Cuyahoga County Board of Health
Ryan White Part A Program
Cleveland TGA
2017
Clinical Quality Management Plan

CUYAHOGA COUNTY

BOARD OF HEALTH

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Approved by the Ryan White Part A Cleveland TGA and
all TGA Service Providers on
April 2017

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Introduction

Background: The Ryan White HIV/AIDS Program provides HIV-related services for those who do not have sufficient health care coverage or financial resources for HIV care and treatment. The program is federally funded through the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). In 1996, HRSA first designated the six county Cleveland region as a Ryan White Part A Transitional Grant Area (TGA).

The Cuyahoga County Board of Health (CCBH) (hereafter referred to as recipient) serves as the administrator of the Cleveland TGA grant which serves the following Ohio counties: Cuyahoga, Ashtabula, Geauga, Lake, Lorain, and Medina.

According to the Ohio Department of Health, in 2015 there were a total of 5,237 individuals living with HIV/AIDS throughout the TGA region. The Cleveland TGA Part A Program provided care and support services to a total of 2,884 individuals in 2015, or 55% of the region's total population living with HIV/AIDS.

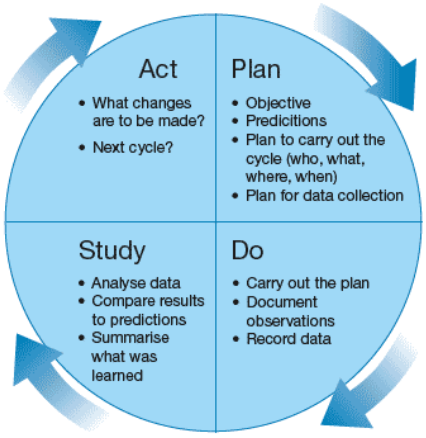
The TGA funds 14 sub-recipients to provide services that are designed to treat individuals living with HIV and provide support services to achieve optimal health outcomes, engage patients in ongoing HIV care, and work towards ending the AIDS epidemic. These services may be social service or clinical in nature, and all service categories have specific quality improvement targets.

Legislative Requirements: Ryan White Part A recipients are required to implement Clinical Quality Management activities. Specifically, the Ryan White Program legislation dictates that all recipients must: "establish a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections. [As applicable, recipients should] develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." In addition to legislative requirements, HRSA/HAB requires recipients to establish and implement a written Clinical Quality Management Plan to guide quality related activities in the local service area.

Quality Terminology

The following definitions are included in the HIV/AIDS Bureau Ryan White Part A Program Manual and used consistently throughout the Cleveland TGA Clinical Quality Management Plan:

- **Quality:** is defined by HAB as the degree to which a health or social service meets or exceeds established professional standards and user expectations. In order to continuously improve systems of care for individuals and populations, evaluation of the quality of care should consider:
  - The quality of inputs
  - The quality of the service delivery process, and
  - The quality of outcomes.
- **Clinical Quality Management (CQM)**: A formal system to routinely evaluate the quality of care and staff/patient experiences at RWHAP-funded organization, including an established infrastructure to manage improvement activities, routine measurement processes, capacity building efforts, and stakeholder involvement.
- **Clinical Quality Management Plan (CQMP)**: A written plan outlining the agency's quality management infrastructure (including clear responsibilities and accountability for activities) and process for ongoing evaluation and assessment to identify and improve the quality of care.
- **Quality Improvement (QI)**: An organizational approach to improving quality of care and services using a specified set of principles and methodologies, including, but not limited to, leadership commitment, staff involvement, cross-functional team approach, consumer orientation, routine performance measurement, and a continuing cycle of improvement activities.
- **Plan Do Study Act (PDSA) Cycles:** A model for performance improvement:
  - PLAN - Identify and analyze what you intend to improve, looking for areas that hold opportunities for change.
  - DO - Carry out the change or test on a small scale (if possible).
  - STUDY - What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?
  - ACT - Adopt the change, abandon it, or initiate the cycle again.



- **Indicator:** A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or the level of quality achieved. Indicators serve as an interim step toward achieving a performance measure and are also referred to as activities.
- **Outcomes:** Results achieved for participants during or after their involvement with a service or program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, conditions or health status.
- **Outcome Indicator:** An outcome indicator is the specific information that tracks program success or failure towards meeting outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.
- **Quality Assurance (QA):** A formal set of activities to review and to safeguard the quality of services provided, QA includes quality assessment and implementation of corrective actions to address deficiencies. It is focused on identifying problems, ensuring that standards are adhered to and solving single quality issues with problem resolution focused on the responsible individual. QA is used more in a regulatory environment.
- **Standards of Care:** Performed and agreed upon principles and practices for the delivery of services that are accepted by recognized authorities. The standard of care is based on research (when available) and the collective opinion of experts.

For additional acronyms definitions, please see *Appendix E.*

Quality Statement

The overall mission of the Cleveland Transitional Grant Area Clinical Quality Management Program is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all HIV-infected individuals served by the TGA. Culturally and linguistically competent medical and social service provider's work collaboratively with administrative staff and consumers to create, implement, and maintain a dynamic program to facilitate receipt of comprehensive, state of the art, high quality care. This Clinical Quality Management Program aligns with the 2020 National HIV/AIDS Strategy goals, and adheres to established HIV clinical practice standards and Public Health Service guidelines in order to best address the needs of the Cleveland TGA community.

The vision of the TGA Clinical Quality Management Program is to improve and enhance the health and wellness of the population we serve. Through the work of the Clinical Quality Management Committee, the CQM Program aims to become a local resource for anyone wishing to improve the outcomes and support services of HIV health care for consumers, communities, and public health.

