QUALITY MANAGEMENT
PROGRAM PLAN

FY2020

(rev. June 2020)
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INTRODUCTION

The purpose of the Quality Management (QM) Plan is to guide the development and implementation of the Atlanta Eligible Metropolitan Area (EMA) Ryan White Part A Quality Management Program into a coordinated approach assessing quality of services delivered and improving processes for the continuum of medical care and support services. This is a living document and is subject to change based on the needs of the program. This plan is effective for **March 1, 2020 to February 28, 2021.**

**DEFINITION OF QUALITY**
The Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) administers the Ryan White HIV/AIDS Program. HAB defines quality as “the degree to which a health or social service meets or exceeds established professional standards and user expectations.”

Definitions of other quality terminology include:

- **Quality Assurance (QA)** refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards.
- **Quality Improvement (QI)** refers to activities aimed at improving performance and is an approach to the continuous study and improvement of the processes of providing services to meet the needs of the individual and others. This term generally refers to the overriding concepts of continuous quality improvement and total quality management.
- **Continuous Quality Improvement (CQI)** is generally used to describe the ongoing monitoring, evaluation, and improvement processes. It is a client/client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. The key components of CQI are:
  - People are first priority.
  - Quality is achieved through people working in teams.
  - All work is part of a process, and processes are integrated into systems.
  - Decisions are based upon objective, measured data.
  - Quality requires continuous improvement.
- **Total Quality Management (TQM)** is a somewhat larger concept, encompassing continuous quality improvement activities and the management of systems that foster such activities as communication, education, and commitment of resources.

**SCOPE OF RYAN WHITE FUNDED ACTIVITIES**
Fulton County Government is the recipient of Ryan White Part A funds for the provision of medical and support services throughout the Atlanta EMA. The Atlanta EMA Ryan White Part A Program serves eligible Persons Living with HIV (PLWH) residing in the following 20 counties: Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Paulding, Pickens, Rockdale, Spalding, and Walton.

The planning and allocation of Part A services are coordinated with Metropolitan Atlanta HIV Health Services Planning Council (Planning Council) using data from **Ryan White Parts B, C, and D, Housing Opportunities for Persons with AIDS (HOPWA), Centers for Disease Control and Prevention (CDC)**
High-Impact HIV Prevention, and other governmental funding sources. In accordance with current resource allocations approved by the Planning Council, Part A funds are allocated to 18 subrecipients for approximately 17,000 HIV/AIDS clients providing the following core and related support services:

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<th>CORE MEDICAL SERVICES</th>
<th>SUPPORT SERVICES</th>
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<td>Outpatient/Ambulatory Health Services</td>
<td>Non-medical Case Management</td>
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<td>Stop Gap Medications</td>
<td>Rapid Entry</td>
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<td>Oral Health Services</td>
<td>Referral for Health Care and Support Services</td>
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<td>Medical Nutrition Therapy</td>
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<td>Medical Case Management</td>
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<td>Substance Abuse Treatment Services – Outpatient</td>
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<td>Child Care Services</td>
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<th>MINORITY AIDS INITIATIVE (MAI)</th>
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<td>Outpatient/Ambulatory Health Services</td>
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<td>Non-Medical Case Management</td>
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<td>Referral for Health Care and Support Services</td>
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<td>Medical Transportation Services</td>
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<td>Emergency Financial Assistance - Utilities</td>
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VISION
The vision of the QM Program is:

An environment of high quality HIV services guided by community input and best practices to eliminate health disparities and attain viral suppression for Ryan White clients.

MISSION
The mission of the Atlanta EMA Ryan White Part A QM Program is:

To provide quality medical and support services by continuously assessing and improving client care, client satisfaction, and client outcomes through the development and maintenance of a comprehensive quality management program.

PRIORITIES FOR THE QUALITY MANAGEMENT PROGRAM
To achieve our vision and to accomplish our mission, the Part A Quality Management Program is committed to ensuring that the people we serve receive comprehensive care based on mandated guidelines, professional standards and best practices. The QM Program is, therefore, designed to engage in activities with the following priorities:

- Establish a quality management structure within the Ryan White HIV/AIDS Part A Program that supports quality improvement activities in the EMA.
- Adopt US Public Health Service guidelines set forth by the Department of Health Services (HHS), International Antiviral Society- USA, CDC and other professional guidelines.
- Evolve and refine Atlanta EMA performance measurement systems to incorporate HRSA HIV/AIDS Bureau and HHS measures that align with the National Goals to End the HIV Epidemic.
- Employ assessment procedures to evaluate efficacy and appropriateness of services and to determine opportunities for improvement.
- Educate providers about QI methodologies and techniques through technical assistance workshops and other training mechanisms.
- Facilitate the active involvement of provider agencies in the implementation of multidisciplinary data driven quality improvement projects and the development of Atlanta EMA Service Standards and Measures (www.ryanwhiteatl.org).
- Promote communication among Ryan White Part A administration, provider agencies, Planning Council, and HRSA regarding performance improvement issues.

GOALS AND OBJECTIVES FOR THE QUALITY MANAGEMENT PROGRAM
- Enhance the infrastructure of the quality management program to plan, implement, and evaluate CQM program activities
  - By February 2021, 95% of the QM Committee will have reviewed the EMA QM Plan and provided recommendations for revisions if any.
  - By February 2021, 95% of the QM Committee will have reviewed the EMA Work Plan and provided recommendations for revisions if any.
By June 2020, 18 Part A subrecipients will have submitted comprehensive QM Plans of agency-level quality management programs to Recipient.

By February 2021, develop and review all standards of care for funded services.


**Improve the performance measurement system to appropriately assess outcomes**

- By February 2021, develop, review and update performance measure portfolio for all service categories.
- By February 2021, the QM Committee will review performance measures data at least quarterly to monitor progress of EMA's performance.

**Promote and foster continuous quality improvement initiatives across the EMA.**

- By February 2021, facilitate and implement at least two EMA wide Quality Improvement initiatives.
- By February 2021, provide resources for QI initiatives by ensuring trainings are offered to agencies and consumers in the EMA.
- By February 2021, engage at least three other HIV funded programs in Quality Management Planning and QI Initiatives.
- By February 2021, promote the coordination of at least one prevention and care quality improvement activity.

**Improve the quality of core medical and supportive services provided in the Atlanta EMA.**

- By February 2021, Linkage to Care within 30 Days will increase from 80% to 85%.
- By February 2021, Viral Load Suppression will increase from 80% to 83%.
- By February 2021, Retention in Medical Care among clients receiving medical case management services will increase from 77% to 84%.
- By February 2021, Retention in Medical Care among clients receiving psychosocial support services will increase from 73% to 75%.
- By February 2021, Retention in Medical Care among clients receiving medical transportation services will increase from 79% to 81%.

**Ensure the comprehensive involvement of people living with HIV in the quality management process.**

- By February 2021, provide at least two opportunities for consumer involvement in the quality management process.
- By February 2021, provide opportunities for consumers to provide input related to quality of services delivered.
Quality Management Plan

Statement of Authority and Accountability:
Section 2604(h)(5)(A) of Title XXVI of the Public Health Services Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that Part A Recipients establish and implement a clinical quality management (QM) program to: (1) assess the extent to which HIV health services provided to clients under the grant are consistent with the HHS guidelines for the treatment of HIV/AIDS and related opportunistic infection, as applicable, and (2) develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

HRSA Ryan White HIV/AIDS Program (RWHAP) requires that Part A Recipients have:
- Established and implemented a quality management plan with annual updates.
- Established processes for ensuring that services are provided in accordance with HHS treatment guidelines and standards of care.
- Incorporated quality-related expectations into Requests for Proposals (RFPs) contracts, including at the subrecipient level.

Diagram I. Ryan White Part A Program Infrastructure

Metropolitan Health HIV Services Planning Council
Quality Management Committee
**Fulton County Government:**

In the Atlanta EMA, Fulton County Government is the recipient of the Ryan White Part A grant. The Chairman of the Fulton County Board of Commissioners serves as the Chief Executive Official (CEO) to establish the Planning Council, appoint Council members, and delegate administrative responsibility for the Ryan White Program to the Ryan White Department. In addition, the Board of Commissioners sets long-range goals and approves strategic plans related to health in the jurisdiction guiding the work of collaborations and initiatives.

**LEADERSHIP**

**Ryan White Part A Recipient:**

The Ryan White Part A Quality Management Program is housed within the Department for HIV Elimination, one of six major departments in the Health and Human Services Branch of Fulton County Government. The Department for HIV Elimination provides oversight and management of the Ryan White Program Part A grant. The Department Director provides leadership and ensures administration of the grant, including resource allocation to develop and implement the Ryan White Part A Quality Management Program. The Director collaborates with county and regional leadership to align the Ryan White Part A Program Quality Management Program with the local, regional, and national strategies to end the HIV epidemic in Metropolitan Atlanta, ensures compliance of National Monitoring Standards (NMS), and guides the implementation of improvement strategies for the HIV Care Continuum outcomes. The Director and Deputy Director work with dedicated Quality Management staff to ensure the development and implementation of the QM plan, including systems-level Continuous Quality Improvement (CQI) projects.

**RYAN WHITE SUBRECIPIENTS**

Part A services are provided directly by subrecipients that are clinics, local health departments, and community partners identified through a competitive selection process. Subrecipients are funded for one year with two annual renewals based on compliance with contractual requirements and meeting goals and objectives. Ryan White Part A subrecipients’ primary role is to provide medical and support services to all eligible PLWH who reside in the Atlanta EMA. Services provided must align with HRSA’s National Monitoring Standards and Atlanta EMA Standards of Care. Each subrecipient must have a quality management program to assess and improve quality of service delivery. The Atlanta EMA improvement activities and performance data are reported to the Planning Council to enable it to evaluate programs and to appropriately allocate Part A funds to core services and health-related support services that most adequately address the needs of the EMA’s client population. Ryan White Part A subrecipients are responsible for ensuring quality management components are met per contractual requirements, in addition to the following:

- Ensuring that the medical management of HIV infection is in accordance with HHS HIV-related guidelines.
- Ensuring that services are provided in accordance with the Part A EMA Standards of Care.
- Developing and implementing a QM Program that includes the following:
  - Written QM plan
  - Leader and team to oversee the QM Program
  - Organizational goals, objectives, and priorities
  - Performance measures and mechanisms to collect data
  - Project-specific CQI plans
  - Communication of results to all levels of the organization, including consumers when appropriate
Fully participating in the Part A QM Committee and monitoring performance measures as determined by the Part A QM Plan.

Ensuring that all physicians, pharmacists, and all other licensed medical professionals possess current licensure and/or certification. Any lapse in licensure and/or the occurrence of suspension that deems a medical professional unable to practice medicine under current laws is to be immediately reported to the agency’s Part A Project Officer.

Participating in the chart reviews conducted by the Part A Program.

Providing QM Plan, reports, and other information related to the agency QM Program as requested by the Part A office.

QUALITY MANAGEMENT COMMITTEES
Ryan White QM Team
The Recipient QM team is responsible for the coordination and implementation of the QM Program and ensures adequate resources to carry out the Quality Management Work Plan. The Recipient QM team assesses funded agencies’ compliance with the Standards of Care and US Public Health Service guidelines, and reporting these findings to the Planning Council. The Recipient QM Team consists of the following staff members:

QM Program Manager
Oversees and manages the Ryan White Part A QM Program through planning and directing quality activities by:

- Serving as liaison/advisor to the Quality Management Committee of the Planning Council.
- Attending Quality Management Committee meetings, identifying QM consultant(s), and manages contract for EMA-wide quality improvement activities.
- Coordinating Recipient QM Team meetings.
- Assessing results of EMA-wide chart reviews and works with subrecipients on corrective action plans.
- Ensuring QM/QI and other HIV-related training is available to agencies and staff.
- Coordinating systems-level CQI projects in coordination with the Quality Management Committee.
- Planning, developing, implementing, and monitoring CQI activities.
- Ensuring the 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.
- Presenting required reports related to QM to Atlanta EMA stakeholders.
- Developing and revising performance measures, goals, and QM guidelines/policies.
- Attending educational conferences or other events sponsored by HRSA/HAB, Georgia Department of Public Health (DPH), SEATEC, or other appropriate sponsoring organizations to maintain current knowledge of Quality Management.
- Ensuring QM/QI findings and reports are shared at regularly scheduled RW Recipient QM Team meetings.

QM Program Specialists:
Closely monitor subrecipient QM Program activities by:

- Reviewing subrecipient QM Plans, conducting annual QM site visits, and programmatic chart reviews to assure compliance with Standards of Care; implementing corrective actions as necessary
- Monitoring submission of assigned agency progress reports and provides updates to QM team.
- Providing technical assistance to the RWHAP subrecipients in the development of QM Plan and CQI activities.
● Implementing, monitoring, and evaluating CQI project activities
● Providing ongoing data analysis of subrecipient’s performance measurement and support for the QM/QI activities, reports, and presentations.
● Participating in Part A quality-related committees and activities; attending all Planning Council QM Committee meetings.

**Project Officers:**
Closely monitor the programmatic and fiscal requirements of all contracts by:
● Reviewing agency reports for completeness; implementing corrective actions as necessary.
● Monitoring submission of assigned agency quarterly reports and provides updates to QM team.
● Conducting annual site visits

**Epidemiologist:**
Designs data tools and collects, and analyzes data to identify trends among clients by:
● Collaborating with the DPH HIV Epidemiology Section, Part B Data Manager, and Prevention Programs to facilitate optimal use of available surveillance data.
● Providing analysis of HIV surveillance data, CAREWare utilization and Ryan White cost data.
● Providing technical assistance to subrecipients and the Quality Management Committee.
● Providing ongoing data analysis and support to consultants in the formulation of the Clinical Chart Review Study analysis, reports, and presentations.
● Conducts special studies to assess and address health disparities

**CAREWare Data Manager:**
Oversees and manages the CAREWare database and ensure data quality by:
● Collaborating with the DPH HIV Epidemiology Section, Part B Data Manager, and Prevention Programs to facilitate optimal use of available data for QM activities.
● Designing procedures for the collection and evaluation of data.
● Maintaining the CAREWare database.
● Reviewing subrecipients’ Ryan White Services Reports (RSR) to ensure data completeness and quality; implementing corrective actions as needed.
● Providing data-related technical assistance and training to agency data designees and data entry staff.
● Generating reports from CAREWare to analyze performance measure data.
● Creating charts and spreadsheets for data analysis.
● Providing client information from random samples for annual chart reviews.

