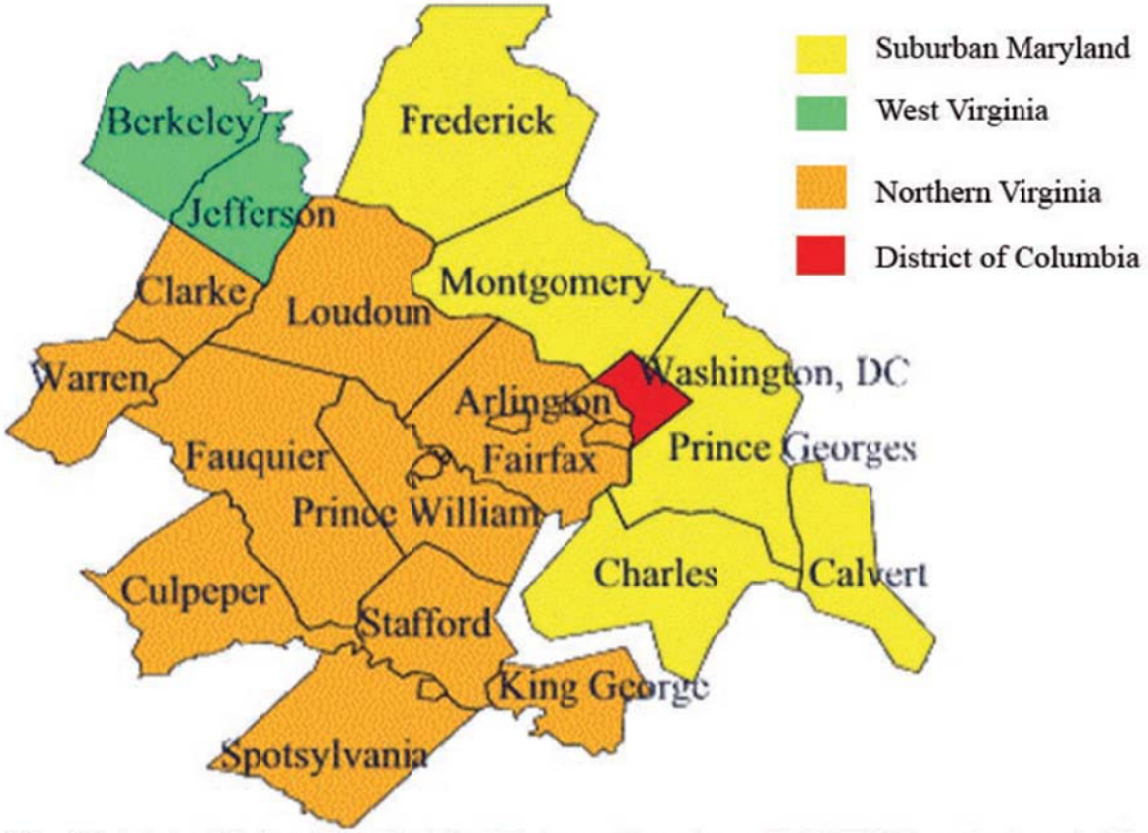
DC CROSS-PART COLLABORATIVE
2015
HIV QUALITY MANAGEMENT PLAN

PREPARED BY:
DC CROSS-PART RESPONSE TEAM



The District of Columbia Eligible Metropolitan Area (DC EMA) as designated by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA) spans a wide area over a metropolitan region of more than 6,000 square miles, three states, 18 counties, and the District of Columbia. Subrecipients/providers throughout the DC EMA receive funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009 through one or more of the Ryan White (RW) Parts (A,B,C,D and F) which fund specific types of programs and target specific activities. Subrecipients include health departments, hospitals, federally qualified health centers, community-based organizations, and training centers, etc.

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INTRODUCTION

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

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

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

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

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

PART B: Grants to States and Territories

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

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

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

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

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

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

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

Special Programs of National Significance (SPNS) Programs support the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the RW HIV/AIDS Programs. There is currently one SPNS initiative in the EMA. The George Washington University YES Center provides technical assistance (TA), training, guidance, and evaluative services to eight demonstration sites around the country working with young men of color who have sex with men. The sites are participants in Outreach, Care, and Prevention to Engage HIV Seropositive Young Men having Sex with Men (MSM) of Color, a SPNS initiative of HRSA.