Quality Aims and Annual Quality Goals

The Clinical Quality Management Program works towards meeting or exceeding HAB expectations to establish and maintain a clinical quality management program and alignment with the National HIV/AIDS Strategy 2020 (NHAS). The Clinical Quality Management Program

includes documented accountability for all service provision, with quantitative performance measurement and capacity building for providers and consumers resulting in ongoing and meaningful improvement activities.

Quality Aims

- Refine and implement the Standards of Care for all funded service categories
- Improve CAREWare data entry: clean, current, comprehensive. The aim is to have CAREWare output more closely aligned with EMR data abstractions.
- Conduct and monitor ongoing quality improvement projects that promote patient linkage, retention, adherence, and viral load suppression.

Quality Goals

Although the TGA assesses performance on numerous measures, the quality improvement focus will target Viral Load Suppression first and Retention in Carew second. Data that depicts progress towards goals are collected quarterly, trended, and shared back with all stakeholders.

Performance Measure	Reporting Provider	*National Benchmark	TGA Goal
Viral Load Suppression: Percentage of HIV patients with a viral load less than 200 copies/ml.	All funded medical providers	72%	80%
Retention in Care, Gap Measure: Percentage of patients who did not have medical visit in the last 6 months.	All funded medical and support service providers	14%	14%

* In+Care Campaign reported mean, 2013

Clinical Quality Management Committee Infrastructure

The Clinical Quality Management Program operates through a Clinical Quality Management Committee (CQMC) which receives guidance and support from the TGA recipient office. Input is received from all providers, both clinical and social service, who are funded by the TGA, in addition to consumers and non-funded community partners. Priorities are established in concert with the Planning Council and aligned with local, regional, and national concerns. CQMC meetings are held quarterly.

The purpose of the CQMC is to establish a vehicle through which all providers can coordinate efforts to demonstrate improvements in the services they provide. Needs for capacity building is assessed and training opportunities are provided as appropriate. These efforts all contribute to an improved health status for Cleveland TGA patients. These activities will yield a higher rate of virally suppressed patients and ultimately, lower HIV transmission rates.

To assure that all aspects of patient health are included in the quality improvement effort, the CQMC is comprised of an array of members, representing all agencies funded by the TGA. The CQMC seeks to represent a variety of skill sets as well as a variety of provider disciplines. In addition to social service and clinical representation, the CQMC engages members who can

manage data, provide secretarial and logistical support, assist with capacity building, and provide the consumer voice. The CQMC acknowledges that all voices are heard and respected.

Key Roles and Responsibilities:
The ultimate responsibility for quality management activities lies with the TGA Project Director. This person provides encouragement and support for improvement work by assuring that the committee has the resources they need to function effectively. The primary resource is sufficient staff time to allow for full participation. Although the Project Director may not be involved in the daily work of quality management, her support will help establish a culture of quality throughout the TGA.

Direct responsibility for the operation of the CQMC will rest with the TGA Program Supervisor. The Program Supervisor is the direct liaison to the HRSA/HAB Project Officer and shares HRSA/HAB priorities with the CQMC membership. The Program Supervisor coordinates sub-recipient contracts and assures the commitment to quality improvement is clear. The Supervisor ensures resources are available for space as needed for meetings, conference lines, photocopying, and any technical audio or video equipment needed to promote communication or encourage learning and sharing. She oversees all CQMC meetings and the overall direction of the committee.

The Program Manager serves as the day to day Quality Leader for the TGA. She sets the overall quality improvement initiatives within the TGA. She assumes the responsibility for monitoring improvement projects conducted by each sub-recipient. In addition, she sets the agendas for the CQMC meetings. The Program Manager, accompanied by the TGA Grant Coordinator, makes an annual site visit to each sub-recipient to assess progress at a local level. She is responsible for completing data reports, including quarterly aggregation and trending data back to CQMC members as a feedback and progress report mechanism. The Program Manager works with TGA data resources to provide timely and informative data reporting. The Program Manager represents the Cleveland TGA on the State of Ohio's Response Team for the HIV Cross-part Care Continuum Collaborative (H4C). This opportunity to liaison between the TGA and statewide H4C Collaborative provides an added opportunity to learn from and share with HIV providers across the State.

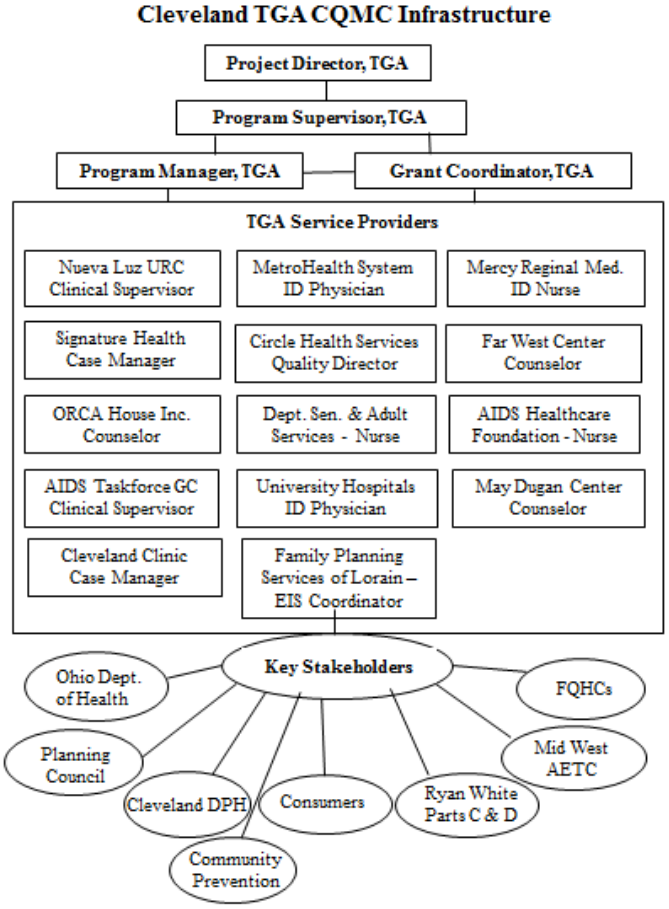
The necessary logistical and secretarial support responsibilities are conducted by the TGA Grant Coordinator. She secures space, takes and publishes meeting minutes, and provides any other facilitation needed by the committee members. The Grant Coordinator works cooperatively with the Program Manager to provide assistance and support for the routine operations of the CQMC. She also works with sub-recipients in their attempts to provide high quality services in alignment with the approved Standards of Care.

