

# Connecticut Ryan White Part B Program

## Quality Management Plan



Connecticut Department of Public Health  
Infectious Diseases  
TB, HIV, STD, & Viral Hepatitis Section  
Health Care & Support Services Unit

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## **Overview**

The Department of Public Health (DPH) Health Care and Support Services (HCSS) Unit is a statewide program serving over 2,000 People Living with HIV (PLWH) in Connecticut. Our program funds the provision of a variety of core medical and support services.

## **I. Quality Statement**

### **Mission Statement**

The mission of the Clinical Quality Management (CQM) program is to provide a diverse structure to assure access to and retention in quality client centered health care and related services for PLWH in Connecticut.

### **Vision**

Our vision is in alignment with the National HIV/AIDS Strategy (NHAS) to promote optimal health outcomes for individuals living with HIV, reducing new HIV infections, and reducing HIV-related health disparities in Connecticut.

### **Purpose**

The purpose of the quality management program is to review, monitor, evaluate, and improve Connecticut's Ryan White (RW) Part B services to ensure they are provided in accordance with the Health and Human Services (HHS) HIV/AIDS Treatments Guidelines and the Health Resources and Services Administration (HRSA) / HIV/AIDS Bureau (HAB) Regulations.

## **II. Annual Quality Goals**

1. Increase the percentage of Part B clients who do not have a gap in medical visits.
2. Determine the number of Connecticut AIDS Drug Assistance Program (CADAP) clients with viral load suppression.
3. Ensure that sub-recipients adhere to the Connecticut Ryan White Part B Program Service Category Standards of Care.

## **III. Quality Infrastructure**

### **Leadership**

The QM program leadership consists of the Program Collaboration and Service Integration (PCSI)/HIV/Hepatitis Program Section Chief, the HCSS Health Program Supervisor, and the HCSS Nurse Consultant/ADAP Coordinator who provide the structure to support the assessment of and improvement in service provision and quality of care. The leadership team is committed to sustaining a culture of quality and guidance in CQM.

### **Quality Committee**

The CQM program consists of two quality teams; one for the overall Part B program and one for CADAP. These teams meet monthly and as needed to coordinate, develop, and sustain the program's QI and QA activities. The Nurse Consultant is the team leader for both and encourages open communication and feedback through meetings, phone calls, and email. The team members are responsible for routinely engaging in QI/QA planning, development, implementation, and evaluation activities to improve client care and health outcomes including client satisfaction.

### Roles & Responsibilities

- **DPH PCSI/HIV/Hepatitis Program Section Chief:** provides oversight to the CQM program and collaboration with the TB, STD, and Viral Hepatitis programs.
- **HCSS Health Program Supervisor:** provides administrative & programmatic oversight to the CQM program including strategic planning in partnership with the Section Chief and Nurse Consultant.
- **HCSS Nurse Consultant/ADAP Coordinator:** is responsible for the leadership of the CQM program including the development, implementation and evaluation of the QMP, selection of annual performance measures, priority setting, and coordinating QI/QA activities.
- **HCSS Program Data Manager:** coordinates data collection, analysis, establishes the baselines for quality improvement activities, compiles, and disseminates reports for the CQM program. Monitors service utilization. Assists with the development and evaluation of the QMP and selection of annual performance measures.
- **HCSS Contract Managers:** conduct QA activities which include, but are not limited to, programmatic and fiscal monitoring to ensure sub-recipient compliance with Federal, State, and DPH policies and procedures. Assist with the development of the QMP, selection of annual performance measures, and participate in QI activities.
- **Department of Social Services (DSS) Health Program Associate/Operations Manager:** coordinates data collection including service utilization and supports QI/QA activities for CADAP. Assists with the development of the QMP.
- **DSS Intake & Eligibility Specialists:** assist with data collection and supports QI/QA activities for CADAP. Assists with the development of the QMP.
- **DSS/Connecticut Insurance Premium Assistance (CIPA) Health Program Associate:** completes the CIPA semi-annual cost effectiveness reports which includes service utilization data, assists with the evaluation of CIPA service delivery, and supports QI/QA activities for CIPA.
- **Clinician:** Provides clinical expertise to plan, implement, and evaluate CADAP services including formulary management. Supports QI activities for CADAP. Assists with the development of the QMP.
- **Clients:** will be recruited during the 2016 calendar year to assist with QI activities.
- **Sub-recipient(s) (Providers):** will be recruited during the 2016 calendar year to assist with QI activities for the Part B program.
- **DPH HIV Prevention staff:** will be recruited during the 2016 calendar year to assist with the planning and collaboration of prevention and care services.