Demographics of the Population in the DC EMA:

General:

The general population is racially, ethnically, and linguistically diverse. The following numbers posted in the document are estimations based on 2014 US Census Data. The total population of the DC region is 6,033,737. According to the 2011 American Community Survey, 48.2% Non-Hispanic White, 25.3% Black or African American, 14.1% Hispanic or Latino, 9.3% Asian and Other Pacific Islanders, and Mixed and Other comprising the remaining 3.1%. Nearly 22% of the DC region population is foreign-born, and 39% have limited English proficiency. This region has significant numbers of people moving here for its economic opportunities.

HIV/AIDS:

Of the 5,703,948 people living in the DC region, 30,954 people were diagnosed living with HIV/AIDS as of December 31, 2010, according to the Centers for Disease Control and Prevention (CDC) Revised 2011 HIV Surveillance Report published in March 2014. When including the CDC estimate of 18% of those that do not know their status, an estimated 36,340 people are living with HIV/AIDS. This represented 0.64% of the region's residents. People of color are disproportionately impacted by HIV/AIDS in the DC region.

- Racial and ethnic minorities make up 51.8% (N=2,040,403) of region's residents, yet they account for 80.1% of the estimated living HIV/AIDS cases in the region.
- Blacks account for only 27.6% (N=1,574,290) of the region's population, but they comprise over 69.2% (N=20,361) of the estimated living HIV/AIDS cases in the region.
- Over 50% of deaths among persons with HIV were among black men, of which 21% were MSM and MSM/IDU and 15% were among black men who inject drugs.
- The top four (4) reported exposure categories among the cumulative HIV/AIDS diagnoses were male-to-male sex 37.4%; heterosexual transmission 26.7%; risk either not reported or not identified 20.5%; and injection drug use 12.3%.
- Although residents of Washington, DC represent only 10.9% (N= 617,996) of the total DC region's population, they accounted for 47.1% (N=14,359) of known HIV/AIDS cases.

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

Structure of the HIV QM Plan

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

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

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

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

The DC Cross-Part Collaborative Quality Management Plan

A. QUALITY STATEMENT

Mission Statement
The DC Collaborative is committed to developing and continually improving a high quality continuum of care to meet the needs of PLWH in the DC EMA and to ensure that it is consistent with the HRSA HAB Standards of Care and recognized national standards. The QM Plan builds capacity in RW-funded programs to improve continuously the quality of care and service delivery for all clients in the DC EMA and those impacted by the service delivery system.

Vision
The Collaborative's QM Program is committed to improving the health and well-being of PLWHA by providing TA and resources in QM to the DC EMA RW Service Providers so that they can provide high-quality healthcare and support services.

Statement of Purpose for QM Plan

The purpose of the DC Collaborative's OM Plan is to communicate the goals, objectives, and implementation steps of the Collaborative's QM Program. Foci of the plan include activities that enhance and support comprehensive HIV care and services in the DC EMA in both urban and rural care settings through monitoring, evaluating, and continuously improving the quality of HIV care and services provided to all Ryan White HIV/AIDS Program (RWHAP) clients in accordance with recognized treatment guidelines, the National HIV/AIDS Strategy (NHAS), standards of care, and best practices.[1] Quality activities assess care, the settings in which it is provided, and the processes by which it is delivered as they affect RWHAP clients in the region. This statement of purpose will be accomplished by:

- Development, implementation, and bi-annual review of an EMA-wide QM plan.
- Improving alignment across providers by monitoring core performance measures.
- Improving alliances among EMA-wide providers by expanding QM management activities and participating in quality improvement projects (QIPs).
- Providing guidance, TA, and training related to QI and QM.

