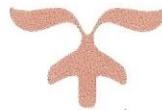


COMPREHENSIVE VIRGINIA RYAN WHITE PART B QUALITY MANAGEMENT PLAN

Grant Year Period: April 2017 – March 2018



VDH VIRGINIA
DEPARTMENT
OF HEALTH
DIVISION OF DISEASE PREVENTION
HIV CARE SERVICES UNIT

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I. INTRODUCTION

Ryan White Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) Program Legislation requires the implementation of Clinical Quality Management Programs as a condition of the Notice of Award. The Virginia Department of Health (VDH) is committed to improving the quality of care and services for people living with HIV (PLWH) through continuous monitoring and through a comprehensive performance measurement program. This effort requires ongoing communication with stakeholders including: PLWH, Quality Management Advisory Committee (QMAC), Quality Management Leadership Team (QMLT), recipients, and sub-recipients. The Quality Management expectations for Ryan White HIV/AIDS (RWHAP) Part B recipients include:

- Assisting funded sub-recipients in assuring that grant supported services adhere to established Department of Health and Human Services Clinical Guidelines to the greatest extent possible;
- Ensuring that strategies for improvements to quality medical care includes the appropriate access and retention to HIV care and support for treatment adherence; and
- Ensuring that available data are used to monitor the health outcomes along the HIV continuum of care.

VDH Quality Management Plan frames the direction of HIV Care Services (HCS) continuous quality improvement activities. Quality efforts are supported through trainings, technical assistance, resources sharing, cross-collaboration among Division of Disease Prevention (DDP) units and multiple external partners. The four units of the DDP include: Sexually Transmitted Disease Surveillance, Operations and Data Administration; HCS; HIV Surveillance; and HIV Prevention and Hepatitis Infection.

The Virginia AIDS Drug Assistance Program (ADAP) selected performance measures provides an indication of how ADAP Program performs in relation to a specified process or outcome. VDH uses ADAP performance measures that are data-driven and quantifiable to increase the likelihood that a certain standard of quality will be achieved. Also, ADAP is involved in the HCS internal quality improvement systematic process that identifies performance measures, vets them, includes staff input, tracks them for success and makes necessary changes along the way.

ADAP provides access to life-saving medications for the treatment of HIV and related illnesses for low-income clients through the provision of medications or through assistance with insurance premiums and medication copayments. The ADAP Program is primarily supported with federal RWHAP Part B grant funding, which is distributed to all 50 states, the District of Columbia, Puerto Rico, Guam, and the United States Virgin Islands, and the six U.S. Pacific Territories/Associated Jurisdictions by a formula based on living HIV and AIDS cases. Virginia ADAP

also receives support from state general funds; other funding sources include Medicaid reimbursements for clients who receive retroactive eligibility, and voluntary rebates from pharmaceutical manufacturers.

VDH uses multiple systems to monitor and assess its Quality Management Program including the practice of quarterly QMAC meetings; review of monthly sub-recipient progress reports including update on quality improvement activities; analysis of performance data to identify areas for improvement; client interviews; review of clinical health outcomes through on-site visits, and ongoing monitoring of site-specific quality improvement projects.

This document is to be shared with all stakeholders and healthcare providers who care for PLWH in Virginia. The Quality Management Plan is available in print and on the following website: <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/>

The implementation of the content will be effective April 1, 2017. If you have any questions concerning this plan, please contact Safere Diawara, MPH, Quality Management Coordinator at (804) 864-8021 or by email at: Safere.Diawara@vdh.virginia.gov

II. QUALITY STATEMENT

A. Mission Statement:

The RWHAP Part B Quality Management Program exists to ensure the highest quality core medical care and supportive services for PLWH in Virginia, as well as to provide medication access to them through statewide leadership and stakeholder collaboration.

B. Vision:

VDH envisions optimal health and medication access for all PLWH, supported by a health care system that assures ready access to comprehensive, competent, and quality care.

C. Values:

VDH believes in creating HIV services that inspire and promote quality, parity, cost effectiveness, client centered, stakeholder input, and teamwork.

D. Goals:

The goals of the RWHAP Part B Quality Management Program are:

- To assess quality management needs and build capacity within RWHAP Part B funded agencies statewide;
- To improve existing databases and data management practices, utilize outcomes data, needs assessment and client satisfaction data to help gauge service quality and improve service delivery; and
- To help prepare consumers and providers to utilize health insurance services.

E. Purpose:

The aim of the RWHAP is to continuously improve the quality of care and services of the HIV, and to be compliant with recognized Department of Health and Humans Services Guidelines, the National Priorities, the Health Resources and Services Administration (HRSA) Monitoring and Service Standards, and research-based best practices. This will be accomplished by:

- Developing and implementing a statewide Quality Management Plan;
- Monitoring core selected performance measures across Ryan White recipients and sub-recipients;
- Providing training and technical assistance related to quality improvement; and
- Participating in national quality management collaborative projects.

III. DEFINITION OF QUALITY TERMINOLOGY

The following definitions can be found on the National Quality Center website: <http://nationalqualitycenter.org/files/hab-faq-s-on-qm-programs-updated/>

A. Quality:

Quality as defined by the HIV/AIDS Bureau (HAB) 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 ideas, information and suggestions, the quality of the service delivery process, and the quality of life outcomes.

B. 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.

C. Performance Measure:

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.

D. Quality Management:

A larger concept, encompassing continuous quality improvement 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 quality management. The Quality Management Program embraces quality assurance and quality improvement functions.

E. Quality Assurance:

A broad spectrum of evaluation activities designed to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent Department of Human and Health Services Clinical Guidelines, and adherence to state and federal laws, rules, and regulations.

F. Quality Improvement:

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

G. Plan, Do, Study, Act Cycles:

The Plan, Do, Study, Act (PDSA) cycle methodology is a model for performance improvement used for all quality improvement 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** – Complete analysis and synthesis, compare data to prediction in PLAN, and record under what conditions the results could be different. Summarize what was learned and what went wrong, and identify if changes led to improvements in the way you had hoped?
- **ACT** – Adopt the change, abandon it, or initiate the cycle again.

H. Outcomes:

Results achieved by 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:

An outcome indicator is the specific information that tracks program success or failure towards meeting standards or projected outcomes. This definition is used to describe observable, measurable characteristics or changes that represent the product of an outcome.

IV. SCOPE OF RYAN WHITE PART B PROGRAMS

The RWHAP Part B attempts to meet the complex needs of eligible PLWH as well as those high risk populations living throughout the Commonwealth. VDH provides core medical and support services for over 6,000 HIV/AIDS clients by funding sub-recipients, as well as Minority AIDS Initiatives and the Emerging Communities Initiatives. Funded agencies provide core and support services, collect client-level data, and develop Quality Management Plans and quality improvement projects relevant to their provided services.

Virginia ADAP provides insurance cost support or directly purchased medications:

- Affordable Care Act (ACA) and Other Insurance: Virginia ADAP pays premiums and medication cost shares (copayments, coinsurance, and deductibles) for plans that meet federal and state ADAP criteria. Payments for medication cost shares count toward an individual annual total maximum out-of-pocket expenditure capped at \$7,350 (or less depending on income). Additionally, ADAP supports medication cost shares for eligible clients who have other forms of private insurance meeting federal and state ADAP criteria under the Insurance Continuation Assistance Program.
- Medicare Part D Assistance Program: The Medicare Part D Assistance Program pays premiums and medication cost shares for ADAP eligible clients enrolled in Medicare Part D that is supported by state appropriated State Pharmaceutical Assistance Program (SPAP) funds.
- Direct Purchase ADAP: Medications on the ADAP formulary are purchased at discounted rates by the Central Pharmacy, and distributed through local health districts and other medication access sites to provide to the clients. Clients who are not eligible for or unable to enroll in other health marketplace insurance or Medicare Part D may receive medications through Direct Purchase ADAP.

