Quality Management Plan

West Palm Beach Eligible Metropolitan Area

2015-2018

QUALITY MANAGEMENT PLAN
West Palm Beach EMA

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Quality Management Committee Members

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West Palm Beach Ryan White
Quality Management Plan

BACKGROUND AND HISTORY

The Ryan White HIV/AIDS Treatment Extension Act is Federal legislation that addresses the unmet health needs of People Living with HIV/AIDS (PLWHA). The United States Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 and reauthorized and amended it in 1996, 2000, and 2009. Congress enacted the Ryan White Treatment and Modernization Act (RWTMA) in 2006, which became known as the Ryan White HIV/AIDS Treatment Extension Act in 2009. The RWTEA provides funding to cities, states, and other public and private entities to provide care and support services to individuals with HIV and AIDS who have low incomes and little or no insurance.

The goal of the RWTEA is to improve the quality and availability of care for individuals and families infected and affected by HIV disease by providing emergency assistance to regions most severely affected by the HIV epidemic. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services is the federal granting agency for the RWTEA. HRSA directs all RWTEA programs to establish a Quality Management Program "to assess the extent to which HIV health services are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections, and to develop strategies for ensuring that such services are consistent with the guidelines for improving access to and quality of HIV services."

The Ryan White Part A Grantee Office (Part A Grantee Office) and Florida Health Palm Beach County (Part B Lead Agency) for the West Palm Beach Eligible Metropolitan Area (EMA) has designed a Quality Management Program (QM Program) to meet those criteria, and to establish a systematic approach to quality assessment and performance improvement.

QUALITY STATEMENT

The purpose of this plan is to establish a systematic approach to quality assessment and performance improvement. In addition, this plan meets the criteria established by the U.S. Health Resources and Services Administration (HRSA) for measuring and influencing quality of care and patient care improvement.

The mission of the Quality Management Program is to:

- Assure equitable access to high-quality care;
- Improve clinical outcomes;

- Maximize collaboration of stakeholders and coordination of services;
- Ensure high quality customer service; and
- Ensure compliance with HRSA mandates.

The QM Program serves to assure that RWTEA -funded medical providers ensure that services adhere to established HIV treatment guidelines; ensure that strategies for improving medical care include health-related supportive services that enhance access to care and adherence to HIV medical regimen; and ensure that available demographic, clinical, and health care utilization information is used to monitor HIV-related illnesses and trends in the local epidemic. The key components of the QM Program are:

- Performance and Outcome Measurement
- Data Analysis and Presentation
- Identification of CQI strategies
- Implementation of CQI initiatives
- Monitoring adherence to the standards of care and performance indicators of the services offered by the agency
- Coordinating data collection for the agency's review by outside organizations
- Identifying processes and procedures for improvement.

Furthermore, in support of the U.S. Department of Health and Human Services, HRSA's Mission, "to improve the Nation's Health by assuring equitable access to comprehensive quality health care", the QM Program incorporates HRSA's five (5) long-range strategies (Appendix B):

- Reduce barriers to care
- Reduce health disparities
- Improve quality of care
- Strengthen public health and health care access
- Improve the emergency preparedness of the health care system

QUALITY INFRASTRUCTURE

The West Palm Beach EMA is given the authority, responsibility, and resources to establish a system-wide QM Program that covers all structures in the system of care including the Planning Council, Part A Grantee Office, the Part A Funded Agencies, Part B Funded Agencies, the Part B Lead Agency, and the consumers of HIV services in the area. The following provides a description of the structures that make up the care system and who will participate in the Quality Management process. (Appendix A, Appendix B)

Ryan White Part A Grantee Office Responsibilities:
The Palm Beach County Board of County Commissioners designates responsibility for management of the grant to the Palm Beach County Department of Community Services (Part A Grantee Office) to ensure that funds are allocated and contracted according to the priorities set by the Planning Council. The Part A Grantee Office must purchase the services according to the local procurement system, ensure that funds awarded are used appropriately, and comply with reporting and other grantee requirements. The Part A Grantee Office also oversees and facilitates the quality management activities throughout all levels of the system. All Part A Grantee Office staff will participate in quality management activities at some level however the position primarily responsible for the quality activities outlined in this plan is the Quality Management Coordinator. Other responsibilities of the QM Coordinator include:

- Implementation of the Quality Management Program
- Assess the quality management activities within the West Palm Beach EMA, oversee activities conducted
- Facilitate the development and implementation of continuous quality improvement (CQI) mechanisms and measures for funded agencies.
- Ensure that technical assistance and training is provided to facilitate ongoing improvement of services.
- Provide updates to the Part A Grantee Office and Planning Council on QM activities within the EMA.
- Report cumulative service outcome results to the Quality Management Committee.

