



**AUSTIN HIV SERVICES
QUALITY MANAGEMENT PLAN
2017**



**Austin Public Health Department
Austin, Texas**



Ryan White Quality Management Program Background

Title XXVI of the Public Health Service Act, Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C and D, requires the establishment of a clinical quality management (CQM) program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service/HHS guidelines for the treatment of HIV disease and related opportunistic infections; and
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV core medical and support services.

CQM is a major component in the National HIV/AIDS Strategy, updated July 2015, for both optimizing health outcomes and ultimately reducing HIV incidence.

RWHAP CQM program activities are coordinated in the greater Austin area across Parts A, B and C. The area does not receive Part D funding. The RWHAP Part B Administrative Agency, Brazos Valley Council of Governments (BVCOG), is represented by membership on the CQM Committee and on the Austin Area Comprehensive HIV Planning Council (Planning Council). Part A and Part B have co-sponsored trainings, and regularly collaborate on varied quality-related issues. As the area recipient for Ryan White Part A and Part C, the Austin Public Health Department ensures coordinated quality management activities through administration of both grants by the HIV Resources Administration Unit.

Quality Management Program Mission

The mission of the Austin HIV services quality management program is to improve quality of care and access to core medical and health-related support services for individuals living with HIV/AIDS. This will be accomplished through the implementation of a quality management plan that uses performance measures and epidemiological data as a foundation to systematically improve delivery of medical and support services, and access and adherence to medical care.

Infrastructure

The Austin TGA CQM program is led by the Quality Management (QM) Coordinator who serves under the direction of the Program Manager of the City of Austin HIV Resources Administration Unit (HRAU). Key responsibilities of the QM Coordinator include:

- Developing, updating and implementing the TGA's Quality Management Plan and revising performance measures as indicated by external or internal factors;
- Reviewing each subrecipient's annual Quality Management Plan, based on the overall Austin HIV Services QM Plan, with monitoring and technical assistance as needed;
- Conducting an annual assessment of the CQM program and submitting a report describing improved service outcomes or opportunities for improvement;
- Coordinating and facilitating CQM Committee meetings to improve client care, client satisfaction, and health outcomes;
- Identifying needs and convening time-limited work groups to address specific issues; and
- Providing training opportunities related to quality improvement

HRAU's Data Manager collaborates regularly with the QM Coordinator to ensure data integrity, analyze data, and develop reports, e.g., client demographics, service utilization, and clinical data trends. Grants Coordinators/contract managers work with the QM Coordinator to assure that pre-approved performance measures and targets are recorded in subrecipient contracts, and that subrecipients attain their annual performance objectives.

The CQM Committee has been meeting continuously six times a year for over a decade. It is comprised of the QM Coordinator, the HRAU Data Manager, the Department epidemiologist for HIV/STIs, a Return to Care program representative, a Prevention Services director, and appointed subrecipient representatives who are managers or supervisors of core medical services such as mental health, substance use, oral health care, medical case management, and medical nutrition therapy. Other members represent essential support services such as non-medical case management, medically-assisted housing, and outreach services. Consumers are involved in the CQM program through their input on client satisfaction surveys and participation in focus groups. The Committee currently is seeking a consumer member. Meetings take place at the one Ryan White-funded outpatient health services clinic. Subcommittees/work groups are formed as needed to address specific issues. Recently, subcommittees have convened to work on centralizing client eligibility services and on updating service category outcome measures and targets. Additionally, the CQM Committee provides input into the development of quality improvement mechanisms such as client satisfaction surveys, client complaint and grievance processes, case management acuity scales, and standards of care. Committee members facilitate implementation of multi-agency subrecipient activities, as appropriate, in order to achieve goals and objectives of the CQM Plan.

The Austin TGA uses the AIDS Regional Information and Evaluation System (ARIES) for HIV client level data collection and reporting. ARIES is a web-based, Ryan White Services Report (RSR)-ready data system that is managed by the Texas Department of State Health Services (DSHS). The HRAU Data Manager performs periodic ARIES desktop monitoring to ensure that subrecipients are collecting all required data elements for the RSR and other reports for stakeholders such as the Planning Council and the CQM Committee. Subrecipients receive regular reports regarding missing and/or unknown data for the RSR on a monthly basis between August and January of each year. Comprehensive annual service utilization and other data reports, sorted by demographic groups and special populations, are reviewed by Planning Council as part of their annual priority-setting and resource allocation process.