Virginia Quality Management Program covers three principal areas including (Appendix F):

1. Infrastructure
2. Performance measures
3. Quality improvement activities

V. QUALITY MANAGEMENT INFRASTRUCTURE

A. Leadership and Accountability:

Health Resources and Services Administration

An agency of the U.S. Department of Health and Human Services is the federal agency for improving access to health care services for PLWH and their families who are uninsured, isolated or medically vulnerable. HRSA provides leadership and financial support to health care providers in every state and U.S. territory.

HIV/AIDS Bureau

Administers the RWHAP, the largest federal program focused exclusively on HIV/AIDS care. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease.

VDH through the Division of Disease Prevention

VDH is the recipient for RWHAP Part B. DDP provides leadership and support to local health districts, medical providers, and community-based organizations in the prevention, surveillance, and treatment of HIV and other sexually transmitted infections, and other complications. It is also dedicated to the provision of education, information, and health care services that promote and protect the health of all Virginians. Additionally, DDP collaborates with the Central Pharmacy to ensure the provision of medications and some vaccines through ADAP statewide.

HIV Care Services

A Director, two Assistant Directors, and Business Manager provide general oversight of the program; coordinate all programs and financial evaluation. They oversee development of service standards, outcome measurement activities, and policy development and implementation.

Quality Management Coordinator

Provides general oversight of the Quality Management Program, coordinates program evaluation and quality management activities, oversees service standards and outcome measurement activities, analyzes outcomes data, and integrates the data into requested reports. The Quality Management Coordinator is responsible for developing the Quality Management Plan, training on quality improvement for providers, coordinating client record reviews, providing technical assistance as appropriate, developing ongoing processes for improvement and modifying the plan as needed in collaboration with the QMAC.

Quality Management Specialist

Reports to the Quality Management Coordinator and must be able to function with a high degree of independence and acts as a representative for the QM leadership team. The Quality Management Specialist works with the Quality Management Coordinator to plan,

organize and oversee funded agencies' Quality Improvement activities, as well as participates in special reviews and assignments as requested by the supervisor, including any grant activities. The Quality Management Specialist assures that funded organization-wide Performance Measures and Quality Improvement Project initiatives are focused on improving program efficiencies. The Quality Management Specialist also participates in agency organizational quality management strategic planning and provides identified technical assistance.

Lead HIV Services Coordinator

Coordinates contract monitoring activities for HIV-related health care and services. Serves as the team's Lead Contract Monitor, supervising other HIV services coordinators in the unit; oversees HIV services coordinators regarding all aspects of the request for proposals, memorandum of agreement or sole source procurement process for federally-funded and state-funded HCS; recommends new and/or revised policies and procedures to meet business needs; reviews work plans and budgets; establishes and monitors performance standards for HIV service contractors; evaluates contracted service delivery systems for compliance with federal and state funding requirements; and compiles and analyzes data and information used to measure health outcomes.

ADAP Coordinator, HCS

Provides general oversight of the program; coordinates program eligibility/recertification and manages ADAP staff. The ADAP Coordinator is a member of the QMAC and ADAP Advisory Committee.

ADAP Operations Specialists, HCS

Provide oversight of the ADAP eligibility staff and conduct ADAP chart reviews to ensure client files have all required documentation for eligibility and recertification.

HIV/AIDS Data Team

Comprised of the HIV Services Analyst, ADAP Data Manager, ADAP Data Entry Technicians, and Ryan White Services Data Manager. The Data Team is responsible for managing the ADAP and the e2Virginia databases. The Data Team also coordinates efforts with CAREWare users, Department of Medical Assistance Services, and other DDP programs to generate data that support quality management efforts. The HIV Services Data Manager works with RWHAP Part B-funded sub-recipients to ensure quality of data collected for federal reporting and for VDH program planning and monitoring.

Sub-recipients and other Providers

Each individual agency is responsible for its own Quality Management Plan and is accountable to the RWHAP Part B for providing data, making improvements in areas of low performance, and reporting to VDH on a monthly basis about implementation status of their Quality Management Plans.

B. Quality Management Committees:

Quality Management Leadership Team

Charged with providing leadership and oversight for all HCS led quality improvement activities. The QMLT ensures adequate resources to carry out the annual quality management work plan. Membership of the QMLT consists of:

- Director of HIV HCS;
- Two Assistant Directors of HCS;
- ADAP Coordinator;
- Lead HIV Services Coordinator;
- HIV Services Analyst;
- Business Manager; and
- Quality Management Coordinator

Quality Management Advisory Committee

Comprised of 35 members including representatives from the five health regions, All Ryan White (A, B, C, D, and F), PLWH, data managers, physicians, AIDS Education & Training Centers, program administrators and PLWH. They are responsible for developing priorities, and setting quality improvement goals and measures. The QMAC has the role and responsibility of reviewing data to identify trends and priorities. Additional responsibilities include developing and coordinating the implementation of the Quality Management Plan, reviewing service standards, and developing strategies to improve care processes. Many members of QMAC are also members of the Community HIV Planning Group. Furthermore, members are responsible for participating in quarterly meetings to review system-wide quality management issues, challenges, and developing strategies to improve care.

The standing Subcommittees of the QMAC includes:

Data Subcommittee: Assists the overall QMAC with identifying potential data improvement projects and advises the QMAC on the development of improvements to the data collection system and performance monitoring initiatives.

Capacity Building Subcommittee: Supports the development of Ryan White Cross-Parts quality management activities by linking training and technical assistance to all Cross-Parts stakeholders inclusive of consumers from each region.

Communication Subcommittee: Serves in an advisory capacity and make recommendations to the QMAC and stakeholders, which have the assigned responsibility for planning and recommending selected quality improvement activities; and its provides input into identified Quality Management Programs.

Quality Improvement Subcommittee: Advises the QMAC committee on the development of improvements to the quality improvement system and performance monitoring initiatives.

Membership on the QMAC is reviewed annually and is open to all Ryan White providers and PLWH. Participating members who wish to serve on the QMAC must complete the application form (Appendix A). The QMAC communication sub-committee's members review all new applications and recommend selection to the Quality Management Coordinator.

HCS Quality Management Team

Comprised of VDH HCS staff who meet on a weekly basis to discuss continuous quality improvement measures. The team discusses improvement ideas with a Quality Coach who provides constructive feedback on improvement initiatives, as well as reviews the PDSA cycle concerning strategies the quality management team will implement.

ADAP Advisory Committee

Comprised of HIV/AIDS medical providers, a pharmacist, consumers, and local health districts' representation. The committee advises VDH on ADAP programmatic, clinical, educational issues and formulary changes.

The quality improvement activities of the committee include:

1. Ensuring necessary therapeutics are made available and set up mechanisms to support treatment adherence;
2. Clearly defining how the ADAP formulary is determined and how it changes over time as new pharmacological knowledge emerges.
3. Assessing how quickly the ADAP Program adjusts its formulary as new treatment advances are made as well as how quickly new antiretroviral medications are approved as new pharmacological knowledge emerges.
4. Conducting continuous improvement activities of the selected ADAP performance measures through the training of staff and stakeholders, and sharing data about any available improvement efforts.