Ryan White Part B Lead Agency Responsibilities:
Florida Health Palm Beach County (Lead Agency) is designated responsible for management of the Part B funds to ensure that funds are allocated and contracted according to the needs of the clients. The Part B Lead Agency elects to use a bid process to secure providers, ensures that funds awarded are used appropriately and comply with reporting and other grantee requirements. The Part B Lead Agency also oversees and facilitates the quality management activities throughout the system for the Part B services. All Part B Lead Agency program staff will participate in quality management activities at some level however the position primarily responsible for the quality management activities outlined in this plan is the Quality Assurance Coordinator. Other responsibilities of the QA Coordinator include:

- Implementation of the Quality Management Program
- Assess the quality management activities within the West Palm Beach EMA, oversee activities conducted
- Facilitate the development and implementation of continuous quality improvement (CQI) mechanisms and measures for funded agencies.
- Ensure that technical assistance and training is provided to facilitate ongoing improvement of services.
- Provide updates to the QM Committee and Care Council on QM activities within the EMA.

- Report cumulative service outcome results to the Quality Management Committee.

Palm Beach County HIV CARE Council:
The Palm Beach County HIV Services Planning Council was created through an ordinance of the Board of County Commissioners in November 1993. In August of 1997, the Planning Council and the Palm Beach County AIDS Consortium officially merged and became the Palm Beach County HIV Comprehensive AIDS Resources Emergency (CARE) Council. This Planning body is assigned with assessing the area's HIV service needs, establishing priorities, allocating funds, developing a comprehensive plan for the delivery of services, and assessing the efficiency of the Part A Grantee Office and the Part B Lead Agency in rapidly allocating funds to areas of greatest need. The Planning Council body is comprised of a maximum of 33 members who represent legislatively mandated membership categories. In addition, the Planning Council's membership includes members of AIDS Service Organizations, Medicaid, HOPWA, VA, and PLWHA. Participation of the Planning Council in quality activities will take place through committee structures and processes. Other responsibilities of the Planning Council include:

- Review and utilize service outcome and quality assurance data of services in the prioritization and allocation of the Ryan White HIV/AIDS Treatment Extension Act Part A Grant Award for the West Palm Beach EMA.
- Review and utilize service outcome and quality assurance data of services in the advisement of the Ryan White Treatment and Modernization Act Part B Grant Award for the West Palm Beach EMA.
- The Planning Council will be educated on the quality assurance activities for the EMA. The Planning Council will review and comment on the QM Plan.
- The Planning Council will be updated on QM activities via the Grantee and Committee reports during monthly meetings.

The Ryan White HIV/AIDS Treatment Extension Act Part A Funded Agencies Responsibilities:
The current Ryan White-funded Continuum of Care includes community based health and social service organizations that provide all of the services through contracts with the Part A Grantee Office. The Part A Agencies collaborate with one another through the monthly Provider Meetings.

- All Part A funded agencies will participate in system-wide quality management activities and be responsible for developing quality management activities of their own.
- Service (process) indicators and health outcomes will be tracked, documented and reported to the Part A Grantee Office through the database system by all funded agencies.
- Part A funded agencies will participate in the annual, standardized, EMA-wide Client Satisfaction Survey.

The Ryan White HIV/AIDS Treatment Extension Act Part B Funded Agencies Responsibilities:

The Part B funded agencies also collaborate with one another through the monthly Provider Meetings and hold the same responsibilities as Part A funded agencies as listed below.

- All Part B funded agencies will participate in system-wide quality management activities and be responsible for developing quality management activities of their own.
- Service (process) indicators and health outcomes will be tracked, documented and reported to the Part B Lead Agency through the CAREWare Data System by all Part B funded agencies.
- Part B funded agencies will participate in the annual, standardized, EMA-wide Client Satisfaction Survey.

Consumer Responsibilities:

Consumers of HIV services in the West Palm Beach EMA participate in the planning process through Planning Council membership. They are also encouraged to participate through various client feedback mechanisms in place both system-wide and with individual funded agencies. Consumers will be appointed to serve on the Quality Management Committee.

- Attend QM training as offered by the Part A Grantee Office, the Part B Lead Agency, or their consultants
- Be involved through the Quality Management Committee in providing input for the Standards of Care, developing Quality Service Indicators, and updating the Quality Management Plan.