The Austin HIV Services Performance Catalog has performance measures for each funded service category (see Performance Measures: Service Categories, p. 4-14). These measures were developed with recommendations from a CQM subcommittee that was tasked with updating service category outcome measures. The work of this subcommittee also resulted in adjustment of outcome targets for some service categories.

Priorities

Implementation of the Austin area Quality Management Program Mission takes place through planning, designing, measuring, assessing and improving performance using the following component priorities:

- a. Planning processes that utilize baseline and target data developed from internal and external sources, including the ARIES client-level database and data produced by DSHS' HIV data and epidemiology units.
- b. Evolving and continuous refinement of measurement systems for identifying trends in care and sentinel events, by collecting and recording data related to the provision of client care at each stage of the HIV Care Continuum
- c. Assessment procedures which determine efficacy and appropriateness, and facilitate evaluation of the quality of services as well as opportunities for improvement
- d. Emphasis on design needs associated with new and existing services, client service delivery, work flow and systems to facilitate optimal outcomes, as well as satisfaction on the part of clients and service delivery staff
- e. Focus on improving quality in all its dimensions by implementing multidisciplinary, data driven project teams and encouraging participatory problem solving in clinical, operational, and programmatic aspects of client care.

Performance Measures: Service Categories

AIDS Pharmaceutical Assistance

Outcome Measures:

1. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year

Outcome target: 90%

Numerator: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

2. Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Outcome target: 80%

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Outcome Measures:

1. Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

Outcome target: 85%

Numerator: 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

Denominator: 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

Client Exclusions: Clients who died at any time during the 24-month measurement period

Medical Case Management, including Treatment Adherence Services

Outcome Measures:

1. Percentage of medical case management clients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year

Outcome target: 80%

Numerator: Number of medical case management clients who had a medical case management care plan developed and/or updated two or more times which are at least three months apart in the measurement year

Denominator: Number of medical case management clients, regardless of age, with a diagnosis of HIV who had at least one medical case management encounter in the measurement year

Client Exclusions:

1. Medical case management clients who initiated medical case management services in the last six months of the measurement year
2. Medical case management clients who were discharged from medical case management services prior to six months of service in the measurement year

2. Percentage of medical case management clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 85%

Numerator: Number of medical case management clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of medical case management clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Medical Nutrition Therapy

Outcome Measures:

1. Percentage of medical nutrition therapy clients who had a nutrition care plan developed and/or updated two or more times in the measurement year

Outcome target: 85%

Numerator: Number of medical nutrition therapy clients who had a nutrition care plan developed and/or updated two or more times which are at least three months apart in the measurement year

Denominator: Number of medical nutrition therapy clients, regardless of age, with a diagnosis of HIV who had at least one medical nutrition therapy encounter in the measurement year

Client Exclusions:

1. Medical nutrition therapy clients who initiated medical nutrition therapy services in the last six months of the measurement year
2. Medical nutrition therapy clients who were discharged from medical nutrition therapy services prior to six months of service in the measurement year

2. Percentage of medical nutrition therapy clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 85%

Numerator: Number of medical nutrition clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of medical nutrition therapy clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Mental Health Services

Outcome Measures:

1. Percentage of mental health services clients making progress towards or attaining their prescribed client treatment plan goals during the measurement year

Outcome target: 70%

2. Percentage of mental health services clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 80%

Numerator: Number of mental health services clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of mental health services clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Oral Health Care

Outcome Measures:

1. Percentage of HIV-infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year

Outcome target: 95%

Numerator: Number of HIV infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year

Denominator: Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year

Patient Exclusions:

1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year
2. Patients who were <12 months old

2. Percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year

Outcome target: 90%

Numerator: Number of HIV infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year

Denominator: Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year

Patient Exclusions:

1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year
2. Patients who were <12 months old

3. Percentage of HIV-infected oral health patients who received oral health education at least once in the measurement year