Consumer Capacity Involvement

Consumers participate on QMAC, Peer Review processes, and other quality improvement initiatives as necessary. They participate in client satisfaction surveys, needs assessment activities, semi-structured interviews, focus groups, and DDP data to care projects. Also, they make suggestions and recommendations on quality improvement initiative needs. In Virginia, PLWH involvement is a crucial part of the RWHAP management with the following goals:

- To educate PLWH about current and future quality of care activities;
- To create a forum to routinely hear from affected communities about quality of care issues; and
- To identify how PLWH can help identify potential solutions.

C. Professional Peer Review Team:

The Virginia Commonwealth University HIV/AIDS Center is the sub-recipient for statewide Peer Review services. It provides planning, logistical support and implementation of the Peer Review activities required to assess the quality of services rendered by RWHAP Part B service providers. During Peer Review activities, the team provides needed technical assistance, collects performance measure data to support the assessment of clinical health outcomes, and reviews client charts and selected quality improvement project data. PLWH team members conduct consumer peer-to-peer interviews assessing quality of care and satisfaction standing from a peer perspective.

D. Dedicated Resources:

- Health Resources and Services Administration/HIV/AIDS Bureau Quality Management Manual: <http://hab.hrsa.gov/affordablecareact/>
- The National Quality Center of the New York State Department of Health: <http://www.NationalQualityCenter.org>
- Ryan White TARGET Center training: <https://careacttarget.org/category/topics/quality-management>
- The Local Performance Sites of the Mid-Atlantic AIDS Education and Training Center:
www.pamaaetc.org
- Virginia Northern, Eastern and Central/Southwest Virginia HIV/AIDS Resource Consultation Center:
www.vharcc.com
- ADAP information can be found at: www.vdh.virginia.gov/ADAP
- Quality management information can be found at: <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/>

E. Meeting Schedule:

The QMAC Team meets quarterly and the Quality Management Coordinator prepares and distributes agendas prior to the meeting. Meeting minutes and work plan updates are maintained and copies of the minutes are disseminated to the members. The QMAC subcommittees meet several times (mostly by conference calls) between QMAC quarterly meetings to work on specific tasks.

F. Expectations to Participate in a Cross-Cutting Statewide Quality Improvement Initiative That is Implemented Each Year:

The following quality management requirements are included in sub-recipients' contractual agreement documents (Appendix B):

1. Each sub-recipient develops, updates and submits an annual Ryan White Quality Management Plan.
The plan must include:
 - a. **Quality Statement** (Brief purpose describing the end goal of the HIV Quality Program);
 - b. **Quality Infrastructure** (Leadership, quality committees, roles and responsibilities, and resources);
 - c. **Performance Measurement** (Identifies indicators, who is accountable, how to report and disseminate. Identifies a process in place to use data to develop quality improvement activities);

- d. **Annual Quality Goals** (Select only a few measurable and realistic goals annually and establish thresholds at the beginning of the year for each goal);
- e. **Participation of Stakeholders** (Lists internal and external stakeholders and specifies their engagement in the Quality Management Program, includes community representatives and partners, and specifies how feedback is gathered from key stakeholders); and
- f. **Evaluation** (Evaluates the effectiveness of the quality management /quality improvement infrastructure to decide whether to improve how quality improvement work gets done and review performance measures).

The Quality Management Coordinator in collaboration with the HIV Services Coordinators reviews progress on quality improvement projects and Quality Management Plans, and provide feedback in their monthly report responses as indicated in the sub-recipient contract deliverables.

- 2. Sub-recipient shall complete a program-specific quality improvement project annually based on 2017 selected quality improvement project: Enhancing medication treatment and adherence by utilizing service standards including viral load suppression and prescribing of highly active antiretroviral therapy medication. Progress of the quality improvement project will be reported on a quarterly basis by using a PDSA template.

Each site can modify the focus of the quality improvement initiative to align with their site-specific needs. In addition, all sites are encouraged to undertake additional quality improvement projects that focus on issues specific to their program.

- 3. Sub-recipient shall participate in statewide quality management activities (meetings, trainings, improvement projects and data/report submission requests), to include three (3) QMAC meetings at a minimum and the annual Quality Management Summit.

G. Legislative:

Salaries for all VDH quality management staff are 100% supported with rebate funding effective April 1, 2017. Full review has been undertaken for all VDH-funded quality management and quality assurance architecture and activities will be allocated appropriately in Grant Year 17 contract modifications and Grant Year 18 contract renewals.

VI. Grant Year 2017-2018 WORK PLAN GOALS AND IMPLEMENTATION

The work plan activities are monitored at least quarterly by the Quality Management Coordinator and presented at the QMAC quarterly meetings for discussion and suggestions. The full implementation work plan is found in Appendix C. Selected quality management goals include:

- Goal A. Developing and implementing the 2017 RWHAP Part B Quality Management Plan.
- Goal B. Strengthening the existing Virginia Ryan White Cross-Parts infrastructure to support quality improvement activities in Virginia.
- Goal C. Ensuring that health-related core and support services, including ADAP, provided by VDH and funded agencies improve the HIV continuum of care status.
- Goal D. Providing technical assistance and quality trainings on an ongoing basis.
- Goal E. Strengthening internal RWHAP Part B Grantee quality improvement initiatives

VII. PERFORMANCE MEASUREMENT

The RWHAP B utilizes performance measurement data to identify and prioritize quality improvement projects, routinely monitor the quality of care provided to PLWH, and to evaluate the impact of changes made to improve the quality and systems of HIV care.

H. Selected Measures for Ryan White Part B:

Specific clinical and prevention indicators to be measured for all the Ryan White Part B funded services for the current year include:

Measurement Outcome	Indicator to be Measured	Data Elements used to Measure Indicator
Percentage of persons who attended a HIV medical care services and had a care marker within 30 days of HIV diagnosis	Linkage to HIV Medical Care	Numerator: Number of persons who attended a HIV medical care services and had a care marker within 30 days of HIV diagnosis Denominator: Number of persons with an HIV diagnosis in the 12-month measurement period
Percentage of persons with an HIV diagnosis who are receiving HIV medical care services who had two care markers in the 12-month measurement period	Retention in HIV Medical Care	Numerator: Number of people enrolled in RWHAP Part B-funded Program living with HIV and receiving HIV medical care services who had at least two care markers in 12-month measurement period that are at least 3 months apart Denominator: Number of people enrolled in RWHAP Part B-funded Program living with HIV and receiving HIV medical care services who had at least one care marker in the 12-month measurement period
Percentage of persons with an HIV diagnosis who are prescribed Antiretroviral therapy in the 12-month measurement period	Antiretroviral Therapy Among Persons in HIV Medical Care	Numerator: Number of persons with an HIV diagnosis who are prescribed Antiretroviral therapy in the 12-month measurement period Denominator: Number of persons with an HIV diagnosis and who had at least one HIV medical care service in the 12-month measurement Period

Measurement Outcome	Indicator to be Measured	Data Elements used to Measure Indicator
Percentage of persons with an HIV diagnosis with a viral load <200 copies/mL at last test in the 12-month measurement period	Viral Load Suppression Among Persons in HIV Medical Care	Numerator: Number of persons with an HIV diagnosis with a viral load <200 copies/mL at last test in the 12-month measurement period Denominator: Number of persons with an HIV diagnosis and who had at least one HIV medical care service in the 12-month measurement period

Virginia RWHAP Part B has selected HIV continuum of care related performance measures for each funded service including ADAP, which include monitoring care markers (CD4 test dates, viral load test dates, antiretroviral therapy prescription dates, and HIV medical care visit dates). Performance measures apply to the following services: ADAP, outpatient/ambulatory care measures; oral health services; mental health services; medical nutrition therapy; medical case management services (including treatment adherence); substance abuse services, outpatient; non-medical case management; emergency financial assistance; food bank/home-delivered meals; health education/risk reduction; housing services; linguistics services; medical transportation services; outreach services; referral for health care; substance abuse –residential services; Minority AIDS Initiative Outreach and Education.

