructure within the DC EMA that supports QI activities.**

AREA		Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Infrastructure	Infrastructure Response Team	Provide leadership and oversight for all QI/management activities.	Work closely with the QM Plan Sub-committee to execute 2013 plan	Response Team	Approved QM Plan.	December 2013
			Implement the 2013 QM Plan.	All stakeholders	Ongoing reports.	Ongoing
		Strengthen collaboration within DC region to share Programs, policies, and best practices.	Use Established QM infrastructures.	Response Team	Conjoint documents, policies and procedures.	Ongoing
	Response Team Sub- Committee	Provide oversight and facilitation of the Collaborative QM Program.	Develop priorities and set QI goals for 2013.	Response Team QM Plan Sub-Committee	Meetings Written documents Results analysis and different reports.	Ongoing
			Expand membership to include other representatives.	All stakeholders	Membership list Attendance to required activities.	Ongoing
	QI Project Sub-committee(QIPS)	Make improvements in specific aspects of care delivery.	Finalize patient engagement/retention project.	Response Team QIPS Members QM in-house teams at RW agencies	QM project reports based on Plan-Do- Study- Act Cycle results.	Ongoing

**Goal C: Ensure that primary care and health-related support services adhere to the most recent HHS guidelines. (subject to change)**

Domain	Area Objectives	Key Action Steps	Person/Agency Responsible for Collection	Timeline	Data Source(s)
Data Collection	Increase the percentage of pediatric patients with HIV infection who had three or more medical visits in a HIV care setting in the measurement year.	-Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all pediatric provider agencies quarterly	ECW CAREWare Database VACRS GE Centricity ADAP database

Increase the percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had a viral load test performed at least every six months.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all quarterly	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of patients, aged 13 years and older, with a diagnosis of HIV/AIDS who had viral load below limits of quantification1 at last test during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical Care provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the number of patients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year at least 6 month apart.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all quarterly	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of adult patients with HIV infection who had a test for syphilis performed in the measurement year to 90%.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical care provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all, quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had a viral load test performed at	Develop data collection methods and tools -Require all RW Parts to report on measures	The Collaborative All stakeholders	Submitted by all MCM provider agencies quarterly	ECW CAREWare Database VACRS GE Centricity

least every six months.	- Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly			ADAP database
Increase the percentage of MCM patients, aged 13 years and older, who had a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical Care provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM clients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all MCM provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all MCM provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted by all pediatric provider agencies quarterly.	ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of ADAP applications approved or denied for new ADAP enrollment <sup>2</sup> within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures quarterly	The Collaborative All stakeholders	Submitted quarterly by ADAP providing agencies.	ECW CAREWare Database VACRS GE Centricity ADAP database

<b>Data Management</b>	Develop data collection plan, methodologies, and instruments.	Develop data collection methodologies and tools for new measures and prepare for CAREWare implementation	Collaborative	By May 2013 Ongoing - TBD	ECW VACRS CAREWare
		Gather and interpret needed data.	Collaborative	Ongoing	ECW VACRS CAREWare
		Present results to the Collaborative each quarter, and share with larger Ryan White community and other partners as necessary	Collaborative	Ongoing	ECW VACRS CAREWare
	Data quality assurance	Discover data issues by running report by individual agency.	Collaborative	Ongoing	ECW VACRS CAREWare
		Evaluate data quality through indicator reports and set action steps to resolve any data issues.	Collaborative	Ongoing	ECW VACRS CAREWare ADAP Database

**Goal D: Quality Improvement Activities and Projects**

<b>Domain</b>	<b>Area</b>	<b>Objectives</b>	<b>Key Action Steps</b>	<b>Person/Agency Responsible for Collection</b>	<b>Timeline</b>	<b>Data Source(s)</b>
<b>Quality Improvement Activities and Projects</b>	Retention in Care	Increase the percentage of HIV patients who are retained in primary HIV healthcare within the measurement year across collaborative participants to a mutually agreed upon goal.	Define Retention measure as In+Care Viral Load Suppression measure Outline a work plan to phase-in patient engagement interventions, starting with Patient Satisfaction	Response Team QI Sub-committee.	November 2013	
			Collect Collaborative measure data every Quarter.	Collaborative Data Team	January 2014 – December 2015 (GY 24-25)	VACRS CAREWare eCW
			Set Project Goal for Retention across Collaborative.	QI Sub-committee	February 2014	
			Implement improvement projects.	QI Lead Collaborative	April 2014 – December 2015	
			Lead PDSA Cycle process and sharing of best practices across Collaborative.	QI Lead QI Sub-Committee Response Team Data Team	April 2014 – December 2015	

