



**Ryan White Program Part B
Quality Management Plan
April 2014-March 2015**



**Georgia Department of Public Health
Division of Health Protection
HIV Office**

Last Revised March 2014

Introduction

Ryan White HIV/AIDS legislation requires clinical quality management (QM) programs as a condition of grant awards. The QM expectations for Ryan White (RW) Program Part B grantees include: 1) Assist direct service medical providers funded through the CARE Act in assuring that funded services adhere to established HIV clinical practice standards and Department of Health and Human Services (DHHS) Guidelines to the extent possible; 2) Ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access and adherence with HIV medical care; and 3) Ensure that available demographic, clinical and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The Georgia RW Program Part B QM Plan is outlined in this document. This document is considered a "living" document and the Georgia Department of Public Health (DPH), Division of Health Protection, HIV Office will continue to develop and expand the RW Program Part B Clinical QM program and plan. This QM Plan is effective **April 1, 2014 to March 31, 2015**. A timeline for annual implementation, revision, and evaluation of the Plan is located in Appendix B of this document. If you have any questions concerning this plan, please contact Eva Williams at 404-657-3113, Michael (Mac) Coker at (404) 463-0387 or Pamela Phillips at (404)-657-8993.

Georgia Ryan White Program Part B Clinical Quality Management Plan

I. Quality Statement

A. Mission

The mission of the RW Part B Clinical Quality Management Program is to ensure the highest quality of medical care and supportive services for people living with HIV/AIDS in Georgia.

B. Vision

The vision of the QM Program is to ensure a seamless system of comprehensive HIV services that provide a continuum of care and eliminates health disparities across jurisdictions for people living with HIV/AIDS in Georgia. This will be accomplished by:

- ❖ Assessing the extent to which HIV health services provided to patients under the grant are consistent with the most recent DHHS guidelines for the treatment of HIV disease and related opportunistic infections.
- ❖ Developing strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.
- ❖ Continuously implementing a statewide quality management plan.
- ❖ Improving access to AIDS Drug Assistance Program (ADAP) and Health Insurance Continuation Program (HICP) services by improving the application and recertification processing.
- ❖ Improving alignment across sub-recipients by monitoring core performance measures across RW Program Part B sub-recipients.
- ❖ Improving alignment across services through standardization of case management.
- ❖ Improving alignment across RW Programs by expanding quality related collaboration.

C. 2014 Goals and Objectives

❖ **Goal 1: Continuously implement a statewide RW Part B quality management plan, which is updated at least annually.**

Objectives include:

- 1.a. Provide at least two quality improvement (QI) /quality management (QM) training workshops based on identified needs.
- 1.b. Assure that at least two quality improvement projects occur at the state and local level during the year.
- 1.c. Assure that at least two quality improvement activities occur in each district during the year.
- 1.d. Communicate findings to key stakeholders at least biannually.
- 1.e. Update the QM plan at least annually and the QM work plan at least quarterly.
- 1.f. Require that all districts revise written QM plans annually, and submit quarterly QM progress reports.

❖ **Goal 2: Improve efficiency of the Georgia AIDS Drug Assistance Program (ADAP).**

Objectives include:

- 2.a. **Increase** the percentage of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application to 95% or greater.
- 2.b. **Increase** the percentage of Georgia ADAP clients recertified for ADAP eligibility criteria at least semi-annually to **85%** or greater.
- 2.c. **Increase** the percentage of correctly completed waiting list ADAP applications submitted to ADAP to **85%** or greater.
- 2.d. Conduct an internal audit of up to 5% of ADAP **new client application forms** annually.
- 2.e. Monitor programmatic compliance and adherence to antiretroviral regimens.
- 2.f. Systematically review data collected by the ADAP to identify inappropriate antiretroviral regimens or components.

❖ **Goal 3: Improve efficiency of the Georgia Healthcare Insurance Continuation Program (HICP).**

Objectives include:

- 3.a. Increase the percentage of active HICP clients recertifying before the 6 month due date to prevent delays in payments for health insurance premiums to 95% or greater.
- 3.b. Conduct an internal audit quarterly of up to 5% of HICP new client application forms.

- ❖ **Goal 4: Improve the quality of health care and supportive services.**
Objectives include:
 - 4.a. Monitor performance measures in all 16 Part B funded sites at least annually.
 - 4.b. **Design and implement statewide CQI projects to improve two In+Care/new HAB Core performance measures**
 - 4.c. Monitor the implementation of the Acuity Scale and Self Management Model.
 - 4.d. Revise the *Georgia HIV/AIDS Case Management Standards*.
 - 4.e. Coordinate quality-related activities across Ryan White Programs (Parts A, B, C, and D) in Georgia.
 - 4.f. The percentage of HIV-infected pregnant women prescribed antiretroviral therapy will be 95% or greater.
 - 4.g. Revise the *Georgia Medical Guidelines for the Care of HIV-Infected Adults and Adolescents*.
 - 4.h. **Monitor measures to verify compliance with HRSA regulations related to the health insurance marketplace.**
 - 4.i. Monitor In+Care Campaign Measures and utilize data to facilitate quality improvement.
 - 4.j. Continually monitor compliance with RW Part B program requirements.

D. Quality Management Work Plan

- ❖ The QM plan includes a “living” Work Plan that is updated at least quarterly.
- ❖ The Work Plan specifies objectives and strategies for QM plan goals.
(The Work Plan is attached in a separate file as Appendix A)

E. Quality Management Plan Timeline

- ❖ The QM plan includes a timeline to ensure annual revision of the QM plan.
- ❖ The timeline incorporates development, implementation, and revision of the plan based on the Ryan White Program Part B grant year.
- ❖ The timeline includes quarterly QM Core Team meetings and progress reports.
(See Appendix B)

II. Organizational Infrastructure

A. Leadership and Accountability

1. Georgia Department of Public Health

The State of Georgia through the Department of Public Health (DPH) is the recipient of the Ryan White Program Part B grant. The DPH administers the grant through the Division of Health Protection, HIV Office. Within the HIV Office,

the HIV Director oversees the HIV Care Manager. The HIV Care Manager is responsible for ensuring administration of the grant, including the development and implementation of the quality management (QM) plan.

2. HIV Office

The HIV Office provides oversight and management of the RW Program Part B grant. The HIV Office monitors all RW Program Part B funds and sub-recipients to ensure that RW Program Part B funds are the payor of last resort. The HIV Office leadership is dedicated to the quality improvement process and guides the quality management plan.

3. Other DPH Sections

HIV/AIDS Epidemiology

The HIV Office continues to work with the HIV/AIDS Epidemiology Unit to utilize HIV and AIDS case reporting data for planning and quality improvement opportunities.

4. Ryan White Program Part B Sub-Recipients

- RW Program Part B sub-recipients are responsible for ensuring quality management components of the Grant-in-Aid agreements are met.
- The FY **2014-2015 Annex** Grant-In-Aid (GIA) deliverables include the following QM language, as referenced in the **Georgia RW Part B/ADAP Policies and Procedures**:
 - Ensure that the medical management of HIV infection is in accordance with the DHHS HIV-related guidelines including:
 - Antiretroviral treatment
 - Maternal-child transmission
 - Post-exposure prophylaxis
 - Management of tuberculosis and opportunistic infections
 - HIV counseling and testing
 - Ensure compliance with the HIV Office manual, *Medical Guidelines for the Care of HIV-Infected Adults and Adolescents*, current edition.
 - Ensure that registered nurses (RNs) and advanced practice registered nurses (APRNs) practice under current HIV/AIDS-related nurse protocols. The recommended protocols include:
 - Georgia DPH, Office of Nursing, Nurse Protocols for Registered Professional Nurses in Public Health, Section 12 HIV/AIDS-related.
 - DHHS, HRSA, Guide for HIV/AIDS Clinical Care, current edition.
 - Georgia DPH, Office of Nursing, Guidelines for Public Health APRN Prescriptive Authority, if applicable.
 - Ensure that all **Physicians**, Pharmacists, and all other licensed medical professionals possess current licensure and/or certification. Ensure that all **Physicians** are practicing under current HIV/AIDS-related protocols

and are practicing under the current laws of the State of Georgia. If there is any lapse in licensure and/or the occurrence of suspension that deems a medical professional unable to practice medicine under current laws, the HIV Care District Liaisons are to immediately be notified.

- Develop and implement a quality management (QM) program according to the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) expectations for RW grantees. Include the following:
 - A written QM plan **and work plan**, which is updated annually.
 - A leader and team to oversee the QM program.
 - QM goals, objectives, and priorities.
 - Performance measures and mechanisms to collect data.
 - Project-specific continuous quality improvement (CQI) **plan (e.g., work plan)**.
 - Communication of results to all levels of the organization, including consumers when appropriate.
- Participate in the statewide Part B QM Program.
- Monitor performance measures as determined by the Part B QM Program.
- Participate in **HIV clinical and case management chart reviews conducted by state office QM staff**.
- Provide QM plan, reports, and other information related to the local QM program as requested by the HIV Care District Liaison and/or State Office QM staff. Allow the HIV Care District Liaison and/or State Office QM staff access to all QM information and documentation.
- Ensure compliance with the Georgia HIV/AIDS Case Management Standards (**current edition**). Include the following:
 - Case managers utilize the standardized case management client intake form or an equivalent.
 - All case managed clients have an Individualized Service Plan (ISP) developed within 30 days of intake. **Districts utilizing the standardized Case Management Acuity Scale and Self-Management Model will revise the ISP as specified according to the Acuity by Level Activities document. The remaining districts must provide documentation that Medical Case Management clients had an ISP developed and/or updated two or more times per year.**
 - Documentation in the ISP and case notes of coordination and follow-up of medical treatments and treatment adherence.
 - **Implement the standardized Case Management Acuity Scale and Self-Management Model into service provision.**

B. Quality Management Committee(s)

1. Quality Management Core Team

a. Purpose

- To provide oversight and facilitation of the Georgia RW Program Part B QM Plan.
- To provide a mechanism for the objective review, evaluation, and continuing improvement of HIV care and support services.

b. Membership

- The Core Team membership will be reviewed annually and changes made accordingly.
- Membership by consumers and RW Program Part B sub-recipients will be on a voluntary basis.
- Persons interested in volunteering will submit requests to the HIV Office or Core Team.
- Composition and Roles/Responsibilities

The Core Team will include the following members:

- **Senior DPH Leadership:** Any or all of the positions below, or their designees, may attend meetings to represent the involvement of senior leadership.
 - ◆ The HIV Office Director – Duties include:
 - HIV Office leadership and coordination of HIV care and prevention activities.
 - ◆ The HIV Care Program Manager – Duties include:
 - Grant oversight and management including: ensuring the development and implementation of the QM plan and systems-level continuous quality improvement (CQI) projects.
- **The HIV Care District Liaisons** – Duties include:
 - ◆ Closely monitor the programmatic and fiscal requirements of all contracts and ~~Annex-GIA Grant-in-Aid~~ awards including quality management requirements.
 - ◆ Ensure QM/QI findings/reports are shared regarding systems-level CQI projects.
 - ◆ Monitor general RW Program performance measures (located in Appendix D).
- **RW Program Part B QM staff members:**
 - ◆ Nurse Consultant (QM Team Leader). Duties include:
 - Functioning as the key contact and team leader for quality management.
 - Coordinating the day-to-day QM Program operations.
 - Supervising QM staff members.
 - Recruiting QM Team members.
 - Coordinating QM Team meetings.
 - Coordinating systems-level CQI projects.