The CQMC recognizes the criticality of consumer participation and welcomes their experience and input. The consumers will describe patient barriers and challenges to care, and provide insight into quality improvement strategies and interventions. With the support of the TGA, consumers will have a basic understanding of HIV terminology and the quality improvement process, and will be willing to take part in additional training opportunities preparing them to contribute effectively.

Internal Key Stakeholders are the contracted sub-recipient service providers. These committee member's each liaison with their own agencies, and share quality improvement tools and trainings with their own quality management staff. The service providers are continually engaged in quality improvement projects, and are responsible to report progress at each quarterly meeting. Clinical sub-recipients share at least one common quality improvement project focusing on true health outcomes, but may engage in additional ones as appropriate. Non-clinical sub-recipients continue to work on an aspect of their funded service delivery that contributes to a positive impact on the patients' health outcomes. This includes helping the patient with linkage, re-engagement and retention in medical care.

The CQMC also engages external stakeholders who will make significant contributions to the successful operation of the committee. The Ohio Department of Health can share surveillance and epidemiology data, the AETC can assist with needs assessments and training programs, and other local experts can share information on mental health, substance abuse and dental concerns. The CQMC will coordinate ongoing improvement projects within the community. In order to enhance communication, the Planning Council Quality Committee has been identified as a key external stakeholder on the CQMC for the purposes of sharing information to ensure all quality projects and outcome are known throughout the community.

The organization of the CQMC can be depicted as such:



Capacity Building

The TGA recipient and the CQMC recognize the need for ongoing capacity building regarding quality improvement, for both the TGA leadership and staff as well as for the sub-recipient providers and CQMC members. It is noted that currently there is a wide range of QI skill level and competency among the providers and CQMC members. The large medical hospitals are already adept in identifying areas for improvement, strategizing to develop feasible interventions, crafting Quality Improvement Projects (QIPs) using the PDSA model, and using data and measurement to demonstrate progress and success.

Although all levels of capacity building and training activities are planned, the immediate focus is on identifying the training needs of the Community-Based Organizations (CBOs). These providers may need more guidance and a different type of training. The CBOs are not clinical organizations, and do not collect viral load or other medical information. Therefore, they are unable to directly impact viral load suppression or other major health outcome indicators. They are however, expected to contribute to the patient's linkage, re-engagement, and retention in medical care. These organizations provide the patients with basic living needs, such as food, shelter, and social service supports. As these needs are being met, the CBO staff encourages continued retention in medical care. Training on how this patient interaction should occur, how patient responses are documented, and how information is communicated between the recipient and the medical provider and the CBO, are all pathways to capacity building opportunities.

The CQMC works with the Program Manager and Grant Coordinator to research and explore the various training resources available. During the span of this CQM Plan, it is expected that the following resources help to shape and guide the capacity building efforts:

- QI 101 tutorials from the National Quality Center (NQC). The specific presentations selected would include basic topics such as why we do improvement work, the PDSA model, identifying areas for improvement, thinking through interventions, and documenting and measuring results.
- The AIDS Education and Training Centers (AETC). The CQMC will engage the expertise of the AETC staff, particularly in training nurses in HIV 101 topics. The AETC may also be asked for referrals regarding other expert speakers as needed when topics are identified.
- Internal experts. There exists a wealth of expertise within the TGA community. Quality Improvement leaders within the Ryan White funded hospitals may be asked to share their knowledge with the rest of the CQMC members and sub-recipient providers. Their "real world" experiences in the QI arena will help others better understand the QI process.
- External experts. Within the larger community there are local experts who are not funded by Ryan White, who may be able to share information regarding their own area of service. These areas might include such services as mental health or substance abuse, and these experts might be able to bring updates or new insights to our own providers.
- NQC conference trainings. One recipient staff member will attend a training on Coaching Basics conference during this CQM Plan period. It is intended that staff who attend the NQC conference trainings will be prepared to share their knowledge and help guide sub-recipients through the QI process. The Quality Program Manager will research future

opportunities and ideally send other recipient staff to an additional NQC conference each CQM Plan cycle.

The Quality Program Manager with the Grants Coordinator and the CQMC members, work together on a two-year calendar of trainings. The trainings are included in the CQM Plan work plan and occur at least twice a year during the regularly scheduled CQMC meetings. An annual assessment of the CQMC needs will also be conducted to ensure that trainings are meeting the local quality improvement needs of the community. It is possible that as the CQM Plan progresses, different topics are identified and the trainings focus on a different priority than initially decided. However, the regularity of trainings should not significantly change.