B. DEFINITION OF QUALITY

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

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

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

c. Plan-Do-Study-Act (PDSA) Cycles:
The Collaborative QI process is based on the PDSA Cycle methodology. This model for performance improvement will be used for all QI activities:

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

d. Quality:
Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should

[1] NAHS Federal Implementation Plan. 2010. Page 17 Available at https://www.whitehouse.gov/files/documents/nhas-implementation.pdf

consider: the quality of the inputs, the quality of the service delivery process, and the quality of life outcomes.

e. Quality Assurance (QA):

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

f. Quality Improvement (QI):

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

g. Quality Management (QM):

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

h. Outcomes:

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

i. Outcome Indicator:

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

C. QUALITY MANAGEMENT INFRASTRUCTURE

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

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

HAHSTA responsibilities over the course of the Collaborative:

- Hosting Response Team meetings & calls
- Providing logistical support for Learning Sessions
- Maintaining a centralized CAREWare database to house DC Collaborative data
- Coordinating with Response Team to dovetail Part A & Part B data collection and initiatives

NQC's ongoing responsibilities to the Collaborative:

- Help facilitate Learning Sessions and/or Regional Quality Summit(s)
- Maintain Glasscubes workspace

- Contribute NQC materials and expertise

b. <u>The leadership of the Collaborative comes from the Response Team.</u>

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

Response Team Responsibilities:

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

<u>Sub-committees</u>

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

1. <u>QI Projects Sub-committee</u>

<u>Responsibilities:</u>

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

2. <u>Data Management Sub-committee</u>

Responsibilities:

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

3. HIV QM Plan Sub-committee

Responsibilities:

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

4. Provider Capacity Development Sub-committee

Responsibilities:

- Support the development of DC Cross-Part QI activities by linking training and TA to all stakeholders;
- Develop and implement QM training opportunities based on identified needs; and
- Facilitate providers' and consumers' ability to conduct QM activities as well as their knowledge about QI concepts.

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

Responsibilities:

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

Participating members who wish to serve on the response team must submit a letter of interest and a Response Team Membership Application form to the Response Team Chairperson. The Response Team will review all applications and selections will be made based on availability

and experience. Applications to join the response team can be submitted each month for review at their meetings. A copy of the form is included as Appendix A.

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

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

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

Consumers:
Consumers are equal partners in the QI process and as such are sought as active members of any QI initiative related to the Collaborative. Because consumers of all HIV-related services are the primary driving force behind the need for continual monitoring, re-evaluations, and improvement of those services, the Collaborative includes consumer representation to advise other members on QI processes. Meaningful consumer involvement reflects an integrated process rather than parallel consumer improvement activities. To that end, the Collaborative felt the need and saw value in the inclusion of consumer representation from the inception of the Collaborative and moving forward. In fact, because of Collaborative efforts the consumer capacity team was able to develop into a fully-fledged funded agency to lead a consumer-driven effort emphasizing the perspective of HIV-positive consumers as invaluable to the design and execution of quality improvement activities.

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

Membership:
The attached Appendix B provides information about the current and potential membership of the DC Collaborative.

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

d. Resources:
QM resources provided by the following organizations are consulted frequently:

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

D. GOALS AND IMPLEMENTATION PLAN

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

QA/process evaluation goals include:

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

    a. Providing consumer perspectives, outreach, and as community liaisons;
    b. Helping with needs assessments for QM and identifying service barriers;
    c. Functioning as trainers for QM; and
    d. Acting as a resource pool for various skill sets needed at agencies for QM.

Implementation Timeline (2016-2018):

Year 6 – 2016:

- Continue collection, synthesis, and analysis of the Collaborative's performance measures through the DC EMA CAREWare System
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA
- Support A4Q, coordinate capacity building for consumers, and promote opportunities for consumers to contribute to QI initiatives where they receive services.
- As a collaborative, discuss new ideas for a joint QI project
- Set project goal for Year Seven & Eight focus across the DC EMA.

Year 7 – 2017:

- Continue collection, synthesis, and analysis of the Collaborative's performance measures in the DC EMA CAREWare system
- Continue to work with and help further the initiatives of A4Q. Align Collaborative and A4Q activities for training consumers and developing consumer capacity at each agency
- Full implementation of best practices from other state collaboratives re: Viral Load Suppression
- Re-evaluate the performance measure portfolio established in 2014
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA.

