AUSTIN HIV SERVICES

Clinical Quality Management 2019 Plan

Austin Public Health
PREVENT. PROMOTE. PROTECT.

CQM Plan updated April 2019

Table of Contents

Ryan White Program Clinical Quality Management (CQM) 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 key RWHAP component for optimizing health outcomes for all persons living with HIV (PLWH), and ultimately for decreasing HIV incidence.

RWHAP CQM 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 various 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 (HRAU).

CQM Program Mission

The mission of the Austin HIV services CQM program is to improve HIV health outcomes by improving the quality of care and access to core medical and health-related support services for all persons living with HIV. This will be accomplished through implementation of a quality management plan that uses data and performance measurement as the foundation for quality improvement interventions.

CQM 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;
- Collecting and analyzing performance data
- Conducting an annual assessment of the CQM program, focusing on service outcomes and 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 and develop reports, e.g., client demographics, service utilization, and performance outcomes data. Grant Coordinators/contract managers work with the QM Coordinator to assure that pre-approved performance measures and targets are documented in subrecipient contracts, and that subrecipients achieve their annual performance objectives. The QM Coordinator, with assistance from the Data Manager, is responsible for collecting and distributing performance measure data quarterly.

The Recipient's CQM Leadership Team consists of the Program Manager, Quality Management Coordinator, and Data Manager. The Leadership Team meets bimonthly, with the overarching purpose of assessing and evaluating the CQM Program. Additional activities are described in the Evaluation section on pages 35-36.

The CQM Committee has been meeting continuously six times a year for over a decade. Its purpose, written at the top of each meeting agenda, is "to improve the quality of care and health outcomes for PLWH by implementing CQI strategies using logical, systematic and effective processes, in order to solve problems in service delivery and clinical care." The Committee is comprised of the QM Coordinator, the HRAU Data Manager, the Department epidemiologist for HIV/STIs, a Return-to-Care Program representative, a local Prevention Services Director, the Austin Area Part B Planner, 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, assisted living residential housing, and early intervention services. Consumers are involved in the CQM program through their input on client satisfaction surveys, as well as participation in focus groups and needs assessments. The Committee 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. 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, service standards, and the CQM Plan. Committee members facilitate implementation of collaborative subrecipient activities, 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 produces other reports for stakeholders such as the Planning Council and the CQM Committee. Subrecipients receive reports regarding missing and/or unknown data for the RSR on a regular basis between August and January of each year. Comprehensive service utilization and other data, stratified by demographic groups and special populations, are reviewed by Planning Council as part of its Integrated Plan assessment and annual priority-setting and resource allocation process.

Priorities

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

a. Planning interventions that utilize baseline and/or target data developed from internal and external sources, including the ARIES client-level database and data produced by the DSHS HIV data and epidemiology teams;

b. Refining measurement systems for identifying trends related to outcomes along stages of the HIV Care Continuum;

c. Assessing efficacy of cultural appropriateness, to identify opportunities for improvement;

d. Focusing on service delivery issues such as work flow, efficiencies and systems, in order to facilitate optimal health outcomes as well as client satisfaction; and

e. Implementing multidisciplinary, data driven project teams and encouraging participatory problem solving in clinical, operational, and programmatic aspects of client care.

Performance Measures

The *Austin HIV Services Performance Catalog* has performance measures for each funded service category (see pages 4-25). Outcome measures originally were selected in January 2017, with recommendations from an Outcomes Measurement Subcommittee of the CQM Committee that was tasked with updating service category outcome measures. The work of this subcommittee also resulted in establishing outcome targets for all performance measures.

In February 2019, the CQM Committee reviewed existing outcome measures and targets, and recommended changes for FY 2019. Several of the outcome measures and targets listed below were revised in order to update and align with current HAB Performance Measures.

As noted above, the Recipient's CQM Leadership Team is responsible for analyzing performance measure data quarterly. Performance measures data are analyzed by: identifying variances of greater than 5% from established outcome targets in the *Austin HIV Services Performance Catalog*; tracking longitudinal trends in achieving outcomes by service category and subrecipient; and using a new program in ARIES to stratify HAB core measures outcomes by race/ethnicity and age.