It is also possible that additional, but smaller and more local trainings may be required to address the needs of smaller groups of providers, or the needs of a single agency. These efforts are coordinated by the Quality Program Manager and the Grants Coordinator as they conduct sub-recipient site visits and identify new QI challenges.

Capacity building for consumers is a training area that is regarded as critical by the CQMC. When the CQMC is well-established and functioning as a cohesive QI group, the Quality Program Manager will seek guidance on how to best train consumers to participate more fully and contribute to the effectiveness of the CQMC activities. This guidance may come from the NQC and HAB, and trainings may either be added to the work plan in 2017, or may be included in the 2018 revision of the CQM Plan.

Performance Measurement

Performance measurement is an integral part of the quality improvement process. Ongoing measurement of core indicators helps to determine and drive the Quality Improvement Projects (QIP). Once a QIP is identified and implemented, repeated measurement of performance helps determine the success or lack of success of a new or ongoing intervention.

There are two main sources of data on which the CQMC can rely for information regarding performance, the first of which is CAREWare. All of the sub-recipients utilize CAREWare, which houses all of the Ryan White Services Report (RSR) requirements. CAREWare queries are run four times a year to inform the CQMC on the TGA's key QIPs. During the initial implementation phase, the key QIP measure will be viral load suppression, followed by retention in care, both of which are briefly outlined in the "Annual Quality Goals, Outcomes and Aims" section. Data from CAREWare can be collected from each sub-recipient, aggregated for a TGA total picture, and trended out over time each quarter by both sub-recipient and aggregate tiers. Each sub-recipient will be able to visualize how their own work is contributing to the larger TGA picture.

Data reports are constructed according to the following time table:

Quarterly Report	Due Date	Measurement Year
1	March, 2016	January 1, 2015 through December 31, 2015

2	August, 2016	March 1, 2015 through February 29, 2016
3	November, 2016	July 1, 2015 through June 30, 2016
4	February, 2017	January 1, 2016 through December 31, 2016
5	April, 2017	March 1, 2016 through February 28, 2017
6	October, 2017	July 1, 2016 through June 30, 2017
7	January, 2018	January 1, 2017 through December 31, 2017
8	April, 2018	March 1, 2017 through February 28, 2018

Recipient staff has access to the medical records and charts at each sub-recipient agency. Thus, additional measures are able to be evaluated during a routinely scheduled annual site visit. Data from charts and EMRs are abstracted on a random sample population. HAB guidance is used to determine the number of records needed to demonstrate confident data. These data are also able to be aggregated, trended out over time by year, and returned to the CQMC for discussion and evaluation.

The following indicators are routinely measured annually via chart abstraction. This activity affords the CQMC an opportunity to review results on the 3 key measures and QIPs from two data sources: CAREWare and chart abstraction. Ideally the two sets of data tell the same story. Recipient staff work with sub-recipients to keep all data, both electronic and charted, as current and as comprehensive as possible. Should the focus of a QIP shift to a measure outside of those routinely evaluated, the CQMC may decide to abstract additional data to help inform that area of interest. These might include Pap screens, flu shots, HCV screens, dental care or numerous other key concerns for HIV patients.

Outpatient Ambulatory Health Services (OAHS): HAB Performance Measure	**National Benchmark**	**Cleveland TGA Target Results**
Viral Load Suppression: Percentage of patients with a HIV viral load less than 200 copies/ml.	**72%** (2013 In+Care Campaign)	**90%**
Prescription of HIV Antiretroviral Therapy: Percentage of patients prescribed HIV antiretroviral therapy.	**91%** (2012 HIV Research Network)	**90%**
HIV Medical Visit Frequency: Percentage of patients who had at least one medical visit in each 6-month period of the 24 month measurement period.	**69%** (2013 In+Care Campaign)	**80%**
Gap in HIV Medical Visits: Percentage of patients who did not have a medical visit in the last 6 months.	**14%** (2013 In+Care Campaign)	**20%**
Pneumocystis jiroveci Pneumonia (PCP) Prophylaxis: Percentage of patients who were prescribed PCP prophylaxis.	**80%** (2011 National HIVQUAL)	**80%**

Medical Case Management: HAB Performance Measure	**National Benchmark**	**Cleveland TGA Target Results**
Medical Case Management Case Plan: Percentage of patients who had a medical case management care plan developed	No National Comparison Available	**80%**

and/or updated two or more times in the measurement year.		
Medical Case Management Linkage to Care: Percentage of MCM patients with at least one medical visit, viral load, or CD4 test within the measurement year	No National Comparison Available	**80%**
Medical Case Management Viral Load Suppression: Percentage of MCM patients with a HIV viral load less than 200 copies/ml.	No National Comparison Available	**80%**

For more information regarding the Cleveland TGA's 2015 and 2016 viral load suppression results, reference **Appendix F**.

Quality Improvement Projects and Monitoring

The implementations of Quality Improvement Projects (QIPs) is the cornerstone of the CQMC work and responsibility. Ongoing measurement determines if a QIP is successful or if it needs modification. These measurements are made quarterly and are prepared for presentation and discussion at each CQMC meeting. The key QIPs are determined at the onset of each new/revised CQM plan, but may be modified at any time during the duration of the CQM plan. Additional QIPs may be assigned at the sub-recipient level at any time during the CQM plan cycle as determined necessary by TGA recipient staff.