Quality Management Committee Responsibilities:

The Quality Management Committee shall meet bi-monthly, or as needed, to fulfill committee responsibilities. It is the primary body to help determine measurement priorities and methods on an ongoing basis. Additionally, the Quality Management Committee will facilitate cross -Part coordination by collaborating with consumers, representatives from Part A&B, and the AIDS Education Training Center (AETC). The Quality Management Committee is also responsible for:

- Providing input and direction on the West Palm Beach EMA Quality Management Program.
- Reviewing and updating the Quality Management Plan annually.
- The Committee will develop Standards of Care and outcome measures utilizing Planning Council Committees, in cooperation with the grantee.
- Make recommendations to the Part A Grantee Office and the Part B Lead Agency for appropriate education relating to quality improvement concepts and techniques.
- The QM/QA Coordinators will report cumulative service outcome results to the Quality Management Committee, which will be presented to the Planning Council.

ENGAGEMENT OF STAKEHOLDERS

Stakeholder Engagement in Quality Management

External stakeholders were selected based on their commitment to improving and ensuring access to quality care for all patients living with HIV/AIDS in the West Palm Beach EMA and on their willingness to participate in ongoing quality improvement initiatives. Stakeholders were strategically selected based on their ability to assist the Ryan White grantee in fulfilling the core and supportive service categories outlined by the Human Resource and Services Administration (HRSA). Internal and external stakeholders are outlined in the table below. The QM Committee will provide feedback through quality needs assessment surveys and other methods appropriate to the specific QM project.

Quality management training for QM staff and stakeholders will be conducted via face-to-face trainings and online self-directed learning. The National Quality Center's (NQC) quality academy will be used as the model for online training. The NQC quality academy can be accessed on the Web via: http://nationalqualitycenter.org/home.cfm.
All staff and stakeholders will be directed to the NQC website for additional online training and links to other quality improvement articles and resources.

Stakeholders

Internal	External
Palm Beach County Board of County Commissioners- Department of Community Services Director of Community Services **Ryan White Part A Program Staff** Program Manager Quality Management Coordinator Health Planner II Grant Compliance Specialist I Computer Specialist II Financial Analyst I	**Training, Education & Capacity Building** Florida/Caribbean AIDS Education and Training Center (FL AETC) **Service Providers** AIDS Healthcare Foundation Compass, Inc. Florida Department of Health Palm Beach County FoundCare, Inc. Health Council of Southeast Florida Legal Aid Society of Palm Beach County, Inc. Palm Beach County Health Care District

Stakeholder Participation

Stakeholder	Involvement in QM Program	QM Program Communication Methods
Consumers	• Participate in quality improvement initiatives as necessary • Participate in client satisfaction surveys • Make suggestions/ recommendations for quality improvement initiatives to the QM program. • Review QM reports • Make suggestions/recommendations to providers on quality improvement needs	• QM reports to Planning Council committees • Participation on QM Committee
External Contractors	• Provide care to consumers that are consistent with public health service guidelines • Ensure that quality management components of their contract are met • Assist the grantee in meeting the medical and supportive service needs of PLWHA • Adhere to standards of care specific to their program service area(s) • Develop a quality management plan for their agency • Provide grantee with requested performance data in respective service category • Participate in continuous quality improvement	• Grantee provider meetings and Planning Council meetings • Technical assistance and education via NQC tutorials and quality improvement workshops • QM performance reports
Quality Management Committee	• Provide input on quality goals and improvement priorities • Review written QM reports • Participate in discussions about performance results • Participate in quality improvement projects as needed • Define, review, and update the standards of care for medical and supportive service categories	• Committee meetings • Reports to the Planning Council • Written and verbal reports
Data manager	• Provide technical support and data on service utilization. • Completes/submits RSR required HRSA data reports	• Electronic mail • Written and verbal reports • Written data requests

QUALITY GOALS

The West Palm Beach EMA is committed to developing and implementing its Quality Management Program in collaboration with consumers, Ryan White Part A Funded Agencies (Part A Funded Agencies), Palm Beach County HIV CARE Council (Planning Council), Ryan White Part B Funded Agencies (Part B Funded Agencies), Part A Grantee Office and the Lead Agency.

The goals of the Quality Management Program are to:

- Provide a common framework, language, and approach for quality improvement initiatives for providers across the EMA.
- Increase accountability and promote informed decision-making particularly in relation to how to use resources to achieve the best outcomes.
- Support and enable the Planning Council's goal to provide a Continuum of Care.
- Build capacity among the Part A Grantee Office, Part B Lead Agency, Planning Council, and Quality Management Committee to coordinate Quality Management (QM) efforts.
- Provide a way of linking population health indicators and outcomes with health systems performance indicators.