- Ensuring development, implementation, and evaluation, of the QM plan and Work Plan.
- Ensuring revision of the QM plan at least annually, and the Work Plan at least quarterly.
- Completing and submitting required reports related to QM.
- Ensuring QM/QI and other HIV-related training is available.
- Closely monitoring assigned districts' QM plans and quarterly reports.
- Providing technical assistance to the RW Program Part B sub-recipients in the development of local QM plans and nursing/clinical services.
- Conducting site visits to review QM plans and activities, and/or to review clinical performance indicators.
- Participating on the DPH Nursing QA/QI Team.
- **Participating in GA Ryan White Programs quality-related committees and activities.**
- Attending the metro Atlanta EMA Quality Management Committee meetings.
- Participating in the revision of the HIV/AIDS-related nurse protocols.
- Developing and revising HIV-related medical guidelines and other guidelines/policies as indicated.
- Attend educational conferences or other events sponsored by HRSA, DPH, SEATEC, professional organizations or other appropriate sponsoring organizations to maintain current knowledge of HIV clinical practice and/or Quality Management.
- ◆ **The QM Coordinator - Duties include:**
 - Assisting with coordination of day-to-day operations of the QM Program:
 - Planning meetings and/or conference calls.
 - Communicating with the Core Team and subcommittees.
 - Completing reports and other assignments.
 - Facilitating the Case Management Subcommittee.
 - Participating in systems-level CQI projects.
 - Participating on the QM Core Team.
 - Ensuring the development, implementation, and evaluation of statewide case management standards and tools.
 - Ensuring QM/QI and case management training is available.
 - Assisting with the revision of the QM plan and Work Plan.
 - Closely monitoring assigned districts' QM plans and quarterly reports.
 - Providing technical assistance to the RW Program Part B sub-recipients in the development of local QM plans and activities.
 - Conducting site visits to review QM plans and activities, and/or to review case management services.

- **Participating in GA Ryan White Programs quality-related committees and activities.**
- Attending the Metro Atlanta EMA Planning Council and Quality Management Committee meetings.
- Attend educational conferences or other events sponsored by HRSA, DPH, SEATEC, professional organizations or other appropriate sponsoring organizations to maintain current knowledge of HIV case management and/or Quality Management.
- ◆ HIV Medical Advisor - Duties include:
 - Participating on the QM Core Team.
 - Providing medical expertise and technical assistance to the HIV Office, ADAP, RW Program Part B sub-recipients and others.
 - Chairing the HIV Medical Advisory Committee.
 - Conducting site visits to review clinical performance measures including: management and utilization of antiretroviral therapy.
 - Revising and approving the HIV/AIDS-related nurse protocols.
 - Providing training to HIV providers and others as indicated.
 - Mentoring physicians inexperienced in HIV care.
 - Assisting with QM-related reports and assignments.
 - Assisting with development and/or revisions of medical guidelines, policies, and/or procedures.
- ◆ Nurse Consultant - Duties include:
 - Assisting with coordination of day-to-day operations of the QM Program:
 - Planning meetings and/or conference calls.
 - Communicating with the Core Team and subcommittees.
 - Completing reports and other assignments.
 - Participating in systems-level CQI projects.
 - Participating on the QM Core Team.
 - Closely monitoring assigned districts' QM plans and quarterly reports.
 - Providing technical assistance to the RW Program Part B sub-recipients in the development of local QM plans and activities.
 - Conducting site visits to review QM plans and activities, adherence activities, or clinical performance indicators.
 - Coordinating the revisions of nurse protocols.
 - Developing or revising medical guidelines, policies, and/or procedures.
 - Attending the Metro Atlanta EMA Quality Management Committee meetings.
 - **Participating in GA Ryan White Programs quality-related committees and activities.**
 - Attend educational conferences or other events sponsored by HRSA, DPH, SEATEC, professional organizations or other

- Needs assessments.
 - Satisfaction surveys.
 - Interviews.
 - Representative from HIV/AIDS Surveillance (Ad hoc) – Duties include:
 - ◆ Providing HIV and AIDS case reporting data for planning and quality improvement opportunities as needed.
 - Ryan White Program Part B sub-recipient (District HIV Coordinator) – Duties include:
 - ◆ Representing his/her agency/program.
 - ◆ Suggesting quality improvement processes and projects.
 - ◆ Providing direct feedback on services and barriers.
 - ◆ Ensuring that Part B QM activities align with his/her local QM plan/activities.
 - Representatives from RW Program Parts A, C, and D – Duties include:
 - ◆ Representing their agencies/programs and ensuring that Part B QM activities align across RW Programs statewide.
 - Medicaid Representative (Ad hoc) – Duties include:
 - ◆ Assisting with Medicaid-related QM activities as needed.
 - Representative from HIV Prevention – Duties include:
 - ◆ Updates on HIV Prevention activities and coordinating activities when possible.
 - Representative from Fetal Infant Mortality Registry (FIMR)/HIV Program – Duties include:
 - ◆ **Updates on progress of program implementation and sharing aggregate data as indicated.**
 - All other RW Program Part B HIV Office staff – Duties include:
 - ◆ Participating in the QM plan as needed. (See Appendix C. for **2014-2015** Core Team Members).
- c. Communication
- The Core Team meets at least once quarterly. In-person meetings are preferred.
 - Additional conference calls and electronic communication is ongoing.
 - The Core Team shares QM/QI findings/reports within DPH; with the HIV Office, RW Program Part B sub-recipients, and others.
 - District Liaisons ensure QM/QI findings/reports are shared at Consortia meetings.
- d. General Core Team Responsibilities
- A Nurse Consultant serves as the key contact and team leader for quality management.

- At least one member of the QM Core Team routinely attends the Metro Atlanta EMA Planning Council and Part A Quality Management Committee meetings.
- The Core Team is responsible for guiding the overall QM program including determining priorities, setting goals, creating/revising the work plan (see Appendix A.), preparing reports, and evaluating the program and plan.
- The Team:
 - Determines the need for subcommittees and guides the subcommittee's work plan.
 - Actively participates in meetings, conference calls, and other activities as needed.
 - Determines performance measures, and identifies indicators to assess and improve performance.
 - Shares findings with the HIV Office, RW Program Part B sub-recipients/Consortia, leadership within DPH, and others.
 - Reviews and updates the QM plan annually.
 - Makes recommendations to the HIV Office for appropriate education related to QI topics.
 - Conducts evaluation activities.

2. Subcommittees

Subcommittees will be created by the Core Team as needed.

- a. Case Management Subcommittee
 - Goal: The committee identifies gaps in service provision, sets priorities for system expansion, discusses case manager training needs, and develops strategies to address client issues.
 - Membership: Members of the subcommittee are selected to represent all Ryan White Parts, and other case management agencies providing services to people living with HIV/AIDS (PLWHA) in Georgia. (See Appendix C. for committee members.)
 - Responsibilities:
 - Comply with the Core Team's overall goals and Work Plan.
 - Communicate with the Core Team.
 - Submit meeting minutes in predetermined format.
 - Monitor Ryan White Program Part B CM standards.
- b. Georgia ADAP/HICP Quality Management Subcommittee
 - Goal: Improve access to ADAP and HICP services by improving the application and recertification process.

- Membership: Will consist of 11 members and include a diverse mix of State Office staff, medical and pharmacy experts, case managers, and consumers. (See Appendix C. for committee members.)
- Responsibilities:
 - Comply with the Core Team's overall goals and Work Plan.
 - Actively communicate with the Core Team.
 - Submit meeting minutes in predetermined format.
 - Monitor ADAP/HICP policy, processes, and progress from a quality management viewpoint.
 - Identify ADAP/HICP problems/issues and make recommendations for improvement.
- The subcommittees will meet quarterly approximately 2-3 weeks prior to the quarterly Core Team meeting. Meetings will take place via phone conferencing.

3. State Office HIV Care Team

- a. Goal: Plan, implement, monitor and evaluate quality, including CQI projects, to improve HIV care systems.
- b. Members: State Office HIV Care Team members including: the QM staff, HIV Care Manager, **Ryan White Specialist**, ADAP/HICP Manager, ADAP Pharmacy Director, ADAP and HICP staff, District Liaisons, CAREWare Team Leader and CAREWare staff.
- c. Responsibilities include:
 - Developing, implementing, monitoring and evaluating the QM Plan.
 - Identifying areas for improvement projects.
 - Conducting and evaluating improvement projects.
 - Documenting improvement projects and results.
 - Utilizing CQI methodologies such as PDSA (Plan, Do, Study, Act) cycles for small tests of change.
 - Reporting back to QM Core Team as appropriate.
 - Systematizing changes if appropriate.

4. Local Sub-Recipient's QM Committee

- Each sub-recipient is required to convene and maintain a local HIV-specific QM committee.
- This committee should contain representation of key stakeholders including: an identified committee chair, a medical provider, nurse, case manager, clerk, consumer, and other relevant persons.
- Local QM committees should meet at least quarterly and guide HIV care related QM activities.
- The local QM committee is responsible for developing, implementing, monitoring and evaluating the local QM plan.

C. Resources

- ❖ Human Resources and Services Administration (HRSA)
 - HIV/AIDS Bureau (HAB)
- ❖ National Quality Center (NQC)
- ❖ The Metro Atlanta EMA Ryan White Part A Quality Management Committee
- ❖ The Southeast AIDS Education and Training Center (SEATEC)
- ❖ HIV/AIDS Epidemiology Unit
- ❖ Ryan White Programs Part C and D
- ❖ Other DPH personnel as needed
- ❖ Local sub-recipients

D. Performance Measurement System

The following outlines the processes for ongoing evaluation and assessment:

- ❖ The Core Team determines quality projects and guides the process.
- ❖ Data is used to identify gaps in care and service delivery.
- ❖ The details for statewide QI activities are described in the QM Work Plan (see Appendix A).
- ❖ All project findings are prepared by the Core Team, and shared with RW Program Part B sub-recipients, the HIV Office, and within the DPH.
- ❖ Evaluation of QI projects is ongoing. The Work Plan is updated at least quarterly.
- ❖ The Part B CAREWare database is utilized whenever possible to collect data for statewide performance measures.
- ❖ RW Program Part B sub-recipients monitor selected performance measures and report to the Program. The Core Team reviews these measures and compiles reports.
- ❖ RW Program Part B sub-recipients and general RW Program performance measures are monitored by the District Liaisons for compliance with the **Annex-GIA** award deliverables. (See Appendix D. Monitoring Table)
- ❖ HIV Nurse Consultants and the HIV Medical Advisor review HIV clinical charts in Part B-funded agencies for specific clinical performance measures (See Appendix D. Monitoring Table). Findings are summarized and reported back to each site with a request for improvement plan based on findings.
- ❖ The QM Coordinator and **HIV Nurse Consultants** monitor Ryan White Part B sub-recipients for compliance with case management standards and performance measures. (See Appendix D. Monitoring Table) Findings are summarized and reported with a request for improvement plan based on findings.
- ❖ The QM Core Team annually assesses the QM Program for effectiveness.

E. Coordination with Other Statewide QI/QA Activities

1. Coordination across RW Programs

- The RW Program Part B QM Plan focuses on collaboration of quality activities across all RW Parts in Georgia.
- The RW Program Part B QM Plan involves participation of members from RW Parts A, C, and D. The Core Team and Subcommittees include members from Parts A, C, and D.
- A QM staff person attends the Metro Atlanta EMA QM Committee meetings. The Core Team collaborates across RW Programs on QM activities, when possible.

2. Coordination within DPH

- The HIV Nurse Consultants participate on the DPH Nursing QA/QI Team led by the Office of Nursing.
- The QM staff collaborates with the Office of Performance Improvement.
- The Core Team includes an ad hoc member of the HIV/AIDS Epidemiology Unit.
- An HIV Prevention Representative and **FIMR/HIV representative** attend Core Team meetings. The Core Team collaborates on strategies to reduce perinatal HIV transmission in Georgia.
- The HIV Nurse Consultants have collaborative relationships with Program Collaboration Service Integration (PCSI), which includes Tuberculosis (TB), Sexually Transmitted Disease (STD), Immunization, Refugee Health, and Hepatitis to provide technical assistance and training as needed.
- At least one member of the Core Team will participate on the Georgia Oral Health Coalition.
- The Core Team will collaborate with other sections and share quality findings within DPH as indicated.