Outcome target: 95%

Numerator: Number of HIV infected oral health patients who received oral health education at least once in the measurement year

Denominator: Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year

Patient Exclusions:

1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year
2. Patients who were <12 months old

4. Percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year

Outcome target: 80%

Numerator: Number of HIV infected oral health patients who had a periodontal screen or examination at least once in the measurement year

Denominator: Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year

Patient Exclusions:

1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year
2. Edentulous patients (complete)
3. Patients who were <13 years

5. Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months of establishing a treatment plan

Outcome target: 80%

Numerator: Number of HIV infected oral health patients that completed Phase 1 treatment within 12 months of establishing a treatment plan

Denominator: Number of HIV infected oral health patients with a Phase 1 treatment plan established in the year prior to the measurement year

Patient Exclusions: Patients who had only an evaluation or treatment for a dental emergency in the year prior to the measurement year

Outpatient Ambulatory Health Services

Outcome Measures:

1. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year

Outcome target: 90%

Numerator: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

2. Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis

Outcome target: 90%

Note: Use the numerator and denominator that reflect patient population.

Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm

Numerator 2: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm or a CD4 percentage below 15%

Numerator 3: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis at the time of HIV diagnosis

Aggregate numerator: The sum of the three numerators

Denominator 1. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm, who had at least two visits during the measurement year, with at least 90 days in between each visit

Denominator 2. All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm or a CD4 percentage below 15%, who had at least two visits during the measurement year, with at least 90 days in between each visit

Denominator 3. All patients aged 6 weeks through 12 months with a diagnosis of HIV, who had at least two visits during the measurement year, with at least 90 days in between each visit

Total denominator: The sum of the three denominators

Patient Exclusions:

Denominator 1 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 200 cells/mm during the three months after a CD4 count below 200 cells/mm

Denominator 2 Exclusion: Patient did not receive PCP prophylaxis because there was a CD4 count above 500 cells/mm or CD4 percentage above 15% during the three months after a CD4 count below 500 cells/mm or CD4 percentage below 15%

3. Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

Outcome target: 80%

Numerator: Number of patients 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

Denominator: Number of patients, 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

Patient Exclusions: Patients who died at any time during the 24-month measurement period

4. Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Outcome target: 80%

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

5. Percentage of patients receiving outpatient ambulatory health services who report overall satisfaction with the quality of medical care services received

Outcome target: 80%

Substance Abuse Outpatient Care

Outcome Measures:

1. Percentage of substance abuse outpatient care clients making progress towards or attaining their prescribed client treatment plan goals during the measurement year

Outcome target: 70%

2. Percentage of substance abuse outpatient care clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 80%

Numerator: Number of substance abuse outpatient care clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of substance abuse outpatient care clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Emergency Financial Assistance

Outcome Measures:

1. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
Outcome target: 90%

Numerator: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

2. Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year
Outcome target: 80%

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Patient Exclusions: None

Food Bank/Home Delivered Meals

Outcome Measures:

1. Percentage of food bank/home delivered meals clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits
Outcome target: 85%

Numerator: Number of food bank/home delivered meals clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of food bank/home delivered meals clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Housing

Outcome Measures:

1. Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits
Outcome target: 70%

Numerator: Number of clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

2. Percentage of clients who increase symptom management during the measurement period
Outcome target: 80%

3. Percentage of clients who report overall satisfaction with the quality of services received
Outcome target: 90%

Medical Transportation

Outcome Measures:

1. Percentage of medical transportation clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
Outcome target: 90%

Numerator: Number of medical transportation 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

Denominator: Number of medical transportation 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

Client Exclusions: Clients who died at any time during the 24-month measurement period

Non-Medical Case Management Services

Outcome Measures:

1. Percentage of non-medical case management clients, regardless of age, with a diagnosis of HIV who had a non-medical case management service plan developed and/or updated two or more times in the measurement year
Outcome target: 80%

Numerator: Number of non-medical case management clients who had a non-medical case management service plan developed and/or updated two or more times which are at least three months apart in the measurement year

Denominator: Number of non-medical case management clients, regardless of age, with a diagnosis of HIV who had at least one non-medical case management encounter in the measurement year