Year 8 – 2018:

- Continue collection, synthesis, and analysis of the Collaborative's performance measures in the DC EMA CAREware system.
- Evaluation of data from the three-year data portfolio (HAB Core Measures)
- Continue sharing best practices surrounding viral load suppression projects to achieve project goal across the DC EMA; and
- Set project goal for Year Ninefocus across the DC EMA

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

Quality Management Program Work Plan, 2016 – 2017

GOALS include:

1. Continue implementation of the DC Collaborative HIV QM Plan. Key activities include:
    - Regional QM Summit
    - Increased Communication – converse with participants in other NQC Learning Collaboratives via conference calls and GlassCubes
    - New training opportunities for consumers in conjunction with A4Q
    - Continue offering several Learning Sessions per year
    - Continue quarterly data submission and summary reports

2. The development and implementation of measurable outcomes and performance measures at all levels.
    - New performance measure - Viral Load Suppression Retention Measure
    - Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year
3. To provide ongoing TA and trainings when necessary.
4. Encourage Collaborative participants to achieve goals for each QI Project.
    - Increase the percentage of HIV patients who are retained in primary HIV healthcare within the measurement year across Collaborative participants to a mutually agreed upon goal to be determined.

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

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

E. CAPACITY BUILDING

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

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

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

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

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

F. PERFORMANCE MEASUREMENT

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

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

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

A. Data Collection

To the extent possible, performance data will be collected from all RW-funded agencies within the DC metropolitan area. Providers will use a standardized reporting template and submit their aggregate data through the Collaborative's secured web-based portal, Glasscubes. The data collection efforts will:

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

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

Data collection will include:

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

Strategies

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

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

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

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

Data sources
The Collaborative is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:
- Chart abstractions from client medical records (paper or electronic);
- Clinical databases;
- Demographic databases;
- Agency Reports;
- CAREWare;
- ADAP database;
- Administrative/programmatic monitoring tools;
- Client satisfaction surveys/interviews;
- Focus group summaries; and
- Unmet Needs Assessments.

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

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

G. PARTICIPATION OF STAKEHOLDERS

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

Goals for Stakeholders are:

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

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

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

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

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

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

I. PROCESS TO UPDATE THE QUALITY MANAGEMENT PLAN

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

revised QM Plan will be submitted to all the Collaborative's RW participants for approval on an annual basis.

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

J. COMMUNICATION PLAN

Communication will be necessary with the following groups:

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

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

- Email blasts
- Announcements and other posts via Glasscubes workspace
- Phone calls
- Face-to-face meetings
- Websites
- Webinars
- Posters
- Formal letters

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

- Introduction to the work of the Collaborative;
- Routine meetings to encourage buy-in of non-participating providers to join and provide their data to feed quality measurements;
- Responding to requests for information;
- Data gathering;
- Responding to results of PDSA Cycles and to implementation of other quality processes;
- Press release style updates as the project progresses;
- Reports tied to output or outcomes more than process;
- Routine leadership communication, such as meeting minutes;
- Demonstration of the "process" of development of QM tools, consensus with brief introduction to the work of the Collaborative;

- Highly structured, polished, succinct reporting methods and tools;
- Outcomes of QI activities; and
- Written information for audiences of varying education levels and competencies.

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

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

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

K. LIMITATIONS

- All stakeholders are at different levels of implementing QM Plans in their programs;
- This plan is only part of a multi-year process to improve outcome measurement;
- Information will not be used to compare providers for funding decisions;
- Resources anticipated at the outset of this plan may be reduced or eliminated;
- Key responsible individuals may leave the DC EMA during period;
- Many interventions can affect outcomes; and
- This document is based on beliefs, expectations, and objectives in the current climate of the DC EMA. We realize that the Collaborative and its stakeholders are subject to possible unforeseen, substantive changes that could cause actual results to be materially different.