**Quality Management Consultant(s):**
● Provides assistance with data collection and analysis and other contract deliverables including impact of unmet need, clinical chart reviews, consumer surveys, and HIV Care Continuum.
● Provides technical assistance and training to ensure that subrecipients are equipped to implement, document, and analyze quality improvement initiatives.
● Recommends practices for improvement in access and retention in care.

**Planning Council Quality Management Committee**
The Planning Council established a standing Quality Management Committee. Planning Council members are assigned to the Quality Management Committee at the beginning of each Planning Council year.
Members include Part A subrecipients and consumers of Part A-funded services as well as other members interested in Quality Management along with representatives from Parts B, C, D, and HOPWA. Part A-funded providers are contractually required to designate a representative to participate in QM activities. The Chair and Vice-Chair of the QM Committee are appointed annually by the Planning Council Chair and are responsible for convening the meetings and coordinating the work of the Committee in collaboration with the Part A office. The QM Program Manager from the Part A office is assigned to coordinate the work of the Committee with HRSA’s requirements and to assist in data evaluation.

The Committee’s responsibilities:
- Updating the Atlanta EMA’s Quality Management Committee Work Plan annually
- Recommending Performance Measures (based upon the EMA’s Standards of Care) to monitor system-wide measures.
- Establishing a timeline for collection and reporting of related data in collaboration with the Part A Recipient’s office.
- Evaluating data and preparing recommendations for QI activities.
- Reviewing EMA chart review results for possible incorporation into committee work.
- Prioritizing opportunities for improvement and approaches to achieve improvement, including delegation of those issues to time sensitive and time limited work groups or task forces.
- Monitoring the work of task forces and work groups to remove barriers and accelerate improvement.
- Reviewing summarized aggregated quality management mechanisms and data and to communicating quality improvement recommendations to the Part A office for incorporation across the EMA.
- Participating in the state-wide CY 2017-2021 Integrated HIV Prevention and Care Plan through the PC Comprehensive Plan Committee.

PARTICIPATION OF STAKEHOLDERS

Consumer Involvement
The involvement of Persons Living with HIV in the development and planning of the Atlanta EMA quality management activities is essential. In addition to the QM Committee, the Planning Council’s Consumer Caucus and each Part A subrecipient’s Consumer Advisory Board are designated avenues to hear the needs and concerns of PLWH. As members of the QM Committee, PLWH provide their input which guides the quality of programs and services that meet their needs.

Other methods of obtaining PLWH input include needs assessment and client satisfaction surveys. Subrecipients are contractually required to utilize at least one of these methods to gain consumer input. Additionally, PLWH participate in quality improvement trainings, such as Training of Consumers on Quality (TCQ) sponsored by Center for Quality Innovation and Improvement (CQII), and/or Recipient sponsored trainings.

Stakeholder Involvement
The Recipient collaborates with stakeholders, including other RW Recipients in the region for state-wide quality improvement purposes. The RW Part A QM Program involves participation of members from RW Parts B, C, and D. The Part A QM Program Manager attends quarterly QM meetings of Part B Core Team and Part D Network. The development of performance measures and multi-jurisdictional quality
improvement projects through participation from Parts B, C, and D recipients. Representatives from Georgia Presentation and Care Council, DPH HIV Surveillance, and Part B has shared resources and information with the Quality Management Program to aid in Ryan White Part A improving service delivery. Stakeholders are given the opportunity to provide feedback and receive updates on quality activities. Representatives from AETC, HOPWA and other HIV Care and Prevention programs are invited to attend QM Committee meetings and assist in planning Quality Management activities. Aggregate level performance is shared quarterly with the Planning Council members and the following key stakeholder groups:

Internal Stakeholders
- RW Part A Recipient
- Fulton County Government- Office of County Manager
- Planning Council and Committees
- QM Committee
- Part A subrecipients

External Stakeholders
- General Public (www.ryanwhiteatl.org)
- HAB Project Officer
- DPH Part B Program
- Part B QM Core Team
- Part C Program Funded Agencies
- Part D Program

COMMUNICATION
The QM Committee meets monthly in-person to update the Work Plan. The QM Committee Chair provides an electronic copy of revised work plan and meeting minutes within 30 days following QM Meetings. The Chair of the QM Committee provides an oral update of work plan activities during each Executive and Planning Council meeting. QM Program Manager meets at least monthly with Recipient Office staff to discuss QM Program updates. QM Program Specialists shares program updates with Planning Council and subrecipients via email, newsletters, or updates on website.

QUALITY MANAGEMENT WORK PLAN
- The QM Plan includes a Work Plan that is updated monthly at QM Committee meetings.
- The Work Plan specifies objectives and strategies for annual QM Plan goals.
- The Work Plan is attached as Appendix A.

QUALITY MANAGEMENT TIMELINE
- The QM Plan includes a timeline to ensure annual CQI activities are achieved (Appendix B).
- The timeline incorporates the implementation and revision of the plan based on the Ryan White Program Part A grant year.

CAPACITY BUILDING
In order to provide training and practice in quality management, the Part A Recipient work with subrecipients to reinforce knowledge and practical skills for performance improvement. The Ryan White Part A QM Program participates in CQII trainings and webinars to support QM skills development. This methodology enables staff and the QM Committee Chairpersons to provide and
coordinate technical assistance/training for RW Part A subrecipients.

- CQII training materials and resources are incorporated in QM activities.
- QM technical assistance/training needs are assessed through requests from subrecipients, monitoring of QM Plans, training evaluations, and the QM Committee.
- QM technical assistance is also available upon request from the HRSA Project Officer for the Atlanta EMA.

RESOURCES
The resources utilized for the Quality Management program are:

- HRSA HIV/AIDS Bureau
- National Institute of Health, Clinical Guidelines
- CAREWare (jProg)
- Center for Quality Innovation and Improvement (CQII)
- Ryan White Programs Part B,C, and D
- City of Atlanta, HOPWA
- DPH HIV/AIDS Surveillance Department
- Georgia AIDS Education & Training Center
- Institute for HealthCare Improvement
- Ryan White subrecipients
- National HIV/AIDS Strategy (NHAS)
- American Society for Quality
- Professional Association of Social Workers in HIV/AIDS (PASWHA)
- American Academy of HIV Medicine
- American Public Health Association
The following outlines the process for establishing and defining performance measures and setting target goals.

**PERFORMANCE MEASUREMENT**
The Quality Management Committee establishes the measures for system-level review. The QM Committee may recommend monitoring existing HAB and EMA measures or creating new measures. Measures are developed based on the Atlanta EMA Standards of Care, HAB Performance Portfolio, NHAS, HHS Common Indicators, Integrated Plan, and other strategic plans and quality forums. Once measures of interest are identified, annual target goals are set based on EMA, Regional, and National Performance. Data review and analysis of performance measures and CQI projects (Appendix E) occur quarterly. Stratified HAB Core measures by age, gender, and race/ethnicity are also shared with the Planning Council. Performance measures are reported using CAREWare data and chart reviews.

The Recipient QM team monitors the performance at the subrecipient-level quarterly. Recipient QM team identifies EMA measures (Appendix E) for subrecipients to measure based on HRSA Policy Clarification Notice 15-02, QM Program priorities, and subrecipient’s past performance. QM Program Specialists review subrecipient’s performance measure data in submitted quarterly reports. Feedback and guidance is provided to subrecipients regarding their program submissions. In addition, the QM team monitors select aspects of the Integrated Plan at the subrecipient-level and EMA-wide.

The QM Consultant will conduct a Clinical Chart Review Study of selected core medical services. The purpose of the clinical chart review is to examine the extent to which Ryan White Part A funded primary care sites are providing care that meets approved EMA performance measures and selected HRSA/HAB Performance Measures. QM Program Specialists also assess and measure subrecipient performance through chart reviews (Appendix B).

**DATA COLLECTION**
Data are collected and used to identify gaps in care and service delivery. The Atlanta EMA utilizes CAREWare for client-level data reporting and performance measurement for all Part A-funded subrecipients. Subrecipients are contractually required to enter data into CAREWare’s centralized server within two weeks of an encounter to assist with completeness and validity of reporting. Other data is collected from funded agencies, PLWH, or external stakeholders to compare performance or identify opportunities for quality improvement. Data sources include the following:

- CAREWare
- RW Data Reports and Service Reports
- Clinical Chart Reviews
- Chart Reviews for Part A-Funded Categories
- Programmatic Monitoring Tools (i.e Part A Site Visit Report)
- QM Plan/Reports from Part A subrecipients
- Client Satisfaction Surveys
- HIV QM Module
- Consumer Needs Assessment from the Assessment Committee
Quality improvement activities are ongoing and continuous. Using available data, best practices, and input from Planning Council, Consumers, and Recipient QM team, strategies are developed that are consistent with the guidelines for improvement in the access to and quality of HIV health services.

**QI Methodology & Project Implementation**

Use of causal analysis, work flow diagrams, and Plan-Do-Study-Act (PDSA) cycles are used to identify and implement quality improvement projects in the Atlanta EMA and at the subrecipient level. Service category specific areas for improvement will be prioritized through the QM Committee and RW Recipient QM Team. Subrecipients will be expected to implement QI projects annually, which may include any system-wide QI project.

If a subrecipient is performing at goal for all service funded categories, subrecipient it may select a QI project on any other measure of interest. A quality improvement project will be required if performance is off by more than 5%, has declined by 5%, or if a subrecipient measured as one of the lowest five performers for a service funded category. In some instances, a corrective action plan will need to be implemented. Recipient QM team will monitor the progress of the quality improvement project and/or corrective action plan.

QI project teams are established by the Ryan White Part A CQM Program to work on specific quality improvement projects with subrecipients. The roles, responsibilities, and composition of the teams will change based on the nature of the project, the service category, or subrecipient.

**Internal QI Project Team’s Responsibilities:**

- Identify the area for improvement that will be the basis of the QI project.
- Work with the subrecipients to delineate goals for the project and develop a timeline for implementation.
- Delineate responsibilities to the subrecipients (e.g., development of the improvement project/PDSA test cycles).
- Develop a data collection plan with the subrecipient for each project.
- Identify potential solutions to make improvement on performance measures.
- Report to QM Committee on CQI improvements in aggregate form.

**Subrecipient Project Team’s Responsibilities:**

- Determine the root causes of the problem.
- Complete a PDSA project cycle.
- Document and track progress on the project.
- Share process on the project with Recipient QM Team and stakeholders
- Develop long term plans to maintain the QI project.

**QM Committee Project Team’s Responsibilities:**

- Select and prioritizes system-wide QI projects with the RW Recipient QM Team.
- Utilize data and CQI tools to guide QI project selection such as the following:
o QI Methodologies such as the Model for Improvement, PDSA: Plan-Do-Study-Act (*Appendix G*).
  o Data reports
  o Cause and effect diagrams
  o Brainstorming
  o Observational studies

Documented improvement projects are presented to the Quality Management Committee by the Part A Quality Management staff and/or subrecipients.

*Reporting Mechanisms*

Subrecipients report performance measure and program data quarterly to the Recipient office. Part A Recipient may provide agency-specific data reports directly to each subrecipient for the purpose of enhancing their quality management program and reviewing data quality. Findings from quality management activities will be reported only in aggregate form and are used to guide CQI activities. Service category data will also be provided in aggregate form during Planning Council meetings, distribution of printed materials, and/or the Recipient Office’s website.
MONITORING AND EVALUATION PLAN

The following outlines the process for ongoing monitoring and evaluation of the quality of services provided to Ryan White Part A clients and the execution of the QM Plan. QM Program activities aim to assess the extent to which funded core medical and support services provided to clients are consistent with the treatment guidelines, standards, and regulations.

System-wide Monitoring and Evaluation
RW Part A Program monitors and evaluates performance using various methods throughout the year. RW Recipient QM Team conducts site visits and chart reviews annually to ensure programmatic and fiscal standards are met according to the Ryan White Program Part A National Monitoring Standards for all funded service categories. The QM Program Specialist reviews and evaluates subrecipient’s QM Plan annually to ensure QM Program requirements are being met. The QM Program Specialists monitors subrecipient-level performance measure data with the Recipient QM Team and aggregate performance measure data with the QM Committee quarterly. The QM Committee and the RW Part A QM Team determines 1-2 QI projects annually. The QM Program Specialist monitors the progress of the QI projects. Feedback from stakeholders is gathered through participation in agency meetings, site visit reports, QI project plans, project workshops and information provided by the Planning Council’s committees and PLWH.

