Virginia Ryan White Part B Quality Management

2025 Annual Report

HIV Care Services

4. FY 2025 CLINICAL QUALITY MANAGEMENT (CQM) UPDATE

a. Describe any significant updates you have made to your CQM Plan submitted FY 2025 in each of the following areas. If no significant updates have been made, please note that for the relevant sections(s).

i. **Quality Statement:**
No significant changes in the Quality Statement for FY 2025.

ii. **Quality Goals:**
No significant changes in the Quality Goals for FY 2025.

iii. **Quality Infrastructure:**
A significant change to the quality infrastructure was Virginia's CQM program postponed the Quality Management (QM) and Case Management annual summits due to the funding constraints. Additionally, membership of the Quality Management Advisory Committee (QMAC) declined following the reduction in RWHAP B-funded agencies, and the significant staffing reductions among the remaining funded agencies. These staffing transitions resulted in changes to overall QMAC membership and subcommittee co-chair roles, requiring VDH intervention to support subcommittees until the QMAC identified new chairs and onboarded them through the QMAC orientation. Further, consumer involvement also declined by 25% from FY 2024 participation levels, largely due to the transition away from in-person events and the discontinuation of incentives for statewide call participation. Despite the decrease in consumer call participants, overall CQM engagement remained strong through the Virginia Quality of Care Consumer Advisory Committee (VACAC) executive team efforts, including the recruitment of three new regional representatives (northwest health planning region).

Additionally, the Clinical Data and Administration Team (CDAT) lost two data analysts responsible for management of the client level data system, data reporting, supervision of staff, and subrecipient data technical assistance (TA) during the grant year. Due to funding limitations, CDAT was unable to recruit for both vacancies; however, the program consolidated critical job functions into a single role for efficiency. The recruitment is currently underway for this position.

iv. **Performance Measurement:**
Process of collecting, analyzing and reporting data for a set of measures tied to patient care, health outcomes, or patient satisfaction. See question 4b for instructions on how to describe updates to specific performance measures (PM). In FY 2025, VDH updated the PM selection process to align with PCN 15-02. CQM program staff selected PMs for both core medical and support services and routinely analyzed service utilization data to determine the number of PMs needed for each funded service category. The program shared these updates on a quarterly basis. In FY 2024, the data team reported a total of 23 PMs for 18 funded services. This is in contrast to FY 2025, where the total number of PMs reported decreased by 52%, which currently includes 11 PMs across 9 funded services. While CDAT continues to monitor patterns and data trends across all funded services, VDH used the selected PMs to assess the quality of care, ensure adherence to

best practices and standards of care guidelines, and identify and prioritize quality improvement (QI) activities.

VDH continued to follow the implementation plan for PM data collection, which included established reporting timeframes and a quality assurance (QA) process for reviewing submitted data. Staff also provided training and TA to the subrecipients on accurate data entry, end-user navigation, and importing procedures within Virginia's client level data system, Provide Enterprise (Provide®). Additionally, VDH continued collecting care marker data from external program data sources within VDH (e.g. eHARS database, VEDSS, lab data, etc.) to support calculations for selected PMs and to allow for further data stratification by subrecipients, race, ethnicity, risk factors, and/or regions. CQM staff reviewed the outcomes for each measure on a quarterly basis to assess alignment with HRSA guidelines and target goals.

v. **Quality Improvement:**

VDH, in collaboration with QMAC, identifies statewide QIP priorities through routine review of performance data, feedback from subrecipients, needs assessments, a VDH townhall, trends from QIP result reviews, contract monitoring, and consumer voices through the VACAC committee. This process ensures that QIP topics reflect areas where change in care processes could strengthen client outcomes through improvement of health outcomes, patient satisfaction, and care.

CQM staff collaborated with subrecipients to develop QIP report based on the Model for Improvement, incorporating the Plan-Do-Study-Act (PDSA) cycle, and root cause analysis. On average, it was taking 120 minutes for VDH to securely transmit QIP data packages to subrecipients. To improve this exchange, the team transitioned to using the REDCap system for efficiently distributing and transferring client-level data securely. In addition to collecting QIP data and reports for the grant year, it stored all grant year QIP data and reports for subrecipient reference in a centralized location. This was essential in helping subrecipients through staff changes and making data-driven decisions for their QIPs. To implement this change, VDH trained providers on REDCap usage through TA sessions and open office hours. This change reduced data distribution time by 75%, from 120 minutes to 30 minutes that helped inform subrecipients change-steps in their respective QIPs.

Further, to support subrecipient staff who were new to QIP reporting, the CQM staff developed a training *titled "Root Cause Analysis: Problem-Solving for Quality Improvement Through the Fishbone and Driver Diagram Models*" and offered this course twice during the reporting period. Collectively, 102 participants representing a range of roles and experience levels attended the sessions. This training outlined the differences between the models and their applications as analysis tools, demonstrated how to develop a diagram, and provided guidance on refining high-level diagrams to identify specific problems and targeted change ideas.