ACRONYMS

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

VA	Virginia
VACRS	Virginia Client Reporting System
VDH	Virginia Department of Health
WV	West Virginia
XPRES	Cross Program Reporting and Evaluation Systems

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

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

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

Demetria Broadnax *Quality Improvement Coordinator* *Family and Medical Counseling Service, Inc.*	**Khalil Hassam** *Data Manager* *MetroHealth (Formerly Carl Vogel Center)*
Justin Britanik *Quality Management Specialist* *District of Columbia Department of Health* *Care, Housing and Support Services Bureau* *HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)*	**Lena Lago, MPH** *Monitoring and Evaluation Manager* *District of Columbia Department of Health* *Care, Housing and Support Services Bureau* *HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)*
Mrs. Martha Sichone Cameron *Director of Policy & Advocacy Programs* *The Women's Collective*	**Nima Ahmady-Moghaddam** *Q.I. Data Specialist* Family and Medical Counseling Service, Inc
Candice Daniel *Quality Care Program Coordinator* *Howard University Hospital*	**Julie Mehan, BSN RN** *Quality Manager* *NVRC - Human Services Division*
Tarsha Harris Moore, MSW, LICSW	**Safere Diawara, MPH**

Suburban Maryland Administrative Agency Quality Assurance Coordinator *Prince George's County Health Department*	*Quality Management Coordinator* *Virginia Department of Health (VDH)*

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

RYAN WHITE CROSS-PART QUALITY IMPROVEMENT COLLABORATIVE

Response Team Membership

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

Data Management Team

The Data Management Team is responsible for:

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

Quality Improvement Team

The Quality Improvement Team is responsible for:

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

Quality Management Plan Team

The Quality Management Plan Team is responsible for:

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

Provider Capacity Development Team

The Provider Capacity Development Team is responsible for:

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

Consumer Capacity Development Team

The Consumer Capacity Development Team will be responsible for:

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

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

Collaborative, Co-Leads

The Collaborative co-leads are responsible for:

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

Communicator

The Communicator is responsible for:

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

Trainer

The Trainer is responsible for:

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

Recorder

The Record is responsible for:

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

Name: _____

Organization: _____
Email: _____
Telephone: _____

I. Overview of Experience and Availability

- Brief description of experience: _____

  _____

  _____

  _____

- List time constraints and availability:

  _____

  _____

  _____

  _____

II. Committee and Role

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

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

APPENDIX B: **COLLABORATIVE MEMBERSHIP**

Agency/Part	Participant and Response Team Role	Resource/Area of Expertise
Ryan White A		
Northern Virginia Regional Commission (NVRC)	Participant **Julie Mehan– Response Team**	Part A & Part B Administrative Agent
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)	Participant **Justin Britanik – Response Team**	Part A Grantee/Administrative Agent
Prince George's County Health Department (PGCHD)	Participant **Tarsha Moore – Response Team**	Suburban MD RW Part A Administrative Agent
AIDS Response Effort, Inc	Participant	Sub-recipient in NOVA providing Medical Care and MCM
Fredericksburg Area HIV/ AIDS Support Services, Inc.	Participant	Sub-recipient in NOVA providing Medical Care and MCM
AIDS Healthcare Foundation	Participant	Sub-recipient in DC providing Medical Care and MCM
Andromeda Transcultural MHHC	Participant	Sub-recipient in DC providing Medical Care and MCM
Community Family Life Services	Participant	Sub-recipient in DC providing MCM
La Clinica del Pueblo	Participant	Sub-recipient in DC providing Medical Care and MCM serving primarily a Latino/Hispanic population
Regional Addiction Prevention	Participant	Sub-recipient in DC providing Medical Care and MCM
The Women's Collective	Participant	Sub-recipient in DC providing Medical Care
United Health Care	Participant	Sub-recipient in DC providing Medical Care and MCM
United Medical Center	Participant	Sub-recipient in DC providing Medical Care and MCM
Us Helping Us	Participant	Sub-recipient in DC providing Medical Care
Ryan White B		
DC HAHSTA	Participant	ADAP agency
Maryland Department of Health and Mental Hygiene (MD DHMH)	Participant	ADAP agency
Virginia Department of Health (VDH)	Participant	ADAP agency
West Virginia Department of Health & Human Resources (WV DHHR)	Participant	ADAP agency
Charles County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing MCM.
Frederick County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Alexandria Neighborhood Health Services	Participant	Part A and Part B sub-recipient in NOVA providing Medical Care and MCM.