As described in the Quality Terminology Section above, the applied framework to implement QIPs is the Plan-Do-Study-Act (PDSA) cycle, developed by Walter A. Shewhart. This approach is part of the Model for Improvement, developed by Associates in Process Improvement, which helps teams accelerate the pace of change. The TGA is committed to these models to improve the quality of care and services that result in better health outcomes.

In addition to sub-recipient progress reports on QIPs during the quarterly CQMC meetings, the TGA recipient staff conduct annual site visits during which improvement work is reviewed in more detail. The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the recipient conduct an annual site visit with each sub-recipient to ensure compliance on proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place. Appropriate quality improvement activities are a key part of the requirement.

During the annual site visit, the Quality Program Manager with the Grant Coordinator will meet with the sub-recipient quality lead to discuss progress and status of the QIP in a one-on-one format. The recipient staff will provide basic training in PDSAs and other aspects of quality improvement if needed. Recipient staff will review status of the QIP and offer possible improvements suggestions when appropriate. If the sub-recipient identifies further need for one-on-one assistance during the annual site visit, the recipient will schedule additional technical assistance specific to the sub-recipients need. The recipient will also use the site visit to gather guidance for additional training opportunities that may be useful for the CQMC.

Participation of Stakeholders

As described in the Clinical Quality Management Committee Infrastructure section in this plan, the collaboration between internal and external stakeholders, and consumers, serves as the pathway to collect and share feedback from a variety of sources. Internal stakeholders are considered as those who are funded by Ryan White through the TGA. These stakeholders include a representative of each of the sub-recipient agencies who are charged with bringing information and updates on their patients to the CQMC forum.

External stakeholders are interested community partners who are not funded by the TGA. These stakeholders are critical as they can share information on the broad range of services they provide, alert the CQMC members to changes in their services or procedures, and offer training in how patients might access and benefit from their services. As the CQM Plan evolves and new priorities develop, additional external stakeholders may be invited to join the CQMC and contribute to the quality improvement process. External stakeholders are invited to participate in each quarterly CQMC meeting. During these meetings they may not only share information about their area of specialty, but they will also learn how they are contributing to the overall quality improvement process.

Consumer involvement is key to a successful effort to improve the health status of patients. Consumers currently attend the CQMC meetings and are engaged in providing feedback. As the CQMC members progress, discussions focusing on the provision of consumer trainings are held during the CQMC meetings. It is anticipated that guidance from HAB and the NQC will be sought in building capacity for effective and impactful consumer engagement.

Evaluation

The CQMC acknowledges that the quality improvement plan is a very dynamic document. As new needs or challenges are discovered, shifts may occur in the CQMC membership, new priority measures may be added, established measures may be updated, or targeted populations may be redefined. The process of plan evaluation is ongoing and periodic adjustments may be made to address any emerging concerns.

During one quality committee meeting each year, an Organizational Assessment, using a standardized Part A Organizational Assessment Tool provided by NQC, will be conducted by the committee participants to help evaluate the effectiveness of the activities implemented. The initial baseline assessment was completed in June 2016. The Program Manager leads the assessment, documents the scores, and makes them available for comparison on a yearly basis. If technical assistance from the National Quality Center (NQC) is requested and granted, NQC would be available to lead the assessment for the committee. In addition, the following topics will be placed on the agenda to garner input and set direction:

- Has the committee used trended data to demonstrate progress towards goals?
- Has the committee been able to determine if specific quality improvement projects had resulted in improvements?
- Are the goals of the committee still appropriate, or do they need revision?

- Are there new/emerging priorities to address through our committee?
- Are we effectively communicating our findings to all internal and external stakeholders?

The discussions resulting from the Organizational Assessment and the questions above will help the committee evaluate their own effectiveness in promoting successful quality improvement activities. Findings from past evaluations will be included in future CQM Plans and work plans to allow for continuous learning.

Procedure for Updating the Clinical Quality Management Plan

The CQM Plan may be revised at any time during its implementation period. As the CQMC conducts the annual evaluation, modifications to the plan may be identified and adjustments may be made. It is recognized that the CQM Plan should reflect any changes in priorities, and therefore may be amended to adopt a new or more appropriate direction at any time. However, a formal and complete update of the CQM Plan will occur every year during the spring quarterly meeting.

Prior to the formal updating process, all committee members receive an electronic copy of the current CQM Plan for their own review. The members come to the spring meeting prepared to provide input on all relevant sections of the CQM Plan. The Quality Program Manager reminds the committee members of where they started at the onset of the current CQM Plan, and of any changes made to it since implementation. She leads the discussion on where the committee would like to be 2 years into the future, and note all desired revisions. The revisions are based on the progress made towards goals during the current CQM Plan period, and any new guidance provided by HRSA/HAB.

The work plan is a vital piece of the CQM Plan. As new goals and objectives are determined, the 2-year work plan is routinely updated to correspond to all activities set to occur during the duration of the new CQM Plan. The work plan construction is the responsibility of the Program Manager and the Grant Coordinator.

Upon initial completion of the new CQM Plan and work plan, a draft is circulated to all CQMC members for final review and approval. This draft is also presented to the full Planning Council for their review and additional input. Subsequent to any additional modifications, the official adoption of the new CQM Plan occurs during the summer quarterly meeting after final discussion, final amendments, and vote. The CQM Plan is signed by all committee members, and thus becomes the guiding document for the subsequent two years. The signature page contains a "Statement of Agreement," which expresses that the work described within is important and represents an opportunity to collectively and collaboratively improve the lives of the patients served.

The intent of the CQM Plan updating procedure is to assure that quality improvement is a continuous process and that the committee members are visionary in establishing new goals and setting new directions.