Internal Evaluation of the Quality Management Program
Beginning January of each fiscal year, the QM Plan will be evaluated for the ability to support and sustain quality improvement activities in the Atlanta EMA. Evaluation of the QM Program by QM Committee is led by the Chair of the Quality Committee and on an annual basis. Evaluation of the QM Program by Ryan White Recipient Staff is led by QM Program Manager. Evaluation will be completed using the National Quality Center’s (NQC) Organizational Assessment for Ryan White HIV/AIDS Program Part A Grantees form (Appendix I) and other methods such as surveys deemed appropriate by the QM Team. The evaluation will include a review of the program’s infrastructure, evaluation of quality improvement activities and appropriateness and results of performance measures. The results will be used to plan for future quality activities and shared with the QM Committee, RW Recipient QM Team and Part A subrecipients.
APPENDIX A

ATLANTA EMA RYAN WHITE QUALITY MANAGEMENT PROGRAM

WORKPLAN FY2020
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<tr>
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<th>ACTIVITIES</th>
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<th>STAFF RESOURCES</th>
<th>DEADLINE</th>
<th>PROGRESS NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. By February 2021, 95% of the QM Committee will have reviewed the EMA QM Plan and provided recommendations for revisions if any.</td>
<td>1. Evaluate QM Program 2. Draft and update the QM Plan with recommendations for future activities 3. Review and approve the QM Plan</td>
<td>1. QM Specialists 2. QM Program Manager 3. QM Committee Chair, Recipient Leadership and QM Program Manager</td>
<td>QM Committee and subrecipients</td>
<td>1. Dec 2020 2. Jan 2021 3. Feb 2021</td>
<td></td>
</tr>
<tr>
<td>b. By February 2021, 95% of the QM Committee will have reviewed the EMA Work Plan and provided recommendations for revisions if any.</td>
<td>1. Develop the annual Work Plan 2. Review and update QM Work Plan monthly</td>
<td>1. QM Committee Chair and QM Program Manager 2. QM Committee Chair and QM Program Manager</td>
<td>QM Committee and Recipient Staff</td>
<td>1. Jan 2021 2. Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
### Quality Management Plan

**c.** By June 2020, **seventeen** Part A subrecipients will have submitted comprehensive QM Plans of agency-level quality management programs to Recipient.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Educate Part A subrecipients on essential components of a quality management plan</td>
</tr>
<tr>
<td>2</td>
<td>Provide feedback to Part A subrecipients to improve previous QM Plan submissions</td>
</tr>
<tr>
<td>3</td>
<td>Require Part A subrecipients to submit quarterly QM reports to include program updates</td>
</tr>
</tbody>
</table>

**QM Program Manager**
- April 2020
- May 2020
- Quarterly
  - June 2020
  - Sept 2020
  - Jan 2021
  - Mar 2021

### Recipient Staff and subrecipients

<table>
<thead>
<tr>
<th>Step</th>
<th>Recipient Staff and subrecipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>QM Program Manager and Recipient Staff</td>
</tr>
<tr>
<td>2</td>
<td>QM Specialist and Recipient Staff</td>
</tr>
<tr>
<td>3</td>
<td>QM Specialist, QM Designees</td>
</tr>
</tbody>
</table>

**d.** By February 2021, develop and review all standards of care for funded services.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Research any updates to professional standards, evidence-based practices, HHS guidelines, or policy clarifications related to funded service categories</td>
</tr>
<tr>
<td>2</td>
<td>Review and update (as needed) all Core</td>
</tr>
</tbody>
</table>

**Recipient Staff**
- Apr 2020
- May 2020
- Feb 2021
- Ongoing

**QM Committee and Recipient Staff**
- Ongoing

**QM Committee Chair and QM Program Manager**
- Ongoing
and non-Core medical standards of care
3. Distribute revised standards of care to Part A subrecipients


1. Update site visit and chart review tools to assess agency compliance with standards of care
2. Conduct site visits, chart audits, data reviews
3. Review subrecipients’ QM quarterly reports and provide feedback
4. Generate corrective action plans for those agencies needing compliance improvement
5. Monitor corrective action plans

II. Improve the performance measurement system to appropriately assess outcomes

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTIVITY</th>
<th>LEAD</th>
<th>STAFF/RESOURCES</th>
<th>DEADLINE</th>
<th>PROGRESS NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. June 2020
2. Dec 2020
3. Quarterly
   - April 2020
   - July 2020
   - Oct 2020
   - Jan 2021
4. Dec 2020
5. Monthly, if any
a. By February 2021, develop, review and update performance measure portfolio for all service categories.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Develop and review current benchmarks for all HAB performance measures by required category (based on PCN 15-02 guidelines).</td>
</tr>
<tr>
<td>2.</td>
<td>Establish performance goals for measurement portfolio</td>
</tr>
<tr>
<td>3.</td>
<td>Prioritize measures based on areas of needed improvement</td>
</tr>
</tbody>
</table>

b. By February 2021, the QM Committee will review performance measures data at least quarterly to monitor progress of EMA’s performance.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Provide QM Committee with a review of outcomes data reports on a quarterly basis</td>
</tr>
<tr>
<td>2.</td>
<td>Identify trends and patterns based on agency progress in meeting standards of care and performance goals to identify performance gaps</td>
</tr>
<tr>
<td>3.</td>
<td>Generate and implement recommendations to</td>
</tr>
</tbody>
</table>

1. Recipient and QM Committee
2. Recipient and QM Committee
3. Recipient and QM Committee

<table>
<thead>
<tr>
<th>Recipient Staff, QM Committee and subrecipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dec 2020</td>
</tr>
<tr>
<td>2. Jan 2021</td>
</tr>
<tr>
<td>3. Feb 2021</td>
</tr>
</tbody>
</table>

1. Recipient Staff; QM Committee; subrecipients
2. Ongoing
3. Ongoing
4. Quarterly
   - July 2020
   - Oct 2020
   - Jan 2021
   - April 2021

1. Quarterly
   - June 2020
   - Sept 2020
   - Jan 2021
III. Promote and foster continuous quality improvement initiatives across the EMA.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTIVITY</th>
<th>LEAD</th>
<th>STAFF/RESOURCES</th>
<th>DEADLINE</th>
<th>PROGRESS NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>address identified performance gaps</td>
<td>4. Require Part A subrecipients to submit quarterly QM Reports to include agency-level performance measures data</td>
<td></td>
<td></td>
<td>Mar 2021</td>
<td></td>
</tr>
</tbody>
</table>
a. By February 2021, facilitate and implement at least two EMA wide Quality Improvement initiatives.

| 1. Identify at least 2 QI Initiatives | 1. QM Committee; Recipient |
| 2. Document and report progress on QI initiative(s) | 2. Subrecipients |
| 3. Communicate best practices and QI progress with community stakeholders on a regular basis. | 3. QM Specialists |
| 4. Determine need for additional QI related studies | 4. QM Program Manager |
| 5. Review subrecipients’ QI projects and provide Technical Assistance | 5. QM Specialists |
| 6. Require Part A subrecipients to conduct at least one quality improvement project each year | 6. QM Specialists, QM Designees |
| | Recipient Staff and subrecipients |

b. By February 2021, provide resources for QI initiatives by ensuring trainings are available.

| 1. Determine training needs of consumers and agencies | 1. Recipient Staff |
| 2. QM Program Manager | 2. QM Program Manager |
| 3. CAREWare Data Manager | 3. CAREWare Data Manager |
| | QM Committee; Recipient Staff; CQII; subrecipients; CAREWare |

<p>| 2. Ongoing | 2. Ongoing |
| 3. Ongoing | 3. Ongoing |
| 4. Ongoing | 4. Ongoing |
| 5. Monthly | 5. Monthly |
| 6. Ongoing | 6. Ongoing |</p>
<table>
<thead>
<tr>
<th>Offered to agencies and consumers in the EMA.</th>
<th>2. Provide Quality Improvement Bootcamp</th>
<th>4. QM Committee; Recipient and jProg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3. Provide additional CAREWARE training to agency representatives in the EMA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Provide access to webinars and trainings online.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>1. Chair, QM Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Recipient Staff</td>
<td>Recipient and QM Committee, DPH Part B, State GPACC, Part C, Part D</td>
</tr>
<tr>
<td></td>
<td>3. Recipient Staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Ongoing</td>
</tr>
<tr>
<td></td>
<td>2. Quarterly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Mar 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o June 2020</td>
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<tr>
<td></td>
<td></td>
<td>o Sept 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Dec 2020</td>
</tr>
<tr>
<td></td>
<td>3. Ongoing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. By February 2021, engage at least three other HIV funded programs in Quality Management Planning and QI Initiatives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Invite Parts B, C, D, AETC and HOPWA, State GPACC representatives to attend joint Part A QM Committee meetings and share QI data and best practices.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Attend and participate in Part B and Part D QM Committee Meetings quarterly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Coordinate quality-related activities across Ryan White</td>
<td></td>
</tr>
</tbody>
</table>
d. By February 2020, promote the coordination of at least one prevention and care quality improvement activity.

1. Attend the meetings hosted by Georgia Prevention and Care Council (G-PACC) Meetings, Fulton County HIV/AIDS Prevention, Care, and Policy Advisory Committee, HIPP and other HIV funded programs.
2. Provide updates on progress of implementation of joint Integrated Plan.
3. Invite subrecipients’ prevention staff to participate in QI Project Workshops and webinars.

<table>
<thead>
<tr>
<th>Programs in the EMA</th>
<th>Activities</th>
<th>Lead</th>
<th>Staff/Resources</th>
<th>Deadline</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. QM Committee Chair</td>
<td>2. QM Specialists</td>
<td>3. Recipient Staff</td>
<td>QM Committee; Recipient Staff; subrecipients; State and local Prevention program staff</td>
<td>1. Quarterly 2. Ongoing 3. Ongoing</td>
<td></td>
</tr>
</tbody>
</table>

IV. Improve the quality of core medical and supportive services provided in the Atlanta EMA.
<p>| | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>a. <strong>By February 2021, Linkage to Care within 30 Days will increase from 80% to 85%.</strong></td>
<td>1. Revise Linkage to Care Flowchart 2. Standardize Linkage to Care Protocols</td>
<td>1. QM Program Manager 2. Recipient 1. QM Program Manager 2. Recipient</td>
</tr>
<tr>
<td></td>
<td>1. Revise Linkage to Care Flowchart 2. Standardize Linkage to Care Protocols</td>
<td>Recipient Staff; QM Committee 1. August 2020 2. Feb 2021</td>
</tr>
</tbody>
</table>
among clients receiving psychosocial support services will increase from 73% to 75%.

1. Review Medical Transportation Processes
2. Make recommendations for improvements
3. Develop standard documentation forms
4. QM Specialists
5. December 2020

By February 2021, Retention in Medical Care among clients receiving medical transportation services will increase from 79% to 81%.

1. Regularly integrate QM activities and updates during Consumer Caucus meetings
2. Provide QM specific trainings to consumers
3. Invite Subrecipients’ peer staff and PLWH to
4. QM Specialist
5. QM Program Manager
6. QM Designees
7. QM Designees
8. QM Committee
9. Subrecipients
10. QM Specialists
11. QM Specialists
12. QM Specialists; subrecipients; CAREWare
13. 1. October 2020
     2. December 2020
     3. February 2021

V. Ensure the comprehensive involvement of people living with HIV in the quality management process.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTIVITIES</th>
<th>LEAD</th>
<th>STAFF/ RESOURCES</th>
<th>DEADLINE</th>
<th>PROGRESS NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Provide QM specific trainings to consumers</td>
<td>2. QM Program Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Invite Subrecipients’ peer staff and PLWH to</td>
<td>3. QM Designees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. QM Designees</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>5. QM Committee</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>6. Subrecipients</td>
<td></td>
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</tbody>
</table>
### Quality Management Plan

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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Conduct annual client satisfaction survey</td>
<td>QM Designees; Subrecipients; Recipient; Consumer Advisory Boards</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Conduct EMA-wide client satisfaction survey</td>
<td>QM Program Manager</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Conduct interviews and focus groups related to quality improvement activities</td>
<td>Recipient and subrecipients</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Recipient and Subrecipients</td>
<td></td>
</tr>
</tbody>
</table>

**b. By February 2021, provide opportunities for consumers to provide input related to quality of services delivered.**

<p>| | | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Participate in QI Project Workshops and webinars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Invite Subrecipients’ peer staff and PLWH to participate in Quality Management Meetings at the agency-level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Enhance PLWH to participate in Quality Management Meetings at the Planning Council level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Establish and/or enhance Consumer Advisory Boards</td>
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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sept 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Dec 2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Ongoing</td>
<td></td>
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</tr>
</tbody>
</table>
4. Utilize consumer feedback to make program improvements
APPENDIX B

Annual QM Program Timeline
APPENDIX C

HIV Care Continuum Targets
ATLANTA EMA RYAN WHITE QUALITY MANAGEMENT PROGRAM
CARE CONTINUUM TARGETS FY2020

The Atlanta EMA targets for the HIV Care Continuum are set to closely align with national and global strategies to end HIV. In table below, the Atlanta EMA QM targets are identified and compared with local, state, national, and global strategies.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Linkage to Care within 30 days</td>
<td>85%</td>
<td>85%</td>
<td>90%</td>
<td>85%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Engaged in Care</td>
<td>90%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Retained in Care (12 months)</td>
<td>80%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescribed ART</td>
<td>95%</td>
<td>-</td>
<td>90%</td>
<td>-</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Viral Suppression</td>
<td>83%</td>
<td>90%</td>
<td>80%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>
APPENDIX D
ATLANTA EMA RYAN WHITE QUALITY MANAGEMENT PROGRAM
FY2020 Performance Goals
ATLANTA EMA RYAN WHITE QUALITY MANAGEMENT PROGRAM
FY2020 PERFORMANCE GOALS