The only exception is for Oral Health Care Services, which will be measured as below:

Oral Health Care Health outcome Indicator to be Measured	Numerator:	Denominator:
Percentage of persons with an HIV diagnosis who are receiving Oral Health education session in the 12-month measurement period	Number of people enrolled in RWHAP Part B living with HIV and receiving oral Health education session at least once during the twelve month period	Number of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Oral Health Care services, regardless of age.

I. Data Collection:

Providers utilize the following methods and databases for data collection: client interviews, chart reviews, e2Virginia or CAREWare. E2Virginia is VDH's official client-level data system a Ryan White Services Report-ready system developed by RDE Systems, LLC specifically for Virginia. Also, VDH maintains a database specifically for ADAP eligibility and service information. Overall collected data

include:

- Client eligibility and recertification data
- Utilization patterns data
- HIV continuum of care data
- Client Satisfaction data
- Needs assessment data
- Other data as required and/or deemed necessary

J. Data Sources:

The Virginia Quality Management Program is responsible for regular analysis and reporting of quality management data that include but is not limited to:

- Client satisfaction surveys/interviews
- HIV continuum of care data
- ADAP data
- Statewide Coordinated Statement of Need
- Enhanced HIV/AIDS Reporting System data
- Unmet Needs data referring to the population that is out of care

VDH collaborates with all Ryan White Part A, B, C, D and F providers in the Commonwealth to provide client-level data on a monthly basis through e2Virginia. Providers that utilize CAREWare directly self-import data into e2Virginia.

K. Reporting Mechanisms of Quality Management Activity Data:

Compiled data findings from several sources are shared in an aggregated format with HIV providers, VDH leadership, and other stakeholders. Data is pulled from the full list of clients served by each recipient, with the previous method assigning a client to a specific recipient based on the client's most recent service date. This provides a more accurate picture of the recipient's client base outcomes. Reports showcasing the recipient's client outcomes show visual comparison of outcomes compared to the outcomes of all quality management recipients pooled together for the preceding three years prior to the reporting period. These specific data reports also show the visual and temporal change in outcomes for the preceding three years prior to the reporting period for the specific recipient's clients.

VDH collects and analyzes HIV Continuum of Care data on quarterly basis to inform the monitoring of HIV care, identify trends in HIV-related health outcomes over time and across jurisdictions, clinics and programs, and determine programmatic needs by analyzing gaps

and health disparities. VDH solicits feedback through quality management committees and sub-recipients in planning, implementing, and evaluating quality of care program activities to be responsive to the changes in clinical and scientific knowledge. Recommendations for actions steps are made to address identified needs and service gaps. Some may be addressed through the services that are supported in the Statewide Quality Management Plan while others provide a vision for longer-term strategies of ideal system of care.

Several types of qualitative and quantitative data give VDH and partners' information on the selected performance measures and help them shape improvement goals and projects. For example, a Data to Care approach have been used to identify, confirm, locate, and follow up with clients who have fallen out-of-care. Identified PLWH who were not in care were linked to—or re-engaged with—HIV care and treatment services. Also HIV data from VDH surveillance and mix methods needs assessment revealed high HIV prevalence and incidence rate in the state for young black men who have sex with men (MSM). In response to this finding, VDH redirected funding to host training for providers and consumers focusing on young black MSM. As to address the identified disparity issues.

VIII. Quality Improvement Activities

Virginia Ryan White quality improvement activities have been conducted based on performance data results. Specific HIV Medication Adherence quality improvement projects have been undertaken which include action steps and a mechanism for integrating change into routine activities. Baseline data results have initially identified area for improvement and the need for re-measuring to assess the impact on care. The selected project address how staff can use the tools and methods of quality improvement to improve systems and processes of care in which they practice. The key principle in this project for improving HIV care is the implementation of an improvement model which includes measuring- testing change- re-measuring, and the application of a change known as PDSA Model. Each funded agency is individually leading the implementation of the project process at local level.

The Quality Improvement Project opportunities have been used to:

- Educate staff about quality improvement activities and provide them with the skills to participate in quality improvement processes;
- Set a routine schedule for monitoring and reviewing data;
- Allow participating institutions to align their own continuous improvement initiatives and projects with required quality improvement project processes;
- Communicate results from improvement projects throughout the clinic and the Community; and
- Provide opportunities for all staff to participate in quality improvement teams.

IX. PARTICIPATION OF STAKEHOLDERS

Stakeholders are expected to participate in the planning process of quality improvement activities including QMAC meetings and quality improvement project teams, as needed. Expected roles include:

- Advance buy-in from stakeholders through role clarification;
- Replicate infrastructures and quality management models that work, within specific geographic areas of the state where similar conditions exist;
- Foster relationships cross Ryan White Collaborative; and
- Provide technical capacity to collect and submit quality improvement related data.

In addition to HRSA and VDH, the following groups are stakeholders currently involved in Virginia RWHAP Part B quality improvement activities:

- Quality Management Advisory Committee;
- Sub-recipients;
- Funded Third Party Providers;
- People living with HIV;
- RDE Systems, LLC;
- The Virginia Local Performance Sites of the Mid-Atlantic AIDS Education and Training Centers Performance sites;
- Virginia HIV/AIDS Resources and Consultation Centers; and
- ADAP Advisory Committee.

X. CAPACITY BUILDING

RWHAP Part B continues to build quality improvement capacity through the provision of trainings and technical assistance. In partnership with various stakeholders, VDH develops and conducts comprehensive trainings for providers, PLWH, and advocacy committees regarding each element of the Quality Management Program.

The quality management staff participates in the HRSA, National Quality Center, and other Ryan White quality trainings offered to recipients and sub-recipients. In addition, Virginia has established an annual Ryan White Cross-Parts **Quality Management Summit** designed to build capacity among all Ryan White clinical providers (A, B, C, D and F) and consumer representatives to conduct quality improvement activities and enlarge the pool of quality improvement trainees statewide. The Summit is an opportunity to build the quality improvement capacity needed to ensure that Virginia HIV clinical providers are able to better their Quality Improvement Programs. Summit participants access peer learning opportunities to share best practices, and have access to national experts without traveling outside the state.

ADAP also continues to build quality improvement capacity through the provision of trainings and technical assistance to HCS staff and stakeholders. There has been an ongoing training process of ADAP staff on how to start using indicators to measure performance that gives baseline against which to measure future performance. Performance data have indicated where potential problems exist and suggest areas for improvement. Staff is actively working on two quality improvement projects to improve the ADAP application completeness rate and ADAP recertification rates. Effectively applied, these improvements benefit the clients and can lead to improvements in overall client health.

Virginia HIV/AIDS Resources and Consultation Centers assists VDH with providing identified ADAP trainings. All stakeholders are encouraged to attend at least one yearly training opportunity related to quality management, process management, leadership development, problem solving, and/or team building.