Communication

Because of the great diversity in skill sets of CQMC members, effective communication is a priority. Internal stakeholders represent the clinical, social service, case management, data and information, and administrative areas of expertise. External stakeholders may or may not be well versed in HIV disease, but they will represent a wide array of community-based services. Consumers bring yet their perspective to the quality improvement process. Additionally, ongoing communication with the Planning Council is vital to a comprehensive approach to quality improvement.

The communication process consists of numerous pieces of information that are shared within the CQMC. These pieces of information help to inform all CQMC members and are shared at least quarterly through the routinely scheduled meetings.

- CQMC meeting agendas help to alert members to the expectations of the upcoming meeting.
- CQMC minutes are widely distributed and provide a history of events.
- QIP updates provided by the sub-recipients on a quarterly basis during the CQMC meetings are helpful to inform all members of the challenges and successes experienced by each agency.
- Successes are celebrated and shared with senior level management as a reminder of the significance of the quality improvement work performed by each agency.
- Trended data reports are the most critical piece of information, as they tell the story of progress. Data can be shared in a variety of ways to a variety of interested parties.
- The work plan is the piece of information that can help the CQMC stay on track and provide guidance and direction for ongoing work.

Any of the above pieces of communication may also be shared outside of the CQMC. Depending on the specific area of interest, certain information is reformatted to improve appeal and interest, and shared with:

- Senior level management within the TGA
- Senior level management at the sub-recipient agency
- HRSA/HAB during site visits or in response to a grant application
- The greater TGA community, local and regional newsletters, or relevant local, regional, or national conferences
- The Ohio statewide H4C cross-Part collaborative project

Appendix A

CQMC Member Guidelines

The following guidelines are designed to ensure that all CQMC meetings are conducted in a positive environment, are productive, open to community input, and respectful of all members and visitors. All CQMC members agree to:

1. Demonstrate trust to other participants.
2. Follow through on any commitments you make or assignments you accept.
3. Display professional courtesy during meetings and discussions with other participants.
    a. Listen to different points of view.
    b. Use respectful speaking
    c. Use respectful listening
    d. Make "I" not "You" statements
    e. Be Present
    f. Make your point and allow others to provide their input. No grandstanding.
    g. Ask for a literacy moment if you do not understand a concept or acronym.
    h. Be positive and constructive.
    i. Focus comments on the process, not the person.
4. Provide regular progress reports to the sponsors.
5. Consider cost-benefit aspects of our actions.
6. Keep sensitive information in the group.
7. Ask for help if you cannot complete assignments on time.
8. Do not let cell phones and laptops interrupt the process.
9. Have fun while making positive changes.

Appendix B

CQMC Member Roster

Representing:	Name:	Agency:
Part A Funded Agency	Christina Humphrey	AIDS Healthcare Foundation
Part A Funded Agency	Bob Candage	AIDS Taskforce
Part A Funded Agency	Fatima Warren	Circle Health Services
Part A Funded Agency	Sarah Schramm	Cleveland Clinic
Part A Funded Agency	Sandrell Porter	DSAS
Part A Funded Agency	Courtney Price	Family Planning Services of Lorain
Part A Funded Agency	Kelly Dylag	Far West
Part A Funded Agency	Doug Vest	May Dugan
Part A Funded Agency	Summer Barnett	Mercy Regional
Part A Funded Agency	Dr. Ann Avery	MetroHealth
Part A Funded Agency	Kim Rodas	Nueva Luz URC
Part A Funded Agency	Myrtle Watson	ORCA House
Part A Funded Agency	Kristin Ziegler Alban	Signature Health
Part A Funded Agency	Dr. Barb Gripshover	University Hospitals
Ryan White Part B	Susan DiCocco	Ohio Department of Health
Ryan White Part C and D	Michelle Kucia	University Hospitals of Cleveland
Planning Council - QI Representative	Jason McMinn	MetroHealth
Planning Council - Consumer Representative	Kimberlin Dennis	N/A
Planning Council - Consumer Representative	Robert Watkins	Recovery Resources
Mid-West AIDS Education Training Center	Jane Russell	Ohio State University
Community Agency	Jan Briggs	Cleveland VA Medical Center
HIV Prevention Services & HOPWA	Tammie Jones	Cleveland Dept. of Public Health

Appendix C

CQMC Work Plan

Activity	Objectives	Responsible Staff	Time Frame
CQMC meetings	Meetings held quarterly. Representation includes clinical and support services.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	June, September, December, March
	Agenda developed/ distributed one week prior to meeting.		
	Updated aggregate trended data presented at each meeting		
	Agencies present QIP updates at each meeting. Updates include challenges and successes, and any QIP modifications.		
	Minutes taken and distributed one week after meeting		
Data collection and performance measurement	Data reports for key TGA-wide QPIs are generated one month prior to CQMC meetings.	Grant Coordinator, Quality Program Manager	May, August, November, February
	Data are aggregated and reports prepared for distribution at CQMC meetings.		
	Data are trended and CQMC discussions link data trends to QIP progress.		
	Guided by data, CQMC members collaborate and brainstorm for strategy tweaks or new interventions	CQMC membership	
Capacity building	General QI trainings held during CQMC meetings: examples may include NQC tutorials, NQC coach webinars, local clinical expert presentations, HIV 101, PDSA 101, CBO service updates.	Quality Program Manager/invited experts	Minimum 2 per year, typically during September and March CQMC meetings.
	Targeted QI trainings conducted on site at the sub-recipient level when need is identified by recipient.	Grant Coordinator, Quality Program Manager	As needed basis
	NQC Trainings: Training on Coaching Basics or Training Quality Leaders	TGA staff	Once per CQM plan cycle
Site visits	Additional QI data abstracted from EMR/charts.	Grant Coordinator, Quality Program Manager	Annual/winter
	Sub-recipient progress towards goals assessed.		
	QI training needs assessed. If needed, plans for targeted trainings are drafted.		
	If deficiencies are noted, follow up visits are scheduled.		