Client Exclusions:

1. Non-medical case management clients who initiated non-medical case management services in the last six months of the measurement year
2. Non-medical case management clients who were discharged from non-medical case management services prior to six months of service in the measurement year

2. Percentage of non-medical case management clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 85%

Numerator: Number of non-medical case management clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of non-medical case management clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Outreach Services

Outcome Measures:

1. Percentage of outreach services clients with unknown HIV disease who attend a routine HIV medical care visit within 3 months of HIV diagnosis

Outcome target: 85%

2. Percentage of out-of-care outreach services clients who attend a routine HIV medical care visit within 3 months of initial encounter

Outcome target: 85%

Psychosocial Support Services

Outcome Measures:

1. Percentage of psychosocial support services clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits

Outcome target: 80%

Numerator: Number of psychosocial support services clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of psychosocial support services clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Substance Abuse Services (residential)

Outcome Measures:

1. Percentage of substance abuse services clients who successfully complete a residential substance abuse treatment program
Outcome target: 70%
2. Percentage of substance abuse residential services clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 12-month measurement period with a minimum of 60 days between medical visits
Outcome target: 85%

Numerator: Number of substance abuse residential services clients in the denominator who had at least one medical visit in each 6-month period of the 12-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

Denominator: Number of substance abuse residential services clients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 12-month measurement period

Client Exclusions: Clients who died at any time during the 12-month measurement period

Performance Measures: Clinical

Data for 14 of the clinical performance measures below are electronically imported into the ARIES database from the Ryan White Outpatient/Ambulatory Health Services clinic's Electronic Health Record (EHR) NextGen. Data for four (4) performance measures are manually entered in ARIES.

1. Percentage of clients with HIV infection who did had two or more CD4 T-cell counts performed in the measurement year
2. Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year
3. Percentage of clients with HIV infection and a CD4 count below 200 cells/mm³ who were prescribed PCP prophylaxis
4. Percentage of clients with AIDS who are prescribed ART

5. Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy
6. Number of HIV infected clients who, as part of their primary care, were assessed and counseled for adherence two or more times, at least three months apart
7. Number of HIV infected clients who had a pap screening in the measurement year
8. Percentage of HIV infected clients with documentation of having ever completed the vaccination series for Hepatitis B
9. Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection
10. Percentage of HIV infected clients who, as part of their primary care, received HIV risk counseling within the measurement year
11. Percentage of clients who had an oral exam by a dentist based on patient self-report or other documentation.
12. Number of HIV infected clients who had a serologic test for syphilis performed at least once
13. Percentage of clients who received documented testing for TB since HIV diagnosis
14. Percentage of clients with HIV infection who have been screened for Hepatitis B virus infection status
15. Percentage of clients with HIV infection who have received influenza vaccination within the measurement period
16. Percentage of new clients with HIV infection who have had a mental health screening
17. Percentage of clients with HIV infection who ever received pneumococcal vaccine
18. Percentage of new clients with new infection who have been screened for substance use (alcohol and drugs) in the measurement year

Quality Improvement Activities

AIM methodology provides a structure for quality improvement. An AIM statement is an explicit description of desired outcomes, which are expressed in a measurable and time-specific way.

AIM statements take into account the following questions:

- What are we trying to accomplish?
- Why is it important?
- Who is the specific target population?
- When will this be completed?
- How will this be carried out?
- What is/are our measurable goal(s) and objective(s)?

SMART (specific, measurable, achievable, realistic, and time-phased) objectives are used in developing AIM statements. The Plan, Do, Study, Act (PDSA) model for improvement also is used, when appropriate, as a structure for continuous quality improvement evolving from design to implementation to evaluation and monitoring, sometimes with multiple PDSA cycle repetitions.

Standards of Care Unified across all Ryan White Parts

Austin is participating in the statewide revised HIV Standards of Care initiative. Along with other revisions, service standards are being updated so that service category names, service category definitions and activities are in compliance with HRSA HAB Policy 16-02, effective FY 2017. At the beginning of each month, DSHS releases a revised draft standards of care for one or more service categories. During the one-month review and comment period, Part A Quality Management staff, service providers, Planning Council and other stakeholders submit questions, concerns, comments, suggestions for change, etc. The project's goal is approval and adoption of common, unified Ryan White service category Standards of Care for use throughout the state. The QM Coordinator is facilitating and aggregating input at the local level, and serving as the liaison with DSHS.