3. Coordination with ADAP/HICP

- The overall RW Program Part B QM plan includes goals specific to ADAP/HICP. The ADAP/HICP Manager and ADAP Pharmacy Director are members of the Core Team.
- The GA ADAP/HICP QM Workgroup meets as a subcommittee and reports to the QM Core Team.

4. Feedback from Key Stakeholders

- The Core Team communicates findings and solicits feedback from both internal and external key stakeholders on an ongoing basis.
- Presentations are made during RW Part B Coordinators meetings, Consortia meetings, RW Programs meetings, and others as identified.
- Written reports are shared with key stakeholders.
- Stakeholders are given the opportunity to provide feedback to reports and to prioritize quality activities.

- The HIV Office maintains current Part B QM plans, reports, and other related information on the Office's web pages.
- The process to complete the Statewide Coordinated Statement of Need (SCSN) involves feedback from key stakeholders including but not limited to consumers, representatives from All Ryan White Parts, HIV Prevention, and faith-based organizations.

III. Implementation

A detailed QM Work Plan is included as Appendix A in an attached file. The Work Plan is revised at least quarterly by members of the Core Team. The Work Plan includes goals, objectives, strategies, assignments, timeline, and progress for performance goals and outcome measures.

A. Data Collection

1. Data Collection Strategies

- The HIV Data Team, HIV/AIDS Epidemiology Unit, and others assist with data collection strategies.
- Data Sources include the following:
 - CAREWare
 - RW Data Reports
 - Enhanced HIV/AIDS Reporting System (eHARS)
 - Vital Records
 - Clinical Chart Review Tool
 - Programmatic monitoring tools
 - Reports from sub-recipients
 - Pharmacy Benefits Manager (PBM) database
 - Client satisfaction surveys
 - Case Management Chart Review Tool
- Data collection is based on appropriate sampling methodologies.

2. Reporting Mechanisms

- Ryan White Program Part B sub-recipients are required to report data on key performance indicators.
- The Core Team reviews and compiles findings.
- District Liaisons and/or Ryan White Program Part B QM staff review sub-recipient QM plans and reports for effectiveness and accuracy.
- Findings are shared with HIV providers, RW Program Part B sub-recipients, Consortia, the HIV Office, the DPH leadership, and others.
- Findings are used to guide CQI activities.

3. Performance Measurement

Key clinical and non-clinical performance indicators are measured statewide.
(See Appendix D Monitoring Table)

- **HRSA/HAB released new HIV Performance Measures in October 2013.**
The new performance measures will be integrated into review tools and prioritized. The new measures will be integrated in CAREWare as they become available. Until this process is complete, the previous HRSA/HAB measures will be used.
- The Part B District reports include performance measures from the Part B Implementation Plan.
- The HIV Nurse Consultants and Medical Advisor will review RW Part B HIV clinical charts for key clinical performance measures.
- The QM Coordinator and HIV Nurse Consultants review case management charts for performance measures.
- District Liaisons monitor **selected** general RW programmatic measures.
- ADAP/HICP staff review ADAP and HICP performance measures through data reports.

B. Quality Improvement Projects

- ❖ The Core Team and/or the State Office Care Team select and prioritize statewide or system QI projects.
- ❖ Data is utilized to guide project selection.
- ❖ CQI Methodology is utilized and includes the following:
 - The Model for Improvement (PDSA [Plan/Do/Study/Act] Cycles). (See Appendix E).
 - Flow chart analysis
 - Cause and effect diagrams
 - Brainstorming
 - Observational studies/patient flow
 - Activity logs
- ❖ *The Testing Change (PDSA) Worksheet* will be utilized to document tests of change during QI projects (See Appendix E).
- ❖ Improvement projects are documented in the QM work plan.
- ❖ Sub-recipient QM plans include CQI projects.
- ❖ The following statewide clinical CQI objectives are included in this plan:
 - **Design and implement statewide CQI projects to improve two In+Care/HAB Core performance measures.**

C. Capacity Building

- ❖ Ryan White Program Part B QM staff participates in NQC trainings and webinars to support their ongoing QM skills development. This enables staff to provide and coordinate technical assistance/training for RW Program Part B sub-recipients.
- ❖ NQC training materials and resources are utilized as much as possible.
- ❖ QM technical assistance/training needs are assessed through requests in sub-recipients' applications, monitoring of local QM plans/programs and quarterly reports, and through training evaluations and/or needs assessments.

IV. Evaluation

A. Self-Assessment

- ❖ The QM Core Team completes the *HAB/NQC Collaborative Ryan White Program Part B QM Assessment Tool* at least annually.
- ❖ The QM plan is assessed using the *Checklist for the Review of an HIV-Specific Quality Management Plan*, assessment tool developed by the NQC.
- ❖ The QM Core Team completes an annual assessment and subsequent revision of the QM plan.
- ❖ The QM Core Team evaluates the RW Part B QM Program on an annual basis including rating the completeness of strategies.

B. Evaluation of Local QM Plans

QM staff members annually review local QM plans including QI activities, progress on case management standards and performance indicators. They provide feedback regarding each plan.

C. External Evaluation

QM plans and progress are reported to HRSA during Part B grant applications and progress reports. HRSA provides external feedback regarding the Georgia RW Part B QM Program.

D. DPH Evaluation

- ❖ At least annually, findings are reported to leadership within DPH.
- ❖ A revised QM plan is submitted to HIV Office leadership for approval on an annual basis.

Appendix A. Quality Management Work Plan

(See attached file. The Work Plan is updated quarterly)

GA Ryan White Part B Program QM Plan - APPENDIX A
April-June 2014 Work Plan

Goal 1: Continuously implement a statewide RW Part B quality management plan, which is updated at least annually

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>1-1 Provide quality improvement/management training workshops based on identified needs.</p>	<p>1-1.a. Plan and conduct two quality management trainings based on identified needs. 1-1.b. Identify topics, dates, and locations for next training(s). 1-1.c. Participate on a Statewide Ryan White Part B conference planning committee and ensure that quality topics are included on the conference agenda. 1-1.d. Consider using webinars to share best practices and provide QM training. 1-1.e. Coordinate quality training efforts with HIVQual consultant. 1-1.f. Collaborate with partners to implement clinical and/or case management training based on identified needs.</p>	<p>Eva Williams, Michael "Mac" Coker, and Pamela Phillips</p>	<p>Part A HIVQual Consultant</p>	<p>1-1.a. March 31, 2015 1-1.b. June 30, 2014 1-1.c. On hold 1-1.d. March 31, 2015 1-1.e. June 30, 2014 1-1.f. March 31, 2015</p>	
<p>1-2 Assure that quality improvement projects occur at the state and local levels during the year.</p>	<p>1-2.a. Facilitate system improvements by utilizing CQI methodologies. 1-2.b. Review local CQI projects and provide technical assistance (TA). 1-2.c. Meet with and provide onsite TA to local QM committees. 1-2.d. Monitor local quarterly QM reports for CQI and best practices. 1-2.e. Solicit input from QM Core Team regarding statewide improvement efforts. 1-2.f. Monitor participation in the In+Care Campaign. 1-2.g. Monitor GPHL HIV viral load specimen reports. 1-2.h. Collaborate with the Centers for Medicaid and Medicare Services (CMS) on CQI projects as they are identified.</p>	<p>Eva Williams, Michael "Mac" Coker, Pamela Phillips and Rachel Powell</p>	<p>Care Team NQC training materials and assessment tools District Liaisons Local Committees</p>	<p>1-2.a. Quarterly 1-2.b. Quarterly 1-2.c. As needed 1-2.d. Quarterly in July, October, and January 1-2.e. Quarterly 1-2.f. Per Campaign due dates 1-2.g. Monthly 1-2.h. As needed</p>	

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Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
1-3 Communicate findings to key stakeholders at least biannually.	<p>1-3.a. Present at Statewide Part B Meetings and other applicable meetings.</p> <p>1-3.b. Share progress reports with All Parts and across programs as appropriate, specifically share work plans with progress notes completed.</p> <p>1-3.c. Update QM information on the HIV Office web page.</p> <p>1-3.d. Explore strategies to involve district staff in the statewide quality process.</p>	Eva Williams, Michael "Mac" Coker, and Pamela Phillips	QM Core Team	<p>1-3.a. When scheduled</p> <p>1-3.b. At least bi-annually</p> <p>1-3.c. As needed</p> <p>1-3.d. Sept. 2014</p>	
1-4 Update the QM plan at least annually and the QM work plan at least quarterly.	<p>1-4.a. Revise work plan quarterly.</p> <p>1-4.b. Send QM plan to PH Clinical and Nursing Coordinators and HIV Coordinators.</p> <p>1-4.c. Share QM Plan with DPH and HIV Office stakeholders.</p> <p>1-4.d. Place revised QM plan on HIV Office web pages.</p>	Eva Williams, Michael "Mac" Coker, and Pamela Phillips	QM Core Team	<p>1-4.a. Quarterly</p> <p>1-4.b. Annually</p> <p>1-4.c. Annually</p> <p>1-4 d. Annually</p>	
1-5 Require that all 16 RW Part B- funded Health Districts revise written QM plans annually, and submit quarterly QM progress reports.	<p>1-5.a. Obtain quarterly QM reports from the Part-B funded health plan districts and monitor QM activities, work plan and PMs.</p> <p>1-5.b. Obtain revised QM plans from each Part-B funded health district by the end of the month of the renewal date (Jan. 31st, April 30th, or July 31st).</p> <p>1-5.c. Review local QM plans and provide feedback.</p>	Eva Williams, Michael "Mac" Coker, Pamela Phillips, and Rachel Powell District Liaisons	District HIV Coordinators and Local QM Committees QM Core Team	<p>1-5.a. Quarterly</p> <p>1-5.b. Per annual renewal date</p> <p>1-5.c. Per annual renewal date</p>	

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Goal 2: Improve efficiency of the Georgia AIDS Drug Assistance Program (ADAP).

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>2-1. Increase the percentage of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application to 95% or greater.</p>	<p>2-1.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee. 2-1.b. Evaluate reports for trends in ADAP State Office performance in processing new applications. 2-1.c. Conduct CQI projects to decrease length of time to determine ADAP eligibility or ineligibility by ADAP State Office. 2-1.d. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed ADAP application submissions. 2-1.e. Provide technical assistance on ADAP applications and required supporting documentation to staff and agencies. 2-1.f. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 2-1.g. Provide or coordinate ADAP-related training for ADAP/HICP Enrollment Site Coordinators and case managers. 2-1.h. Communicate GA ADAP updates via conference calls, email listserv, and HIV Office web pages. 2-1.i. Convene the Georgia ADAP/HICP Quality Management Subcommittee at least quarterly.</p>	<p>Libby Brown, Alysia Johnson, Kimberly Morrow</p>	<p>Pamela Phillips ADAP Associates</p>	<p>2-1.a. Monthly, quarterly 2-1.b. Quarterly 2-1.c. As needed 2-1.d. Monthly 2-1.e. As needed 2-1.f. During internal review as needed 2-1.g. As needed 2-1.h. As needed 2-1.i. Quarterly</p>	