### Stakeholders

HCSS staff participates in statewide collaborations with the Part A, C, and D Ryan White quality management initiatives to maximize resources, identify the needs of PLWH and to implement responsive HIV care activities/resources.

- **The Connecticut HIV Planning Consortium (CHPC)** is the state's integrated care and prevention planning body which meets eight times a year. CHPC consists of members and participants from Community Based Organizations, AIDS Service Organizations, Ryan White Parts A, B, C, D and F, DPH HIV Prevention Program, DPH HIV Surveillance Program, governmental agencies, PLWH, and the public. HCSS staff works

in partnership with other CHPC members to ensure quality HIV/AIDS prevention and care public health planning in Connecticut (e.g. development of the Statewide Coordinated Statement of Need (SCSN), a service matrix, unmet need and gap analysis).

- **CT Cross Parts Quality Management Collaborative (CPC)** mission is to systematically monitor, evaluate and continuously improve the quality of HIV care and services provided for Ryan White clients in the state. CPC will become a part of CHPC in January 2016 to continue their quality improvement work in the most efficient manner.
- **Ryan White Part A Planning Councils:** HCSS staff are members of the Hartford County TGA and the New Haven/Fairfield County EMA Planning Councils. They attend meetings to help collaborate and maximize resources to continuously improve the quality of HIV care and services provided for HIV clients statewide.
- **The CT HIV/AIDS Identification and Referral (CHAIR) Task Force** meets monthly and focuses on the continuous improvement for the referral and linkage services for people living with HIV. It also supports the identification, linkage, and referral of PLWH who are unaware of their status to prevention and care services.
- **The CADAP Advisory Group (CAG)** meets two-three times per year and involves statewide participants including medical providers, Community Based Organization staff, PLWH, and members of the public. The purpose of the meetings is to share information and gather input from the participants on the status of CADAP services, the Formulary and related topics.

### Resources

All HCSS staff has dedicated time to participate in QM/QI activities. QM trainings will be provided during the monthly QM meetings. Staff is encouraged to participate in the online National Quality Center (NQC) Quality Academy Tutorials.

### IV. Capacity Building

The QM staff will utilize the following resources to support capacity building activities:

Connecticut HIV Planning Consortium (CHPC), Ryan White Planning Councils, Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR), CADAP Advisory Group, HRSA Target Center, NQC, National Alliance of State and Territorial AIDS Directors, HIVQUAL, and the Institute for Healthcare Improvement.

### V. Performance Measurement

- The Part B sub-recipients and PLWH participate in the selection of Part B performance measures through their involvement in the CHPC Quality and Performance Measure team, the Connecticut Cross Part Quality Management Collaborative (CPC), CHAIR, and CAG.
- The Part B program collaborates with the Part A programs in setting performance measures through Part B representation on the Planning Councils.
- Part B sub-recipients are required to document PM data in the client record and CAREWare on a regular basis, review the data, and implement quality improvement activities as needed. HCSS Contract Managers review the CQM data in CAREWare three times a year and annually in a random sampling of client records. Any deficiencies noted in the PM reviews are immediately followed-up by the Contract Manager. HCSS' policy

is that the Ryan White Part B program aggregate CQM data is generated, reviewed, analyzed, and then disseminated to the sub-recipients at least once per year.

- Health Disparities CQM data: viral load (VL) suppression, anti-retroviral prescription, HIV medical visit frequency and gap in HIV medical visits were analyzed in 2015 to identify any health disparities. Our analysis indicates that although there are disparities in who receives Ryan White Part B clinical services compared to the general population in CT, once clients are identified and retained in Ryan White Part B programs there are few if any disparities in the care received based on age, sex or race/ethnicity.
- Data from the annual sub-recipient review is analyzed and reviewed by the QM team to determine the PMs for the next year. Measures that the sub-recipients have reached and maintained at the 80-90% threshold are retired.
- The CT HIV Continuum of Care for 2014 (preliminary data reported through July 2015) shows 86% of HIV positive individuals who are in-care (1 visit in past 12 months) have achieved viral suppression (VL < 200 copies/ml).