Return-to-Care Program

The Return-to-Care Program is operated by the Ryan White outpatient medical care provider in collaboration with case management providers. It focuses on medical patients who are at-risk for out-of-care status, defined for purposes of this project as patients who have not had a medical appointment in nine (9) months. Patients who have not had a medical appointment in over 12 months are referred to Austin Public Health Department disease intervention specialists (DIS) for follow up. Per these criteria, at-risk data are being pulled on a monthly basis. Lists of client numbers are sent to Austin area Ryan White case management providers for assistance with location of clients. Information is collected on reasons for out-of-care status, including issues such as work, homelessness, relocation out of area, transferred care, or incarcerated. Information on barriers to care also is collected and includes issues such as transportation and health literacy. These data are used to inform service delivery improvement.

Training

Intermediate-Advanced Case Management Care Plan training in December 2016 was an all-day session with topics including rapport and client involvement, comprehensive assessments, service plan development, documentation best practices with examples, motivational interviewing techniques during service, effective use of SMART objectives, effective use of reassessments, and making best use of the Trans-Theoretical Model.

Confidentiality/Privacy Training was held in April 2017. Topics included definition of protected health information (PHI), patients' rights, elements of an authorization for release of PHI, special issues related to emails, faxes and phone calls, potential breaches of unsecured PHI in both electronic and paper formats, subpoenas, HIPAA and other sources for federal and state confidentiality/privacy laws.

A training on awareness of transgender health issues, with focus on best practices for serving transgender clients, is planned for July. Tentatively, topics will include stigma and

discrimination against the transgender community, HIV's effect on transgender people, and important factors to keep in mind when interacting with transgender clients.

Program evaluation training has been requested by a CQM Committee member.

E-therapy

Mental Health Services is adding the new service delivery option of E-therapy for appropriate clients who live in outlying counties or have other limitations that create barriers to accessing in-person mental health counseling. Electronic media and information technologies, used by skilled and trained licensed professionals, will allow a range of services such as screening, assessment, primary treatment and aftercare. E-therapy can be provided as a sole treatment modality or in combination with other treatment modalities.

Electronic Client Management System

The Part A funded Housing program provides medically assisted housing for low income persons living with HIV who require recuperative care. This residential facility is transitioning to an electronic client management system in order to improve quality of care, especially by facilitating communication and collaboration between the many different types of providers who work together to serve these high-needs clients.

Medical Care Performance Outcomes

The number of medical care performance measures being imported into ARIES from the NextGen EHR has increased from three (3) to fourteen (see p. 14-15).

Oral Health Care

A definition for Phase 1 Treatment Plan was established to clarify what diagnostic, preventive, and therapeutic services are provided. Concurrently, the dental clinic implemented a system to collect, enter, and report on HAB Measure five, percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months. The completion percentage has improved from 19 percent in 2016, to 50 percent as of April 2017, with a goal of reaching the target of 80 percent completion by the end of the fiscal year.

Substance Abuse Services

The substance use disorder services program, which provides both outpatient services and residential services via contract, has created a new and improved comprehensive substance use assessment tool, and has successfully integrated the new tool into the electronic EHR.

Action Plan with Timeline and Responsible Parties

GOAL 1: Increase Quality Assurance and Continuous Quality Improvement efforts

- a. Complete and submit to HRAU the agency's 2017 Quality Management and Improvement Plan.
- b. Participate actively in CQM Committee bimonthly meetings and related activities.
- c. Participate on CQM issue-focused subcommittees.
- d. Review and analyze service delivery-related outcomes data at least biannually at CQM Committee meetings; incorporate service changes in response to data, as appropriate.