The following service categories were selected based on service utilization per HRSA PCN 15-02 and prioritization due to past performance.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>CAREWare Code</th>
<th>Performance Measure</th>
<th>Target Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV Care Continuum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care02a</td>
<td>Linked to Care within 30 days of Diagnosis</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Care03</td>
<td>Engaged in Medical Care</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>HAB01</td>
<td>Retained in Medical Care (12 months)</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Core02</td>
<td>Prescribed ART</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Core01</td>
<td>Viral Load Suppression</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Care04a</td>
<td>Viral Load Suppression among those who are retained</td>
<td>90%</td>
</tr>
<tr>
<td><strong>HAB Measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Core03</td>
<td>HAB: HIV Medical Visit Frequency</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Core04</td>
<td>HAB: Gap in Medical Visits</td>
<td>17%</td>
</tr>
<tr>
<td></td>
<td>HAB03a</td>
<td>PCP Prophylaxis</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>HAB06</td>
<td>Adherence Assessment</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>HAB07a</td>
<td>Cervical Cancer - 3years</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>HAB09</td>
<td>Hepatitis C Screening</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>HAB12</td>
<td>Oral Exam</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>HAB13</td>
<td>Syphilis Screening*</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td>HAB14</td>
<td>TB Screening</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>HAB15</td>
<td>Chlamydia Screening</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>HAB16</td>
<td>Gonorrhea Screening</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>HAB17</td>
<td>Hepatitis B Screening</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>HAB21</td>
<td>Mental Health Screening*</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>HAB23</td>
<td>Substance Abuse Screening</td>
<td>79%</td>
</tr>
</tbody>
</table>
## ATLANTA EMA RYAN WHITE QUALITY MANAGEMENT PROGRAM
### FY2020 PERFORMANCE GOALS

<table>
<thead>
<tr>
<th>Service Category</th>
<th>CAREWare Code</th>
<th>Performance Measure</th>
<th>Target Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health Services</td>
<td>EMA01a</td>
<td>Oral Health: HAB Annual Retention in Care*</td>
<td>94%</td>
</tr>
<tr>
<td>Medical Case Management</td>
<td>EMA05a</td>
<td>MCM: HAB Annual Retention in Care*</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>EMA06</td>
<td>MCM: Viral Load Suppression</td>
<td>80%</td>
</tr>
<tr>
<td>Psychosocial Support</td>
<td>EMA16a</td>
<td>Psychosocial: HAB Annual Retention in Care*</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>EMA16c</td>
<td>Psychosocial Support: Viral Load Suppression</td>
<td>80%</td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>EMA17a</td>
<td>Medical Transportation: HAB Annual Retention in Care*</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>EMA17c</td>
<td>Medical Transportation: Viral Load Suppression</td>
<td>80%</td>
</tr>
<tr>
<td>Referral for Health Care &amp; Support Services</td>
<td>EMA215</td>
<td>Referral for Hlth/Support: Viral Load Suppression *</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>EMA216</td>
<td>Referral for Hlth/Support: HAB Annual Retention in Care*</td>
<td>87%</td>
</tr>
</tbody>
</table>

*PC QM Committee Quarterly Review Measure*
APPENDIX E

ATLANTA EMA PERFORMANCE MEASURES PORTFOLIO

FY2020
The following measures are being monitored at the agency level for program quality of care and data quality issues on a routine basis by Recipient QM team.

### HIV CARE CONTINUUM

<table>
<thead>
<tr>
<th>Performance Measure/Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Linkage to Care</strong> (HAB Systems-level; NHAS Indicator 4)</td>
<td>Number of persons who attended a routine HIV medical care visit within 1 month of HIV diagnosis</td>
<td>Number of clients, regardless of age, with an HIV diagnosis in 12-month measurement year</td>
<td>None</td>
<td>CARE02a</td>
</tr>
<tr>
<td>Percentage of clients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Number of persons with an HIV diagnosis in 12-month measurement period</td>
<td>None</td>
<td>CARE03</td>
</tr>
<tr>
<td><strong>Engaged in Care</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Number of persons with an HIV diagnosis in 12-month measurement period</td>
<td>None</td>
<td>CARE03</td>
</tr>
<tr>
<td>Percentage of people living with HIV who had at least one HIV medical care visit during measurement year</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>HAB01</td>
</tr>
<tr>
<td><strong>Retained in Care</strong> (Archived HAB Medical Visits)</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>HAB01</td>
</tr>
</tbody>
</table>
## HIV CARE CONTINUUM

<table>
<thead>
<tr>
<th>Performance Measure/Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription of HIV ARV Therapy (HAB Core Measure)</strong>&lt;br&gt;Percentage of clients who were prescribed HIV antiretroviral therapy during the measurement year</td>
<td>Number of clients from the denominator prescribed HIV antiretroviral therapy during the measurement year</td>
<td>Number of clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year</td>
<td>None</td>
<td>Core02</td>
</tr>
<tr>
<td><strong>HIV Viral Load Suppression (HAB Core Measure)</strong>&lt;br&gt;Percentage of clients who have a HIV viral load less than 200 copies/ml at last HIV Viral load test during the measurement year</td>
<td>Number of clients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year</td>
<td>Number of clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year</td>
<td>None</td>
<td>Core01</td>
</tr>
<tr>
<td><strong>HIV Viral Load Suppression Among those who are Retained</strong>&lt;br&gt;Percentage of <em>retained in care</em> clients who have a HIV viral load less than 200 copies/ml at last HIV Viral load test during the measurement year</td>
<td>Number of clients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>Care04a</td>
</tr>
<tr>
<td>Performance Measure</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Data Exclusions</td>
<td>CAREWare Code</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
| **Medical Visit Frequency** *(HHS Retention in Care (24 months))*  
Percentage of clients who had at least one medical visit in a 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the 6 month period and the last medical visit in the subsequent 6-month period | Number of clients in the denominator 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 first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period | Number of clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period | None                                                      | Core 03       |
| **Gap in HIV Medical Visits**  
Percentage of clients who did not have a medical visit in the last 6 months of the measurement year | Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year | Number of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year | Clients who died at any time during the measurement year                                              | Core 04       |
| **Prescription of PCP Prophylaxis**  
Percentage of clients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis medications within 3 months of CD4 count below 200 cells/mm3 | Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm3 who were prescribed PCP prophylaxis | Number of HIV-infected clients who: had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and had a CD4 T-cell count below 200 cells/mm3 | Clients with CD4 T-cell counts below 200 cells/mm3 repeated within 3 months rose above 200 cells/mm3. Clients newly enrolled in care during last three months of the measurement year | HAB03          |
<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cervical Cancer Screening</strong></td>
<td>Number of clients in the denominator who were screened for cervical cancer in the last three years</td>
<td>Number of female clients with a diagnosis of HIV who: ● Had at least one medical visit with provider with prescribing privileges and ● Were &gt; 21 years old in the measurement year</td>
<td>Clients who had a hysterectomy for non-dysplasia/non-malignant indications</td>
<td>HAB 07a</td>
</tr>
<tr>
<td><strong>Hep C Screening</strong></td>
<td>Number of clients with a diagnosis of HIV who have documented HCV status in chart</td>
<td>Number of clients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>None</td>
<td>HAB09</td>
</tr>
<tr>
<td><strong>Oral Exam</strong></td>
<td>Number of clients with a diagnosis of HIV who had an oral exam by a dentist during the measurement year, based on client self-report or other documentation</td>
<td>Number of clients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>None</td>
<td>HAB12</td>
</tr>
</tbody>
</table>
### Outpatient Ambulatory Health Services

#### HAB ADOLESCENT/ADULT PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlamydia Screening</strong></td>
<td>Number of clients with a diagnosis of HIV who had a test for chlamydia</td>
<td>Number of clients with a diagnosis of HIV who: ● Were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months, and ● Had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients who were &lt; 18 years old and denied a history of sexual activity</td>
<td>HAB 15</td>
</tr>
<tr>
<td><strong>Gonorrhea Screening</strong></td>
<td>Number of clients with a diagnosis of HIV who had a test for gonorrhea</td>
<td>Number of clients with a diagnosis of HIV who: ● Were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months, and ● Had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients who were &lt; 18 years old and denied a history of sexual activity</td>
<td>HAB16</td>
</tr>
</tbody>
</table>
### Outpatient Ambulatory Health Services

#### HAB ADOLESCENT/ADULT PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hep B Screening</strong></td>
<td>Number 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</td>
<td>Number of clients, regardless of age, with a diagnosis of HIV or for whom there is documented infection or immunity</td>
<td>None</td>
<td>HAB17</td>
</tr>
</tbody>
</table>
| **Syphilis Screening**  | Number of clients with a diagnosis of HIV who had a serologic test for syphilis performed at least once during the measurement year | Number of clients with a diagnosis of HIV who:  
- Were >18 years old in the measurement year or had a history of sexual activity < 18 years, and  
- Had a medical visit with a provider with prescribing privileges at least once in the measurement year | Clients who were < 18 years old and who denied a history of sexual activity | HAB13         |
### HAB ARCHIVED PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Abuse Screening</strong></td>
<td>Number of <strong>new</strong> clients with a diagnosis of HIV who were screened for substance use within the measurement year</td>
<td>Number of HIV-infected clients who: <em>were new during the measurement year, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.</em></td>
<td>None</td>
<td>HAB23</td>
</tr>
<tr>
<td><strong>Adherence Assessment</strong></td>
<td>Number of HIV-infected clients, as part of their primary care, who were assessed and counseled for adherence two or more times at least three months apart</td>
<td>Number of HIV-infected clients on ARV therapy who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</td>
<td>Clients newly enrolled in care during last six months of the year, Clients who initiated ARV therapy during last six months of the year</td>
<td>HAB06</td>
</tr>
</tbody>
</table>
## HAB Archived Performance Measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB Screening</strong></td>
<td>Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis</td>
<td>Number of HIV-infected clients who: do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>None</td>
<td>HAB14</td>
</tr>
<tr>
<td><strong>Mental Health Screening</strong></td>
<td>Number of new HIV-infected clients who received a mental health screening</td>
<td>Number 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</td>
<td>None</td>
<td>HAB21</td>
</tr>
</tbody>
</table>
### ORAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Health: HAB Annual Retention in Care</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of oral health clients, regardless of age, with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>EMA01a</td>
</tr>
</tbody>
</table>
## Medical Case Management

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCM: HAB Annual Retention in Care</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of medical case management clients, regardless of age, with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>EMA05a</td>
</tr>
<tr>
<td><strong>MCM: HIV Viral Load Suppression</strong></td>
<td>The number of medical case management clients with a viral load &lt;200 copies/mL at last test during the 12 month measurement period</td>
<td>All medical case management clients with at least one medical visit during the 12 month measurement period</td>
<td>None</td>
<td>EMA06</td>
</tr>
</tbody>
</table>
### Psychosocial Support Services

<table>
<thead>
<tr>
<th>Performance Measure/Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychosocial Support Services: HAB Annual Retention in Care</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of clients who received psychosocial support services, regardless of age, with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>EMA16a</td>
</tr>
<tr>
<td><strong>Psychosocial Support Services: HIV Viral Load Suppression</strong></td>
<td>The number of clients who received psychosocial support services with a viral load less than 200 copies/mL at last test during the 12 month measurement period</td>
<td>All clients who received psychosocial support services and had at least one medical visit during the 12 month measurement period</td>
<td>None</td>
<td>EMA16c</td>
</tr>
<tr>
<td>Performance Measure/Indicator</td>
<td>Numerator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Transportation Services: HAB Annual Retention in Care</td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Transportation Services: HIV Viral Load Suppression</td>
<td>The number of clients who received medical transportation services with a viral load &lt;200 copies/mL at last test during the 12 month measurement period</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Data Exclusions</th>
<th>CAREWare Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients who received medical transportation services, regardless of age, with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
<td>Clients newly enrolled in care during last six months of the year</td>
<td>EMA17a</td>
</tr>
<tr>
<td>All clients who medical transportation services and had at least one medical visit during the 12 month measurement period</td>
<td>None</td>
<td>EMA17c</td>
</tr>
<tr>
<td>Performance Measure/Indicator</td>
<td>Numerator</td>
<td>Denominator</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Referral for Health Care and Support Services: HIV Viral Load Suppression</strong></td>
<td>The number of clients who received referral for health care and support services with a viral load &lt;200 copies/mL at last test during the measurement year</td>
<td>All clients who received referral for health care and support services and had at least one medical visit during the measurement year</td>
</tr>
<tr>
<td><strong>Referral for Health Care and Support Services: HAB Annual Retention in Care</strong></td>
<td>Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</td>
<td>Number of clients who received referral for health care and support services with a HIV diagnosis who had a medical visit with a provider with prescribing privileges at least once in the measurement year</td>
</tr>
</tbody>
</table>
APPENDIX F
QI Project Plan
RYAN WHITE PART A PROGRAM: *Organization Name*
QUALITY MANAGEMENT PROGRAM
PROJECT PLAN: *Project Name*

Agency Name____________________________________________________________________ Date___________________

Agency Representative(s)________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Goal</th>
<th>Performance Measure (Data)</th>
<th>Plan</th>
<th>Actions</th>
<th>Start/Implementation Date</th>
<th>Outcome measure</th>
<th>Frequency of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX G

PDSA Template
**PDSA Cycle Template**

**Directions:** Use this Plan-Do-Study-Act (PDSA) tool to plan and document the progress with tests of change conducted as part of your Quality Improvement Projects (QIP). Answer the first two questions below for your QIP. As you plan to test changes to meet your aim answer, question 3 below. Proceed to plan, conduct, and document your PDSA cycles. Remember that a QIP will usually involve multiple PDSA cycles in order to achieve your aim. Use as many forms as you need to track your PDSA cycles.