XI. COMMUNICATION

Communication to and between stakeholders is an important part of the quality management process. The purpose, method and frequency of communication depend upon the audiences. There are different communication tools and technique that VDH uses to communicate quality improvement activities and results. Most improvement programs use a balanced mix of paper and electronic communication means, like: Posters, fliers and brochures, website, QMAC newsletters, and VDH E-Bulletin. Structured face-to-face meetings such as QMAC Collaborative Quarterly Learning Sessions and Quality Management Summits are open to all Ryan White providers and PLWH. These forms of communication help to understand the changes, and to build trust. Other methods for distribution of the quality improvement results and requirements include contractual documents, and trainings through VDH, Virginia HIV/AIDS Resources and Consultation Centers, and AIDS Education and Training Centers. Sharing for example individual HIV Continuum of Care related performance measures per site using visual management (graphs) pictures the achievement trends in reaching projected goals and approaches. It motivates people and agencies to commit to change, by showing expected benefits and early results.

All ADAP and Ryan White stakeholders are kept up-to-date with periodic stakeholder emails surrounding ACA enrollment, the QMAC meetings, and the quarterly ADAP conference calls, and quarterly sub-recipient meetings. The ADAP Hotline and VDH website offer information to respond to questions from stakeholders and clients.

HCS staff participates in all regional health meetings, quarterly sub-recipient meetings, and Ryan White Part A Planning Council meetings in an effort to provide RWHAP Part B updates to consumers and sub-recipients. The QMAC and ADAP Advisory Committee have representation from all regions of the state, all Ryan White Cross-Parts, and non-RWHAP Part B funded agencies.

XII. EVALUATION OF THE VIRGINIA RYAN WHITE PART B QUALITY MANAGEMENT PROGRAM

The functioning of the Quality Management Program is assessed by examining the following components:

- 1) Infrastructure;
- 2) Performance measurement; and
- 3) Quality improvement activities

Based on the findings, VDH will refine strategies for the following year. Regular feedback regarding overall quality improvement is critical in sustaining improvements over time. VDH communicates findings and solicits feedback from key stakeholders on an ongoing basis and data presentations are made during identified meetings and trainings. In addition, written technical assistance and site visit reports are shared with stakeholders who are given the opportunity to provide feedback on the reports.

A. Infrastructure:

a. Quality Management Plan

VDH evaluates the Quality Management Plan on a quarterly and annual basis, including assessing the completeness dates of goals and key activities undertaken during the year. Results, challenges, and comments are used to:

1. Determine the effectiveness of the Quality Management Plan selected infrastructure and activities;
2. Review annual goals, identify those that have not been met, as well as the reasons these goals were not met, and assess possible strategies to meet them before the next review.

- b. QMAC structure, purpose and membership are reviewed on quarterly basis and adjustments are completed as needed. The four sub-committees are given enough time during the quarterly meetings to meet in groups and discuss specific achievements and ability to meet the planned expectations related to each sub-committee.

The evaluation areas include assessing if:

- The QMAC meet at least quarterly and maintain minutes at all its meetings;
- The monitoring and evaluation of quality management activities, objectives and approaches are effective; and
- The implementation of action plans to improve or correct identified problems has been completed as planned.

B. Performance Measurement:

- a. Specific quality indicators are reviewed for appropriateness and continued relevance. Upon completion of the annual review, a new set of quality indicators are identified, quality goals for the upcoming year established, and specific quality initiatives are identified in the updated Quality Management Plan.
- b. Peer Review site visits (including performance measure data extraction and analysis, and client interviews) are performed every other year for each selected services provider agency. Findings from those reviews are used to assist in the development of agency specific Quality Management Plans and corrective action plans. Agencies review the results from their site visit reports and identify areas in need of improvement.
- c. ADAP quality efforts are monitored on ongoing basis and reported on monthly basis including the length of time to determine ADAP eligibility and/or ADAP re-certification, and the outcome of the ADAP application completeness improvement activities. Also ADAP site visits (including chart review) are performed every other year for medication access sites where at least five or more clients are accessing medications. Selected ADAP charts are reviewed to ensure that all eligibility and recertification documents are in place and are current. Additionally, other issues discovered in the process of reviewing the selected charts may expand the scope of the review.
- d. Grant Year 2017 Selected Outcome Measures Goals for RWHAP Part B for each funded Services also will be evaluated and shared with stakeholders on quarterly basis and annually shared with HRSA (Appendix D).

C. Quality Improvement:

- a. Routine monitoring of the Quality Management Plan, health outcomes, goals and objectives achievement, and client satisfaction and dissatisfaction will be used to gauge and strengthen program improvement. Data from varied sources are used to plan, design, measure, assess and improve quality of services and processes. Quality improvement activities examine and modify existing processes, if needed, to address quality challenges.
- b. Statewide quality improvement projects evaluations (HIV Medication and Treatment Improvement project) will assist with answering the following questions: Did we select the appropriate project, did we have appropriate measures that could document progress, were sites able to implement changes that were effective, was it clearly defined so that everyone was using the same measure and we could compare apples to apples. Ultimate analysis of results of the quality improvement projects will assist to find the answer to question whether we are making a difference in the quality of care and whether are we having an impact on Viral load suppression and retention in care.

- c. Client interviews provide additional information regarding how well organizations meet PLWH expectations and information pertinent to the organization's quality improvement efforts. In addition to the Peer Review activities, each RWHAP Part B funded provider is contractually required to measure client satisfaction. Peer Review employs the use of a Peer-Administered Survey tool with questions that address the service, the provider, and the health system as whole. In addition, PLWH participate in different needs assessment interviews, focus groups, and surveys to supplement Peer Review client interviews.
- d. Evaluation will be a regular part of the planned trainings and workshops as it gave the chance for honest feedback on the process and content of the training; which allows the facilitators to learn from their experiences. The evaluation also will help participants feel heard and to improve future training process, reduce frustration and create hope that meetings will continue to evolve. Findings will allow to build on what's working well and improve in the future.

Overall, the Quality Management Program's evaluation strengthens organizational performance and links organizations to operational decision-making within the state system. PDSA cycle is a way of continuously checking progress in each step of the focused process. This process assists teams in focusing on specific improvement activities. Findings and revised Quality Management Plan are submitted to VDH leadership for approval on an annual basis.

APPROVAL OF THE 2017 QUALITY MANAGEMENT PLAN

This plan has been reviewed and approved by the Ryan White Part B Grantee as listed below. This plan will expire March 31, 2018.

Ryan White Part B – Virginia Department of Health

Kimberly A. Scott, M.S.P.H.
Director, HIV Care Services

Signature and Date Reviewed:

 10/2/17

APPENDIX A: QUALITY MANAGEMENT ADVISORY COMMITTEE TEAM MEMBER APPLICATION INFORMATION FORM

Date: _____ Source/Referral: _____

Representation: _____

Name: _____
First Last Middle Initial

Mailing Address: _____
City State Zip Code

Phone # (Work): _____ Cell #: _____

Home #: _____ Fax #: _____

Email: _____

Present Employment: _____

Approval Received from Respective Agency Concurring Acceptance into the Committee? Yes _____ No _____

Please state your qualifications, interest and/or reasons for wanting to be a member of the Quality Management Advisory Committee

Qualification Assessments: _____ Phone: _____ Email: _____ Letter: _____

Contacts/Communications: _____

Comments: _____

Signature of Approval:

Quality Management Coordinator: _____

Date: _____

Quality Management Advisory Committee Communication Subcommittee: _____

Date: _____

APPENDIX B: 2017 QUALITY MANAGEMENT PROGRAM SUB-RECIPIENT REQUIREMENTS SUMMARY

Quality Area	Quality Activity	Responsible Person	Timeline
Quality Management plan and Quality Improvement Project	Ryan White Provider Quality Management Plan development and submission to VDH	Sub-recipients	60 days after the start date of the grant year
	Quality Improvement project proposal development and submission to VDH (selected 2017 topic is HIV/AIDS medication treatment and Adherence) The proposal should include the site baseline data on selected performance measures	Sub-recipients	60 days after the start date of the grant year
	Quality Improvement project reports required on quarterly basis	Sub-recipients	Project quarterly reports are due: April 2017, July 2017, October 2017, January 2018
	Quality Management Plan reports required on monthly basis	Sub-recipients	Monthly By March 2018
	Participation in the statewide Peer Review bi-annual site visits activities	Sub-recipients	By March 2018
Quality Monitoring	Performance Measures Monitoring (<i>via Monthly Report and quarterly HIV continuum of care data monitoring reports</i>) & Feedback (<i>via Monthly Report Responses and through quality meetings</i>)	Sub-recipients HIV Service Coordinators Data team Quality Management Coordinator	Monthly and quarterly feedback

Planning and Evaluation	QMAC Meetings	QMAC Members	May 10, 2017 August 30, 2017 February 10, 2018
Training	Quality Management Summit	Quality Management Summit Planning Committee QMAC AIDS Education and Training Center Virginia HIV/AIDS Resource Consultation Center Quality Management Coordinator	October 5, 2017
	Consumers Trainings	Quality Management Coordinator QMAC	May 8, 2017 July 19, 2017 August 9, 2017 August 29, 2017 October 2017
	Case Management Summit	Planning Committee AIDS Education and Training Center Quality Management Coordinator	March 2-3, 2018
	Training and technical assistance as needed	Quality Management Coordinator AIDS Education and Training Center Virginia HIV/AIDS Resource Consultation Center	Ongoing

The work plan includes goals, areas, objectives, key actions, responsible persons and/or parties, reporting methods, timeline, and status/follow-up.

APPENDIX C: IMPLEMENTATION OF HIV SERVICES WORK PLAN FY 2017-2018

Goal A: Developing and Implementing the 2017 Ryan White Part B Quality Management Plan and Work Plan					
Areas	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Quality Management Plan	Plan and Update 2017 Annual Quality Management Plan by April 1, 2017	Develop 2017 Quality Management Plan based on feedback from Quality Management Committees	VDH Quality Management Coordinator and ADAP staff	Write and incorporate submitted feedback	March 2017
		Approval process of the Quality Management Plan by VDH and posting it on website	Director HCS	Approval notice	April, 2017
	Implement Quality Management Plan during the Grant 2017	Each Ryan White funded agency is required to have in place an annual Quality Management Plan, selected quality improvement project, and incorporate statewide performance goals into their agency's quality improvement activities	All sub-recipients	Number and percent of RWHAP Part B Program with Quality Management Plan and quality improvement project in place	March 2018
	Evaluate Agency Quality Management Program on monthly basis for the Quality Management Plan and Quarterly basis for the quality improvement project.	Monitor implementation of Quality Management Plan and quality improvement project through on-site visits, Ryan White data analysis and submitted report documents	HCS staff	Site visit reports, e2Virginia health outcome performance measure data analysis, and Submitted reports	Monthly and quarterly reports by March 2018

APPENDIX C: IMPLEMENTATION OF HIV SERVICES WORK PLAN FY 2017-2018

Goal B: Strengthening the Existing Virginia Ryan White Quality Management Cross-Parts Infrastructure that Supports Quality Improvement Activities in Virginia					
Areas	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Statewide Ryan White Cross-Parts Collaborative	Implement and monitor a comprehensive set of HIV Continuum of care related performance measures and a quality improvement project by at 100 % of all Ryan White Grantees	Provide technical assistance as needed	All Ryan White recipients	Selected performance measures data directly entered into e2Virginia or imported from other data sources	March 2018
	Strengthen Virginia Cross-Parts Collaborative by providing consistent opportunities for VA sub-recipients to network and exchange ideas on quarterly meetings	Hold consistent quarterly meetings of the QMAC members	Ryan White Quality Management Cross-Parts Collaborative members and invited guests	Meeting agendas and minutes, action plans, and meeting evaluations.	May 10, 2017 August 30, 2017 February 13, 2018
Collaboration with Training and Education Centers	Use Local Mid Atlantic AIDS Education Training Center Performance sites and the Virginia HIV/AIDS Resources and Consultation Centers to provide identified quality management trainings and technical assistance	Plan the Annual Quality Management Summit, consumers training in quality, QMAC meetings, and Case Management trainings.	Quality Management Coordinator, Local Mid Atlantic AIDS Education Training Center and Performance sites	Meeting agendas and minutes, action plans, and meeting evaluations.	March 2018

APPENDIX C: IMPLEMENTATION OF HIV SERVICES WORK PLAN FY 2017-2018

Goal C: Ensuring that Primary Care and Health-Related Support Services Provided by Funded Agencies improve the HIV continuum of care status						
Area	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline	
Quality Improvement Activities	Encourage incorporating RWHAP Part B Quality Management goals into agencies' Quality Management Plans and 100% of sub-recipients will timely submit required documents to VDH	Disseminate selected performance measure goals to all agencies	All stakeholders	Written documents, face-to-face meetings, telephone, webs and emails	March 2018	
	Develop strategies to achieve Grant Year 2017 Selected RWHAP Part B Outcome Measures Goals for each funded Services (see appendix D)	Implementation of agency selected quality improvement activities to meet annual goals	All providers	Submitted quality improvement project reports on quarterly basis to VDH	April 2017 July 2017 October 2017 January 2018	
	Develop strategies to achieve Grant Year 2017 Selected RWHAP Part B Outcome Measures Goals for each funded Services (see appendix D)	Collect and monitor health outcome measure data and implement need improvement activities by RWHAP Part B agencies	All providers and VDH staff	Reports on selected measures shared with stakeholders on quarterly basis	April 2017 July 2017 October 2017 January 2018	
	Ensure Case Management quality improvement efforts of its related health outcome performance measures (See appendix D)	Provide needed trainings and technical assistance on best practices	Quality Management Coordinator, Local Mid Atlantic AIDS Education Training Center and Performance sites, and the Virginia HIV/AIDS Resources Center and Consultation	Evaluation of provided trainings and monitoring of HIV continuum data by funded agencies	By March 31, 2018	
				Follow up on improvement action steps		

	Case Management Summit to provide at least 80 Ryan White Medical and Non-Medical Case Managers an in-depth learning experience on the integration of quality improvement initiatives with models and systems of Case Management.	Planning, implementing and evaluating the Summit	Quality Management Coordinator, Local Mid Atlantic AIDS Education Training Center and Performance sites	Evaluation of provided trainings and trained number professional statewide	By March 31, 2018
Peer Review	Update Peer Review tools to match with the selected HIV continuum of care performance measures and address the HRSA policy clarification notice #16-02	Update Peer Review tools and assess 10 RWHAP Part B funded providers' achievement with selected health outcome measures and client satisfaction status	Peer Review Team and Quality Management Coordinator	Revised Peer Review tools and collection health outcome performance measures and client satisfaction data	March 2018
Ensure eligibility and recertification determination adheres to most recent HRSA Guidelines.	Ensure ADAP eligibility occurs every year and recertification has been completed every 6 months (Appendix D)	Ensure current unit policy to obtain documentation based on date of last application and 6 months from that date	ADAP and other HCS staff	ADAP Database	Monthly by March 2018
		Eligibility and recertification completed at agency level	Recipients and sub-recipients	Monthly progress reports, e2virginia, Electronic Medical Records, CAREWare and Client Files	Monthly by March 2018
Outreach	Ensure information regarding all Ryan White Programs including ADAP is available and communicated.	Periodic stakeholder letters through the listserv; updating ADAP website and providing updates at statewide and stakeholder meetings.	ADAP and other HCS staff	written documents, power point presentations, emails, website updates	March 2018