- e. Present performance update reports to Planning Council at least two meetings each year.
- f. Prepare Agenda and convene monthly Administrative Agency QM Staff Meetings.
- g. Conduct subrecipient site visits at least annually to discuss CQM issues
- h. Provide at least two CQM training opportunities for service providers and members of the CQM Committee.
- i. Distribute DSHS revised draft service category Standards of Care to relevant service providers within two business days after they are issued by DSHS.
- j. Facilitate Planning Council approval of revised Standards of Care for all funded core medical and support service categories that have been finalized by DSHS.

GOAL 2: Improve the quality of ARIES Data for management, planning, and reporting

- a. Monitor and document efforts for timely input of all client-level data, with exceptions noted.
- b. Develop and implement approved action plan for data quality issues previously identified.
- c. Request and receive ARIES technical assistance and training for all new employees performing ARIES data entry, and for continuing employees as needed.

GOAL 3: Reduce health disparities for HIV clients system-wide

- a. Provide and document at least one annual staff training on cultural competency.
- b. Assess remaining potential barriers related to language, socio-economic and/or cultural issues, and develop plans for improvement.

GOAL 4: Increase the number of HIV positive individuals who are in care

- a. Participate in Return-to-Care efforts by investigating and reporting per program procedures.
- b. Implement and measure at least two new return-to-care interventions during FY 2017.
- c. At minimum, review in-care status of all clients during six-month recertification, and provide follow-up action as needed to ensure that clients remain in care.

GOAL 5: Improve health outcomes for all clients

- a. Report biannually to HRAU on outcomes achieved for each funded service category, at the six-month interval so that corrective action can be considered as needed, and at year-end closeout.
- b. Monitor service category outcomes data collection and reporting.
- c. Implement Plan, Do, Study, Act (PDSA) model to address issues related to outcomes that are below targets shown in the Austin HIV Services Performance Catalog.
- d. Based on FY 2016 actual performance, select at least one key outcome for specific focus this year, and develop action plans for improving performance in FY 2017.

Goal 1: Increase Quality Assurance and Continuous Quality Improvement Efforts			
Objective	Time Frame/ Completion Date	Person(s) Responsible	Progress/Comments
a. Complete and submit to HRAU the agency's 2017 QM/QI Plan.	May 30, 2017	Agency staff	
b. Participate actively in CQM Committee bimonthly meetings and related activities.	Every two months commencing Feb. in 2017	CQM Committee members	
c. Participate on CQM issue-focused subcommittees.	Ad hoc as needed	CQM Committee members	
d. Review and analyze service delivery-related outcomes data at least biannually at CQM Committee meetings; incorporate service changes in response to data, as appropriate	December 2017 and June 2018 CQM Committee Meetings	QM Coordinator and CQM Committee members	
e. Present performance update reports to Planning Council at least two meetings each year	November 2017 and May 2018	QM Coordinator	
f. Prepare Agenda and convene monthly Administrative Agency QM Staff Meetings	Second Tuesday of each month	QM Coordinator, Data Manager, and Program Manager	
g. Conduct subrecipient site visits at least annually to discuss CQM issues	April 2017	QM Coordinator Agency staff	
h. Provide at least two CQM training opportunities for service providers and members of the CQM Committee.	Feb. 28, 2018 HIPAA training April 2017; other to be determined	QM Coordinator	
i. Distribute DSHS revised draft service category Standards of Care to relevant service providers after they are issued by DSHS.	Within 2 business days after receipt from DSHS	QM Coordinator	

j. Facilitate Planning Council approval of revised Standards of Care for all funded service categories finalized by DSHS	December 31, 2017	QM Coordinator	
Goal 2: Improve the Quality of ARIES Data for Management, Planning, and Reporting			
Objective	Time Frame/ Completion Date	Person(s) Responsible	Progress/Comments
a. Monitor and document efforts for timely input of all client-level data, with exceptions noted.	Within 5 business days of service delivery	Agency ARIES data staff	
b. Develop and implement approved action plan for data quality issues previously identified.	To be determined	Agency ARIES data staff and ARIES Data Manager	
c. Request and receive ARIES technical assistance and training for all new employees performing ARIES data entry, and for continuing employees as needed.	Ongoing	Agency ARIES data staff and ARIES Data Manager	
Goal 3: Reduce Health Disparities for HIV Clients System-Wide			
Objective	Time Frame/ Completion Date	Person(s) Responsible	Progress/Comments
a. Provide and document at least one annual staff training on cultural competency.	February 28, 2018	Agency staff	
b. Assess remaining potential barriers related to language, socio-economic and/or cultural issues, and develop plans for improvement.	Ongoing assessment; plans submitted by May 30, 2017	Agency staff	
Goal 4: Increase the Number of HIV Positive Individuals who are in Care			
Objective	Time Frame/ Completion Date	Person(s) Responsible	Progress/Comments
a. Participate in Return-to-Care efforts by investigating and reporting per program procedures.	Monthly	Agency staff	