**Model for Improvement: Three questions for improvement**

<table>
<thead>
<tr>
<th>1. <strong>What are we trying to accomplish (aim)?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State your aim:</strong> (review your QIP – and include your bold aim that will improve health outcomes and quality of care)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. <strong>How will we know that change is an improvement (measures)?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Describe the desired measureable outcome(s):</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. <strong>What change can we make that will result in an improvement?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Define the processes currently in place:</strong></td>
</tr>
</tbody>
</table>

**Identify opportunities for improvement that exist:** (look for causes of problems that have occurred or identify potential problems before they occur)

Examples:
- Points where breakdowns occur
- “Work-a-rounds” that have been developed
- Variation that occurs
- Duplication or unnecessary steps

**Decide what you will change in the process; determine your intervention based on your analysis:**
- Identify better ways to do things that address the root causes of the problem
- Learn what has worked at other organizations
- Review the best available evidence for what works (literature, studies, experts, guidelines)
- Remember, the solution does not have to be perfect the first time
What is the purpose of this cycle? Details: Who, What, Where, When, and 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?
Who will be involved in this PDSA? (e.g., Subrecipient, client, Part

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Fill out before the test/cycle) List your action steps along with person(s) responsible and timeline.</td>
<td></td>
</tr>
<tr>
<td>(Fill out during the test/cycle) Describe what actually happened when you ran the test.</td>
<td></td>
</tr>
<tr>
<td>List the tasks necessary to complete this step</td>
<td>Person responsible (who)</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
</tbody>
</table>

Carry out the test on a small scale. Was the test/cycle carried out as planned? Yes No
If no, why not?
What did we observe that was not part of our plan?
### Study

- Study and analyze the data.
- How did we study and understand the result?
- How did the outcome of this test/cycle agree or disagree with our expectation (prediction)?
- Were there implementation lessons?
- **Summarize what was learned.** *(Fill out after the test/cycle)*

- Describe the measured results and how they compared to the predictions.

### Act

**Based on what was learned from the test:**

- **Adapt** – modify the changes and repeat PDSA cycle.
- **Adopt** – select changes to implement on a larger scale and develop an implementation plan and plan for sustainability
- **Abandon** – discard this change idea. Change your approach and repeat PDSA cycle.

**Describe what modifications to the plan will be made for the next cycle from what you learned.** *(Fill out after the test/cycle is completed)*

---

<table>
<thead>
<tr>
<th>Team Name:</th>
<th>Date of test:</th>
<th>Test Completion Date:</th>
<th>Cycle#:</th>
</tr>
</thead>
</table>

**Overall team/project aim:**

**What is the objective of the test?**
APPENDIX H
Quality Improvement Dictionary
from Center for Quality
Improvement and Innovation
## Quality Improvement Dictionary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algorithm</td>
<td>Description of an ordered sequence of steps. Algorithms can be used to display a decision tree for certain care conditions.</td>
</tr>
<tr>
<td>Baseline Data</td>
<td>Data collected at the beginning of an improvement project. They are compared with future data collected on the same system to measure any changes in the data, especially improvements.</td>
</tr>
<tr>
<td>Benchmark, Benchmarking</td>
<td>A benchmark is a comparative measure for a particular indicator or performance goal; within the health care or non-health care field. The benchmarking process identifies the best performance in an industry for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance.</td>
</tr>
<tr>
<td>Brainstorming</td>
<td>Brainstorming is a technique to freely and uninhibitedly generate ideas, problems, or opportunities using a group approach.</td>
</tr>
<tr>
<td>Cause-and-Effect Diagram</td>
<td>A Cause-and-Effect Diagram is a picture of various system elements and is used to identify possible variables influencing a problem, outcome, or effect. The diagram is sometimes called an Ishikawa diagram or a fishbone diagram because its resemblance to the skeleton of a fish.</td>
</tr>
<tr>
<td>Confidence Intervals (95%)</td>
<td>95% confidence intervals state that if all records of an organization were reviewed, the performance score attained would fall between the upper and lower confidence limits. For a 95% Confidence Interval, if many samples are collected and the Confidence interval computed, in the long run about 95% of these intervals would contain the true performance score.</td>
</tr>
<tr>
<td>Cross-functional</td>
<td>Representation of members of different professional and functional backgrounds within a program (or from different departments within the overall organization) in quality committees or in Quality Improvement Teams (e.g., inclusion of professional disciplines other than healthcare workers). Synonym includes multidisciplinary teams (in medical setting usually refers to different departments or divisions or professional disciplines).</td>
</tr>
<tr>
<td>Denominator</td>
<td>That number in a fraction that is below the line that is used to divide the number above the line (the numerator).</td>
</tr>
<tr>
<td>Flow Chart</td>
<td>A Flow Chart is a picture of any process, such as sequence of events, steps, activities, or tasks. Flow Charts are drawn with standard symbols that represent different types of activities or tasks.</td>
</tr>
<tr>
<td>Gantt Chart</td>
<td>A Gantt Chart is a list of all activities (including the roles and responsibilities) to accomplish a specific goal. It helps to highlight key components of a problem and sequence of tasks to be completed based on authoritative sources, including clinical literature and expert consensus.</td>
</tr>
<tr>
<td>Histogram</td>
<td>A Histogram is a bar graph representing the frequency of individual occurrences or classes of data. It provides basic information about the presented data set, such as central location.</td>
</tr>
<tr>
<td>Indicator/Measure</td>
<td>A measurement tool or operational definition of one specific quality characteristic that can be measured (e.g., retention, viral load suppression) conforming to guidelines or standards of care. They are often categorized as either outcome or process indicator. It can also be called a measure.</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mean</td>
<td>The arithmetic average of a set of numbers.</td>
</tr>
<tr>
<td>Median</td>
<td>The median is the value that divides an ordered series of numbers so that there is an equal number of values on either side of the center (or median).</td>
</tr>
<tr>
<td>Mode</td>
<td>The mode is the most frequently occurring number in a given set of numbers.</td>
</tr>
<tr>
<td>Model for Improvement</td>
<td>An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number in a fraction that is above the line and that is divided by the number below the line (the denominator).</td>
</tr>
<tr>
<td>Outcome</td>
<td>The results achieved through the performance of a process or function.</td>
</tr>
<tr>
<td>Pareto Chart</td>
<td>A Pareto Chart or Diagram is a simple bar chart, which ranks related categories (e.g., barriers to retention) in decreasing order of occurrence. It can be used to analyze causes, study results, or plan for improvements.</td>
</tr>
<tr>
<td>Plan-Do-Study-Act Cycle (PDSA)</td>
<td>A process to describe a quality improvement cycle using four-steps: Plan, Do, Study, and Act. It is sometimes referred to as the Shewhart cycle (Walter A. Shewhart) or as the Deming cycle (W. Edwards Deming). Also called Plan-Do-Check-Act (PDCA) Cycle and is a component of the Model for Improvement</td>
</tr>
<tr>
<td>Process</td>
<td>An action, or series of actions, that transform inputs into outputs.</td>
</tr>
<tr>
<td>Provider</td>
<td>An institution, organization, or person that provides health care services.</td>
</tr>
<tr>
<td>Quality Assessment</td>
<td>A measurement activity that includes the review of a process, data analysis, and report of findings. To assess a care process is an important step in the quality improvement cycles.</td>
</tr>
<tr>
<td>Quality Assurance (QA)</td>
<td>A formal set of activities to review and to safeguard the quality of medical services provided. QA includes quality assessment and implementation of corrective actions to address deficiencies. It is focused on ensuring standards are adhered to, identifying problems, and solving single quality issues with problem resolution focused on the responsible individual. QA is used more in a regulatory environment.</td>
</tr>
<tr>
<td>Quality Improvement (QI)</td>
<td>Quality Improvement (QI) is defined as an organizational approach to improve quality of care and services using a specified set of principles and methodologies. Those principles include, but</td>
</tr>
</tbody>
</table>
are not limited to, leadership commitment, staff involvement, cross-functional team approach, consumer orientation, and a continuing cycle of improvement activities and performance measurements. Synonyms include Continuous Quality Improvement (CQI) and Total Quality Management (TQM).

<table>
<thead>
<tr>
<th>Quality Management Plan (QM)</th>
<th>A written QM plan defines a process for ongoing evaluation and assessment to identify and improve the quality of care, and the infrastructure that clearly indicates responsibilities and accountability for the quality program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement (QI) Team</td>
<td>A specially constituted working group to address one specific opportunity for improvement. QI Team consists of those people who have regular involvement in the process and have a leader and sometimes a facilitator (e.g., QI Team to improve the client adherence to antiretroviral therapy). Synonyms include CQI (Continuous Quality Improvement) Team.</td>
</tr>
</tbody>
</table>
APPENDIX I

Organizational Assessment for Ryan White HIV/AIDS Program Part A Recipients
Organizational Assessment for Ryan White HIV/AIDS Program Part A Recipients

(Issued April 2014)
Purpose of the Organizational Assessment:
Ongoing improvement activities require a sustainable quality management program (QMP). Development, implementation and spread of sustainable quality improvement (QI) processes throughout an HIV program are built upon an organizational commitment to quality management, effective leadership, a functional organizational quality management (QM) infrastructure, competent staff, access to QI training and support, time for QI teams to meet and data systems for tracking outcomes. This structure supports quality initiatives that apply robust process improvement including: reliable measurement, root cause analysis and finding solutions for the most important causes identified. This organizational assessment tool aims to provide an evaluation tool to ensure that all key organizational components are in place to meet key improvement milestones.

The Ryan White Program requirements and expectations for quality improvement, which apply to all Ryan White recipients regardless of their funding stream, have been taken into account when this organizational assessment tool was designed. Part A recipients are not only responsible for conducting QI activities within their organization but also throughout the network of contracted service providers. The recipient is responsible for ensuring that QI projects are being undertaken throughout the EMA/TGA and how QM data are used to change service delivery.

Overview of Organizational Assessment Tool:
This organizational assessment tool (OA) identifies all essential elements associated with a sustainable quality management program. Detailed scoring instructions are provided to identify gaps in the QMP and to set program priorities for improvement. When assigning a score for individual components select the whole number that most accurately reflects the organizational achievement in that area for the review period. If there is any uncertainty in assessing whether performance is closer to the statement in the next higher or next lower range, choose the lower score. Scoring is designed so that all items in the score must be satisfied to reach any one score for a component. Applied annually, this assessment will help a program evaluating whether the Part A recipient is closer to meet Ryan White requirements and HIV/AIDS Bureau expectations, its progress over time and guiding the development of quality management priorities for the future.

The OA can be implemented in two ways: 1) by a QI expert, internal or external to the organization; or 2) as a self-evaluation. The results are ideally used to develop a work plan for each element with specific action steps and timelines guiding the planning process to focus on priorities, setting direction and assuring that resources are allocated for the QMP. Whether performed by a QI expert or applied as a self-evaluation, key leadership and staff should be involved in the assessment process to ensure that all key stakeholders have an opportunity to provide important input during the scoring process.

Results of the OA should be communicated to internal key stakeholders, leadership and staff. Engagement of program leadership and staff is critical to ensure buy-in across the program, and essential for translating results into improvement practice.
Scoring the Organizational Assessment Tool
Each domain has various sections that delineate different aspects of the domain’s topic. Each section has three columns: A brief description of the “state” of the quality program, a numeric score and a list of attributes that are used to determine the “state” and therefore the score. To achieve a score, the NQC Coach and the recipient must determine if the recipient has met all of the attributes. It is likely that the recipient has also achieved some of the attributes in the next highest score in the section but since all the attributes are not met, the Coach cannot give the recipient the higher score.
A. Quality Management

GOAL: To assess the overall EMA/TGA quality management infrastructure to support a systematic process with identified leadership; quality planning and accountability; and dedicated resources.

Leadership

Senior leadership personnel are defined by each EMA/TGA since titles and roles vary among organizations. The recipient staff should include a clinical leader (Medical Director, Senior Nurse) and an administrative leader (Program Coordinator, Clinic Manager, and Administrative Director). Larger programs may include additional leadership positions. There may be other informal leaders in the organization who support quality activities, but these are not included in this section.

Leaders establish a unity of purpose and direction for the recipient and work to engage all personnel, consumers and external stakeholders in meeting organizational goals and objectives; this includes motivation that promotes shared responsibility and accountability with a focus on teamwork and individual performance. EMA/TGA leaders should prioritize quality improvement goals and improvement projects for the year, and establish accountability for performance for the recipient and subrecipients. The benefits of strong leadership include clear communication of goals and objectives, where evaluation, alignment and implementation of activities are fully integrated.

Evidence of leadership support and engagement includes establishment of clear goals and objectives, communication of program/organizational vision, creating and sustaining shared values, active support of ongoing quality improvement activities and provisions of necessary resources for implementation.

Recipient Quality Management Committee

A quality management committee drives implementation of the written quality management plan and provides high-level comprehensive oversight of the quality program. This process involves reviewing performance measures, developing work plans, chartering project teams, and overseeing progress. The membership of the quality management committee should be multidisciplinary, cross-functional and include a client when feasible. Consumer representation on the committee should be part of a formal engagement process where consumer feedback is solicited and integrated into the decision making process. The quality management committee should have an assigned committee chairperson(s), regularly scheduled meetings and meeting notes to be taken and distributed throughout the program. The recipient should also involve the planning council or advisory body in the planning, implementation and evaluation of quality improvement activities although the recipient is solely responsible for overseeing quality improvement activities throughout the subrecipient network. Subrecipients should participate in QI activities throughout the EMA/TGA. Recipients should also strive to foster cross-Part collaborations wherever possible and integrate the voices of other Ryan White funded recipients in the quality management committee.

Quality Management Plan

Quality improvement planning occurs with initial program implementation and annually thereafter. A written quality management plan documents programmatic structure and annual quality improvement goals. The quality plan should serve as a roadmap to guide improvement efforts and include a corresponding work plan to track activities, monitor progress and signify achievement of milestones.