APPENDIX C: IMPLEMENTATION OF HIV SERVICES WORK PLAN FY 2017-2018

Goal D: Providing Technical Assistance and Capacity Building Trainings on an Ongoing Basis					
Area	Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Technical assistance and Training Activities	Hold a Ryan White Cross-Parts Annual Quality Management Summit in October 2017	Identify topics, dates, and locations of the Summit. Develop and provide training event	VDH Quality Management Coordinator and other resources	Trainings developed and conducted during the Summit	October 5, 2017
	Provide ongoing Quality Management technical assistance to providers	Provide technical assistance to providers on Quality Management Principles and any needed specific topics	Quality Management Coordinator and QMAC	Number of requested technical assistance; Number of technical assistance provided	March 2018
	Provide five regional consumers training in quality to promote and support full and effective participation by PLWH. Projected at 25 participants per region.	Identify topics, dates, and locations of the trainings. Train the trainers (all consumers) Develop and provide training event. It will help them acquire the knowledge and develop the skills integral to carrying out ongoing quality improvement Work.	Quality Management Coordinator and QMAC	Trainings developed and conducted. Numbers of consumers trained per region and statewide	May 8, 2017 - Train-of-trainers July 19, 2017- Eastern , August 9, 2017- Central August 29, 2017- Northwest October 2017- Northern
	Provide ongoing ADAP technical assistance to consumers, providers and local health department and medication access site staff	Provides technical assistance on Ryan White service options and ADAP	HCS Staff	Hotlines; ADAP Database; completed technical assistance report forms	March 2018

APPENDIX C: IMPLEMENTATION OF HIV SERVICES WORK PLAN FY 2017-2018

Goal E: Strengthening Internal Ryan White Part B Grantee Quality Improvement Initiatives					
Area	Objectives	Key Action Steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
	Virginia Department of Health Part B Grantee Quality Management Strategic Planning Session during the first quarterly of the Grant Year 2017	Identify priority areas of focus, explore ways in which HCS staff are currently involved in quality activities, and generate ideas for future involvement	HCS staff and the Quality Management Team	Minutes of the meeting Identified action steps Developed work plans	By May 31, 2017
Explores opportunities for HCS staff to expand their role and increase engagement in the quality activities	Provide training on various quality concepts, starting with the fundamentals of quality management on monthly basis	Learn how to incorporate Quality Management into the respective roles.	HCS staff and the Quality Management Team	Training evaluations Survey staff satisfaction Number of trainings provided	By March 31, 2018
	Create mentoring opportunities for all new employee so that staff can shadow someone in the role before taking a lead	Learn the points of intersection, commonality and potential duplication in the role of Service Coordinators and Quality Management Coordinator as it relates to Quality Management activities	HCS staff and the Quality Management Team	Number of staff that benefited provided mentoring services Survey staff satisfaction	By March 31, 2018

Explore ADAP-related quality management activities	Strengthen the following three major components by the end of the Grant Year 2017: 1) performance measurement; 2) Quality improvement projects; and 3) infrastructure.	Facilitate cross-communication and learning	HCS staff and the Quality Management Team	Survey staff satisfaction	By March 31, 2018
		Identify potential ADAP quality improvement projects on a range of issues Implement quality improvement projects to streamline the client eligibility/recertification process and ADAP application completeness	HCS staff and the Quality Management Team	Identified and implemented quality improvement projects	By March 31, 2018
		Train ADAP staff and the ADAP Advisory Committee on quality management concepts	HCS staff and the Quality Management Team	Training evaluations Survey staff satisfaction Number of trainings provided	By March 31, 2018

APPENDIX D: GRANT YEAR 2017 SELECTED OUTCOME MEASURES GOALS FOR RWHAP B FUNDED SERVICES

RWHAP Part B is specifically reporting on the following health outcome measures for funded HRSA services. Benchmark data are from Grant Year 2016 achievement rates. **Selected HIV Continuum of Care measure for specific service is marked with an X in each respective box.**

AIDS Drug Assistance Program

During FY 2017, 80% of ADAP clients receiving medications or medication copayments and Medical Case Management services, regardless of age, will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the 12-month measurement period.

Benchmark for viral load suppression measure: 77%

During FY 2017, 90% of ADAP applicants will be approved or denied for ADAP enrollment within two weeks of ADAP receiving a complete application during the 12-month measurement period.

Benchmark for new ADAP applications: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Outpatient/Ambulatory Medical Care Measures

During FY 2017, 85% of PLWH and receiving Outpatient/Ambulatory Medical care services, regardless of age, will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the 12-month measurement period.

Benchmark: 77%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Oral Health Care

During FY 2017, 90% of people enrolled in the RWHAP Part B-funded program and receiving oral health services, regardless of age, will have oral health education session at least once during the 12-month measurement period.

Benchmark: 88%

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Mental Health Services

During FY 2017, 95% of people enrolled in RWHAP Part B-funded Program who received a Mental Health service, regardless of age, will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

- I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Medical Nutrition Therapy

During FY 2017, 80% of people enrolled in RW Part B-funded Program living with HIV regardless of age and receiving medical nutrition services, will have at least two care markers in a 12-month period, that are at least 3 months apart. (Care marker defined as evidenced of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: Unknown, will be established in this performance period.

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

- I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Medical Case Management Services (Including Treatment Adherence)

During FY 2017, 80% of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Medical Case Management services, regardless of age, will have an HIV viral load lesser than 200 copies/mL at last HIV viral load test during the 12-month measurement period.

Benchmark: 77%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

- I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Early Intervention Services

During FY 2017, 75% of newly enrolled EIS clients who have documentation of education given regarding HIV disease process, risk reduction, and maintenance of the immune system. The number of people serve could potentially increase and there may be variance in the number of units each clients receive in the EIS encounter. VDH will provide partial salary support of staff who will provide EIS services as well as testing supplies, if needed.

Benchmark: Unknown, will be established in this performance period.

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Substance Abuse Services – Outpatient

During FY 2017, 90% of people enrolled in RW Part B-funded Program living with HIV regardless of age and receiving Substance Abuse Outpatient services, will have at least two care markers in a 12-month period, that are at least 3 months apart.

Benchmark: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Non-Medical Case Management

During FY 2017, 85% of people enrolled in RWHAP Part B-funded Program living with HIV regardless of age and receiving non-Medical Case Management services, will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 81%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Emergency Financial Assistance

During FY 2017, 90% of people enrolled in RWHAP Part B-funded Program and receiving Emergency Financial Assistance will have two or more care markers in the 12-month measurement period that are at least 90 days apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Food Bank/Home-delivered Meals

During FY 2017, 90% of PLWH and receiving Food Bank/Home-delivered Meals will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 87%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Health Education/Risk Reduction

During FY 2017, 90% of persons living with HIV and receiving Health Education/Risk Reduction services will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 86%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Housing

During FY 2017, 75% of people enrolled in RWHAP Part B-funded Program living with HIV, regardless of age and receiving Housing services, will have at least two care markers in a 12-month measurement period that are at least 6 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: No prior benchmark, which will be set during this grant year.

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Linguistics

During FY 2017, 95% of PLWH and receiving Legal services, regardless of age, will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Medical Transportation Services

During FY 2017, 90% percent of people enrolled in RWHAP Part B-funded Program living with HIV regardless of age and receiving Medical Transportation services, will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 86%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Outreach Services

During FY 2017, 80% of PLWH and receiving Outreach services, regardless of age, will have at least two care markers in a the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 74%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Referral for Health Care

During FY 2017, 80% of PLWH and receiving Referral for Health Care/Supportive Services, regardless of age, will have at least two care markers in the 12-month measurement period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: No prior benchmark, which will be set during this year.