The goals of the West Palm Beach EMA Quality Management Program for 2015-2018 are as follows:

GOAL 1: To ensure all Part A funded services are of the highest quality.		
OBJECTIVE 1: To develop and implement a three-year Quality Management Plan for the West Palm Beach EMA.		
Key Action Step	**Time Frame**	**Accountability**
1. Review and revise the QM Plan to meet HRSA guidelines and to incorporate the needs/goals of sustaining quality of care.	Annually	• Quality Management Committee, QM Coordinator
2. Integrate data collection and reporting systems, and ensure that the Data Management system supports Quality Management.	Ongoing	• Grantee Office staff, QM Coordinator
OBJECTIVE 2: To ensure Ryan White funded service providers conform to measurable standards of care and the HIV/AIDS Case Management Operating Guidelines.		

Key Action Step	Time Frame	Accountability
1. Review, revise, and develop Standards of Care as needed.	Continuous	• Planning Council Medical and Support Committees, Quality Management Committee, QM Coordinator
2. Monitor compliance with Standards of Care and quality indicators.	Annually	• QM Coordinator
3. Report cumulative compliance and quality indicators by service category to the Quality Management Committee and Planning Council.	Annually	• QM Coordinator
4. Provide technical assistance to funded agencies.	Ongoing	• QM Coordinator
OBJECTIVE 3: To improve consumer satisfaction.		
Key Action Step	**Time Frame**	**Accountability**
1. Distribute Consumer Satisfaction Survey.	Annually	• QM Coordinator
2. Analyze and report findings to the Quality Management Committee, Planning Council, and funded agencies.	Annually	• QM Coordinator
3. Develop strategies to improve consumer satisfaction.	Annually	• Planning Council, Grantee Office staff, Lead Agency staff

GOAL 2: Raise and standardize the quality of care/service delivery to improve health outcomes.		
OBJECTIVE 1: To improve client health outcomes.		
Key Action Step	**Time Frame**	**Accountability**
1. Monitor each primary medical care clinic for adherence to the recommended screenings, assessments, exams, referrals, and education guidelines in the HHS Guidelines/Standards of Care.	Annually	• QM Coordinator, Grant Compliance Specialists

2. Identify and select measurable health outcomes and process indicators.	Ongoing	• Planning Council Medical and Support Committees, Quality Management Committee
3. Collect client health outcome and process data.	Annually	• QM Coordinator
4. Analyze health outcome and process data.	Annually	• QM Coordinator
5. Report cumulative service category findings to Quality Management Committee and Planning Council.	Annually	• QM Coordinator
6. Report agency specific findings to each agency.	Annually	• QM Coordinator
7. Develop strategies to improve health outcomes and process.	Ongoing	• Planning Council, Grantee Office staff

OBJECTIVE 2: To develop a data management process that meets HRSA requirements and supports data driven priority setting and resource allocation for the EMA		
Key Action Step	**Time Frame**	**Accountability**
1. Analyze submitted data collected and make recommendations for improvement of services to funded agencies.	Ongoing	• Grantee Office staff and Lead Agency staff
2. To track and report on service utilization. a. Medical records/chart reviews b. Monthly reports c. Database data	Quarterly	• QM Coordinator, Program Monitors, Grantee Office staff, Part A funded agencies Part B funded agencies and Lead Agency staff

OBJECTIVE 3: To ensure a Continuity of Care among the Ryan White funded agencies		
Key Action Step	**Timeline**	**Accountability**
1. Training will occur across all service providers.	Ongoing	• QM Coordinator

2. Review and standardize service delivery standards and requirements.	Ongoing	• QM Coordinator, Planning Council Medical and Support Committees, Quality Management Committee

PERFORMANCE MEASUREMENT & EVALUATION

Ryan White Part A Contractual Monitoring

The Part A Grantee Office executes and manages all Part A contracts with funded agencies, conducts program and fiscal monitoring of service contracts, maintains a service utilization database, and participates in evaluation studies conducted by the Planning Council. The Part A Grantee Office: a) requires (contractually) of all service providers the monthly submission of programmatic and financial data reports ; b) conducts annual program and fiscal monitoring visits on all funded agencies; and c) reports information to the Planning Council through its various Committee and Council processes. The Part A Grantee Office will perform Contractual Monitoring which consist of an evaluation of general organizational policies and procedures, quality management efforts, financial policies and procedures/financial expenditures, and other contractual requirements including the scope of services plan for purposes of accountability requirements. The monitoring visit team will also conduct a review of randomly selected set of charts of HIV/AIDS clients for evidence of documentation only of specific data.Cumulative findings will be reported to the Quality Management Committee annually.