A.1. To what extent does the Part A recipient creates an environment that focuses on improving the quality of HIV care?

| Getting Started | 0 | □ The recipient is not actively supplying internal guidance or direction to establish a quality management program nor are they providing guidance |
| Planning and initiation | 1 | □ Primarily focused on external requirements and supporting compliance with regulations.  
□ Inconsistent in use of data to identify opportunities for improvement. |
<table>
<thead>
<tr>
<th>Quality Management Plan</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Beginning Implementation</strong></td>
<td>The recipient is: (Not engaging optimally)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>☐ Engaged in quality of care with focus on use of data to identify opportunities for improvement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Somewhat involved in directing improvement efforts.</td>
<td></td>
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<tr>
<td></td>
<td>☐ Somewhat involved in coordinating quality meetings internally or with the planning council or advisory body.</td>
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<tr>
<td></td>
<td>☐ Supporting some resources for QI activities.</td>
<td></td>
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<tr>
<td><strong>Implementation</strong></td>
<td>The recipient:</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>☐ Provides routine leadership to support the quality management program.</td>
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<td></td>
<td>☐ Provides routine and consistent allocation of staff or staff time for QI depending on the EMA/TGA size and number of supported subrecipients.</td>
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<tr>
<td></td>
<td>☐ Actively engages in QI planning and evaluation.</td>
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<td></td>
<td>☐ Engages the planning council or advisory council in QI efforts including support for a quality committee.</td>
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<tr>
<td></td>
<td>☐ Clearly communicates quality goals and objectives to all subrecipients via contractual language.</td>
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<tr>
<td></td>
<td>☐ Periodically reviews performance measures and outcomes to inform program priorities to subrecipients and data use for improvement ideas.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Periodically reviews performance measures and outcomes to inform program priorities to planning council or advisory body by service category.</td>
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<tr>
<td></td>
<td>☐ Attentive to national health care trends/priorities that pertain to the EMA/TGA.</td>
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</tr>
<tr>
<td><strong>Progress toward systematic approach to quality</strong></td>
<td>The recipient:</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>☐ Supports development of a culture of QI with subrecipients, including provision of resources for subrecipient participation in QI learning opportunities, seminars, professional conferences or QI storyboards for distribution.</td>
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<tr>
<td></td>
<td>☐ Supports prioritization of quality goals based on data, and critical areas of care are addressed in coordination with broader strategic goals for HIV care.</td>
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<tr>
<td></td>
<td>☐ Promotes client-centered care and consumer involvement through the EMA/TGA Quality Management Program along with contractual language to subrecipients.</td>
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<tr>
<td></td>
<td>☐ Engages routinely in QI planning and evaluation in cooperation with the planning council or advisory bodies.</td>
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<tr>
<td></td>
<td>☐ Provides technical assistance to subrecipients on their quality efforts.</td>
<td></td>
</tr>
<tr>
<td><strong>Full systematic approach to quality management in place</strong></td>
<td>The recipient:</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>☐ Provides guidance to subrecipients and encourages open communication related to quality activities and routinely provides supportive feedback.</td>
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<tr>
<td></td>
<td>☐ Encouraging subrecipient innovation through QI awards and incentives.</td>
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<tr>
<td></td>
<td>☐ Directly linking QI activities back to the overall EMA/TGA strategic plans and initiatives.</td>
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<tr>
<td></td>
<td>☐ Considers the quality of care at the subrecipient level when making programmatic and financial funding decision.</td>
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<tr>
<td></td>
<td>☐ Recipient has documented efforts to foster cross-Part collaboration.</td>
<td></td>
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</tbody>
</table>

**Comments:**
A.2. To what extent does the recipient have an effective quality management infrastructure to oversee, guide, assess, and improve the quality of HIV services provided by subrecipients?

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>□ A quality management committee has not yet been developed or formalized or is not currently meeting regularly to provide effective guidance to the subrecipients on effective quality programs.</th>
</tr>
</thead>
</table>
| Planning and initiation | 1 | The recipient:  
□ May review data triggered by an event or problem, or generated by regulatory urging.  
□ Has minimally integrated quality activities into other existing meetings or with a planning council or advisory body. |
| Beginning Implementation | 2 | The recipient:  
□ Has plans to hold regular quality management committee meetings, but meetings may not occur regularly and/or do not focus on performance data.  
□ Has identified roles and responsibilities for individual who participate in the recipient’s quality improvement efforts.  
□ Has not yet implemented a structured process to review data for improvement.  
□ Has minimally involved the planning council in quality management planning. |
| Implementation | 3 | The recipient:  
□ Has a formally established quality management program led by a Program Director, Medical Director or senior clinician specifically tasked with active oversight of the work of the quality committee with established annual schedule of meeting dates, outlined tasks and responsibilities and meeting notes.  
□ Has defined roles and responsibilities as codified in the quality management plan for the EMA/TGA.  
□ Reviews and/or discusses performance data at each quality committee meeting by service category, including consumer satisfaction, if available.  
□ Discusses QI progress and formulates guidance to redirect quality improvement efforts with subrecipients as appropriate.  
□ Actively utilizes a work plan to closely monitor progress of quality activities in the EMA/TGA.  
□ Discusses QI data with the planning council or advisory board by service category at least yearly to assist in service planning. |
| Progress toward systematic approach to quality | 4 | The recipient:  
□ Has established a quality committee that meets with the members of the planning council or advisory body’s quality committee as active partners in decision making.  
□ Has established a performance review process to regularly evaluate measures and use results to set priorities for EMA/TGA by service category.  
□ Provides progress reports to the planning council or advisory body and the subrecipients on the quality program by service category. |
The recipient:
- Has established a quality management program that is led by a senior clinician or administrator and, where appropriate, is linked to other quality committees at the recipient through common members.
- Has established a systematic performance review process for subrecipient data, including clinical, consumer satisfaction and operational measures to identify annual goals.
- Is responsive to changes in treatment guidelines and external/national priorities (NAHS, HAB, CMS), which are considered in development of indicators and choosing improvement initiatives.
- Has fully engaged senior leadership at the EMA/TGA level and they lead or participate in discussions during committee meetings.
- Effectively communicating activities, annual goals, performance results and progress on improvement initiatives to all stakeholders, including subrecipients, consumers and planning council members or advisory body members.
- Engages consumers as active participants and has subrecipient representation and cross-functional membership.

Comments:

A.3. To what degree does the recipient have a comprehensive quality plan that is actively utilized to guide quality improvement activities both internally and with the subrecipients? (part of the strategic plan, set expectations for subrecipients, etc.)

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>☐ An EMA/TGA wide written quality management plan, including elements necessary to guide the administration of the quality program, has not been developed.</th>
</tr>
</thead>
</table>
| Planning and initiation | 1 | ☐ The quality plan:  
☐ Is written with some but not all of the essential components necessary to direct an effective quality program (see level 3).  
☐ May be written for the EMA/TGA but does not include language that involves the work at the subrecipient level. |
| Beginning Implementation | 2 | ☐ The quality plan:  
☐ Is written for the EMA/TGA and contains essential elements for subrecipients, and contains some of the essential components found in level 3.  
☐ Is under review for approval by the EMA/TGA senior leadership and the planning body and includes steps for implementation. |

Full systematic approach to quality management in place

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td>The recipient has a quality plan that:</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>☐ Reflects an effective HIV-specific quality program with all essential QM components including:</td>
</tr>
<tr>
<td></td>
<td>• quality statement and mission</td>
</tr>
<tr>
<td></td>
<td>• annual goals and objectives</td>
</tr>
<tr>
<td></td>
<td>• roles, responsibilities, pertaining to the recipient</td>
</tr>
<tr>
<td></td>
<td>• subrecipients responsibility for conducting QI activities</td>
</tr>
<tr>
<td></td>
<td>• expectations assigned by the recipient to the subrecipients for their quality management programs</td>
</tr>
<tr>
<td></td>
<td>• quality management committee meeting frequency and membership</td>
</tr>
<tr>
<td></td>
<td>• performance measurement and review processes</td>
</tr>
<tr>
<td></td>
<td>• QI methodology to prioritize and implement quality improvement projects,</td>
</tr>
<tr>
<td></td>
<td>• communication strategy to key stakeholders in the EMA/TGA</td>
</tr>
<tr>
<td></td>
<td>• consumer involvement both at the recipient and subrecipient level</td>
</tr>
<tr>
<td></td>
<td>• service category evaluation procedure</td>
</tr>
<tr>
<td></td>
<td>• workplan with timeline for implementation</td>
</tr>
<tr>
<td></td>
<td>☐ Is routinely communicated to EMA/TGA staff, the QM committee and the planning council/advisory body’s quality committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progress toward systematic approach to quality</th>
<th>The quality plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>☐ Has been implemented and regularly used by the recipient’s quality committee to guide the quality program.</td>
</tr>
<tr>
<td></td>
<td>☐ Includes annual goals identified on the basis of internal performance measures and external requirements through engagement of the quality committee, the overall planning body and the subrecipients.</td>
</tr>
<tr>
<td></td>
<td>☐ Includes a work plan/timeline outlining key activities in place and routinely used to track progress of performance measures and improvement initiatives, and is modified as needed to achieve annual goals.</td>
</tr>
<tr>
<td></td>
<td>☐ Is routinely communicated by the recipient to key stakeholders, including EMA/TGA staff, consumers, and planning body members.</td>
</tr>
<tr>
<td></td>
<td>☐ Directs that a needs assessment is conducted periodically (once at least every 2 years) to assess the needs of consumers and utilize results in service planning.</td>
</tr>
<tr>
<td></td>
<td>☐ Defines how changes in the healthcare and regulatory environment are assessed to ensure that the services meet the changing needs of the HIV client.</td>
</tr>
<tr>
<td></td>
<td>☐ Recipient requires that subrecipients have written QM plans in place and provides feedback on the plans.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Full systematic approach to quality management in place</th>
<th>The quality plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>☐ Includes regularly updated annual goals that were identified by the quality committee using data on internal performance measures and external requirements through engagement of the planning council/advisory body’s quality committee and the subrecipient.</td>
</tr>
<tr>
<td></td>
<td>☐ Is communicated broadly to all stakeholders, including EMA/TGA staff, consumers, planning council/advisory body’s quality committee.</td>
</tr>
<tr>
<td></td>
<td>☐ Has a mechanism for the planning council/advisory body’s quality committee to provide feedback to the recipient on the changing needs of the HIV clients.</td>
</tr>
</tbody>
</table>
Comments:

B. Workforce Engagement in the HIV Quality Improvement

**GOAL:** To assess awareness, interest and engagement of staff in quality improvement activities.

Staff engagement in quality activities at the recipient and subrecipient is central to the success, which includes development and promotion of staff knowledge around organizational systems and processes to build sustainable quality management programs, such as internal management processes, client interaction, and successful strategies to address quality improvement (QI) implementation barriers.

Ongoing training and retraining in QI methodology and practical skills reinforces knowledge and the building of workforce expertise around QI. As staff progress along the continuum of QI sophistication, improvement is slowly integrated into clinic practice, enhancing staff engagement in the process. Immediate access to improvement data, for example, empowers staff to focus on key areas of care and builds consensus around QI activities to improve client outcomes.

As QI becomes part of the institutional culture and the culture of the EMA/TGA, staff embrace their respective roles and responsibilities, acquiring a sense of ownership and deeper involvement in improvement work. The recipient also provides quality improvement opportunities to their network of subrecipients. Sound educational opportunities enhance the subrecipients’ ability to conduct local and network-wide quality improvement activities.

**B.1. To what extent are recipient staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?**

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>Core recipient staff are not routinely engaged in QI activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions.</th>
</tr>
</thead>
</table>
| Planning and initiation | 1 | Engagement of core staff in QI:  
- Is under development and includes training in QI methods and opportunities to attend meetings where QI projects are discussed.  
- Subrecipients are given guidance on training guidelines for staff. |
| Beginning Implementation | 2 | Engagement of core staff in QI:  
- Is underway and some staff have been trained in QI methodology.  
- Includes QI meetings attended by some designated staff.  
- Subrecipient staff have had at least one training opportunity on QI methodologies. |
### Implementation

<table>
<thead>
<tr>
<th></th>
<th>Engagement of core staff in QI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Includes attendance in at least two hour-long training in QI methodology in the past 12 months. Staff members are generally aware of program QI activities (quality plan/priorities).</td>
</tr>
<tr>
<td></td>
<td>□ Includes involvement in QI projects, project selection and participation in either an established QM committee or an ad hoc committee.</td>
</tr>
<tr>
<td></td>
<td>□ Includes QI project development, where projects are discussed and reviewed during staff meetings.</td>
</tr>
<tr>
<td></td>
<td>□ Includes defined roles and responsibilities related to QI. All staff are aware of written quality plan and priorities for improvement.</td>
</tr>
<tr>
<td></td>
<td>□ Includes a formal process for regularly recognizing staff performance in QI via performance appraisals, public recognition during staff meetings, etc.</td>
</tr>
<tr>
<td></td>
<td>□ Subrecipients have been provided QI trainings and submit schedule of their own trainings to recipient for review.</td>
</tr>
</tbody>
</table>

### Progress toward systematic approach to quality

<table>
<thead>
<tr>
<th></th>
<th>Engagement of core staff in QI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Is demonstrated by evidence that staff members are engaged and encouraged to use those skills to identify QI opportunities and develop solutions.</td>
</tr>
<tr>
<td></td>
<td>□ Involves a shared language regarding quality, which is evidenced in routine discussion.</td>
</tr>
<tr>
<td></td>
<td>□ Is described in the annual written quality plan, and includes staff training, and roles and responsibilities regarding staff involvement in QI activities.</td>
</tr>
<tr>
<td></td>
<td>□ Includes a formal process for recognizing staff performance internally. QI teams are provided opportunities to present successful projects to all staff and leadership.</td>
</tr>
<tr>
<td></td>
<td>□ Subrecipients are given specific guidance on quality improvement topics with which staff should be familiar.</td>
</tr>
</tbody>
</table>
### Full systematic approach to quality management in place

<table>
<thead>
<tr>
<th></th>
<th>Engagement of core staff in QI (clinical and non-clinical):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Their participation in identifying QI issues, developing strategies for improvement and implementing strategies.</td>
</tr>
<tr>
<td></td>
<td>Is evidenced by regular and continuous QI education and training in QI methodology focused on clinical and non-clinical issues.</td>
</tr>
<tr>
<td></td>
<td>Is reinforced by leadership who encourages all staff to make needed changes and improve systems for sustainable improvement including the necessary data to support decisions.</td>
</tr>
<tr>
<td></td>
<td>Involves formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior.</td>
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<tr>
<td></td>
<td>Incorporates routine communication about new developments in QI, including promotion of QI projects both internally (e.g., quality conferences) and externally (e.g., related conferences).</td>
</tr>
<tr>
<td></td>
<td>Includes a formal process for recognizing staff performance internally, and QI teams are provided opportunities to present successful projects to all staff and leadership.</td>
</tr>
<tr>
<td></td>
<td>Includes opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional QM programs.</td>
</tr>
<tr>
<td></td>
<td>Involves clearly defined roles and responsibilities that are utilized to assess staff performance.</td>
</tr>
<tr>
<td></td>
<td>Subrecipients participate in all required workshops and are provided additional venues for training.</td>
</tr>
<tr>
<td></td>
<td>Recipient conducts annual review of the subrecipient staff involvement in quality including trainings attended, improvement projects undertaken and the extent to which all staff are involved in the QI culture.</td>
</tr>
<tr>
<td></td>
<td>The recipient recognizes the subrecipients that have excelled in improving services by a formal process (e.g., awards, certificates, etc.).</td>
</tr>
</tbody>
</table>

### Comments:
C. **Measurement, Analysis and Use of Data to Improve Program Performance in HIV Care**

**GOAL:** To assess how the overall EMA/TGA HIV program uses performance data and information to identify opportunities for improvement; to develop and implement measures to evaluate the success of change initiatives; review existing measures (such as the HAB Measures) and refine to meet local needs; to set funding priorities and allocations; to align initiatives; to monitor program status; and to ensure that accurate, timely data and information are available to stakeholders to help Part A subrecipients to drive effective decision making.