Montgomery County Department of Health and Human Services	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Prince George's County Department of Health	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.
Damien Ministries	Participant	Part B sub-recipient providing MCM services in DC
Homes for Hope	Participant	Part B sub-recipient providing MCM services in DC
Shenandoah Valley Medical Systems	Participant	Part B sub-recipient providing outpatient medical care and MCM services in WV, Part A sub-recipient in DCA EMA
Ryan White C		
Greater Baden Medical Services Inc.	Participant	Part A sub-recipient and Part C EIS program grantee in Suburban MD
Howard University Hospital Comprehensive Clinic	Participant **Candice Daniel** **Response Team**	Part A sub-recipient and Part C EIS program grantee
MetroHealth (formerly Carl Vogel Center)	Participant **Khalil Hassam– Response Team**	Part A sub-recipient and Part C EIS program grantee
Medstar Research Institute	Participant	Affiliated with Washington Hospital center, one of two Part C recipients in Suburban MD
Whitman-Walker Health	Participant **Koyinsola Aladesuru – Data Team**	Part A sub-recipient and Part C EIS program grantee
Unity Healthcare	Participant	Part A sub-recipient and Part C EIS program grantee
Family and Medical Counseling Service	Participant	Part A sub-recipient and Part C EIS program grantee
Mary Washington Healthcare (formerly known as Medicorp)	Participant	Part A sub-recipient and Part C EIS program grantee in NOVA
Ryan White D		
Children's National Medical Center	Participant	Part D Administrative agent, Part A, B, & C funding
Inova Juniper Program	Participant	Part D Administrative Agent and Part A, B & C Funding
Ryan White F AIDS Education Training Center		
Washington, DC Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation
A4Q		
Martha Cameron	**– Response Team** Consumer Lead A4Q	Consumer trained in Quality Management Principles
Keith Callahan	Response Team – Consumer Support Financial Liaison A4Q	
Debra Frazier	Vice Chair	
Laura Morrow	Chairperson	

Anthony Seymore	Secretary	
Joe Henson	Membership Specialist	
Danielle Pleasant	Communications/PR	
Doug Fogal	Data and Technical Support Specialist	

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

Domain	Area	2015	2016	2017
Alignment	**HIV QM Plan**	Evaluate, re-develop, update and, implement QM Plan, including a Work Plan.	Continue QM Plan implementation; revise as needed, Rewrite Work Plan annually if needed.	Review QM Plan; revise as needed, Revise and update with new 3-year plan
	QM Summit	Hold RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in July 2015.	Hold annual RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in Summer 2016.	Recommend holding annual RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in Summer 2017
	Annual Report	Develop a template. Do an annual summary of Collaborative Activities by calendar year, release in Q1 2016	Revise and update the template. Release new report on an annual basis.	Continue annual reports each year.
	Expand the Collaborative to:	Involve all committed RW grantees, providers, consumers and other key stakeholders.	Encourage participation of RW funded agencies in the DC region, special focus on re-engaging ADAP providers, get them to submit data.	Encourage participation from non-RW funded providers who provide HIV care in the DC region. Continuously involve new people at key agencies who may not have been involved. Consider expansion to all Core – service providers beyond OAMC and MCM.
Data	**Data Management**	Continue to refine data collection process. Ensure more robust data submission.	Reduce missing data. Adapt data collection process for new CAREWare implementation in Maryland and DC.	Standardize data collection for accuracy and completeness. Ensure maintenance of data status.
		Select specific indicators to be tracked, analyzed, and reported.	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date. Guide transition to new data measures collected in new data systems	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date, relevant QI projects, common core indicators for monitoring HHS-funded HIV prevention, treatment, and care services, and new core HAB Measures
QI Activities	**QM Consultation, Training and Assistance**	Provide ongoing TA/consultations to providers in developing	Provide ongoing TA/consultations to providers in developing QI	Provide ongoing TA/consultations to providers in developing QI