CORE MEDICAL SERVICES

AIDS Pharmaceutical Assistance

Service Description:

AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

1. A Local Pharmaceutical Assistance Program (LPAP) is operated by a HRSA RWHAP Part A or B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when an HRSA RWHAP ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary that is:
  - Approved by the local advisory committee/board, and
  - Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
  - A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients in the absence of any other resources.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance:
For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service categories for non-routine, short-term medication assistance.

See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services.

Unit of Service:

Per prescription (not pill or dose)

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 95%

   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: 85%

   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

Early Intervention Services

Service Description:

The Ryan White HIV AIDS Program (RWHAP) legislation defines Early Intervention Services (EIS) for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

RWHAP Parts A and B EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

RWHAP Part C EIS services must include the following four components:

- Counseling individuals with respect to HIV
- High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
  - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
  - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
- Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
- Other clinical and diagnostic services related to HIV diagnosis

Unit of Service:

Per encounter with client previously unlinked to care

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

Outcome Measures:

1. **Percentage of clients, regardless of age, who attended a routine HIV medical care visit within one month of diagnosis**
   Outcome target: 85%

   Numerator: Number of clients who attended a routine HIV medical care visit within one month of diagnosis

   Denominator: Number of clients, regardless of age, with a HIV diagnosis in a 12-month measurement year

   Client Exclusions: None

2. **Percentage of out-of-care EIS clients who attended a routine HIV medical care visit within three months of initial encounter**
   Outcome target: 85%

   Numerator: Number of out-of-care EIS clients who attended a routine HIV medical care visit within three months of initial encounter

   Denominator: Number of out-of-care EIS clients with initial encounter in a 12-month measurement year

   Client Exclusions: None

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

Service Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for

medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

See PCN 14-01: *Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act*
See PCN 18-01: *Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance*

Unit of Service:

Per payment

Output Measures:

1. Number of units of health insurance assistance provided
   a. Number of premium payments provided
   b. Number of co-payments provided
   c. Number of deductibles payments provided
   d. Number of risk pools payments provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 85%

   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

Medical Case Management, including Treatment Adherence Services

Service Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes, whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category, whereas Treatment Adherence Services provided during an Outpatient/Ambulatory Health Services visit should be reported under the Outpatient/Ambulatory Health Services category.

Unit of Service:

Per 15 minutes

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 85%

   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

Service Description:

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation

- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

Unit of Service:

Medical nutrition therapy counseling – per 15 minutes
Medical nutrition therapy supplements – per transaction

Output Measures:

1. Number of units of service provided
   a. Number of units of nutrition therapy provided
   b. Number of units of supplements provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

Outcome Measures:

1. **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

Service Description:

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a

mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:
Mental Health Services are allowable only for HIV-infected clients.

Unit of Service:

Per visit

Output Measures:

3. Number of units of service provided
4. Number of unduplicated clients served
    c. Number of continuing clients served
    d. Number of new clients served

Outcome Measures:

1. **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

Service Description:

Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance:
None at this time

Unit of Service:

Per visit

Output Measures:

1. Number of units of Oral Health Care services provided
   a. Number of units of routine treatment provided
   b. Number of units of prophylaxis treatment provided
   c. Number of units of specialty care treatment provided
2. Number of unduplicated patients served
   a. Number of continuing patients served
   b. Number of new patients served

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: 95%

   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: 90%

   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**
   Outcome target: 75%

   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

Service Description:

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.
Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing

- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services. Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: *Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program*

See also Early Intervention Services

Unit of Service:

Per visit – services provided by licensed healthcare provider
Per test – laboratory

Output Measures:

1. Number of units of service provided
   a. Visits
   b. Laboratory tests
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 95%

   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: 85%

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

Substance Abuse Outpatient Care

Service Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan. Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

Unit of Service:

Per visit

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served
3. Number of unduplicated clients receiving individual counseling
4. Number of unduplicated clients receiving group counseling

Outcome Measures:

1. **Percentage of substance use disorder 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 use disorder 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 use disorder 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

SUPPORT SERVICES

Emergency Financial Assistance

Service Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

Unit of Service:

Per prescription

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 95%

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

Service Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

Unit of Service:

Per visit (food pantry/voucher visit without nutritional supplements or food pantry/voucher visit with nutritional supplements)

Output Measures:

1. Number of units of service provided
   a. Number of food pantry/voucher visits without nutritional supplements provided
   b. Number of Food pantry/voucher visits with nutritional supplements provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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

Service Description:

Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services). Housing activities also include housing referral services, including assessment, search, placement, and housing advocacy services on behalf of the eligible client, as well as fees associated with these activities.