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Substance Abuse Services – Residential

During FY 2017, 90% of people enrolled in RWHAP Part B-funded Program living with HIV regardless of age and receiving Residential Substance Abuse services, will have at least two care markers in the 12-month measurement period, that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

Benchmark: 90%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

MAI Outreach Services

Outreach

a) During FY 2017, 70% of MAI Outreach Services clients will be verified as enrolled in ADAP or another prescription medication program.

Benchmark: 66%

b) During FY 2017, 65% of MAI Outreach Services clients will have an HIV viral load less than 200 copies/mL at last viral load test in the last the 12-month measurement period.

Benchmark: 57%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

Education

a) During FY 2017, 80% of MAI clients who receive HIV education services will be verified as enrolled in ADAP or another prescription medication program.

Benchmark: 74%

b) During FY 2017, 90% of MAI clients who receive HIV education services will have at least two care markers in the 12-month measurement period that are at least 3 months apart.

Benchmark: 87%

Data source: CAREWare, eHARS, e2Virginia, ADAP Database

Stage of the HIV Care Continuum:

I. Diagnosed II. Linked to Care III. Retained in Care IV. Prescribed Antiretroviral Therapy V. Virally Suppressed

APPENDIX E: HUMAN RESOURCES AND SERVICES ADMINISTRATION HIV/AIDS BUREAU SERVICE CATEGORY

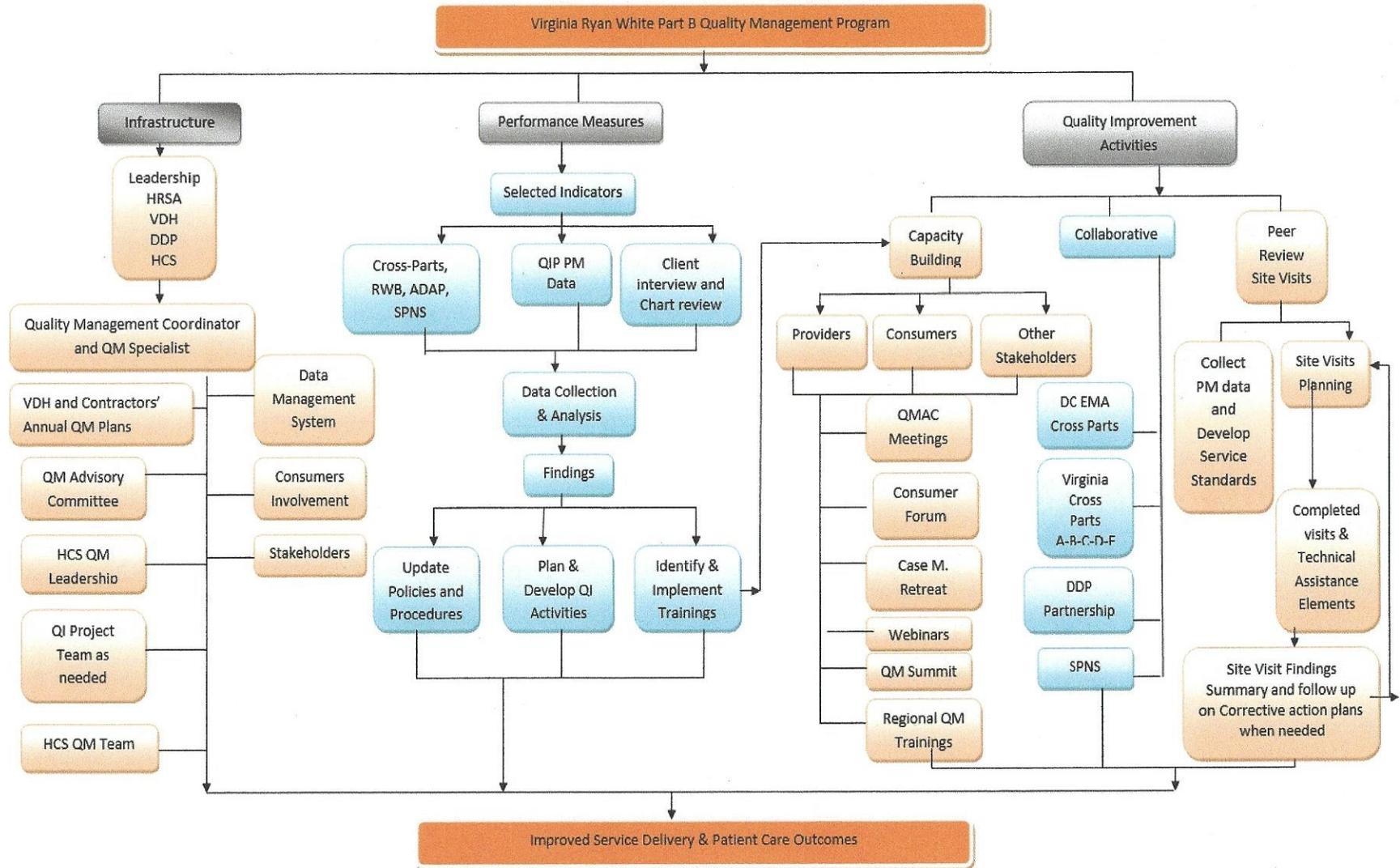
Allowable Program Services	
CORE MEDICAL SERVICES	
1.	AIDS Drug Assistance Program Treatments
2.	AIDS Pharmaceutical Assistance
3.	Early Intervention Services
4.	Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
5.	Home and Community-Based Health Services
6.	Home Health Care
7.	Hospice
8.	Medical Case Management, including Treatment Adherence Services
9.	Medical Nutrition Therapy
10.	Mental Health Services
11.	Oral Health Care
12.	Outpatient/Ambulatory Health Services
13.	Substance Abuse Outpatient Care
SUPPORT SERVICE	
14.	Child Care Services

15.	Emergency Financial Assistance
16.	Food Bank/Home Delivered Meals
17.	Health Education/Risk Reduction
18.	Housing
19.	Linguistic Services
20.	Medical Transportation
21.	Non-Medical Case Management Services
22.	Other Professional Services (including legal services)
23.	Outreach Services
24.	Permanency Planning
25.	Psychosocial Support Services
26.	Referral for Health Care and Support Service
27.	Rehabilitation Services
28.	Respite Care
29.	Substance Abuse Services (residential)

The Ryan White Program Service Definitions were revised by HRSA/HAB in 2016 with an effective date of October 1, 2016. The revised service definitions are included in *Policy Clarification Notice #16-02, RWHAP Services: Eligibility Individuals & Allowable Uses of Funds* available online at:

http://www.vdh.virginia.gov/content/uploads/sites/10/2016/12/ServiceCategoryPCN_16-02Final.pdf

APPENDIX F: Virginia Quality Management Program Flow Chart



APPENDIX G: GLOSSARY

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
DDP	Division of Disease Prevention
HAB	HIV/AIDS Bureau
HIV	Human Immunodeficiency Virus
HCS	HIV Care Services
HRSA	Health Resources and Services Administration
MSM	Men who have Sex with Men
PDSA	Plan Do Study Act
PLWH	People Living with HIV
QMAC	Quality Management Advisory Committee
QMLT	Quality Management Leadership Team
RWHAP	Ryan White HIV/AIDS Program
SPAP	State Pharmaceutical Assistance Program
VDH	Virginia Department of Health