Additional statewide QI activities included the biennial implementation of the CQM organizational assessment of the Virginia RWHAP B CQM program. The QMAC QI

subcommittee reviewed, compiled, and presented the results at the February cross-parts collaborative QMAC meeting. The RWHAP Part B team will use the feedback from the assessment to guide FY 2026 CQM goals and activities.

b. Are you currently using service utilization data to determine whether a performance measure is needed for each funded service category as described in Policy Clarification Notice (PCN) #15-02 Clinical Quality Management?
Yes, the Virginia RWHAP B Program uses service utilization data to determine the need for PMs in accordance with PCN #15-02. VDH calculated utilization thresholds by measuring the number of unique clients utilizing RWHAP-B funded services against the total served RWHAP-B served population, including ADAP clients, over a 12-month period. Virginia defines a "*served-client"* as any individual who received at least one RWHAP-B service during the 12-month reporting period. The CDAT monitors the PMs for all service categories on a quarterly basis. In FY 2025, the CDAT identified three PMs as having 50% or greater client utilization: Outpatient Ambulatory Health Services, ADAP Medications, and Non-medical Case Management. The five PMs identified as having 15%-50% utilization were: ADAP Insurance for Medications, Food Bank Home Delivered Meals, Psychosocial Support Services, Oral Health, Medical Transportation, and Medical Case Management. Although Virginia has no reported PMs for service categories with 15% or lower utilization, the team continues to monitor those 14 service categories on a quarterly basis for internal uses.

c. List the performance measure(s) you have identified for each required core medical and support service category.
Please see the uploaded document, "VIRGINIA RWHAP B FY 2025 APR SECTION 5 CQM PLAN PERFORMANCE MEASURES."

d. Discuss how you determine your quality improvement projects. Identify challenges you have with implementing quality improvement projects. Describe your most recently completed or underway quality improvement project including:

- ***Specific patient care process, health outcome, or patient satisfaction you wanted to improve:***
  The QIP aimed to improve access to and retention in quality HIV care and services by reducing the time between diagnosis and ART initiation. Quarterly monitoring tracks the percentage of clients who begin ART within 0-14 days of initial diagnosis and evaluates patient engagement, retention in care after diagnosis, as well as viral load suppression.

- ***Reason for working on the quality improvement project:***
  For FY 2025 planning, VDH reviewed statewide baseline data to assess progress and remaining gaps. Among newly diagnosed clients in early stages of care, linkage to care remained stable at 95% from FY 2024 baseline, while ART initiation rates decreased from 82% to 60% over the same period. Performance varied across agencies, with challenges attributed to small numbers of newly diagnosed clients, differences in internal processes, delays in referral pathways, gaps in coordination between testing and medical providers, and barriers to timely appointment scheduling. Based on this review, VDH continued the statewide QIP topic: "*Targeted Strategies to Increase ART Initiation and*

Linkage to Care Rates Among Clients Newly Diagnosed". Continuing the same QIP topic allowed VDH to build on existing efforts and support agencies in refining workflows that impact timely linkage to care and treatment initiation.

VDH observed variation in QIP performance across sites. Continuing the project allowed the team to provide targeted TA to agencies experiencing challenges with implementing quality initiatives and the Model for Improvement methodology, amid provider-level infrastructure and staffing changes. Frequent changes in QIP points of contact across agencies also highlighted the ongoing need for continuous training and support.

- ***Service category involved in the quality improvement project:***
  The QIP spans several service categories, including HIV Medication Access (Health Insurance Premiums and Medication Provision), Medical Case Management Services, Non-Medical Case Management Services, Outreach Services, Early Intervention Services (EIS), Outpatient/Ambulatory Health Services, and Referral for Health Care and Psychosocial Support Services.

- ***Timeline for the quality improvement project:***
  The QM team monitored the FY 2025 statewide QIP quarterly, from April 1, 2025, to March 31, 2026. Using baseline data, the team reviewed performance and subrecipient quarterly reporting to assess progress of the QIP. As such, the team was able to identify barriers and provide guided TA throughout the project period when necessary.

- ***Quality improvement approach or methodology used when implementing the quality improvement project:***
  The VDH uses several well-established QI methodologies, including the Model for Improvement and the PDSA cycle, that all Part B subrecipients implemented and monitored on a quarterly basis. In addition, the subrecipients employed tools such as process mapping and root cause analysis to identify underlying reasons why clients may not successfully link to care. The Model for Improvement, combined with PDSA cycles, enables rapid testing of targeted strategies and is particularly effective for improving linkage-to-care processes due to its flexibility and iterative nature. This approach allows programs to set clear targets, test interventions efficiently, and continuously refine strategies based on real-world data.

- ***Results of quality improvement project:***
  The data indicates a strong performance across the HIV care continuum for the QIP cohort during the reporting period. There were 92% of QIP cohort participants linked to HIV medical care within 30 days of receiving a new HIV diagnosis. This demonstrates effective coordination between testing, referral, and treatment services. Agencies initiated ART medications for approximately 67% of the QIP cohort within an average of 14 days and more people following diagnosis. While this reflects progress toward early ART initiation goals, the difference between linkage to care and ART initiation rates suggests potential barriers to immediate treatment uptake, such as readiness for treatment, insurance or medication access issues, scheduling delays, or client engagement challenges. Despite these gaps, the cohort demonstrated excellent clinical outcomes. By

the end of Quarter 4, 92% of clients who received early ART achieved viral load suppression (VLS). This finding highlights the effectiveness of early initiation of ART in improving health outcomes and reducing HIV transmission risk. The equivalence between the linkage-to-care rate and the VLS rate further suggests that clients who successfully engaged in care were highly likely to remain adherent to treatment and achieve positive clinical outcomes.

- ***Ways that the quality improvement project informed funding decisions or enhanced service delivery:***
  Several challenges affected implementation across subrecipients during FY 2025. Small cohorts of newly diagnosed clients limited the ability to establish stable trends, with results often fluctuating between reporting periods. VDH monitored variation in early care engagement across subrecipients to identify barriers delaying treatment initiation noted in QIP reports. Findings informed program monitoring and QMAC discussions focused on strengthening rapid referral pathways between testing, eligibility, case management, and medical providers. The QM team encouraged providers to improve internal workflows to support timely appointments and ART initiation. Although measurable improvements were difficult to demonstrate consistently due to small cohort sizes, these efforts supported a data-informed approach to improving linkage to care, earlier ART initiation, and coordination across the care continuum.