**APPENDIX E: CAPACITY BUILDING**

<b>Quality Improvement Project</b>	<b>Person/Agency Involved</b>	<b>Method and Frequency of Communication</b>	<b>Use of Data</b>
Develop and implement a QM training conducted by designated NQC Training of Trainers (TOT) Program.	Andre Farquaharson/Howard University Dental Program. Martha Cameron – A4Q	Trainings will be conducted throughout the DC EMA in two tiers (basic and advanced). Content for Advanced trainings will be derived from results of Organizational assessments.	Updates will be provided to the DC EMA Collaborative to determine their impact.
Develop and implement QM webinars.	NVRC NOVA/WDC AETC Data Team Leaders.	Webinars will be conducted throughout the DC EMA based on requests for TA as needed.	Updates will be provided to the DC metropolitan Collaborative to determine their impact.
Develop and disseminate DC Cross-Part Newsletter to HIV providers and community at large.	Response Team Newsletter Committee Volunteers.	Newsletter template will be created and content gathered from various collaborative participants.  Newsletter will be published quarterly.	Copies to be distributed electronically.
Develop and facilitate QM trainings/workshops for PLWHA.	Martha Sichone-Cameron/Response Team Adam Thompson/ NQC Consumer Consultant.	Identify training needs from contents from results of the QM Surveys and Focus Group. Develop curriculum. Provide and evaluate trainings.	Updates will be provided to the DC EMA Collaborative to determine their impact.
Develop and implement specific guidelines for consumer involvement in QM activities.	Martha Sichone-Cameron/Response Team Adam Thompson/ NQC Consumer Consultant.	Establish a formal program to educate consumers about improving quality of care by increasing self-management practices.  Disseminate relevant information on QI activities at consumers’ meetings.	Number of training and trainees.
Develop and implement specific guidelines for consumer involvement in QM activities.	A4Q NQC	Establish a formal program to educate consumers about improving quality of care by increasing self-management practices. Trainings provided quarterly.  Disseminate relevant information on QI activities at consumer meetings.	Number of training and trainees.

APPENDIX F: PERFORMANCE MEASURES

CORE CLINICAL MEASURES – PENDING NEW HAB MEASURES					
Measurement Outcome	Indicator to be Measured	Data Elements used to Measure Indicator	Data Source & Methods	Analyzing & Reviewing Data	Data Usage
Percent of RW pediatric patients with HIV infection who had three or more medical visits in an HIV care setting in the measurement year.	Change in the number of RW pediatric patients with HIV infection who had three or more medical visits in an HIV care setting in the measurement year.	<p><b>Numerator:</b> Number of HIV-infected pediatric patients who had a medical visit with a provider with prescribing privileges in an HIV care setting three or more times at least three months apart in the measurement year.</p> <p><b>Denominator:</b> Number of HIV-infected pediatric patients who had a medical visit with a provider with prescribing privileges in an HIV care setting at least once in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Sub-Committee and Response Team are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	Change in the number patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	<p><b>Numerator:</b> Number of patients with a viral load test performed at least every 6 months.</p> <p><b>Denominator:</b> Number of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 60 days between each visit.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Sub-committee and Response Team are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of patients, aged 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification <sup>1</sup> at last test	Change in the number of patients, age 13 years and older, with a diagnosis of HIV/AIDS with viral load below	<p><b>Numerator:</b> Number of patients with viral load below limits of quantification at last test during the measurement</p>	Providers to supply aggregate performance data on the selected measures at the NQC	The Data Sub-committee and Response Team are responsible for reviewing data and	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue

<p>during the measurement year.</p>	<p>limits of quantification at last test during the measurement year.</p>	<p>year.</p> <p><b>Denominator:</b>  Number of patients who:</p> <ul style="list-style-type: none"> <li>• were aged 13 years and older with a diagnosis of HIV/AIDS; and</li> <li>• had at least two medical visits during the measurement year with at least 60 days between each visit; and</li> <li>• were prescribed antiretroviral therapy for at least 6 months; and</li> <li>• had a viral load test during the measurement year.</li> </ul>	<p>Glasscubes.</p>	<p>presenting to the stakeholders.</p>	<p>track this measurement?  3) Identify issues/ challenges and implement needed improvements.</p>
<p>Percentage of patients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.</p>	<p>Change in the number of patients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.</p>	<p><b>Numerator:</b>  Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges1, i.e., MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</p> <p><b>Denominator:</b>  Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>	<p>Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.</p>	<p>The Data Subcommittee and Response Team are responsible for reviewing data and presenting to the stakeholders.</p>	<p>Provide data to the Response Team and stakeholders to determine:</p> <ol style="list-style-type: none"> <li>1) Was the goal met?</li> <li>2) Should we continue track this measurement?</li> <li>3) Identify issues/ challenges and implement needed improvements.</li> </ol>
<p>Percentage of adult patients with HIV infection who had a test for syphilis performed in the measurement year.</p>	<p>Change in the number of adult patients with HIV infection who had a test for syphilis performed in the measurement year.</p>	<p><b>Numerator:</b>  Number of HIV-infected adult patients who had a serologic test for syphilis at least once in the measurement year.</p>	<p>Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.</p>	<p>The Data Subcommittee and Response Team are responsible for reviewing data and presenting to the stakeholders.</p>	<p>Provide data to the Response Team and stakeholders to determine:</p> <ol style="list-style-type: none"> <li>1) Was the goal met?</li> <li>2) Should we continue track this measurement?</li> <li>3) Identify issues/</li> </ol>