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>2-2. Increase the percentage of Georgia ADAP clients recertified for ADAP eligibility criteria at least semi-annually to 85% or greater.</p>	<p>2-2.a. Generate monthly reports to monitor this objective and share quarterly with the ADAP/HICP Subcommittee. 2-2.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status. 2-2.c. Monitor the ADAP enrollment sites systems to track ADAP client recertification due dates. 2-2.d. Provide technical assistance to those who need assistance developing or improving their system to track ADAP client recertification due dates. 2-2.e. Ensure that ADAP coordinators and case managers comply with the approved Georgia ADAP Policies and Procedures manual. 2-2.f. Provide or coordinate ADAP-related training for ADAP/HICP Enrollment Site Coordinators and case managers. 2-2.g. Conduct administrative site visits. 2-2.h. Communicate GA ADAP updates via conference calls, email listserv, and HIV Office web pages. 2-2.i. Convene the Georgia ADAP/HICP Quality Management Workgroup at least quarterly. 2-2.j. Generate reports of the percentage of discontinued clients enrolling in ADAP, and share quarterly with the ADAP/HICP Subcommittee. 2-2.k. Implement and monitor a self-attestation recertification process.</p>	<p>Libby Brown, Alysa Johnson, Kimberly Morrow</p>	<p>Pamela Phillips Roderick Newkirk ADAP associates</p>	<p>2-2.a. Monthly, quarterly 2-2.b. Monthly. 2-2.c. During admin. site visits as needed 2-2.d. As needed 2-2.e. During internal review as needed 2-2.f. As needed on location or at the State office 2-2.g. March 31, 2015 2-2.h. As needed 2-2.i. Quarterly 2-2.j. Monthly, quarterly 2-2.k. Implement April 1, 2014, monitor monthly</p>	

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>2-3 Increase the percentage of correctly completed new ADAP applications submitted to 85% or greater.</p>	<p>2-3.a. Generate monthly reports to monitor this objective, and share quarterly with ADAP/HICP Workgroup. 2-3.b. Utilize reports to communicate with district and agency staff regarding their rates of correctly completed new ADAP application submissions. 2-3.c. Provide technical assistance on ADAP applications and backup documentation to staff and agencies as needed. 2-3.d. Ensure that ADAP coordinators and case managers comply with the approved Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 2-3.e. Provide or coordinate ADAP-related training for ADAP/HICP Enrollment Site Coordinators and case managers as needed. 2-3.f. Communicate GA ADAP updates via conference calls, email listserv, and HIV Office web pages. 2-3.g. Convene the Georgia ADAP/HICP Quality Management Workgroup at least Quarterly. 2-3.h. Implement an electronic ADAP application submission process. 2-3.i. Monitor the implementation of an electronic ADAP application submission process.</p>	<p>Libby Brown, Alysa Johnson, Kimberly Morrow, Roderick Newkirk</p>	<p>Pamela Phillips ADAP Associates</p>	<p>2-3.a. Monthly 2-3.b. Monthly 2-3.c. As needed 2-3.d. During internal reviews as needed 2-3.e. As needed 2-3.f. As needed 2-3.g. Quarterly 2-3.h. April 1, 2014. 2-3.i. Daily</p>	

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
2-4 Conduct an internal audit of up to 5% of ADAP new client applications forms annually.	<p>2-4.a. Review complete audit of all active client files.</p> <p>2-4.b. Utilize the "ADAP Documentation Checklist" to evaluate if ADAP applications forms were correctly completed and if approved or denied according to ADAP policies and procedures.</p> <p>2-4.c. For applications forms that were incomplete, request and obtain required documentation.</p> <p>2-4.d. Create quarterly Report Card from CAREWare summarizing key findings.</p> <p>2-4.e. Share findings with ADAP district or agency enrollment sites.</p> <p>2-4.f. Share findings with the GA ADAP/HICP QM Workgroup to initiate CQI projects as indicated.</p>	Libby Brown, Alysia Johnson	ADAP Team QM Team	2-4.a. Annually 2-4.b. Daily 2-4.c. As needed 2-4.d. Quarterly 2-4.e. Quarterly 2-4.f. Quarterly	
2-5 Monitor programmatic compliance and adherence to antiretroviral regimens.	<p>2-5.a. Instruct Districts participating in the ACP to utilize PBM reports to routinely monitor clients who pick up medications.</p> <p>2-5.b. Review PBM compliance/adherence reports.</p> <p>2-5.c. Provide medication adherence training to ADAP contract pharmacies.</p> <p>2-5.d. Conduct ACP Network audits.</p>	Gay Campbell	Libby Brown, Alysia Johnson	2-5.a. Monthly 2-5.b. Quarterly 2-5.c. As needed 2-5.d. As indicated	
2-6 Systematically review data collected by the ADAP to identify inappropriate antiretroviral therapy (ART) regimens or components.	<p>2-6.a. Discuss with PBM how to best monitor for inappropriate ART regimens or components including development of a report and an electronic system to hard-halt components at pharmacy point of service if these regimens are ordered.</p> <p>2-6.b. Review PBM reports to monitor inappropriate ART regimens or components.</p> <p>2-6.c. Require ADAP contract pharmacies to maintain a separate ADAP medication error log.</p>	Gay Campbell	QM Team PBM Libby Brown Dr. Felzien	2-6.a. As needed 2-6.b. As needed 2-6.c. As indicated during audits	

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Goal 3: Improve the quality of the Georgia Healthcare Insurance Continuation Program (HICP)

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>3-1 Increase the percentage of active HICP clients recertifying before the 6 month due date to prevent delays in payments for health insurance premiums to 95% or greater</p>	<p>3-1.a. Generate monthly reports to monitor this objective. 3-1.b. Utilize reports to communicate with district and agency staff regarding clients' recertification status. 3-1.c. Provide technical assistance on HICP applications and backup documentation to staff and agencies as needed. 3-1.d. Encourage adherence to the Georgia Ryan White Part B/ADAP/HICP Policies and Procedures by the ADAP/HICP enrollment sites. 3-1.e. Ensure that ADAP/HICP coordinators and case managers are aware of updates to the Georgia Ryan White Part B/ADAP/HICP Policies and Procedures. 3-1.f. Provide or coordinate HICP-related training for ADAP/HICP Enrollment Site Coordinators and case managers. 3-1.g. Communicate GA HICP updates via conference calls, email listserv, and HIV Office web pages. 3-1.h. Convene the Georgia ADAP/HICP Quality Management Workgroup at least quarterly. 3-1.i. Implement an electronic HICP application submission process. 3-1.j. Monitor the implementation of an electronic HICP application submission process.</p>	<p>Libby Brown, Alysia Johnson, Kimberly Morrow</p>	<p>HICP Team District Liaisons Pamela Phillips</p>	<p>3-1.a. Monthly 3-1.b. Monthly 3-1.c. As needed 3-1.d. During internal reviews as needed 3-1.e. Apr. 2014 3-1.f. As needed 3-1.g. Monthly 3-1.h. Quarterly 3-1.i. April 1, 2014 3-1.j. Daily</p>	

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>3-2 Conduct an internal audit of up to 5% of HICP new client application forms quarterly.</p>	<p>3-2.a. Review complete audit of all active client files. 3-2.b. Utilize the "HICP Documentation Checklist" to evaluate if HICP applications or recertification forms were correctly completed and if approved or denied according to HICP policies and procedures. 3-2.c. For application forms that were incomplete, request and obtain required documentation. 3-2.d. Create quarterly report card from CAREWare summarizing key findings. 3-2.e. Share findings with the ADAP/HICP QM subcommittee Workgroup to initiate CQI projects as indicated.</p>	<p>Libby Brown, Alysia Johnson</p>	<p>HICP Team QM Team</p>	<p>3-2.a. Annually 3-2.b. Daily 3-2.c. As indicated 3-2.d. Quarterly 3-2.e. Quarterly</p>	

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Goal 4: Improve the quality of health care and supportive services.

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>4-1 Monitor the approved HAB performance measures (PM) in all 16 Part B-funded sites at least annually.</p>	<p>4-1.a. Include HAB measures in monitoring tools, chart reviews, and QM plans. 4-1.b. Generate quarterly reports from CAREWare on the HAB PMs and share with HIV Coordinators. 4-1.c. Provide technical assistance to improve the accuracy of CAREWare HAB Measure data and reports. 4-1.d. Conduct clinical and CM chart reviews. 4-1.e. Create custom reports in CAREWare for performance measures. 4-1.f. Collaborate with Part A to obtain an update on the accuracy of the ambulatory care subservice category with regard to the HAB PMs.</p>	<p>Eva Williams, Pamela Phillips, Michael "Mac" Coker, Rachel Powell Kimberly Morrow Part A</p>	<p>QM Core Team District Liaisons</p>	<p>4-1.a. As needed 4-1.b. Quarterly 4-1.c. As needed 4-1.d. As needed 4-1.e. As needed 4-1.f. As needed</p>	

Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>4-2 Design and implement statewide CQI projects to improve two in+Care/new HAB Core performance measures</p>	<p>4-2.a. Utilize stakeholder buy-in and data to select two In+Care/new HAB Core performance measures for statewide quality improvement. 4-2.b. Encourage health districts to include the measure in their local QM Plans, if not at goal. 4-2.c. Research best practices on how to improve the measures. 4-2.d. Obtain and disseminate best practices from health districts. 4-2.e. Design a statewide CQI project to improve the measure using CQI methodologies. 4-2.f. Use the PDSA cycle to test interventions and monitor changes.</p>	<p>Eva Williams, Michael "Mac" Coker, Pamela Phillips and Rachel Powell</p>	<p>QM Core Team HRSA/HAB National Quality Center</p>	<p>4-2.a. June 2014 4-2.b. July 2014 4-2.c. Sept. 2014 4-2.d. March 31, 2015 4-2.e. Sept. 2014 4-2.f. March 31, 2015</p>	
<p>4-3 Monitor the implementation of the Acuity Scale and Self Management Model.</p>	<p>4-3.a. Provide technical assistance to districts utilizing an acuity scale and self management model.</p>	<p>Pamela Phillips and CM Subcommittee</p>	<p>QM Core Team</p>	<p>4-3.a. As needed</p>	
<p>4-4 Revise the Georgia HIV/AIDS Case Management Standards.</p>	<p>4-4.a. Subcommittee to meet monthly to revise the GA HIV/AIDS Case Management Standards. 4-4.b. Revise the Standards to include sections related to an Acuity Scale and Self Management Model.</p>	<p>Pamela Phillips and CM Subcommittee</p>	<p>QM Core Team</p>	<p>4-4.a. Monthly 4-4.b. August 2014</p>	
<p>4-5 Coordinate quality-related activities across Ryan White Programs (Parts A, B, C, and D) in GA.</p>	<p>4-5.a. Attend the Part A Planning Council and QM Committee. 4-5.b. Include across Ryan White Programs representation on the Part B QM Core Team. 4-5.c. Provide quality-related training to RW staff statewide based on identified needs. 4-5.d. Coordinate quality training efforts with HIVQual consultant.</p>	<p>Eva Williams, Michael "Mac" Coker, and Pamela Phillips</p>	<p>Part A QM Committee Part B QM Core Team SEATEC</p>	<p>4-5.a. Monthly 4-5.b. Mar. 2015 4-5.c. As needed 4-5.d. As needed</p>	

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Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>4-6 The percentage of HIV-infected pregnant women prescribed antiretroviral therapy will be 95% or greater.</p>	<p>4-6.a. Complete Hiring Package. 4-6.b. Complete branding of the FIMR/HIV project. 4-6.c. Initiate and launch Community Review Team (CRT) meetings. 4-6.d. Begin reviewing cases. 4-6.e. Collaborate with the FIMR/HIV staff. 4-6.f. As part of the RW Part B clinical chart review, assess management of pregnant HIV-infected women.</p>	<p>Dr. Robertson-Beckley, Amy Woodell, Rakia Arnold</p> <p>Eva Williams, Michael "Mac" Coker, and Dr. Felzien</p>	<p>SEATEC</p> <p>QM Core Team</p>	<p>4-6.a. Apr. 1, 2014 4-6.b. Apr. 30, 2014 4-6.c. April - June 2014 4-6.d. Aug. 1, 2014 4-6.e. As needed 4-6.f. As indicated</p>	
<p>4-9 Revise the GA DPH, Medical Guidelines for the Care of HIV-Infected Adults and Adolescents</p>	<p>4-9.a. Complete revisions to retain only the Clinic Personnel section.</p>	<p>Eva Williams, Michael "Mac" Coker, and Dr. Felzien</p>	<p>Medical Advisory Group</p> <p>PH Programs</p> <p>HIV Coordinators</p> <p>HIV clinical staff</p>	<p>4-9.a. July 2014</p>	
<p>4-10 Monitor measures to verify compliance with HRSA regulations related to the health insurance marketplace.</p>	<p>4-10.a. Communicate updates as they are received. 4-10.b. Provide technical assistance based on identified needs, including tools to assist districts with compliance. 4-10.c. Update site visit monitoring tools to include payor of last resort.</p>	<p>Mirelys Ramos, Eric Boson-Campbell, Rolanda Hall, Shandrecka Murphy</p>	<p>HIV Care Team</p>	<p>4-10.a. As needed 4-10.b. As needed 4-10.c. June 30, 2014</p>	