The Measurement, Analysis and Use of Data section assesses how the EMA/TGA selects, gathers, analyzes and uses data to improve performance at the EMA/TGA level. This includes how the recipient conducts performance reviews to ensure that actions are taken, when appropriate, to achieve program goals and how a lack of action is addressed. The recipient should have a process in place to support data collection, validation and reporting at the subrecipient level.

### C.1. To what extent does the EMA/TGA routinely measure performance and use data for improvement?

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>☐ Performance measures have not been identified by the recipient.</th>
</tr>
</thead>
</table>
| **Planning and initiation** | 1 | Performance measures:  
☐ Have been identified to evaluate some components of the overall EMA/TGA, but do not cover all service categories.  
Performance data:  
☐ Collection is planned pending initiation of an EMA/TGA wide electronic data reporting system. |
| **Beginning Implementation** | 2 | Performance measures:  
☐ Are defined and used by the EMA/TGA for each key service category.  
☐ Results are not reported outside the recipient’s organization.  
Performance data:  
☐ Validation, analysis and interpretation of results on measures are in early stages of development and use: annual goals have not been established.  
☐ Results are occasionally shared with staff and the planning council/advisory body/subrecipients. |
| **Implementation** | 3 | Performance measures:  
☐ Are nationally endorsed and/or externally defined (e.g., NQF, HAB), with the intent to meet external regulatory requirements and the needs of stakeholders, including clients.  
☐ Are defined and consistently used by the EMA/TGA for each key service category. |
<table>
<thead>
<tr>
<th>Progress toward systematic approach to quality</th>
<th>Full systematic approach to quality management in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance data:</td>
<td>Performance measures:</td>
</tr>
<tr>
<td>☐ Are validated for accuracy on all measures by qualified recipient staff.</td>
<td>☐ Are defined for each service category and actively used to drive improvement activities.</td>
</tr>
<tr>
<td>☐ Are tracked, analyzed and reviewed at least annually to identify areas in need of improvement.</td>
<td>☐ Are evaluated regularly to ensure that the recipient is able to respond effectively to internal and external changes in a timely manner.</td>
</tr>
<tr>
<td>☐ Are reviewed and used regularly by the EMA/TGA leadership to identify and prioritize improvement needs and to initiate action plans to ensure that internal goals are achieved.</td>
<td>☐ Are nationally endorsed, outcome focused and/or externally defined (e.g., NQF, HAB,) and aligned with state (if applicable) and national priorities.</td>
</tr>
<tr>
<td>☐ Are shared with the QM committee of the planning council/advisory body by service category.</td>
<td>☐ Reflect the continuum of client care.</td>
</tr>
<tr>
<td>☐ Are shared with subrecipients by service category.</td>
<td>☐ Are defined and consistently used by personnel at the recipient.</td>
</tr>
<tr>
<td>☐ Results and associated measures are routinely shared with recipient staff and the QI QM committee of the planning council/advisory (by service category) their input is elicited to make improvements.</td>
<td>☐ Are validated for accuracy.</td>
</tr>
<tr>
<td>☐ Have additional data available for HIV infected individuals in their area.</td>
<td>☐ Are visible or easily accessible to ensure data reporting transparency throughout the Ryan White Program including the planning council and the sub recipients.</td>
</tr>
<tr>
<td>☐ Results and associated measures are frequently shared with recipient staff to elicit their input and engage them in improvement processes aligned with organizational goals.</td>
<td>☐ Are presented in an easy to understand format for recipient staff, planning council/advisory body members, and subrecipients in order to help them understand the data.</td>
</tr>
<tr>
<td>☐ Results are shared with subrecipients and recommendations are made to the subrecipient for improvement activities with a time line for implementation and plan for follow up.</td>
<td>☐ Are used to focus the EMA/TGA efforts on improvement by service category and results are shared throughout the EMA/TGA at least yearly.</td>
</tr>
<tr>
<td>☐ Have additional data available for HIV infected individuals in their area.</td>
<td>☐ Have cross-Part and other data available that is shared internally and with planning council or advisory body.</td>
</tr>
</tbody>
</table>
Comments:

C.2. To what extent does the EMA/TGA routinely measure performance and use data for improvement across the subrecipient network?

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>☐ Subrecipients have not been given guidance on the performance measures for the service categories under which they are funded.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and initiation</td>
<td>1</td>
<td>Performance measures: ☐ Have been defined for the service categories under which they are funded but have not been effectively communicated to or fully implemented by subrecipients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance data: ☐ Collection is planned pending initiation of a data collection system at the subrecipient or the implementation of an EMA/TGA wide data collection system.</td>
</tr>
<tr>
<td>Beginning Implementation</td>
<td>2</td>
<td>Performance measures: ☐ Have been effectively communicated to and fully implemented by subrecipients for the service categories under which they are funded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance data: ☐ Validation standards are developed and given to subrecipients. ☐ Analysis and interpretation of results on measures is in early stages of development and use. ☐ Subrecipient does not receive feedback on the data submitted.</td>
</tr>
<tr>
<td>Implementation</td>
<td>3</td>
<td>Performance measures: ☐ Are routinely used by the subrecipients and reported to the recipient. ☐ Are consistently used at all subrecipient sites.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance data: ☐ Are validated for accuracy on all measures at all applicable sites. ☐ Are tracked, analyzed and reviewed with the frequency required to identify areas in need of improvement. ☐ Are used to prioritize improvement activities with timelines to achieve the subrecipient’s improvement goals. ☐ Are used by the leadership of the subrecipient as part of a structured review process to review the subrecipients attainment of its goals. ☐ Are collected by staff with working knowledge of indicator definitions and their application. ☐ Results and associated measures are routinely shared with subrecipient staff and their input is elicited to make improvements by use of scorecards by service category, storyboards or other means.</td>
</tr>
<tr>
<td>Progress toward systematic approach to quality</td>
<td>Performance measures:</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>□ Used are defined by the recipient and based on nationally endorsed and/or externally defined measures (e.g., HAB), with the intent to meet external regulatory requirements and the needs of stakeholders, including clients and goals align with current evidence in the diagnosis and treatment of HIV.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are defined and consistently used by personnel at all applicable sites.</td>
<td></td>
</tr>
<tr>
<td>Performance data:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>□ Are validated for accuracy on all measures at all applicable sites.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are used to prioritize improvement activities with timelines to achieve the subrecipient’s improvement goals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are used by the leadership of the subrecipient as part of a structured review process to review the subrecipient’s attainment of its goals and to provide feedback along with corrective action recommendations.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Results and associated measures are frequently shared with staff to elicit their input and engage them in improvement processes aligned with organizational goals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Results from the subrecipient are shared with the recipient along with improvement efforts as required by the contract with the recipient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Data are posted to the recipient website by service category.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are used to recognize significant accomplishments by selected recipients that have achieved outstanding improvements in prioritized service categories.</td>
<td></td>
</tr>
<tr>
<td>Full systematic approach to quality management in place</td>
<td>Performance measures:</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>□ Are selected using HAB measures and/or other nationally endorsed measures to assist in meeting the goals of the organization and external regulatory requirements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are selected to meet the needs of stakeholders and clients, with a goal of alignment with current evidence in the diagnosis and treatment of HIV.</td>
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</tr>
<tr>
<td></td>
<td>□ Reflect priorities of subrecipient clients, in consideration of local issues/needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Are defined for each service category and actively used to drive improvement activities.</td>
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</tr>
<tr>
<td></td>
<td>□ Are evaluated regularly to ensure that the program is able to respond effectively to internal and external changes quickly.</td>
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</tr>
<tr>
<td></td>
<td>□ Results are reported the subrecipient boards of directors.</td>
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</tr>
<tr>
<td></td>
<td>□ Are selected in a cooperative process with subrecipients given the opportunity to have input into their selection.</td>
<td></td>
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</tbody>
</table>
Quality Management Plan

D. Quality Improvement Initiatives

**GOAL: To evaluate how the HIV program applies robust process improvement methodology* to achieve program goals and maintain high levels of performance over long periods of time.**

The Quality Improvement Initiatives section examines how leadership and workforce use these methods and tools to conduct improvement initiatives with emphasis on identification of the exact causes of problems and designing effective solutions; determining program specific best practices and sustaining improvement over long periods of time. In high reliability organizations robust process improvement methodology is routinely utilized for all identified problems and improvement opportunities to assure consistency in approach by all staff members. The recipient is responsible for quality management for the EMA/TGA. This includes ensuring that subrecipients are conducting QI activities that are consistent with sounds QI practice, with the goals of the EMA/TGA and with the data presented to them.

*Robust process improvement includes reliably measuring the magnitude of a problem, identifying the root causes of the problem and measuring the importance of each cause, finding solutions for the most important causes, proving the effectiveness of those solutions, and deploying programs to ensure sustained improvements over time.

D.1. To what extent does the EMA/TGA identify and conduct quality improvement initiatives using robust process improvement methodology (e.g., PDSA Cycles, Ishikawa Diagrams) to assure high levels of performance over long periods of time?

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>□ Formal quality improvement projects have not yet been initiated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and initiation</td>
<td>1</td>
<td>QI initiatives:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No assessment of the recipient’s organizational performance or system level analysis of EMA/TGA data performed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Are not team-based and do not use specific tools or methodology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Reviews are primarily used for quality assurance.</td>
</tr>
<tr>
<td><strong>Beginning Implementation</strong></td>
<td><strong>QI initiatives:</strong></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>□ Are prioritized by the recipient based on program goals, objectives and analysis of performance measurement data.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Involve team leaders and team members who are assigned by the recipient’s quality committee or other leadership.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Begin to use specific tools or methodology to understand causes and make effective changes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Implementation</strong></th>
<th><strong>QI initiatives:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>□ Are ongoing based on analysis of performance data results and other program information, including external reviews and assessments.</td>
</tr>
<tr>
<td></td>
<td>□ Are undertaken at the subrecipient level and reported to the recipient.</td>
</tr>
<tr>
<td></td>
<td>□ Are regularly documented and updates are provided to the recipient’s QM committee.</td>
</tr>
<tr>
<td></td>
<td>□ Are cross departmental/cross functional depending on specific project needs.</td>
</tr>
<tr>
<td></td>
<td>□ Are regularly communicated to the subrecipients, quality committee, staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Progress toward systematic approach to quality</strong></th>
<th><strong>QI initiatives:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>□ Can be identified by any member of the program team through direct communication with program leadership.</td>
</tr>
<tr>
<td></td>
<td>□ Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities.</td>
</tr>
<tr>
<td></td>
<td>□ Are supported with appropriate resources to achieve effective and sustainable results.</td>
</tr>
<tr>
<td></td>
<td>□ Involve support of data collection with results routinely reported to QI project teams.</td>
</tr>
<tr>
<td></td>
<td>□ Recipient directs QI projects by service categories that do not achieve EMA targets to improve services using ad hoc work groups.</td>
</tr>
<tr>
<td></td>
<td>□ Are guided by a team leader or sponsor, and include all relevant staff depending on specific project needs.</td>
</tr>
<tr>
<td></td>
<td>□ Subrecipients are provided technical assistance in how to conduct QI projects. □ Routinely involve consumers on QI project teams at subrecipient level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Full systematic approach to quality management in place</strong></th>
<th><strong>QI initiatives:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>□ Are ongoing in every service category.</td>
</tr>
<tr>
<td></td>
<td>□ Correspond with a structured process for prioritization based on analysis of performance data and other factors.</td>
</tr>
<tr>
<td></td>
<td>□ Consistently and routinely utilizes robust process improvement methodologies such as PDSA Cycles and multidisciplinary teams to identify actual causes of variation and apply effective sustainable solutions.</td>
</tr>
<tr>
<td></td>
<td>□ Are presented – by service category - in storyboard context or other formats and reported to the EMA including the Planning Council, consumer committees, and posted to the recipient’s website.</td>
</tr>
<tr>
<td></td>
<td>□ Involve recognition of successful teamwork by senior leadership.</td>
</tr>
<tr>
<td></td>
<td>□ Are supported by development of sustainability plans.</td>
</tr>
<tr>
<td></td>
<td>□ Undertaken by the subrecipients are reviewed and guidance is provided on the methodology and outcomes of the projects.</td>
</tr>
</tbody>
</table>
Comments:

**E. Consumer Involvement**

*Goal: To assess the extent to which consumers are formally integrated into the quality management program.*

Consumer involvement not only includes planning council or advisory body members but also encompasses the diversity of individuals using HIV programmatic services at the subrecipient level. Recipients should involve consumers in their quality management planning and if the planning council or advisory body has a quality management committee, consumers should be represented on it as well.