		<p><b>Denominator:</b> Number of HIV-infected patients who:</p> <ul style="list-style-type: none"> <li>• were &gt;18 years old in the measurement year or had a history of sexual activity &lt; 18 years, and</li> <li>• had a medical visit with a provider with prescribing privileges at least once in the measurement year.</li> </ul>			challenges and implement needed improvements.
Percent of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Change in the number of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	<p><b>Numerator:</b> Number of patients who had an oral exam by a dentist during the measurement year, based on patient self-report or other documentation.</p> <p><b>Denominator:</b> Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and Response Team are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of patients, over the age of 24months, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year	Change in the number of patients successfully retained in care as measured by being adherent to treatment and achieving durable viral suppression.	<p><b>Numerator:</b> Number of patients with a viral load less than 200 copies/mL [2] at last viral load test during The measurement year.</p> <p><b>Denominator:</b> Number of patients, over the age of 24months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and Response Team are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM	Change in the number of	<b>Numerator:</b>	Providers to supply	The Data Sub-	Provide data to the

patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	MCM patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	Number of MCM patients with a viral load test performed at least every 6 months that is documented in the MCM record.  <b>Denominator:</b> Number of MCM patients, regardless of age, with a diagnosis of HIV/AIDS and had at least one MCM encounter in the measurement year.	aggregate performance data on the selected measures at the NQC Glasscubes.	committee and Response Team are responsible for reviewing data and presenting to the stakeholders.	Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM patients, aged 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	Change in the number of MCM patients, age 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	<b>Numerator:</b> Number of MCM patients with a viral load below limits of quantification at last test during the measurement year that is documented in the MCM record.  <b>Denominator:</b> Number of MCM patients who: • were age 13 years and older with a diagnosis of HIV/AIDS; and • had at least one MCM encounter in the measurement year; and • were prescribed antiretroviral therapy for at least 6 months; and • had a viral load test during the measurement year.	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Change in the number of MCM patients with HIV infection who received an oral exam by a dentist at least once during the	<b>Numerator:</b> Number of MCM patients who had an oral exam by a dentist during the measurement year, based	Providers to supply aggregate performance data on the selected measures at the NQC	The Data Subcommittee and NQC are responsible for reviewing data and	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue

	measurement year.	on client self-report or other documentation that is documented in the MCM record.  <b>Denominator:</b> Number of MCM patients with HIV infection who had at least one MCM encounter in the measurement year.	Glasscubes.	presenting to the stakeholders.	track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	Change in the number of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	<b>Numerator:</b> Number of MCM patients who had a visit with a provider with prescribing privileges two or more times at least three months apart in the measurement year that is documented in the MCM record.  <b>Denominator:</b> Number of HIV-infected MCM patients who had at least one MCM encounter in the measurement year.	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	Change in the number of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	<b>Numerator:</b> Number of HIV-infected infants or children who were prescribed PCP prophylaxis during the measurement year  <b>Denominator:</b> Number of: • HIV-infected infants or children > 6 weeks of age who meet the following age specific eligibility criteria: • <12 months = All HIV-infected infants regardless of CD4 count	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.

		<ul style="list-style-type: none"> <li>• 1-5 yrs = CD4&lt;500 cells/mm<sup>3</sup> or CD4%&lt;15%</li> <li>• &gt;6 yrs = CD4&lt;200 cells/mm<sup>3</sup> or CD4%&lt;15%</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• had a medical visit with with a provider with prescribing privileges.</li> </ul>			
Percent of ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	Change in the number of ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	<p><b>Numerator:</b> Number of HIV-infected patients who have been approved or denied for ADAP services within two weeks of ADAP receiving a complete application.</p> <p><b>Denominator:</b> Number of HIV-infected patients who have newly applied for ADAP assistance.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: <ol style="list-style-type: none"> <li>1) Was the goal met?</li> <li>2) Should we continue track this measurement?</li> <li>3) Identify issues/ challenges and implement needed improvements.</li> </ol>
Percent of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.	Change in the number of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.	<p><b>Numerator:</b> Number of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.</p> <p><b>Denominator:</b> Number of patients enrolled in ADAP in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: <ol style="list-style-type: none"> <li>1) Was the goal met?</li> <li>2) Should we continue track this measurement?</li> <li>3) Identify issues/ challenges and implement needed improvements.</li> </ol>

**IN+CARE RETENTION PROJECT MEASURE**

Measurement Outcome	Indicator to be Measured	Data Elements used to Measure Indicator	Data Source & Methods	Analyzing & Reviewing Data	Data Usage
<p>Percentage of patients over the age of 24 months, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year</p>	<p>Change in the number of patients with a suppressed viral load</p>	<p><b>Numerator:</b> Number of patients with a viral load less than 200 copies/mL at last viral load test during the measurement year.</p> <p><b>Denominator:</b> Number of patients, over the age of 24months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year</p>	<p>Providers to supply aggregate performance data on the selected measures at the NQC Glasscubes.</p>	<p>The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.</p>	<p>Provide data to the Response Team and stakeholders to determine:</p> <ol style="list-style-type: none"> <li>1) Was the goal met?</li> <li>2) Should we continue track this measurement?</li> <li>3) Identify issues/ challenges and implement needed improvements.</li> </ol>