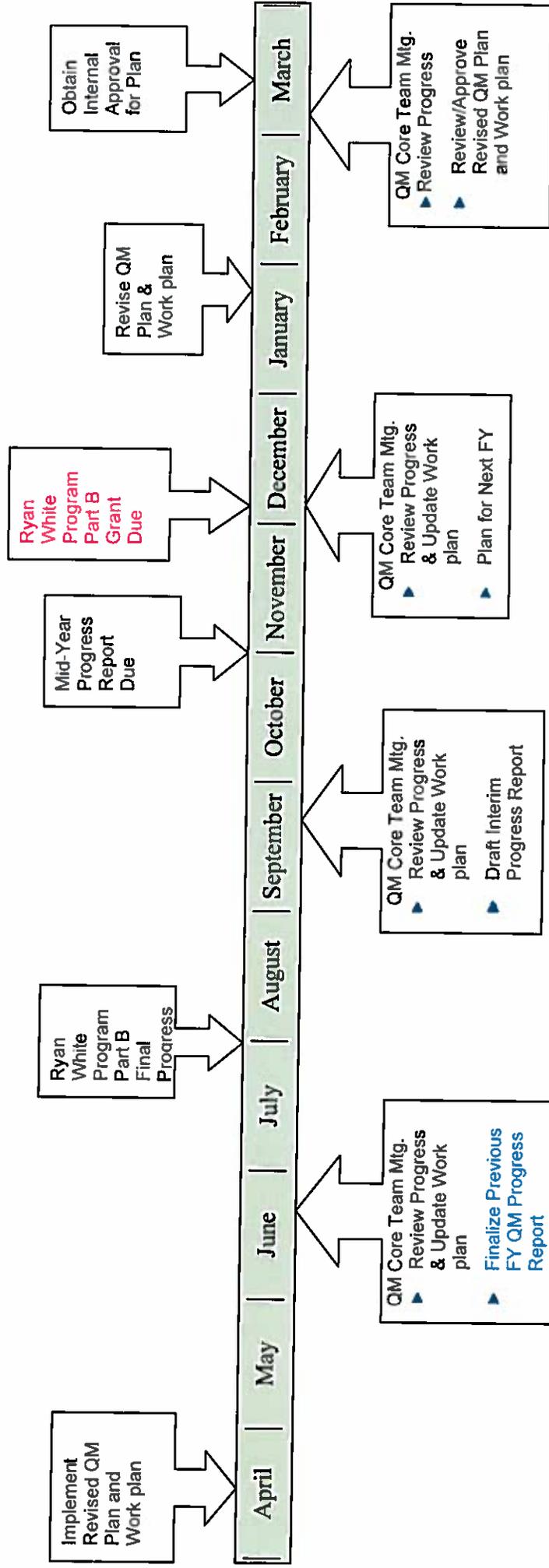
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Objectives	Strategies	Lead	Staff/ Resources	Timeline	Progress notes
<p>4-11 Monitor In+Care Campaign Measures and utilize data to facilitate quality improvement.</p>	<p>4-11.a. Collect data on In+Care Measures 1,2,3,4 from all Part B districts. 4-11.b. Provide regular updates and summary spreadsheets to the districts for quality use. 4-11.c. Provide technical assistance to districts with difficulty obtaining In+Care data. 4-11.d. Utilize In+Care Campaign data to collaborate with other Parts on retention in care. 4-11.e. Collaborate with other DPH Programs and sections working on linkage and retention in care. 4-11.f. Encourage and highlight In+Care Campaign related quality projects. 4-11.g. Provide health districts with information and updates from the National In+Care Campaign.</p>	<p>Eva Williams, Michael "Mac" Coker, Pamela Phillips, Rachel Powell</p>	<p>Kimberly Morrow In+Care Campaign Coach</p>	<p>4-11.a. As indicated 4-11.b. As indicated 4-11.c. As needed 4-11.d. As indicated 4-11.e. As indicated. 4-11.f. As identified 4-11.g. As needed</p>	
<p>4-12 Continually monitor compliance with RW Part B program requirements.</p>	<p>4-12.a. Conduct site visits and provide summary reports, including feedback as appropriate. 4-12.b. Update site visit tools for districts and contractors in accordance with federal program requirements. 4-12.c. Assess services provided at the district level and share common findings with the QM Core Team. 4-12.d. Provide technical assistance to districts in need of compliance support. 4-12.e. Develop processes to improve compliance with RW Part B program requirements.</p>	<p>Mirelys Ramos, Rolanda Hall, Eric Boson- Campbell, Shandrecka Murphy</p>	<p>Eva Williams, Michael "Mac" Coker, Pamela Phillips</p>	<p>4-12.a. March 31, 2015 4-12.b. June 30, 2014 4-12.c. Quarterly and as needed 4-12.d. As needed 4-12.e. As needed</p>	

Appendix B. Annual QM Plan Timeline

Annual QM Plan Timeline

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Appendix C.
**2014-2015 Ryan White Part B Program
Quality Management Committees**

Ryan White Part B QM Program 2014-2015 Quality Management Core Team Members

- ❖ Susan Alt, RN, BSN, ACRN District HIV Director, District 9-1 Coastal (Parts B, C and D)
- ❖ Eric Boson-Campbell, District Liaison
- ❖ Libby Brown, BA, ADAP/HICP Manager
- ❖ Gay Campbell, RPh, ADAP Pharmacy Director
- ❖ Marisol Cruz, MS, DBA , HIV Care Manager
- ❖ Michael (Mac) Coker, RN, MSN, ACRN, HIV Nurse Consultant
- ❖ Malembe S. Ebama, MPH, HIV Prevention Representative
- ❖ Gregory Felzien, MD, HIV Medical Advisor
- ❖ FIMR/HIV Representative (rotating)
- ❖ LaShawne Graham, BSW, MSPSE, Social Services Provider 1, Adult Health Promotion Clinic North, District 8-1 (Parts B and C)
- ❖ Rolanda Hall, MPH, District Liaison
- ❖ Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- ❖ Sandra Jump, RN, District 9-2 Coffee Wellness Center
- ❖ Adolphus "Tony" Major, Lead Consumer Advocate, District 8-2
- ❖ Kimberly Morrow, MPH, CAREWare Team Leader
- ❖ Shandrecka Murphy, HIV Care District Liaison
- ❖ Jacqueline Muther, Grady IDP (Parts A and D)
- ❖ Pamela Phillips, BSW, MSA, Part B QM Coordinator
- ❖ Mirelys M. Ramos, MPH, CHES, Part B Ryan White Specialist
- ❖ Nicole Roebuck, LMSW, AID Atlanta (Part A)
- ❖ Rachel Waltenburg Powell, MPH, Part B QM Data Manager
- ❖ Tina Washington, Senior Peer Advocate, Chatham CARE Center
- ❖ Kathy Whyte, Fulton Co. Government (Part A)
- ❖ Eva Williams, FNP, MPH, AACRN, HIV Nurse Consultant (Part B QM Team Lead)

Ryan White Part B QM Program 2014-2015 Case Management Subcommittee

- ❖ Maureen Asiimwe, BDVS, MSW, Case Manager, Specialty Care Clinic
- ❖ Robbie Bowman, RN, STD/HIV Coordinator, South Central Health District
- ❖ Brandon Cawthon, MSW, Social Services Provider I, Northeast Health District
- ❖ Michael (Mac) Coker, RN, MSN, ACRN, HIV Nurse Consultant
- ❖ Karen Cross, LCSW, Clinical Case Manager Team Leader, AID Gwinnett, East Metro
- ❖ LaShawne Graham, BSW, MSPSE, Social Services Provider 1, South Health District
- ❖ Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- ❖ Sister Judy Jones, M. Div., Case Manager, West Central Health District
- ❖ Sheryl Lewis, MBA, Communicable Disease Specialist, Southeast Health District
- ❖ Mikita Lofton, BSW, Behavior Health Specialist Supervisor, North Central Health District
- ❖ Flossie Loud, SST., III, Southwest Health District
- ❖ Adolphus "Tony" Major Lead Consumer Advocate, Southwest Health District
- ❖ Pamela Phillips, BSW, MSA, HIV Quality Management Coordinator
- ❖ LaToya Robinson, BSW, ADAP Coordinator, SSP III, Southwest Health District
- ❖ Nicole Roebuck, LMSW, Director of Client Services, AID Atlanta
- ❖ Terrena Sanks, M.Ed, Medical Case Manager, LaGrange Health District
- ❖ Jeffery D. Vollman, MPA, District HIV Director, North GA Health District
- ❖ Eva Williams, FNP, MPH, AACRN, HIV Nurse Consultant (Part B QM Team Lead)

**Ryan White Part B QM Program
2014-2015 Georgia ADAP/HICP QM Subcommittee**

- ❖ Libby Brown, BA, ADAP/HICP Manager
- ❖ Valerie Buice, Program Associate, Haven of Hope, District 4
- ❖ Gay Campbell, RPh, ADAP Pharmacy Director
- ❖ Michael (Mac) Coker, RN, MSN, ACRN, HIV Nurse Consultant
- ❖ Mary Dillard, ADAP/HICP Coordinator, Specialty Clinic, District 1-1
- ❖ Alysia Johnson, BHS, ADAP/HICP Assistant Manager
- ❖ Gregory Felzien, MD, HIV Medical Consultant
- ❖ Shanna Mattis, MSW, Emory Midtown
- ❖ Vacant, Consumer Advocate

Appendix D. Monitoring Table

Georgia HIV Client Services Quality Management Program Monitoring Table

Note: For data collected through client record or chart review, the indicator, numerator and denominator of the Measure are calculated according to the sample size of charts provided for review.

Note: Measures with a numerator or denominator stating "medical visit with a provider with prescribing privileges" or similar are captured according to the current CAREWare service categories. The current CAREWare service categories count medical, lab and nursing visits and does not yet have the capability to separate medical or other visits only.