Ryan White Part B Contractual Monitoring

For those agencies receiving Part B funding, the Part B Lead Agency executes and manages the contracts, conducts program and fiscal monitoring of service contracts, maintains a service utilization database, and participates in evaluation studies conducted by the Planning Council. The Part B Lead Agency: a) requires (contractually) of all service providers the monthly submission of programmatic and financial data reports ; b) conducts annual program and fiscal monitoring visits on all funded agencies; and c) reports information to the Planning Council through its various Committee and Council processes. The Part B Lead Agency will perform Contractual Monitoring which consist of an evaluation of general organizational policies and procedures, quality management efforts, financial policies and procedures/financial expenditures, and other contractual requirements including the scope of services plan for purposes of accountability requirements. The monitoring visit team will also conduct a review of randomly selected set of charts of HIV/AIDS clients for evidence of documentation only of specific data. Cumulative findings will be reported to the Quality Management Committee annually.

Ryan White Part A Performance Indicators and Outcomes

The Part A Grantee Office and the Planning Council will continue client-and system-level outcome tracking throughout the EMA. The EMA requires all Part A funded agencies enter client information into the local Data Management system; including viral load and CD4 counts, among other important biological and clinical indicators. These data can then be extracted to allow data base queries by client, provider, and service category.

Outcomes have been and will be developed to measure the impact for each of the service categories as part of the Standards of Care (SOC). The HAB Performance Measures will be used to measure medical, dental, and medical case management (MCM) outcomes. These include:

- **CD4 T-cell count**- percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year
- **HAART**- percentage of clients with AIDS who are prescribed HAART
- **Medical Visits**- percentage of clients with HIV infection who had 2 or more medical visits in an HIV care setting in the measurement year
- **PCP Prophylaxis**- percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm3 who were prescribed PCP prophylaxis
- **ARV Therapy for Pregnant Women**- percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy.
- **MCM Care Plan-** percentage of HIV-infected MCM clients who had a MCM care plan developed and/or updated 2 or more times in the measurement year.
- **MCM Medical Visits-** percentage of HIV-infected MCM clients who had 2 or more medical visits in an HIV care setting in the measurement year.
- **Dental and Medical History-** percentage of HIV-infected oral health patients who had a dental and medical health history (initial or update) at least once in the measuremetn year.
- **Dental Treatment Plan-** percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measuremetn year.
- **Oral Health Education-** percentage of HIV-infected oral health patients who received oral health education at least once in the measuremetn year.
- **Periodontal Screening or Examination-** percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measuremetn year.

In addition to the above HAB measures, our local EMA will be focusing on the newly released Common Indicators for HHS-funded HIV Programs and Services.

These include:

- **HIV Positive-** number of HIV positive tests in the 12-month measurement period
- **Late HIV Diagnosis-** number of persons with a diagnosis of Statge 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12-month measurement period

- **Linkage to HIV Medical Care-** number of persons who attend a routine HIV meical care visit within 3 months of HIV diagnosis
- **Retention in HIV Medical Care-** number of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequesnt 6 month period
- **Antiretroviral Therapy (ART) Among Persons in HIV Medical Care-** number of persons with an HIV diagnosis who are prescribed ART in the 12-month measurement period
- **Viral Load Suppression Among Persons in HIV Medical Care-** number of persons with an HIV diagnosis with a viral load <200 compies/mL at last test in the 12-month measurement period
- **Housing Status-** number of persons with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period

These measures will also be reflected through the HIV Care Continuum Treatment Cascade and the Ryan White Part A Implementation Plan (Appendix E).