b. Implement and measure at least two new return-to-care interventions during FY 2017.	February 28, 2018	Agency staff	
c. At minimum, review in-care status of all clients during six-month recertification, and provide follow-up action as needed to ensure that clients remain in care.	Ongoing six-month intervals for each client	Agency staff	
Goal 5: Improve Health Outcomes for All Clients			
Objective	Time Frame/Completion Date	Person(s) Responsible	Progress/Comments
a. Report biannually to HRAU on outcomes achieved for each funded service category, at the six-month interval so that corrective action can be considered as needed, and at year-end closeout.	October 14, 2017 and April 14, 2018	Agency staff	
b. Monitor service category outcomes data collection and reporting.	Late October, 2017	HRAU; independent, external monitor	
c. Implement Plan, Do, Study, Act (PDSA) model to address issues related to outcomes that are below targets shown in the Austin HIV Services Performance Catalog.	30 days following submission of outcomes reports	Agency staff	
d. Based on FY 2016 actual performance, select at least one key outcome for specific focus this year, and develop action plans for improving performance in FY 2017.	May 30, 2017	Agency staff	

Evaluation

The CQM program is assessed by HRAU staff who identify priorities for quality improvement in collaboration with other stakeholders. Performance measures outcomes data are reviewed by the CQM Committee, Planning Council including consumers, subrecipients, staff in the HRAU, and other units in the Austin Public Health Department. In 2013, the CQM program was evaluated by an outside consultant, a quality coach from the National Quality Center. Organizational infrastructure factors reviewed included sustained leadership, staff training and support, team meetings, and use of data systems for tracking outcomes. The CQM program is successfully collaborating with other Ryan White recipients in the area to create uniform, consistent service category standards of care that can be used for evaluating service quality across all Ryan White Parts.

HRAU CQM staff work together to ensure a foundation for program evaluation. Production of data reports is facilitated by the Data Manager in consultation with the QM Coordinator. Staff develop methods for collecting and processing performance data, conduct service category outputs monitoring, and contribute recommendations for subrecipients' quality improvement plans. HRAU staff also review subrecipient contracts to ensure that CQM requirements are addressed, including issues such as grievance policies and procedures, standards of care, CQM plans, cultural competency, client satisfaction, and adherence to all data entry requirements.

Ryan White subrecipients are required to have an annual CQM Plan, and to use data to evaluate their program's performance in meeting CQM goals and objectives. Analysis includes outputs and outcomes data, client satisfaction surveys, client chart reviews, and other health-related data sources. The Outpatient/Ambulatory Health Services provider is required to perform regular chart audits and quality control reviews as set forth in the FQHC Quality Management/Risk Management Plan. This Plan addresses quality management and quality improvement across all services provided including medical care, behavioral health, pharmacy, as well as safety and risk management.

The QM Coordinator analyzes clinical and service utilization data, ensures target outcomes are achieved, provides technical assistance for service providers in developing quality improvement plans, and tracks progress in implementing improvement strategies. The QM Coordinator also arranges for periodic client chart audits to ensure adherence to HRSA/HAB National Program Monitoring Standards and Austin HIV Services Standards of Care. In FY 2016, the City of Austin contracted with an independent external monitor to complete on-site monitoring reviews of all Ryan White Program subrecipients, in order to ensure compliance with HRSA objectives and requirements. Some aspects of quality management were addressed, e.g., a licensed RN/HRSA consultant reviewed outpatient medical care charts for consistency with Department of Health and Human Services Guidelines. An increase in the monitoring scope for performance measurement/quality management is planned for FY 2017 independent site visit monitoring.