Consumer involvement can be achieved in multiple ways including solicitation of consumer perspectives through focus groups, key informant interviews and satisfaction surveys; a formal consumer advisory board at the subrecipient that is actively engaged in improvement work; having consumers as members of ad hoc program committees and boards; and conducting consumer needs assessments and including consumers in specific QI initiatives. Ideally consumers have a venue to identify improvement concerns and are integrated into the process to find solutions and develop improvement strategies. Overall, consumers are considered valued members of the program, where consumer perspectives are solicited, information is used for performance improvement and feedback is provided to consumers.

**E.1. To what extent are consumers effectively engaged and involved in the EMA/TGA’s HIV quality management program?**

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>☐ There is currently no process to involve consumers in HIV quality management program activities.</th>
</tr>
</thead>
</table>
| Planning and Initiation | 1 | Consumer involvement:  
☐ No formal process is in place for ongoing and systematic participation in quality management program activities.  
☐ Is occasionally addressed by soliciting consumer feedback. |
| Beginning Implementation | 2 | Consumer involvement:  
☐ Includes engagement with consumers to solicit perspectives and experiences related to quality of care. |
| Implementation (Meets HAB requirements) | 3 | Consumer involvement:  
☐ Is addressed by routinely soliciting consumer feedback, and using feedback to identify opportunities for improvement.  
☐ Participation in quality management program activities is documented and/or assessed.  
☐ Occurs at the subrecipient level and guidelines are given in subrecipient contracts. |
### Progress toward systematic approach to quality

<table>
<thead>
<tr>
<th></th>
<th>Consumer involvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>In improvement activities is facilitated by providing: (a) encouragement of consumers to provide recommendations for improvements based on performance data; and (b) training of consumer on quality management principles and methodologies.</td>
</tr>
<tr>
<td></td>
<td>Information gathered through the above noted activities is documented and used to improve the quality of care.</td>
</tr>
<tr>
<td></td>
<td>Includes sharing data with consumers by service category and discussing quality during consumer advisory board meeting.</td>
</tr>
<tr>
<td></td>
<td>Is accomplished by the inclusion of consumers on a quality management committee of the planning council/planning body.</td>
</tr>
<tr>
<td></td>
<td>Occurs at the subrecipient level and guidelines are given by service category and the recipient requires that the subrecipient report on their consumer quality improvement activities.</td>
</tr>
</tbody>
</table>

### Full systematic approach to quality management in place

<table>
<thead>
<tr>
<th></th>
<th>Consumer involvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Occurs via an established consumer advisory committee that is integrated into the planning process of the EMA/TGA including the planning council/planning body.</td>
</tr>
<tr>
<td></td>
<td>Information gathered through the above is documented, assessed and used to drive QI projects and establish priorities for improvement.</td>
</tr>
<tr>
<td></td>
<td>Includes work with program staff to review changes made based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care.</td>
</tr>
<tr>
<td></td>
<td>Involves an annual review by the quality management team/committee of successes and challenges of consumer involvement in quality management program activities to foster and enhance collaboration between consumers and providers engaged in quality improvement.</td>
</tr>
<tr>
<td></td>
<td>On a consumer advisory committee is coordinated with the quality management committee.</td>
</tr>
<tr>
<td></td>
<td>Subrecipients routinely document inclusion of consumers in quality initiatives.</td>
</tr>
<tr>
<td></td>
<td>Occurs at the subrecipient level and guidelines are given by service category and the recipient requires that the subrecipient report on their consumer quality improvement activities and provides direction to the recipients when gaps are identified.</td>
</tr>
</tbody>
</table>

### Comments:
### F. Quality Program Evaluation

**GOAL:** *To assess how the recipient evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities and implementation.*

Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality goals outlined in the written QM plan: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data, at least by service category, to drive improvements, success of QI project teams; and effectiveness of quality structure. Where appropriate, external evaluations and assessments should be utilized in partnership with the internal evaluation. The evaluation is most effectively performed by recipient’s leadership and the recipient’s quality committee, optimally with some degree of consumer involvement.

Subrecipients of the Ryan White program are required to conduct QI activities. The recipient is tasked with overseeing those activities and providing guidance to focus the subrecipients’ activities. It is the recipients’ responsibility to ensure that the subrecipient is conducting QI activities and to provide feedback to the subrecipient and technical assistance as needed.

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>☐ No formal process is established to evaluate the quality program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and Initiation</td>
<td>1</td>
<td>Quality program evaluation: ☐ To assess program processes and systems is exclusively external.</td>
</tr>
<tr>
<td>Beginning Implementation</td>
<td>2</td>
<td>Quality program evaluation: ☐ Is part of a formal process and is integrated into annual quality management plan development.</td>
</tr>
<tr>
<td>Implementation</td>
<td>3</td>
<td>Quality program evaluation: ☐ Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions. ☐ Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs. ☐ Results are used to plan for future quality efforts. ☐ Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects.</td>
</tr>
<tr>
<td>Progress toward systematic approach to quality</td>
<td>4</td>
<td>Quality program evaluation: ☐ In addition to the elements listed in F1.3, findings are integrated into the annual quality plan and used to develop and revise program priorities. ☐ Is reviewed during quality committee meetings to assess progress toward planning goals and objectives. ☐ Includes review of performance data, which is used to inform decisions about potential changes to measures. ☐ Is used to determine new performance measures based on new priorities. ☐ Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability.</td>
</tr>
</tbody>
</table>
### Quality Management Plan

Full systematic approach to quality management in place

- **Quality program evaluation:**
  - Findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals with regular updates to quality committee provide.
  - Is used by the quality committee to regularly assess the success of QI project work, successful interventions and other markers of improved care.
  - Data are used by the quality committee to formulate changes to service category guidance.
  - Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities.
  - Includes a detailed assessment process. The results of this assessment are utilized to revise and update the annual quality plan; adjust the HIV program priorities; and identify gaps in the program.
  - Includes an analysis of progress towards goals and objectives and QI program successes and accomplishments.
  - Describes performance measurement trends which are used to inform future quality efforts.

### Comments:

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**G. Achievement of Outcomes**

**GOAL: To assess EMA/TGAs capability for achieving excellent results and outcomes in areas that are central to providing high quality HIV care.**

In order to determine whether an EMA/TGA program is achieving excellence in HIV care, a system for monitoring and assessing outcomes should be in place. This system should include analysis of an appropriate set of measures; trending results over time; stratifying data by high-prevalence populations and comparison of results to a larger aggregate data set* used for programmatic target setting. A set of appropriate measures may be externally developed (i.e., HAB, HIVQUAL) and/or internally developed based on program goals. Viral load suppression and retention in care are two essential measures of outcome that should be incorporated into the EMA/TGAs’ set of clinical measures.

*Possible data sets for comparison include HAB, RSR, HIVQUAL Regional Groups, in+care Campaign, VA, Kaiser, HIVRAD.

**G.1. To what extent does the EMA/TGA monitor client outcomes and utilize data to improve client care?**

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>0</th>
<th>□ No performance results are routinely reviewed or used to guide improvement activities.</th>
</tr>
</thead>
</table>
| Planning & Initiation | 1 | Data:  
   □ For some measures are routinely reviewed and used to guide improvement activities.  
   □ Trends for some measures are developed and used to determine improvement over time. |
<table>
<thead>
<tr>
<th><strong>Beginning Implementation</strong></th>
<th>2</th>
<th>Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Results for most measures are routinely reviewed and used to guide improvement activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Trends for most measures are developed and many show improving trends over time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Implementation</strong></th>
<th>3</th>
<th>Data:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Results for all measures are routinely reviewed and used to guide improvement activities, including viral load suppression and retention in care.</td>
</tr>
<tr>
<td></td>
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<td>☐ Trends for all measures are developed and many show improving trends over time.</td>
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<td>☐ Results are compared to a larger aggregate data set for at least 2 outcome measures: viral load suppression and retention in care.</td>
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<td>☐ Comparison to larger aggregate data set is used to set EMA/TGA-wide programmatic targets.</td>
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<tr>
<th><strong>Progress toward systematic approach to quality</strong></th>
<th>4</th>
<th>Data:</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>☐ Results for all measures are routinely reviewed and used to guide improvement activities, including viral load suppression and retention in care.</td>
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<td>☐ Trends are developed for all measures and most show improving trends over time.</td>
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<td>☐ Results are compared to a larger aggregate data set for 2 outcome measures: viral load suppression and retention in care.</td>
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<td>☐ Comparison to larger aggregate data set are used to set EMA.TGA-wide programmatic targets and targets are met for at least 50% of measures.</td>
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<tr>
<td></td>
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<td>☐ Results for viral load suppression and retention in care scores are equal to or greater than the 75th percentile of comparative data set.</td>
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<tr>
<th><strong>Full systematic approach to quality management in place</strong></th>
<th>5</th>
<th>Data:</th>
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<td></td>
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<td>☐ Results for all measures are routinely reviewed and used to guide improvement activities, including viral load suppression and retention in care.</td>
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<td>☐ Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals.</td>
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<td>☐ Results are compared to a larger aggregate data set for 2 outcome measures: viral load suppression and retention in care.</td>
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<td>☐ Comparison to larger aggregate data set are used to set EMA/TGA programmatic targets and targets are met for at least 75% of measures.</td>
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<tr>
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<td>☐ Results for viral load suppression and retention in care scores are above the 75th percentile of comparative data set.</td>
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<th><strong>Comments:</strong></th>
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G.2. Reduction in Disparities in HIV Care

Goal: To assure that all clients receive the same level of quality services and resulting health outcomes regardless of their exposure category, race/ethnicity, gender, age or economic status.

This section assesses the program’s ability to assure that all individuals served by Ryan White funded programs in the EMA/TGA, regardless of their exposure category, race/ethnicity, gender, age or economic status, receive the same level of quality care and services. In order to achieve equity in quality and outcomes for all individuals, a system for consistent review of data stratified by these factors, and evidence

| G.2. To what extent does the EMA/TGA measure disparities in care and in outcomes, and use performance data to improve care to eliminate or mitigate discernible disparities? |
|---|---|
| Getting Started | 0 | □ No performance results are routinely reviewed or used to address disparities. |
| Planning & Initiation | 1 | Performance measures/data: □ Systems are in place to stratify data for analysis of disparities by gender, age, SES, risk factor, geography, etc. |
| Beginning Implementation | 2 | Performance measures/data: □ Are used to identify disparities. □ Are used to plan improvement strategies. |
| Implementation | 3 | Performance measures/data: □ Are stratified for analysis of disparities by gender, age, SES, risk factor, geography, etc. throughout the EMA/TGA subcontractor network. □ Are used to develop and implement general but not targeted improvement strategies based on data analysis. |
| Progress toward systematic approach to quality | 4 | Performance measures/data: □ Are analyzed by service category and reported to subrecipients. □ Are used to develop and implement general and targeted improvement strategies based on data analysis. □ Demonstrate some evidence of improvement of outcomes for identified disparities. |
| Full systematic approach to quality management in place | 5 | Performance measures/data: □ Are reported to the Planning Council, consumer advisory committees and posted to the EMA/TGA website. □ Demonstrate sustained evidence of improvement of outcomes for identified disparities |

Comments:
Summary of Results

What are the major findings from the Organizational Assessment?
Please number and link all findings with key recommendations and suggestions. Major findings should address all components.

What are the key recommendations and suggestions? What specific areas should be improved? What are specific improvement goals for the upcoming year?
Please include associated timeframe for each recommendation and improvement goal. Recommendations and areas in need of improvement should address all components of importance.

Comments By: ___________________________ Date: ____________
Program Information Organizational Quality Assessment Tool

Recipient Name:

Contact Person Name:

Contact Email/Phone:

Main Program Address:

City: __________________________ State: ______ Zip Code: ______

Fax: __________________________ Email: __________________________

Services funded

Attach list of funded service categories

☐ FT HIV Medical Director ☐ FT HIV Administrator
☐ FT HIV Quality Manager If not FT, ______% HIV Quality Manager
Background of Q Manager: ☐ MD ☐ Nurse ☐ PA ☐ Other

☐ FTEs HIV Clinical Providers (NP, PA, MD)
☐ FTEs HIV Case Managers ☐ Other access to MIS Staff
☐ FTE Data manager FTEs: Other HIV staff

Regional Group/Learning Network/Collaborative Involvement

Initiative Name

Initiative Name

Please note any events or other information that may have impacted service delivery, positively or negatively, since the last organizational assessment:

OA Completed:

Name: __________________________ Date: ______________

Assessment: ☐ baseline ☐ annual

Additional Questions
1) Does your EMA/TGA use CAREWare or another database/software program to manage and/or monitor HIV care?
   _______CAREWare
   _______Different database or software program. Please specify: _____

2) Please provide a list of the members of the quality management team (add emails if you wish them to be included in NQC emails)
APPENDIX J

Quality Management Plan
Approval
The FY2020 Ryan White Part A QM Plan and Work Plan are approved by the following:

Nicole Roebuck, QM Committee Chair
Metropolitan Atlanta HIV Health Services Planning Council

6/11/2020

Jocelyn McKenzie, QM Program Manager
Fulton County Government, Department for HIV Elimination

06/10/2020

Bridget Harris, Deputy Director
Fulton County Government, Department for HIV Elimination

6.15.2020

Jeff Cheek, Director
Fulton County Government, Department for HIV Elimination

6/11/2020