		QI activities and projects.	activities and projects.	activities and projects.
	Collaborative Activities	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative	Review of Collaborative quality improvement measures quarterly. Facilitate best practices dialogue surrounding quality measures across Collaborative
QI Projects	**Continuum of Care**	Use the EMA-wide care continuum, look at improving linkage, retention, ARV prescription, treatment adherence and VL suppression	Monitor changes in the Care Continua in the EMA and the region. Share best practices across Collaborative.	Evaluate retention project. Response team to assess the efficacy of the project.
	Pap Smear Project	Identify HIV positive patients who need PAP/Anal Smear screening. Agencies submit and carry out PDSA cycles, report data.	Observe the results. HAHSTA to collate report and present to providers Meetings with providers to share results. Monitor and refine PDSA process to meet outcomes	Formalize procedures and policies if necessary, spread best practices Routinize the activities in clinics to sustain 90% goal.
	Expand the QI Projects to other core services and support services	Invite those delivering other core and support services to 2016 QM Summit	Expand the QI Projects to other core services and support services, get them participating not necessarily submitting data	Retain participants and expand QM opportunities for support service providers.
	Develop QM Training Team	Develop QM Training Team to roll out activities as part of QI Plan.	Implement strategies and trainings devised by QM Training Team. These will be informed from the QIP Team about topics relating to, retention in care, Viral Load Suppression, and Patient engagement.	Assess impact of QM Training Team through measures such as participant satisfaction, and pre/post tests for knowledge retention.
	Developing Training Programs/Tools Accordingly	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.

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

APPENDIX D: **IMPLEMENTATION/WORK PLAN CY 2016-2017**

Goal A: Continue Implementation of the DC Cross-Part Collaborative HIV Quality Management Plan						
Domain	**Area**	**Objectives**	**Key Action Steps**	**Person/Agency Responsible for Collection**	**Timeline**	**Resources**
Alignment	Quality Management Plan	**Develop the DC Cross-Part HIV QM Plan and Work Plan for 2013-14.**	-Develop draft of the HIV QM Plan - Distribute draft to stakeholders for review - Review and revise Plan at response team meetings - Finalize plan and post on the different websites.	Response Team QM plan team All stakeholders.	May-October 2015	Previous QM Plans NQC /HRSA materials DOHs (in all four jurisdictions) websites
		Implement DC HIV QM Plan across RW agencies in the DC EMA.	- Provide training on QM principles including development of the QM Plan for providers.	QM Training Team All stakeholders	Ongoing	Work plans
		Evaluate and update HIV QM Plan annually	Utilize Cross-Part outcomes evaluation data/ information to update QM Plan	Collaborative All stakeholders	May 2016	Data/information from chart review, final year outcomes data report, HRSA and other federal mandates
	QM Summit Meeting	**Provide QM Training.**	Identify topics, dates, and locations for meetings and collaborate with all stakeholders to provide all-parts EMA training in July 2013.	NQC Response Team	Summer 2016	Face-to-Face meeting all providers, parts and roles for a skill building TA day, focus on NAHAS
	Newsletter	**Spread information on Cross-Part activities.**	Identify interested parties, generate content, collect information, and release a new Newsletter on a quarterly basis.	Collaborative	Ongoing	Collaborative All other RW providers Other Consumers Any others

Goal B: Strengthen the existing HIV QM Infrastructure within the DC EMA that supports QI activities.						
AREA		**Objectives**	**Key action steps**	**Person/Agency Responsible for Collection**	**Method of Reporting/Data Sources**	**Timeline**
Infrastructure	**Infrastructure** Response Team	Provide leadership and oversight for all QI/management activities.	Work closely with the QM Plan Sub-committee to execute 2013 plan, and update for 2015	Response Team	Approved QM Plan.	December 2015
			Implement the 2015 QM Plan.	All stakeholders	Ongoing reports.	Ongoing
		Strengthen collaboration within DC region to share Programs, policies, and best practices.	Use Established QM infrastructures.	Response Team	Conjoint documents, policies and procedures.	Ongoing
	Response Team Sub- Committee	Provide oversight and facilitation of the Collaborative QM Program.	Develop priorities and set QI goals for Collaborative going forward.	Response Team QM Plan Sub-Committee	Meetings Written documents Results analysis and different reports.	Ongoing
			Expand membership to include other representatives.	All stakeholders	Membership list Attendance to required activities.	Ongoing
	QI Project Sub-committee(QIPS)	Make improvements in specific aspects of care delivery.	Evaluate patient engagement/retention project. Work on new project informed from 2015 provider survey.	Response Team QIPS Members QM in-house teams at RW agencies	QM project reports based on Plan-Do- Study- Act Cycle results.	Ongoing