**Performance Measures retired as of September 2015 (HCSS will still monitor)**

CD4 Counts	Viral Load
HBV Screening	HCV Screening
TB Testing	Mental Health Screening
Substance Abuse Screening	HIV Risk Reduction Counseling
ADAP Formulary	

**Performance Measures selected for 2016-2017**

<b>Performance Measures for the AIDS Drug Assistance Program</b>
1. ADAP applications approved/denied for new enrollment within 14 days of ADAP receiving a complete application
2. ADAP eligibility recertification reviewed for continued eligibility every 6 months
<b>Performance Measures for Outpatient/Ambulatory Medical Care, Medical Case Management, and Non-Medical Case Management</b>
1. Gap in HIV Medical Visits
2. Retention in Care
3. Prescribed HAART within the previous twelve months
4. PCP Prophylaxis: CD4 counts below 200 cells/mm <sup>3</sup> who were prescribed prophylaxis
5. Viral Load Suppression
6. Hepatitis B vaccination series completed
7. Syphilis test performed within the previous year
<b>Health Disparities</b>
<b>For the followings clients: Youth (13-24 yrs.), MSM, Black &amp; Hispanic</b>
1. Viral Load Suppression
2. Prescribed HAART within the previous twelve months
3. Gap in HIV Medical Visits

**The Service Category Standards of Care Performance Measures for 2016-2017 are listed in Appendix C.**

## **VI. Quality Improvement**

The process for identifying priorities for quality improvement start with the Health Program Supervisor and Nurse Consultant reviewing annually the NHAS, the CT HIV Continuum of Care, the SCSN, the CT HIV Epidemiological Reports, the Statewide HIV Prevention & Care Plan for Connecticut, and Healthy People 2020. The HCSS and CADAP QM teams meet monthly to discuss and identify areas for improvement directed at improving client care, health outcomes, and client satisfaction based on the above information and the results of the sub-recipient performance measurement reviews (CAREWare, DSS databases, and chart audits).

The QM teams monitor the Part B program (recipient) and sub-recipients progress towards meeting QI goals, improvements made, and the sustainability of those improvements three times a year.

The recipient will distribute their QMP to the sub-recipients by January 31, 2016 so the sub-recipients can align their QMP goals, objectives, performance measures, and quality improvement projects with the recipient's plan. The sub-recipient QMPs are due to the Nurse Consultant on June 30, 2016 for review and approval. The Plan Do Study Act (PDSA) is the quality improvement model being used by both the recipient and sub-recipients.

The Program Data Manager is available to assist sub-recipient staff with the collection of data from CAREWare, provides continuing education on performance measurement, and CAREWare updates. The Nurse Consultant and the Contract Managers provide Technical Assistance (TA) as needed for the individual sub-recipients to support their quality management program and activities.

## **VII. Quality Assurance**

The recipient will review a statistically valid random sampling of sub-recipient client charts at the annual quality management site visit to check for compliance with the HRSA National Monitoring Standards, the Service Category Standards of Care, and DPH contract requirements. The recipient will also review the sub-recipient client CAREWare data; the Ryan White Services Report (RSR); the ADAP Data Report (ADR); and the DSS programmatic and fiscal reports to monitor sub-recipient adherence with DPH Policies, the National Monitoring Standards, and the Services Category Standards of Care.

Sub-recipients report on the status of their QI projects three times a year in the Program Narrative Reports and starting April 1, 2016 during the monthly monitoring calls.

Also starting April 2016, HCSS will host bi-annual regional meetings in addition to the annual meeting for the Part B sub-recipients to provide training, updates, program requirements, etc.

The CADAP meetings are held as needed with the QM team meeting monthly and the CIPA team meets monthly via teleconferencing and as needed.

### **VIII. Participation of Stakeholders**

- Internal - HCSS is part of the DPH's PCSI model which addresses interrelated health issues through the development and implementation of integrated planning, results-based accountability, and quality improvement among the Department's TB, HIV, STD, & Viral Hepatitis Programs.
- External - HCSS collaborates in statewide quality improvement initiatives: Connecticut HIV Planning Consortium (CHPC), Ryan White Planning Councils, Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR), and the CADAP Advisory Group (these initiatives include sub-recipients & consumers) to maximize resources, avoid duplication of efforts, and to develop and implement quality improvement activities.