Criteria	Indicators	Data Elements	Data Sources & Methods
General Ryan White Program Performance Measures			
Ryan White funds are used as payor of last resort	<p>Clients screened for other healthcare providers and insurance.</p> <p>Eligible clients referred for enrollment into Medicare, or Medicaid</p>	<p>Documentation indicating that clients are screened at intake and recertified every 6 months.</p> <p>Documentation that clients are referred for enrollment into Medicare or Medicaid.</p>	Client record review
<p>Eligibility documented for all clients receiving Ryan White Program Part B services:</p> <ul style="list-style-type: none"> - HIV status - Income - Proof of residency - Assets 	<p>Documented HIV+ status.</p> <p>Clients with documentation of financial screening initially then every 6 months; and income below or at 300% of FPL.</p> <p>Documentation of GA residency.</p>	<p>Documentation of HIV test result or physician signed statement of HIV infection.</p> <p>Documentation of financial screening and proof of residency at intake and every 6 months.</p>	Client record review
Ryan White-funded providers coordinate the delivery of services and funding mechanisms with other programs or providers.	<p>Memoranda of agreements (MOA) exist with community partners.</p> <p>Contracts executed for subcontracted services.</p> <p>Districts conducted site visits where subcontracted services are provided.</p>	<p>MOA on file</p> <p>Contracts on file</p> <p>Documentation of site visits to subcontractors and evaluation of the quality of services provided by subcontractors.</p>	<p>Review of MOAs and contracts.</p> <p>Site visit reports for subcontractors.</p> <p>Evaluation of the quality of services, such as performance measure reports and client satisfaction surveys.</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Client security and confidentiality maintained.	<p>Employees' signed confidentiality agreements.</p> <p>Charts secured under lock.</p> <p>Electronic records are password protected.</p> <p>Access to areas with medical records and computers restricted</p>	<p>Signed confidentiality agreements.</p> <p>Locked storage area for client charts and other information.</p> <p>Computers password protected and secure while in use.</p> <p>Layout of clinic prevents unauthorized access to records and computers.</p>	<p>Review of employee files</p> <p>Observation of security/ confidentiality measures.</p> <p>Review of written policy and procedures regarding security and confidentiality.</p>
<p>Ryan White funded providers ensure that every client is informed about:</p> <ul style="list-style-type: none"> - Client confidentiality - Client grievance - Client rights & responsibilities 	Percent of clients informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities.	Documentation in chart that client is informed of confidentiality policy, grievance policies and procedures, and rights and responsibilities initially then annually.	Client record review
HIV-infected clients are satisfied with the Ryan White Program Part B services they receive.	Percent of clients who indicate they are satisfied with the services they have received.	Client responses to questions about their satisfaction with specific services.	<p>Review of District level client satisfaction survey results.</p> <p>Results from 2013 Statewide Client Satisfaction Survey</p>
Ryan White-funded providers implement QM Plans with continuous quality improvement (CQI) projects.	Percent of Ryan White Part B-funded programs with written quality management plans and a current report of CQI activities and results.	<p>Written Quality Management Plan.</p> <p>Copies of the most current report of CQI activities and results.</p>	Review of quality management plans and reports

Criteria	Indicators	Data Elements	Data Sources & Methods
Case Management Performance Measures			
All case managed clients receiving case management services will have a Ryan White Part B standardized intake or equivalent completed within 30 days of beginning the initial intake assessment.	Percent of newly enrolled or reactivated clients in case management who had an intake and assessment completed.	N: # of newly enrolled or reactivated clients in case management and had an intake and assessment completed during the measurement year. D: # of clients who were newly enrolled or reactivated in case management during the measurement year.	Client chart review
All newly enrolled or reactivated case management clients will have a comprehensive ISP within 30 days of beginning the initial intake assessment	Percent of clients newly enrolled or reactivated with a documented comprehensive ISP within 30 days of beginning the initial intake assessment	N: # of clients newly enrolled or reactivated in case management who had a comprehensive ISP within 30 days of beginning the initial intake assessment D: # of clients who were newly enrolled or reactivated in case management during the measurement year.	Client chart review
Ensure that all case managed clients have Individualized Service Plan (ISP) goals established after initial assessment.	Percent of case managed clients who had ISP goals established after initial assessment.	N: # of case managed clients who had ISP goals established after initial assessment. D: # of case managed clients who had ISPs completed at initial assessment during the measurement year.	Client chart review
Case managed clients should have documented evidence of coordination of services required to implement the ISP during service provision.	Percent of chart documentation that reflect evidence of coordination of services required to implement the ISP during service provision, referrals and follow-up.	N: # of client charts with documentation reflecting evidence of coordination of services required to implement the ISP during service provision, referrals and follow-up during the measurement year. D: # of case managed clients in a measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Ensure that clients receiving medical case management services have ongoing monitoring to assess the efficacy of the ISP.	Percent of client charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP.	N: # of client charts with documented evidence of ongoing monitoring to assess the efficacy of the ISP during the measurement year D: # of medically case managed clients in a measurement year.	Client chart review
Clients receiving medical case management services should have periodic re-evaluation and adaptation of the ISP at least every 6 months.	Percent of client charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 6 months.	N: # of client charts with documented evidence of periodic re-evaluation and adaptation of the ISP at least every 6 months during the measurement year D: # of case managed clients in a measurement year.	Client chart review CAREWare-pending
Case managed client chart documentation must reflect assistance with linkage to other programs for which clients are eligible.	Percent of client chart documentation must reflect assistance with linkage to other programs for which clients are eligible.	N: # of client charts with documentation reflecting assistance with linkage to other programs for which clients are eligible during the measurement year D: # of case managed clients in a measurement year.	Client chart review
Ensure that all clients receiving medical case management services have documentation which includes coordination and follow up of medical treatment.	Percent of client chart documentation which includes coordination and follow-up of medical treatment.	N: # of MCM client charts with documentation including coordination and follow-up of medical treatment. D: # of MCM clients in a measurement year.	Client chart review
All case managed clients must have documented evidence of ongoing assessment of client and other key family members' needs and personal support system.	Percent of clients charts who had documented evidence of ongoing assessment of client and other key family members' needs and personal support system.	N: # of clients charts with documented evidence of ongoing assessment of client and other key family members' needs and personal support system. D: # of case managed clients in the measurement year.	Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
All clients receiving medical case management services will have treatment adherence assessed at least every 4 months.	Percent of medical case management clients who charts had a documented treatment adherence visit 2 or more times at least 4 months apart.	N: # of MCM clients who had a documented treatment adherence visit 2 or more times at least 4 months apart in a measurement year. D: # of MCM clients in the measurement year	Client chart review
All medical case management clients will attend 2 or more HIV medical visits during a measurement year.	Percent of medical case management clients chart who had 2 or more documented medical visits by the case manager in an HIV care setting in a measurement year at least 3 months apart	N: # of MCM clients chart who had 2 or more documented medical visits by the case manager in an HIV care setting in a measurement year at least 3 months apart. D: # of medical case management clients in the measurement year	Client chart reviews
Documentation should reflect that client advocacy has occurred during service provision.	Percent of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision.	N: # of client charts who had documented evidence of client advocacy (e.g., promotion of client needs for: transportation, housing or/and scheduling of appointments) has occurred during service provision in a measurement year. D: # of medical case management clients in the measurement year	Client chart reviews
Ensure that benefits/entitlement counseling and referral services were provided.	Percent of clients charts who had documented that benefits/entitlement counseling and referral services were provided.	N: # of client charts who had documented evidence that benefits/entitlement counseling and referral services were provided in the measurement year. D: # of medical case management clients in the measurement year	Client chart reviews

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>Case management chart documentation of services and encounters must include:</p> <ul style="list-style-type: none"> ○ Client Identifier on all pages ○ Date of each encounter ○ Types of services provided ○ Types of encounters/ communication ○ Duration and frequency of encounters 	<p>Percent of client charts who had documented services and encounters.</p>	<p>N: # client charts who had documented services and encounters.</p> <p>D: # of case management clients in the measurement year</p>	<p>Client chart reviews</p>
<p>All entries in the client record by the case manager should contain the case manager's professional title and signature.</p>	<p>Case management documentation should contain the case manager's professional title and signature.</p>	<p>N: # of client charts with documentation reflecting the case manager's professional title and signature.</p> <p>D: # of clients charts in the measurement year</p>	<p>Client chart reviews</p>
<p>Obtain assurances and documentation showing that case management staff are operating as part of the clinical care team.</p>	<p>Percent of case managed client charts who had documentation showing that case management staff are operating as part of the clinical care team.</p>	<p>N: # of case managed client charts who had documentation showing that case management staff are operating as part of the clinical care team in the measurement year.</p> <p>D: # of case managed clients in the measurement year.</p>	<p>Client chart reviews</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Case management client documentation must ensure that housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received.	Percent of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received	N: # of case managed client charts who had documented housing referrals include: housing assessment, search, placement, advocacy, and financial assistance received in the measurement year D: # of case managed clients in the measurement year.	Client chart reviews
Case managed client documentation must reflect that clients received assistance in obtaining stable long-term housing.	Percent of case managed client charts who had documentation reflecting that clients received assistance in obtaining stable long-term housing.	N: # of case management clients chart who had documentation reflecting that clients received assistance in obtaining stable long-term housing in the measurement year. D: # of case managed clients in the measurement year	Client chart reviews
Provide written assurances and maintain documentation showing that case management services are provided by trained professionals who are either medically credentialed or trained health care staff who are part of the clinical care team.	Review credentials and/or evidence of training of health care staff providing case management services.	N: # of staff with credentials and/or evidence of training of health care staff providing case management services in the measurement year D: # of staff providing case management services in your Ryan White Part B program within your district in the measurement year	Client chart reviews