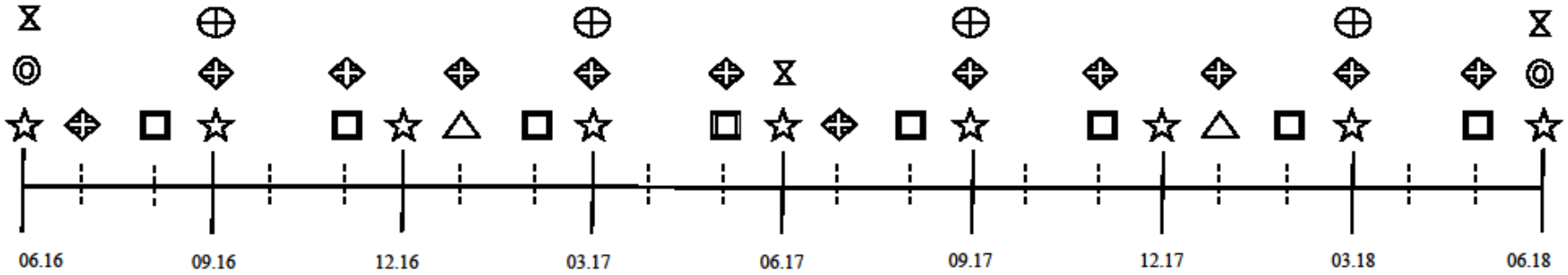
Planning Council Communication	Quality Program Manager liaisons with Planning Council	Quality Program Manager and Planning Council representative	10 meetings per year
	Planning Council member attends TGA CQM meetings and shares Planning Council priorities		June, September, December, March
	Quality Program Manager presents at each Planning Council meeting and reports on QI progress and updates		10 meetings per year
Quality Improvement Projects	TGA-wide QIP priorities determined. At least one clinical outcomes project and one support service or case management project underway TGA-wide at all times.	Sub-recipient representatives, Quality Program Manager, Quality Grant Coordinator	June 2016
	Review QIP priorities for long-term progress and continued relevance. Adjust or modify as needed.		June 2017
	Review QIP priorities for short-term progress quarterly during CQMC meetings.		June, September, December, March
	Review QIPs for alignment with national directives such NHAS 2020, HAB priorities, and In Care Campaign. Consider adding/dropping/enhancing/stratifying measures and QIPs for ongoing work.		May 2018
Evaluation	Conduct annual Organizational Assessment.	NQC TA Coach	June 2016, June 2017
	Use results to provide future direction and priorities.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	
	Compare annual OA results.		
	Use trended data on outcome measure to depict degree of progress.		
Update CQM Plan	CQMC reviews pieces of CQM plan and identifies areas needing revision.	Grant Coordinator, Quality Program Manager, Program Supervisor, CQMC members	March 2018
	Draft of revised CQM plan is circulated for review, input, and modifications		May 2018
	Final CQM plan is circulated for approval and signature		June 2018

Appendix D

Event Timeline

TGA Major QI Event Timeline

This graphic depiction of the major QMC activities is based on the most commonly occurring events. As priorities shift and new concerns arise during this two-year period, the dates of the activities below may change to accommodate the larger quality improvement process. This depiction is intended to be used as a way to easily track progress, as it serves to remind the QMC of upcoming commitments.



Time Line Legend:

- QMC Meeting & QI Project Updates
- Data Report Due
- Training
- Winter Site Visits
- Planning Council Presentations
- Updated 2-year QMP Finalized
- Organizational Assessment