### **IX. Work Plans – See Appendices D & E**

### **X. Evaluation**

Progress towards meeting the objectives will be reviewed at each QM meeting. The QM program is evaluated annually by the QM teams by assessing quality infrastructure and QI/QA activities.

### **XI. Procedures for updating the QMP**

The annual QMP is reviewed and updated by the QM teams each December with the final plan being approved by the PCSI/HIV/Hepatitis Program Section Chief.

### **XII. Communication**

- Internal communication will consist of a set agenda, committee meeting minutes, work plan, and an annual timeline.
- External communication will consist of sharing the results of PM outcomes and data analysis along with the results of QI projects with our stakeholders.

### **Quality Definitions**

**Data Collection Plan:** describes the data to be collected, the interval of collection, and the source of the data.

**Goal:** is a broad statement identifying a program's intentions about what they want to achieve.

**Implementation:** is taking a change and making it a permanent part of the system.

**Outcome Measure:** is the benefit or other result (positive or negative) for clients that may occur during or after receiving a service.

**PDSA Cycle:** is a cycle of change which includes four phases: Plan, Do, Study, and Act which naturally leads to another cycle of change if needed to accomplish the quality improvement goal.

**Performance Measure (PM):** is a quantitative tool that provides an indication of the quality of a service or process.

**Quality:** is defined as the degree of excellence of a product or service. In terms of the Ryan White Program, the quality of a service is the degree to which a service meets or exceeds professional standards, guidelines, and user expectations.

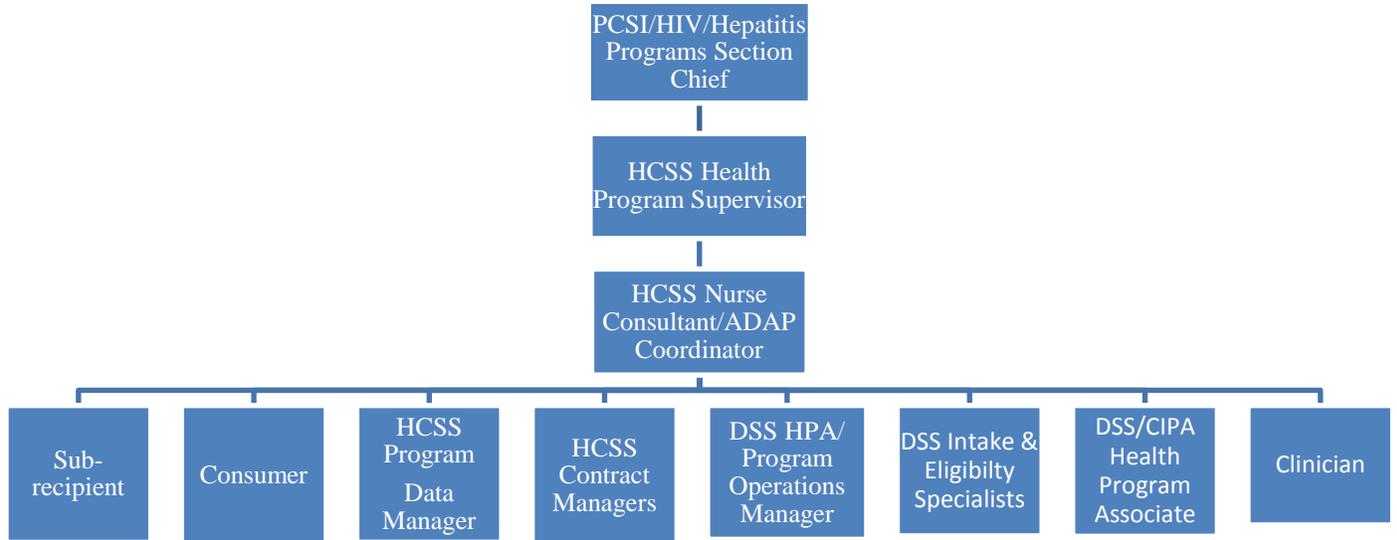
**Quality Assurance (QA):** refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards.

**Quality Improvement (QI):** refers to conducting activities aimed at improving the process to enhance the quality of care and services.