Criteria	Indicators	Data Elements	Data Sources & Methods
All newly enrolled or reactivated case management clients will have a completed Acuity Scale within 30 days of initial intake assessment.	Percent of case managed client charts with an acuity scale completed within 30 days of the client's initial intake assessment.	<p>N: # of case managed clients who had an acuity scale completed within 30 days of initial intake during the measurement year</p> <p>D: # of case managed clients who were enrolled or were re-activated in case management during the measurement year.</p>	Client Chart Review
All case managed clients' charts containing a completed Acuity Scale will have the level of acuity assigned according to the Acuity Scale Instructions.	Percent of case managed client charts containing an Acuity Scale with the level of acuity assigned according to the Acuity Scale Instructions.	<p>N: # of case managed clients who had a completed Acuity Scale with the level of acuity assigned according to the Acuity Scale Instructions during the measurement year.</p> <p>D: # of case managed clients who had a completed Acuity Scale during the measurement year.</p>	Client Chart Review
ADAP Performance Measures			
<p>All ADAP clients must recertify for ADAP every 6 months.</p> <p>Note: Verifying Medicaid status is part of ADAP policy</p>	<p>ADAP enrollment sites have systems to track ADAP client recertification due dates.</p> <p>Percentage of eligible ADAP applicants who successfully recertified according to their recertification due date.</p>	<p>System to track ADAP recertification</p> <p>N: # of ADAP clients who are reviewed for continued ADAP eligibility in the measurement period.</p> <p>D: # of ADAP clients in the measurement period.</p>	<p>Review of ADAP recertification tracking systems</p> <p>Client record review</p> <p>Custom report from CAREWare</p> <p>Georgia Health Partnership Portal to verify Medicaid eligibility</p>
Local ADAP enrollment site representatives will submit correctly completed ADAP applications to the State ADAP Office.	Percent of correctly completed ADAP applications submitted to ADAP Office during the reporting period.	<p>N: # of correctly completed ADAP applications submitted to ADAP during the reporting period</p> <p>D: # of ADAP applications submitted to ADAP during the reporting period</p>	Custom reports from CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
Initial ADAP applications should be correctly and completely submitted	Percent of ADAP applications sent back for specified deficiencies	N: # of ADAP applications sent back to ADAP enrollment sites for a specified deficiency D: # of ADAP applications submitted to State ADAP Office during the reporting period	Custom reports from CAREWare
State ADAP Office will approve or deny clients for ADAP services within 2 weeks of receiving a complete ADAP application.	Percent of new ADAP applications approved or denied for ADAP enrollment within 2 weeks of ADAP receiving a complete application during the reporting period.	N: # of applications that were approved or denied within two weeks of ADAP receiving a complete application during the reporting period D: # of complete applications received during the reporting period	Custom reports from CAREWare
Local ADAP enrollment site representatives must inform the State ADAP Office when a patient discontinues or terminates ADAP services. Clients are discontinued from ADAP services if the client has not picked-up medications for 60 or more consecutive days and/or if the client has not recertified within the last 8 months.	Local ADAP enrollment sites follow the ADAP "Procedures for Discontinuation." ADAP Discontinuation Forms are completed and sent to ADAP	Procedures for discontinuation Discontinuation Forms	Review of procedures during site visits Client chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
ADAP clients will receive appropriate antiretroviral (ARV) regimens.	Percent of identified inappropriate ARV regimen or component prescriptions that are reviewed and resolved by ADAP during the measurement year.	<p>N: # of ARV regimens or component prescriptions listed in the Table, "Antiretroviral Regimens or Components that Should Not Be Offered At Any Time," of the DHHS ART guidelines that are reviewed and resolved by ADAP during the measurement year</p> <p>D: # of inappropriate ARV regimen or components that are prescribed and funded by ADAP</p>	<p>PBM reports – in process</p> <p>Client chart review</p>
ADAP will conduct an internal audit of up to 5% of ADAP new client applications quarterly to determine if the applications and recertifications are completed and approved or denied according to ADAP policies and procedures.	Percent of ADAP new client application forms that were correctly completed during the quarter.	<p>N: # of ADAP new client applications that were correctly completed during the reporting period.</p> <p>D: # of ADAP new client applications reviewed during the reporting period.</p>	Internal audit of ADAP new client applications
Clinical Performance Measures – General			
HIV-infected clients who are in medical care should be clinically stable.	Percent of HIV-infected clients who were clinically stable prior to the measurement year.	<p>N: # of HIV-infected clients who were clinically stable prior to the measurement year</p> <p>D: # of HIV-infected clients who had at least 1 medical visit prior to the measurement year and had 2 or more medical visits in the measurement year.</p>	Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
Data collection to assess how many new Ryan White Program clients have an AIDS diagnosis.	Percent of HIV-infected new clients with an AIDS diagnosis admitted during the quarter of interest	Numerator (N): # of clients with an AIDS diagnosis newly admitted for any service during the quarter of interest Denominator (D): # of HIV-infected clients newly admitted for any service during the quarter of interest	CAREWare
HIV-infected clients should receive ongoing risk reduction counseling as part of their medical care.	Percent of HIV-infected clients who received HIV risk counseling within the measurement year	N: # of HIV-infected clients who received HIV risk counseling as part of their medical care. D: # of HIV-infected clients who had at least 2 medical visits in the measurement year.	CAREWare
HIV-infected clients should receive substance abuse screening when they initiate primary medical care.	Percent of new clients with HIV infection who have been screened for substance use (alcohol and drugs) in the measurement year	N: # of HIV-infected clients who were screened for substance use within the measurement year. D: # of HIV-infected clients who were new during the measurement year, and had a medical visit with a medical provider with prescribing privileges at least once in the measurement year.	CAREWare
HIV-infected clients should receive mental health screening when they initiate primary care.	Percent of new clients with HIV infection who have had a mental health screening	N: # of HIV-infected clients who received a mental health screening D: # of HIV-infected clients who were new during the measurement year, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Physical and Dental Exams			
HIV-infected clients will receive a complete physical examination at least annually.	Percent of HIV-infected clients who had a complete physical examination within the measurement year	N: # of HIV-infected clients who had a complete physical examination within the measurement year D: # of HIV-infected clients who had at least 2 medical visits during the measurement year	Clinical chart review
HIV-infected clients will receive an oral examination by a dentist at least annually.	Percentage of HIV-infected clients who received an oral examination by a dentist in the measurement year	N: # of HIV-infected clients who had an oral exam by a dentist in the measurement year D: # of HIV-infected clients who had at least 2 medical visits during the measurement year.	CAREWare Clinical chart review
Clinical Performance Measures – Medical Visits			
HIV-infected clients should be seen at least every 6 months for routine medical evaluation and monitoring.	Percent of HIV-infected clients who had 2 or more medical visits (i.e., seen by a physician, PA, APRN) in an HIV care setting in the measurement year.	N: # of HIV-infected clients who had medical visits in an HIV care setting 2 or more times at least 3 months apart during the measurement year D: # of HIV-infected clients who had medical visits at least once during the measurement year.	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients should be seen every 3-6 months for routine medical evaluation and monitoring.</p>	<p>1) Percent of HIV-infected clients who had at least 1 medical visit during each 6 month period of the measurement year</p> <p>2) Percent of HIV-infected clients who were seen by an HIV specialist during each half of the measurement year</p>	<p>1) N: # of HIV-infected clients who had a medical visit at least once during each 6 month period of the measurement year</p> <p>D: # of HIV infected clients who had medical visits at least once during the measurement year</p> <p>2) N: # of HIV-infected clients who were seen by an HIV specialist during each 6 month period of the measurement year</p> <p>D: # of HIV infected clients who had medical visits at least once during the measurement year</p>	<p>Clinical chart reviews</p>
<p>Clinical Performance Measures – CD4 Counts and HIV Viral Loads</p>			
<p>HIV-infected clients should have CD4 counts measured at baseline then repeated at least every 3-6 months.</p>	<p>Percent of HIV infected clients who had CD4 counts performed 2 or more times in the measurement year (at least every 6 months).</p>	<p>N: # of HIV-infected clients who had CD4 counts performed 2 or more times at least 3 months apart in the measurement year (at least every 6 months)</p> <p>D: # of HIV-infected clients who had at least 2 medical visits in the measurement year</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>HIV-infected clients who are clinically stable (ie, suppressed for 2-3 years) may consider having HIV viral load measured at least every 6 months.</p>	<p>Percentage of clients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every 6 months during the measurement year.</p>	<p>N: # of clients with a viral load test performed every 6 months</p> <p>D: # of clients, regardless of age, with a diagnosis of HIV/AIDS who had at least 2 medical visits during the measurement year, with at least 60 days in between each visit.</p>	<p>CAREWare pending</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Antiretroviral Therapy			
HIV-infected clients will be appropriately managed on highly active antiretroviral therapy (ART).	Percent of HIV-infected clients on ART according to Department of Health and Human Services (DHHS) antiretroviral treatment guidelines in the measurement year.	N: # of HIV-infected clients on ART according to DHHS guidelines in the measurement year D: # of HIV-infected clients on ART and who had at least 2 medical visits in the measurement year	Clinical chart review ADAP reviews and reports
HIV-infected clients on ART should be clinically stable.	Percent of HIV-infected clients on ART who were clinically stable during each trimester of the measurement year.	N: # of HIV-infected clients on ART who were clinically stable during each trimester of the measurement year D: # of HIV-infected clients on ART and who had at least 2 medical visits in the measurement year	Clinical chart reviews
HIV-infected clients on ART who are clinically unstable should have resistance testing done.	Percent of HIV-infected clients on ART who were clinically unstable and had resistance testing performed within each trimester of the measurement year.	N: # of HIV-infected clients on ART who were clinically unstable and had resistance testing performed within each trimester of the measurement year D: # of HIV-infected clients on ART who were clinically unstable within each trimester of the measurement year	Clinical chart review
HIV-infected clients receiving ART should improve their immune status.	Percent of HIV-infected clients on ART with CD4 counts > 200/mm ³ within the last 4 months of the review period	N: # of HIV-infected on HAART clients with CD4 counts > 200/mm ³ within the last 4 months D: # of HIV-infected clients on ART who had at least 1 CD4 count performed within the last 4 months	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
HIV-infected clients should have undetectable viral loads.	Percentage of HIV-infected clients, regardless of age, with a diagnosis of HIV/AIDS with a VL below limits of quantification at last test during the measurement year.	N: # of clients with VL < 200 copies/mL at the last test during the measurement year D: # of clients, regardless of age, with a diagnosis of HIV/AIDS who had at least 2 medical visits during the measurement year with at least 60 days in between each visit; and had a viral load test during the measurement year.	Clinical chart review
HIV-infected clients diagnosed with AIDS will be prescribed ART.	Percent of HIV-infected clients diagnosed with AIDS who were prescribed ART.	N: # of clients with AIDS who were prescribed ART within the measurement period D: # of clients with AIDS who received at least one medical visit during the measurement period	CAREWare Clinical chart review
HIV-infected pregnant females should be prescribed ART.	Percent of HIV-infected pregnant females who were prescribed ART.	N: # of HIV-infected pregnant females who were prescribed ART during the 2 nd and 3 rd trimesters D: # of HIV-infected pregnant females who had at least 2 medical visits during the measurement year	CAREWare Clinical chart review
HIV-infected clients who are taking ART will be assessed and counseled for adherence during each medical visit.	Percent of HIV-infected clients on ART who were assessed and counseled for adherence 2 or more times in the measurement year.	N: # of HIV-infected clients on ART who were assessed and counseled for adherence as part of their medical care 2 or more times at least 3 months apart during the measurement year D: # of HIV-infected clients on ART who had at least 2 medical visits during the measurement year	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients on ART should have lipids monitored before ART initiation or switch; if borderline or abnormal at last measurement, every 6 months; or if normal, at least annually.</p>	<p>Percent of HIV-infected clients on ART who had a fasting lipid panel in the measurement year.</p>	<p>N: # of HIV-infected clients on ART who had a fasting lipid panel in the measurement year</p> <p>D: # of HIV-infected clients on ART who had at least 2 medical visits during the measurement year</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>Clinical Performance Measures – Pelvic Exams, Pap Smears and Sexually Transmitted Infection (STI) Screening</p>			
<p>HIV infected female clients 18 yrs. or older <u>or</u> who reported sexual activity will receive a pelvic examination and a Pap smear at least annually</p>	<p>Percent of HIV-infected female clients who received a pelvic examination and a Pap smear in the measurement year.</p>	<p>N: # of HIV-infected female clients who had at least one pelvic examination and Pap smear results documented in the measurement year</p> <p>D: # of HIV-infected female clients 18 years or older <u>or</u> who reported sexual activity and had at least 2 medical visits during the measurement year</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>All female clients with abnormal Pap smear results will be referred for diagnostic evaluation.</p>	<p>Percent of HIV-infected female clients with abnormal Pap smear results referred for diagnostic evaluation (e.g., colposcopy plus biopsy)</p>	<p>N: # of HIV-infected female clients with abnormal Pap smear results referred for diagnostic evaluation</p> <p>D: # of female clients with abnormal Pap smear results</p>	<p>Referral modules in CAREWare or manual referral logs</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
All female clients with abnormal Pap smear results will complete a diagnostic evaluation within 60 days of abnormal screening results.	Percent of HIV-infected female clients with abnormal Pap smear results that completed diagnostic evaluation within 60 days of abnormal screening	N: # of female clients with abnormal Pap smear results that completed diagnostic evaluation within 60 days D: # of female clients with abnormal Pap smear results	Referral modules in CAREWare or referral logs Clinical chart review
HIV-infected clients at risk for an STI should be screened for Chlamydia at least annually.	Percent of clients with HIV infection at risk for STIs who had a test for Chlamydia within the measurement year.	N: # of HIV-infected clients who had a test for Chlamydia D: # of HIV-infected clients who were either newly enrolled in care, sexually active, or had an STI within the last 12 months, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	CAREWare
HIV-infected clients at risk for an STI should be screened for Gonorrhea at least annually.	Percent of clients with HIV infection at risk for STIs who had a test for Gonorrhea within the measurement year.	N:# of HIV-infected clients who had a test for Gonorrhea D: # of HIV-infected clients who were either newly enrolled in care, sexually active, or had an STI within the last 12 months, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	CAREWare
Clinical Performance Measures – Syphilis, TB, and Hepatitis Screening			
HIV-infected clients will be screened for syphilis at least annually.	Percent of HIV-infected clients who were screened for syphilis (i.e., RPR or VDRL) in the measurement year	N: # of HIV-infected clients who had an RPR or VDRL done in the measurement year D: # of HIV-infected clients who had at least 2 medical visits in the measurement year	CAREWare Clinical chart review