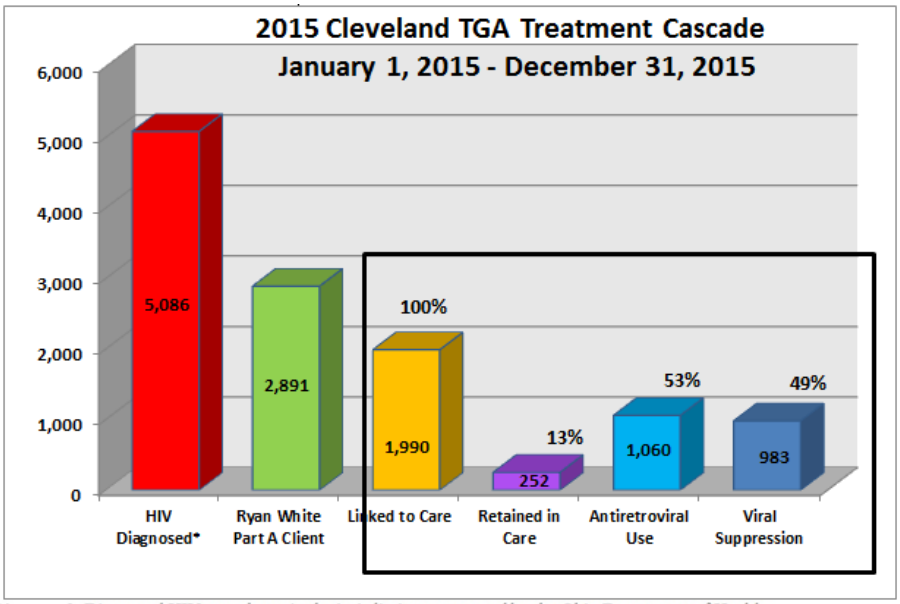
Appendix E

CQM Acronyms and Definitions

Acronym	Full Phrase
AETC	AIDS Education and Training Center
ASO	AIDS Service Organization
CBO	Community Based Organization
CCBH	Cuyahoga County Board of Health
CQM	Clinical Quality Management
CQMC	Clinical Quality Management Committee
EMR	Electronic Medical Record
HAB	HIV AIDS Bureau
HRSA	Health Resources and Services Administration
NHAS	National HIV AIDS Strategy
NQC	National Quality Center
OAHS	Outpatient Ambulatory Health Services
PDSA	Plan-Do-Study-Act Cycle
QI	Quality Improvement
QM	Quality Management
QA	Quality Assurance
QIP	Quality Improvement Project
RSR	Ryan White HIV AIDS Services Report
RWHAP	Ryan White HIV/AIDS Program
TGA	Transitional Grant Area

Term	Full Definition
Antiretroviral Therapy (ART)	An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable level
CAREWare	A scalable software package provided by HRSA to its grantees and their funded providers that enables users to monitor services and report on HIV clinical and supportive care.
Core Medical Services	A set of essential, direct health care services provided to people with HIV/AIDS and specified in the Ryan White HIV/AIDS Treatment Extension Act. In the Cleveland TGA, funded core medical services include: Early Intervention Services; Health Insurance Premium and Cost Sharing Assistance; Home and Community Health Services; Home Health Care; Local AIDS Pharmaceutical Assistance; Medical Case Management; Medical Nutrition Therapy; Mental Health Services; Oral Health Services; Outpatient Ambulatory Medical Care; and Outpatient Substance Abuse Services.
HIV Care Continuum	The HIV Care Continuum is the extent to which individuals living with HIV are engaged in care and fully benefiting from antiretroviral therapy in terms of full viral suppression.
Recipient	Direct recipient of federal funds to administer the Ryan White Part A program.
Support Services	A set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. In the Cleveland TGA, funded support services include: Case Management (non-medical); Emergency Financial Assistance; Food Bank / Home Delivered Meals; Legal Services; Medical Transportation Services; Outreach Services; Psychosocial Support Services; and Residential Substance Abuse Services.
Sub-Recipient	Contracted service providers that receive funds directly from the Part A Recipient.
Viral Load	The amount of virus present in an individual's blood. Tracking viral load is used to monitor therapy during chronic viral infections.
Viral Load Suppression	When the amount of HIV virus present in an individual's blood is below the level of detectability of the assay used (i.e. "undetectable"). Individuals whose viral load is detectable and less than or equal to 200 copies/mL are also considered to be "suppressed."

Appendix F



- **HIV-Diagnosed**: Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health.
  * Please note: the most recently available prevalence data from the Ohio Department of Health is as of December 31, 2014.
- **Ryan White Part A Clients**: Number of diagnosed individuals who received a Ryan White Part A funded service in the measurement year.
- **Linked to Care**: Number of HIV positive individuals that had at least one Ryan White Part A funded medical visit, viral load test, or CD4 test in the measurement year.
- **Retained in Care**: Number of HIV positive individuals who had two or more Ryan White Part A funded medical visits, viral load tests, or CD4 tests performed at least three months apart during the measurement year.
- **Antiretroviral Use**: Number of HIV positive individuals receiving Ryan White Part A funded medical care who have a documented antiretroviral therapy prescription on record in the measurement year.
- **Viral Suppression**: Number of HIV positive individuals receiving Ryan White Part A funded medical care whose most recent HIV viral load within the measurement year was less than 200 copies/mL.

Cleveland TGA Treatment Cascade by Demographics
January 1, 2016 - December 31, 2016

2015 Treatment Cascade Totals	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
	2,842	1,917	67%	296	15%	1,704	89%	1,576	82%

Race	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Black Non-Hispanic	1,677	1,111	66%	145	13%	981	88%	876	79%
Hispanic	286	193	67%	35	18%	172	89%	166	86%
White Non-Hispanic	837	593	71%	111	19%	533	90%	516	87%
More Than One Race/Other	42	20	48%	5	25%	18	90%	18	90%

Age	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
2-12	4	2	50%	0	0%	2	100%	2	100%
13-24	172	105	61%	5	5%	82	78%	63	60%
25-44	1,009	687	68%	85	12%	564	82%	523	76%
45-64	1,508	1,030	68%	187	18%	970	94%	906	88%
65+	149	93	62%	19	20%	86	92%	82	88%

Gender	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
Male	2,144	1,450	68%	209	14%	1,262	87%	1,200	83%
Female	665	446	67%	84	19%	409	92%	356	80%
Transgender	33	21	64%	3	14%	19	90%	20	95%

HIV Risk Factor	Part A	Linked to Care		Retained in Care		Prescribed ART		Virally Suppressed	
MSM	1,571	1,081	69%	145	13%	930	86%	897	83%
IDU	137	102	74%	21	21%	89	87%	84	82%
MSM and IDU	27	17	63%	2	12%	16	94%	16	94%
Heterosexual	1,171	766	65%	131	17%	696	91%	624	81%

Cleveland TGA Cascade Definitions

- **HIV-Diagnosed**: Diagnosed HIV prevalence in the jurisdiction as reported by the Ohio Department of Health.
  * Please note: the most recently available prevalence data from the Ohio Department of Health is as of December 31, 2014.
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