**Quality Management (QM):** program encompasses all recipient specific quality activities, including the formal organizational quality infrastructure (e.g. committee structures with stakeholders, service providers, and consumers) and quality improvement related activities (e.g. Performance Measurement, Quality Improvement projects, and Quality Improvement training).

**Quality Management Plan (QMP):** is a written document that outlines the recipient's HIV Quality Program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for the ongoing evaluation and assessment of the Program.

**Quality Management Organizational Chart**



**Service Categories Performance Measures for 2016-2017**

<b>Service Category</b>	<b>Measure</b>	<b>Numerator</b>	<b>Denominator</b>
<b>CADAP</b>	Prescription of ARV	95% of clients prescribed ARV during the measurement year	Clients with 1 Viral Load test result in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 Viral Load test result in the measurement year
<b>CIPA</b>	Health Insurance Coverage	95% of clients with 1 health premium payment in the measurement year	Clients with 1 Viral Load test result in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 Viral Load test result in the measurement year
<b>O/A Medical Care</b>	HIV Medical Visit Frequency	45% of clients will have 1 medical visit each 6 month period of the 24 month measurement period	Clients with 1 medical visit in the first 6 months of the 24 month measurement period
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Oral Health Services</b>	Dental Treatment Plan	95% of clients will have a dental treatment plan in the measurement year	Clients with 1 clinical oral evaluation in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 clinical oral evaluation in the measurement year
<b>Medical Case Management (MCM) Services</b>	Gap in HIV Medical Visits	20% of clients who did not have a medical visit in the last 6 months	Number of clients who had at least 1 medical visit in the first 6 months of the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Mental Health Services</b>	Individual Counseling Session	85% of clients will have individual counseling session in the measurement year	Clients with 1 individual counseling session in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Early Intervention Services</b>	Completed EIS Intake	85% of newly diagnosed clients will have a completed EIS Intake in the measurement year	Newly diagnosed clients with 1 EIS visit in the measurement year
	Completed referral to MCM	85% of out-of-care clients will have completed referral to MCM	Out-of-care clients with 1 EIS visit in the measurement year

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<b>Service Category</b>	<b>Measure</b>	<b>Numerator</b>	<b>Denominator</b>
<b>Non-Medical Case Management Services</b>	Individual Non-MCM session	90% of clients will complete at least 1 Non-MCM session in the measurement year	Clients with 1 Non-MCM visit in the measurement year
	Completed referral to MCM	87% of clients will have completed referral to MCM in the measurement year	Clients with 1 Non-MCM visit in the measurement year
<b>Medical Transportation</b>	Access to transportation for medical appointments	95% of clients will have transportation services documented in CAREWare in the measurement year	Clients with 1 medical transportation service during the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Emergency Financial Assistance (EFA)</b>	Access to EFA for assistance with utilities, heat, and medications	95% of clients will have EFA services documented in CAREWare in the measurement year	Clients with 1 EFA service during the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Housing Services</b>	Access to housing assistance	95% of clients will have housing services documented in CAREWare in the measurement year	Clients with 1 housing service during the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Medical Nutrition Therapy (MNT)</b>	Completed Nutritional Plan	95% of clients will have a completed Nutritional Plan in the measurement year	Clients with 1MNT encounter in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 Viral Load test result in the measurement year
<b>Food Bank/Home-Delivered Meals</b>	Access to food and/or food voucher	95% of clients will have food and/or food voucher services documented in CAREWare in the measurement year	Clients with 1 food/food voucher service during the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year
<b>Health Insurance Premium &amp; Cost Sharing Assistance</b>	Medical co-payment/deductible payment	95% of clients will access at least 1 medical co-payment/deductible payment in the measurement year	Clients with 1 medical co-payment/medical deductible payment in the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year

## Connecticut Ryan White Part B Quality Management Plan

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<b>Service Category</b>	<b>Measure</b>	<b>Numerator</b>	<b>Denominator</b>
<b>Psychosocial Support Services</b>	Individual or Group Encounter	80% of clients will have an individual or group encounters documented in CAREWare in the measurement year	Clients with 1 individual or group encounter during the measurement year
	Viral Load Suppression	80% of clients with VL<200 in the measurement year	Clients with 1 medical visit in the measurement year