Goal C: Quality Improvement Activities and Projects						
Domain	**Area**	**Objectives**	**Key Action Steps**	**Person/Agency Responsible for Collection**	**Timeline**	**Data Source(s)**
Quality Improvement Activities and Projects	Evaluation of the Project	Increase the percentage of HIV patients who are retained in primary HIV healthcare	Review PDSA cycles and data. Find out what was tried, what worked, what could've worked better, what didn't work. Strategize on how to improve	Response Team QI Sub-committee.	November 2015-	CAREWare

		within the measurement year across collaborative participants to a mutually agreed upon goal.	active participation on the next project.			
			Collect Collaborative measure data every Quarter.	Collaborative Data Team	January 2014 – February 2016 (GY 24-25)	CAREWare
			Implement improvement projects.	QI Lead Collaborative	December 2015-March 2016	
			Lead PDSA Cycle process and sharing of best practices across Collaborative.	QI LeadQI Sub-Committee Response Team Data Team	December 2015-March 2016	

Goal D: Data Improvement, Reporting, and Analysis Activities						
Domain	**Area**	**Objectives**	**Key action steps**	**Person/Agency Responsible for Collection**	**Method of Reporting/Data Sources**	**Timeline**
Data Analysis	Data for Collaborative	Data analyses to inform QI projects	Drill Down: Race/ethnicity, age,	Data Team	CareWare, Access	Quarterly
			Data Integrity Checks	HAHSTA, Data Team	CareWare	Annually
		Presentations	New Data Process Documentation	Data Team Data Lead	Access	2-3 per year
	Provider Level TA	Provider Report Cards	Drill Down	Data Team RT Leads	Access PDF report cards	Annual, per provider
			Compare similar providers, layout graphs	Data Team RT Leads		
	Publications	Present posters and workshops at conferences	Create	Data Team RT Leads Communicator		1-2 annually

APPENDIX E: PERFORMANCE MEASURES

OUTPATIENT AMBULATORY MEDICAL CARE MEASURES

Focus	Performance Measure – OAMC
Medical Visits	% of Patients who had at least one medial visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
Gap in Medical Visits	% of Patients who did not have a medical visit in the last 6 months of the measurement year
PCP Prophylaxis	% of Patients with CD4 <200 cells/mm^3 prescribed PCP prophylaxis
ARV Prescription	% of MCM HIV+ Patients prescribed antiretroviral therapy
VL suppression	% of Patients who had a suppressed viral load (<200 copies/ml)
Cervical Cancer Screening	% of female patients with a diagnosis of HIV who have a Pap screening in the measurement year
Oral Exam	% of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year
Syphilis Screening	% of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year.

Medical Case Management Mesures

Focus	Performance Measure – MCM
Medical Visits	% of MCM clients who had at least one medial visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.
Gap in Medical Visits	% of MCM clients who did not have a medical visit in the last 6 months of the measurement year.
PCP Prophylaxis	% of MCM clients with CD4 <200 cells/mm^3 prescribed PCP prophylaxis
ARV Prescription	% of MCM HIV+ MCM clients prescribed antiretroviral therapy
VL suppression	% of MCM clients who had a suppressed viral load (<200 copies/ml)

Care Plan	% of MCM clients who had a MCM care plan developed and/or updated two or more times

ADAP

Focus	Performance Measure – ADAP
Application	% of ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement year
Recertification	% of ADAP enrollees who are reviewed for continued ADAP eligibility two or more times in the measurement year
Formulary	Percentage of new anti-retroviral classes that are included in the ADAP formulary within 90 days of the date of inclusion of new anti-retroviral classes in the PHS Guidelines for the Use of Antiretroviral Agents in HIV- 1-infected Adults and Adolescents1 during the measurement year