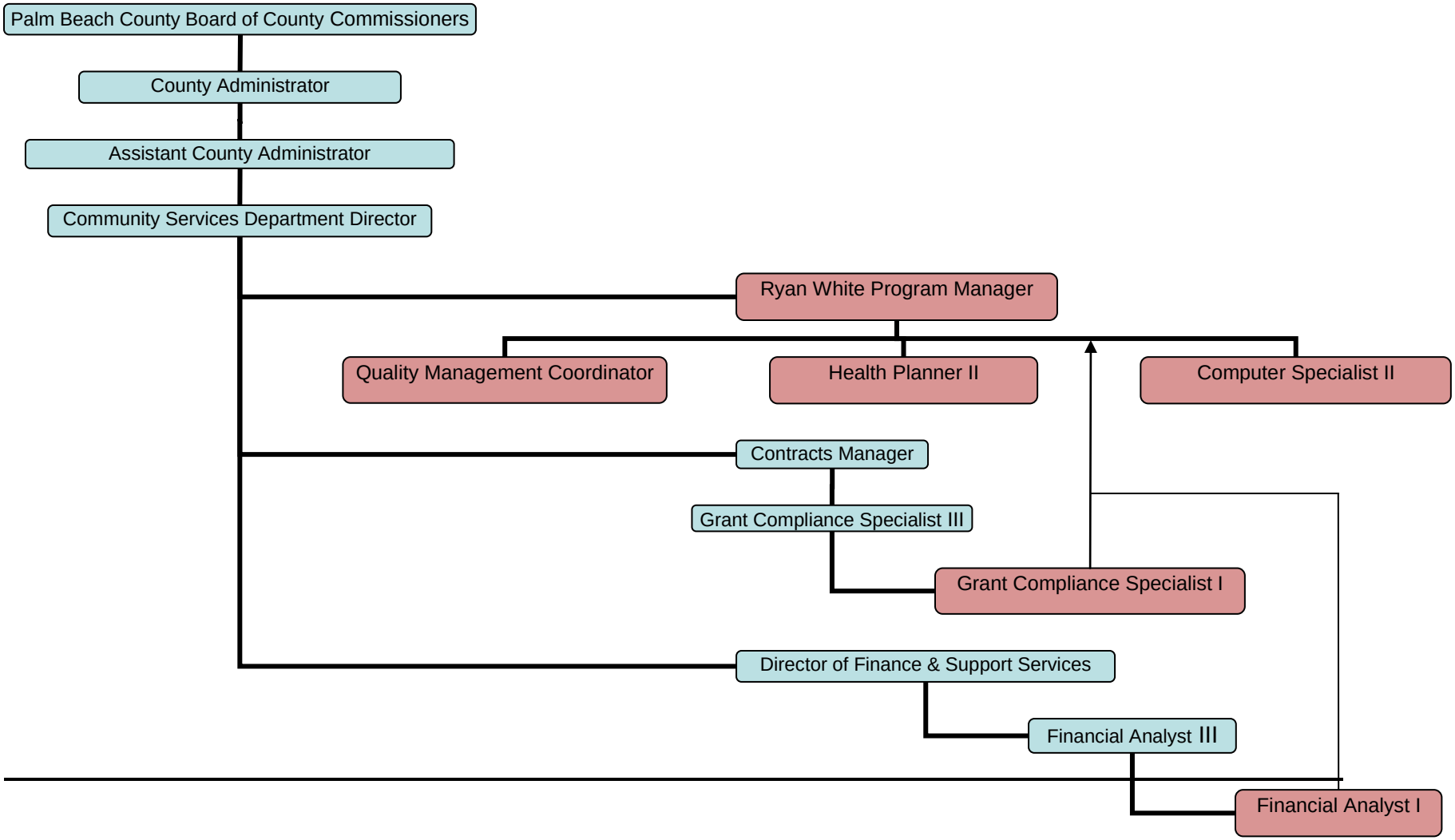
Ryan White Part B Performance Indicators and Outcomes

The Part B Lead Agency will continue client-and system-level outcome tracking throughout the EMA. The EMA has implemented the CAREWare Data System and requires all Part B -funded agencies to enter information such as viral load and CD4 counts, among other important biological and clinical indicators. These data can then be extracted to allow data base queries by client, provider, and service category.

Outcomes have been and will be developed to measure the impact for each of the service categories as part of the Standards of Care (SOC). The HAB Performance Measures will be used to measure the following:

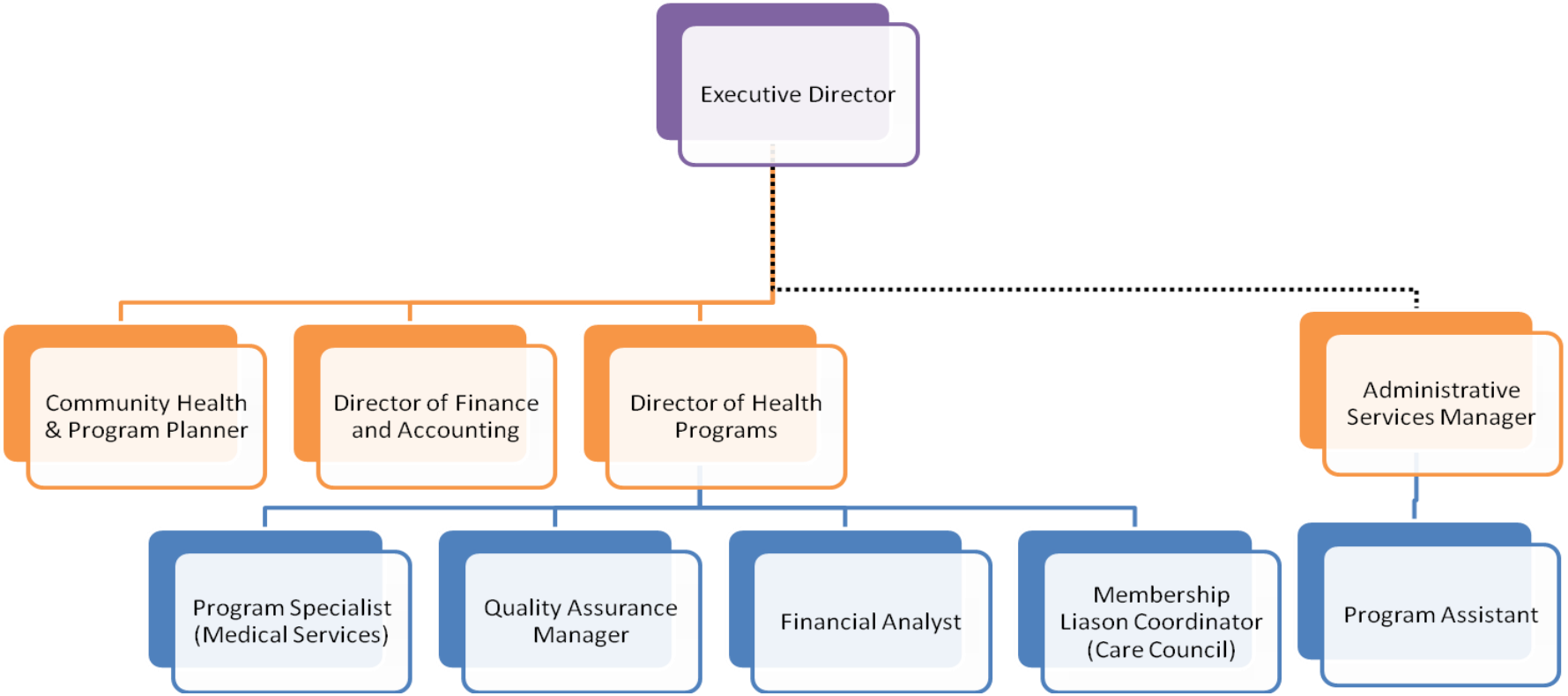
- **CD4 T-cell count**- percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year
- **MCM Medical Visits-** percentage of HIV-infected MCM clients who had 2 or more medical visits in an HIV care setting in the measurement year.
- **Substance Abuse Screening**- percentage of new clients with HIV who have been screened for substance use (alcohol and drugs) in the measurement year.

APPENDIX A: **West Palm Beach EMA Grantee Organizational Chart**



APPENDIX B:

West Palm Beach EMA Part B Lead Agency
Organizational Chart
Health Council of Southeast Florida



APPENDIX C: Data Collection Plan

Major Function	Part A or B (or Both)	Important Aspect of Care	Opportunity Identified	Timeline
Case Management	Both	Case Management Standards	New guidelines warrant tracking of progress towards implementing	Annual monitoring
	Both	Eligibility Guidelines	New guidelines warrant tracking of progress towards implementing	Annual monitoring
	Both	Payer of Last Resort	Ensure Database documentation reflects referrals to PAC Waiver when appropriate	Data collected quarterly
	Part B	Total # of clients seen per month by provider agency	Monitor Database for client totals	Data collected quarterly
Continuity of Care	Both	Patient/Client Retention	Monitor Database for clients who do not have a documented medical appointment within 6 months. (Performance Measures) Monitor Database for clients who do not have t-cells and/or viral loads in the past 6 month. (Performance Measures) Monitor Database that clients receive treatment adherence every 6 months. Monitor Database for the number of missed or late redeterminations.	Data collected biannually Data collected biannually Quarterly Quarterly
Information Systems	Both	HRSA Mandates	Monitor Database to ensure that Client Level Data is being recorded	Data collected ongoing
Patient Satisfaction	Both	Patient/Client Retention	Analyze customer satisfaction surveys	Annually
Residential Substance Abuse Treatment	B	Patient Retention	Monitor client records to determine percentage of clients who completed treatment	Data collected biannually

APPENDIX D:

DEFINITIONS

For the purposes of this QM Plan, the following definitions are used:

DATABASE-A management information system that helps grantees and service provides collect, manage and report client-level data. Downloadable software, a user manual, instructions and technical support are available.

BEST PRACTICES (also called Benchmarks) - Best practices are proven solutions to common problems. They provide performance data that are used for comparisons.

CLIENT SATISFACTION-The assessment of consumer/client satisfaction with services provided using periodic written surveys, oral interviews or other methods.

CONTINUOUS QUALITY IMPROVEMENT (CQI) -A never-ending series of changes and measurements designed to keep quality improving and programs adapting to meet changing needs.

DATA COLLECTION AND ANALYSIS - A process to measure health status, utilization of services (e.g., number of clients served, demographics, units of service provided, outcomes, etc.)