Criteria	Indicators	Data Elements	Data Sources & Methods
<p>HIV-infected clients without a history of previous tuberculosis (TB) treatment or positive TB skin test (TST) will be screened for TB at least annually.</p>	<p>1-a) Percent of HIV-infected clients with a TST (i.e., purified protein derivative (PPD) by the Mantoux method) placed in the measurement year.</p> <p>1-b) Percent of HIV-infected clients who had a TST read by a trained healthcare worker within 72 hours of placement</p> <p>2) Percent of HIV-infected clients who completed TB screening (i.e., had a TST placed and read within 72 hours, or Interferon-Gamma Release Assay (IGRA) performed) at least once in the measurement year.</p>	<p>1-a) N: # of HIV-infected clients who had a TB screening test in the measurement year</p> <p>D: # of HIV-infected clients who had at least 2 medical visits during the measurement year and did not have a history of TB treatment or positive TST</p> <p>1-b) N: # of HIV-infected clients who had a TST read within 72 hours of placement.</p> <p>D: # of HIV-infected clients who had a TST placed in the measurement year</p> <p>2) N: # of HIV-infected clients who completed TB screening during the measurement year</p> <p>D: # of HIV-infected clients with at least 2 medical visits in the measurement year and did not have a history of TB treatment or positive TST</p>	<p>CAREWare</p> <p>Clinical chart review</p>
<p>All HIV-infected persons with a TST induration of ≥ 5mm (positive TST) and/or active TB disease will be referred to the TB Program for co-management</p>	<p>Percent of HIV-infected clients with a TST induration of ≥ 5mm (positive TST) and/or active TB disease who were referred to the TB Program during the measurement year</p>	<p>N: # of HIV-infected clients with a TST induration of ≥ 5mm (positive TST) and/or active TB disease who were referred to the TB Program during the measurement year</p> <p>D: # of HIV-infected clients with a TST induration of ≥ 5mm (positive TST) and/or active TB disease and who had at least 2 medical visits in the measurement year</p>	<p>CAREWare – Referral modules</p> <p>Clinical chart review</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
All HIV-infected clients will be screened for Hepatitis B at least once since HIV diagnosis, unless there is documented infection or immunity.	Percent of patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity.	N: # of clients for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. D: # of clients, regardless of age, with a diagnosis of HIV/AIDS and who had at least 2 medical visits during the measurement year, with at least 60 days in between each visit.	CAREWare pending
All HIV-infected clients must be screened for Hepatitis C virus (HCV) at least once after HIV diagnosis.	Percent of HIV-infected clients for whom HCV screening was performed at least once since HIV diagnosis.	N: # of HIV-infected clients who have documentation of HCV status D: # of HIV-infected clients who had at least 2 medical visits during the measurement year.	Clinical chart review CAREWare
All HIV-infected and HBV or HCV-infected clients should receive counseling to avoid alcohol consumption at least annually.	Percent of HIV-infected and HBV or HCV-infected clients who received counseling to avoid alcohol consumption at least once during the measurement year.	N: # of HIV-infected and HBV or HCV-infected clients who have documentation that they received counseling to avoid alcohol consumption during the measurement year. D: # of HIV-infected and HBV or HCV-infected clients who had at least 2 medical visits during the measurement year.	Clinical chart review
Clinical Performance Measures – Hepatitis, Influenza and Pneumococcal Vaccination			
All HIV-infected clients who do not have evidence of Hepatitis B (HBV) virus infection or past immunity should receive the HBV vaccination series.	Percent of clients with HIV infection who completed the vaccination series for Hepatitis B	N: # of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B D: # of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the	CAREWare GA Immunization Program Review

Criteria	Indicators	Data Elements	Data Sources & Methods
		<p>measurement year.</p> <p>N: # of HIV-infected clients who completed the HBV vaccination series and had antibody response assessed.</p> <p>D: # of HIV-infected clients who completed the HBV vaccination series</p> <p>N: Number of HIV-infected clients who completed the HBV vaccination series and had antibody response assessed within 1 month after completion.</p> <p>D: # of HIV-infected clients who completed the HBV vaccination series since the previous clinical chart review measurement year.</p>	Clinical chart review
All non-allergic HIV-infected clients should receive the influenza vaccine at least annually.	Percent of clients with HIV infection who have received influenza vaccination within the measurement period (year).	<p>N: # of HIV-infected clients who received influenza vaccination</p> <p>D: # of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year</p>	CAREWare
All HIV-infected clients with CD4 counts >200 cells/mm ³ should receive the pneumococcal vaccine.	Percent of clients with HIV infection who ever received pneumococcal vaccine.	<p>N: # of HIV-infected clients who ever received pneumococcal vaccine</p> <p>D: # of HIV-infected clients who ever had a medical visit with a provider with prescribing privileges at least once in the measurement year</p>	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
Clinical Performance Measures – Opportunistic Infection Prophylaxis and Screening			
All HIV-infected clients with CD4 counts below 200 cells/mm ³ should receive chemo-prophylaxis against <i>Pneumocystis pneumonia</i> (PCP).	Percent of HIV-infected clients with CD4 counts below 200 cells/mm ³ who were prescribed PCP prophylaxis in the measurement year.	<p>N: # of HIV-infected clients with CD4 counts below 200 cells/mm³ who were prescribed PCP prophylaxis</p> <p>D: # of HIV-infected clients with CD4 counts below 200 cells/mm³ and who had at least 2 medical visits during the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>
All HIV-infected clients with CD4 counts below 50 cells/mm ³ should receive chemo-prophylaxis against <i>Mycobacterium avium</i> complex (MAC).	Percent of HIV-infected clients with CD4 counts below 50 cells/mm ³ who were prescribed MAC prophylaxis in the measurement year.	<p>N: # of HIV-infected clients with CD4 counts below 50 cells/mm³ who were prescribed MAC prophylaxis</p> <p>D: # of HIV-infected clients with CD4 counts below 50 cells/mm³ and who had at least 2 medical visits during the measurement year.</p>	<p>CAREWare</p> <p>Clinical chart review</p>
All HIV-infected clients, except those with known toxoplasmic disease, should be screened for Toxoplasma.	Percent of clients with HIV infection for whom Toxoplasma screening was performed at least once since the diagnosis of HIV infection.	<p>N: # of HIV-infected clients who have documented Toxoplasma status in health record</p> <p>D: # of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>	<p>CAREWare</p>

Criteria	Indicators	Data Elements	Data Sources & Methods
In+Care Campaign Performance Measures – Retention in Care			
<p>In+Care Measure 1: Gap Measure</p> <p>HIV-infected clients should not have more than 6 months between medical visits.</p>	<p>Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year</p>	<p>N: # of patients who had no medical visits in the last 180 days of the measurement year</p> <p>D: # of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in the first 6 months of the measurement year</p>	CAREWare
<p>In+Care Measure 2: Medical Visit Frequency</p> <p>HIV-infected clients should have at least one medical visit in each 6 month period in the last 2 years.</p>	<p>Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6 month period of the 24 month measurement period with a minimum of 60 days between medical visits.</p>	<p>N: # of patients with a least one medical visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between the first medical visit in the prior 6 month period compared to the last medical visit in the subsequent 6 month period.</p> <p>D: # of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the first 6 months of the 24 month measurement period.</p>	CAREWare
<p>In+Care Measure 3: Patients Newly Enrolled in Medical Care</p> <p>HIV-infected clients who are newly enrolled should have frequent medical visits.</p>	<p>Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4 month periods of the measurement year.</p>	<p>N: # of patients who had at least one medical visit in each 4 month period of the measurement year.</p> <p>D: # of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled with a medical provider AND had at least one medical visit with a provider with prescribing privileges in the first 4 months of the measurement year.</p>	CAREWare

Criteria	Indicators	Data Elements	Data Sources & Methods
In+Care Measure 4: Viral Load Suppression HIV-infected clients with suppressed viral replication are less likely to transmit the HIV virus.	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year.	N: # of patients with a viral load less than 200 copies/ml at last viral load test during the measurement year. D: # of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year.	CAREWare
October 2013 HRSA Core Performance Measures			
HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/ml at the last viral load test during the measurement year.	N: # of patients with a viral load less than 200 copies/ml at last viral load test during the measurement year. D: # of patients, regardless of age, with a diagnosis of HIV with at least one medical visit during the measurement year.	CAREWare pending per HRSA
Medical Visit Frequency	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.	N: # of patients with a least one medical visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between the first medical visit in the prior 6 month period compared to the last medical visit in the subsequent 6 month period. D: # of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the first 6 months of the 24 month measurement period.	CAREWare pending per HRSA

Criteria	Indicators	Data Elements	Data Sources & Methods
Gap in Medical Visits	Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	<p>N: # of patients who had no medical visits in the last 180 days of the measurement year</p> <p>D: # of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in the first 6 months of the measurement year</p>	CAREWare pending per HRSA

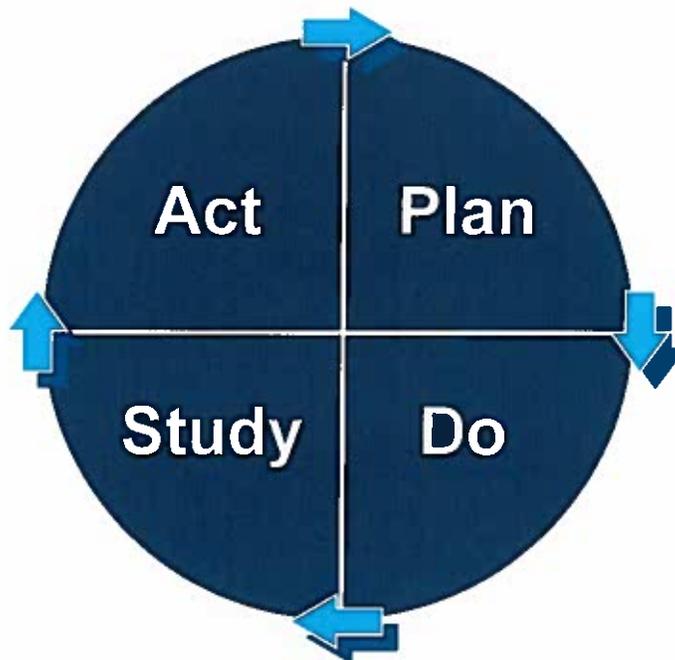
Appendix E. Model for Improvement

Model for Improvement

- ❖ What are we trying to accomplish?
- ❖ How will we know that a change is an improvement?
- ❖ What change can we make that will result in improvement?

PDSA Cycles

<p>ACT What changes are to be made? Next cycle? Adapt, Adopt, Abandon?</p>	<p>PLAN Objective Questions and predictions (why) Plan to carry out the cycle (who, what, where, when)</p>
<p>STUDY Complete the analysis of the data Compare data to predictions Summarize what was learned</p>	<p>DO (Small Scale) Carry out the plan Document problems and unexpected observations Begin analysis of the data</p>



From the HAB/NQC Ryan White Program Part B Collaborative, LS1, National Quality Center (NQC)

Testing Change (PDSA) Worksheet

Date: _____ Cycle#: _____ Began: _____ Completed: _____ Team: _____

PLAN (fill out before the test/cycle)

What is the purpose of this cycle?

Details: Who, What, Where, When, How

What do we expect (predict) will be the effect or outcome of the change?

If our expectation (prediction) is on target, what will be our next test/cycle or action?

DO and STUDY (fill out during and after the test/cycle)

Was the test/cycle carried out as we planned? Yes No If no, why not?

What did we observe that was not part of our plan?

How did we study and understand the result?

How did or didn't the outcome of this test/cycle agree with our expectation (prediction)?

What did we learn from this test/cycle?

ACT: (fill out after the test/cycle is completed)

Given the above understanding and learning, what are we going to do now?

Are there forces in our organization that will help or hinder these changes?

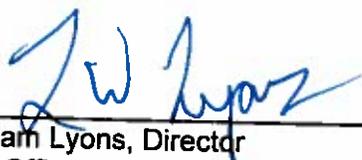
Appendix F. QM Plan Approval

FY2014-2015 QM Plan and Work Plan Approval

The FY2014-2015 RW Part B QM Plan and Work Plan are approved by the following:

Ryan White Part B QM Core Team

3/31/14
Date



William Lyons, Director
HIV Office
Georgia Department of Public Health

4/1/14
Date