FOCUS-PDSA (Plan, Do, Study, Act) CYCLE- "F" or "find" a process to improve. "O" or "organize" a team that knows the process. "C" or "clarify" current knowledge of the process. "U" or "understand" causes of process variation. "S" or "select" the process improvement. - "P" or "plan" involves identifying an area of need or an opportunity for improvement and determining the root causes of the problem. "D" or "do" requires coming up with strategies to prevent the problem or improve the way things are done. "S" or "study" involves collecting data to evaluate the effectiveness of the strategies tested. "A" or "act" is about making these strategies part of the ongoing work. If strategies don't work, you go back to the "plan" stage, and try again."

HEALTH DISPARITIES -Distinct differences in kind and quality of healthcare among members of various groups defined by race/ethnicity, gender, sexual orientation, socio-economic status, and age.

HIV/AIDS QUALITY ASSURANCE-Measuring performance to prove it meets standard or benchmark.

HRSA STRATEGIES -HRSA's strategic plan describes four long-range strategies that support the Agency's goal of "100% Access and 0 Health Disparities." (HRSA Strategic Plan)

> *Strategy 1: Eliminate Barriers to Care* to assure access to comprehensive, timely, culturally competent, and appropriate health care services for all underserved, vulnerable, and special needs populations. HRSA increases the use of health care services by underserved populations, increases access points, and focuses on target populations.
>
> *Strategy 2: Eliminate Health Disparities* in health status and health outcomes for underserved, vulnerable, and special needs populations. HRSA reduces the incidence/prevalence of disease and morbidity/mortality, increases the use of services by underserved populations, and focuses on target populations.
>
> *Strategy 3: Assure Quality of Care* is provided to the underserved by fostering a diverse, high quality workforce and using emerging technologies. HRSA accomplishes this by promoting appropriateness of care, assuring effectiveness of care, and improving customer and patient satisfaction.
>
> *Strategy 4: Improve Public Health and Health Care Systems* to improve the delivery of health-related systems by enhancing the infrastructure of public health and health care systems. HRSA improves information development and dissemination, promotes education and training of the public health and health care workforce, and promotes systems and infrastructure development.

OUTCOMES -Results for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or status.

OUTCOME INDICATORS - Specific items of information that track a program's success (or failure) on outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.

QUALITY - The degree to which a health or social support service meets or exceeds established standards of care and user expectations.

STANDARDS OF CARE- Standards of Care are principles and practices for the delivery of health and social services that are accepted by recognized authorities and used widely. Standards of care are based on specific research (when available) and the collective opinion of experts.

APPENDIX E:

Ryan White Part A Implementation Plan: HIV Care Continuum Table FY 2015-16

* HHS Measures can be found at http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf* HAB Core performance measures can be found at: http://hab.hrsa.gov/deliverhivaidscare/coremeasures.pdf

Stages of the HIV Care Continuum	Goal	Outcome		Service Category (One or more may apply)
I. Diagnosed	Increase in the percentage of clients who are aware of their HIV Status	HIV Positivity* Late HIV Diagnosis*		EIS
		Baseline: Numerator/Dominator, % 8.4/10 84%	Target: Numerator/Dominator, % 9.5/10 95%	
II. Linked to Care	Increase in the percentage of clients linked to care	Linkage to HIV Medical Care*		OAMC, HIPC, NMCM, EIS
		Baseline: Numerator/Dominator, % 8.1/10 81%	Target: Numerator/Dominator, % 8.5/10 85%	
III. Retained in Care	Increase in the percentage of clients retained in care	Retention in HIV Medical Care* HIV Medical Visit Frequency**		OAMC, LPAP, Mental Health, MCM, Oral Health, Home Health, Medical Nutrition Therapy, Substance Abuse Treatment, Food Bank, EFA, Medical Transportation, Legal Services, NMCM
		Baseline: Numerator/Dominator, % 4.8/10 48%	Target: Numerator/Dominator, % 5.5/10 55%	
IV. Prescribed ART	Increase in the percentage of clients with access to prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care* Prescription of HIV Antiretroviral Therapy **		OAMC, LPAP, HIPC, MCM, EIS
		Baseline: Numerator/Dominator, % 4.3/10 43%	Target: Numerator/Dominator, % 5/10 50%	
V. Virally Suppressed	Increase in the percentage of clients with a viral load of <200	Viral Load Suppression Among Persons in HIV Medical Care* HIV Viral Load Suppression**		OAMC, LPAP, HIPC, Mental Health, MCM, Oral Health, Home Health, Medical Nutrition Therapy, Substance Abuse Treatment, Food Bank, EFA, Medical Transportation, Legal Services, NMCM
		Baseline: Numerator/Dominator, % 3.4/10 34%	Target: Numerator/Dominator, % 4.5/10 45%	