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients, and at least annually for existing clients.

HRSA RWHAP recipients and subrecipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing.

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,[6] although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards.

Housing, as described here, replaces PCN 11-01.

Unit of Service:

Per day

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 75%

   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 have decreased or maintained their viral load over the course of service**
   Outcome target: 80%

[6] See sections 2604(i), 2612(f), 2651(b), and 2671(a) of the Public Health Service Act.

   Numerator: Number of clients with a diagnosis of HIV who have decreased or maintained their viral load during the measurement year

   Denominator: Number of clients with a diagnosis of HIV who had at least two viral load tests during the measurement year

   Client Exclusions: Clients who dropped out of services less than 45 days after intake; end-of-life clients who elected to stop their HIV medications; clients who died at any time during the measurement period

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

   Numerator: Number of clients who report satisfaction during the measurement period, with an overall rating of at least 4 on a 5-point scale

Denominator: Number of clients who complete satisfaction surveys during the measurement period

Client Exclusions: None

Medical Transportation

Service Description:

Medical Transportation is the provision of nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical Transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.
Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Unit of Service:

Per one-way trip

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
   a. Number of continuing clients served
   b. Number of new clients served

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: 85%

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

Service Description:

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Unit of Service:

Per 15 minutes

Output Measures:

1. Number of units of service provided
2. Number of unduplicated clients served
    a. Number of continuing clients served

b. Number of new clients served

Outcome Measures:

1. **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

Substance Abuse Services (residential)

Service Definition:

Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.
Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.
RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

Unit of Service:

Per day

Output Measures:

1. Number of units of service provided
   a. Number of units of residential treatment provided
   b. Number of units of residential detox provided
2. Number of unduplicated clients receiving residential treatment services
   a. Number of continuing clients served
   b. Number of new clients served
1. Number of unduplicated clients receiving residential detox services
   a. Number of continuing clients served
   b. Number of new clients served

Outcome Measures:

1. **Percentage of substance use disorder residential services clients who successfully complete a 30-day residential substance use disorder treatment program**
   Outcome target: 80%

   Numerator: Number of clients, with a diagnosis of HIV, who successfully complete a 30-day residential substance use disorder treatment program during the measurement period

   Denominator: Number of clients, with a diagnosis of HIV, who enrolled in a 30-day residential substance use disorder treatment program during the measurement period

   Client Exclusions: Clients who are enrolled in, but have not yet completed, a 30-day residential substance use disorder treatment program

2. **Percentage of substance use disorder 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 use disorder 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 use disorder 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

Quality Improvement Activities

AIM methodology provides a structure used 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 consider 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.

Rapid Linkage to Care

Team members at the Ryan White outpatient medical care clinic have initiated a new Rapid Linkage to Care Program. The Rapid Linkage model, which adapts innovative rapid linkage strategies taking place throughout the country, has the goal of patients diagnosed and linked to care, including starting antiretroviral therapy (ART), within 72 hours. Delay in the onset of treatment has long been a clinical issue, both for persons newly diagnosed with HIV as well as HIV positive persons who were out-of-care for greater than 12 months. As a part of this design, patients start medications the same day they initially meet with a medical provider. In the weeks prior to the start of the program, baseline data were collected for all initial visit patients and newly diagnosed patients.

Rapid Linkage Program interventions include:

- Same-day social work intake, provider visit, and ART initiation unless contraindicated;
- Streamlined social work intake process;
- Eight additional medical appointments per week for patients
- Enhanced prescription assistance coordination; and
- Improved care coordination activities.

Procedural improvements focus on condensed intake documentation and streamlined initial provider visit. The traditional 50-minute initial provider visit was divided into two visits. The first visit focuses on immediate ART initiation or addressing acute barriers to starting medication. The second visit, scheduled 10-14 days later, focuses on follow-up to ART initiation or assessing readiness to start ART. Access was increased by adding initial visit slots. A rapid linkage phone number was piloted, as a way for community-based HIV services providers to engage immediately with a member of the social work team to consult on coordination of patient care.

There has been a significant decrease in time to care for patients newly diagnosed. Between June and February 28, 2019, the clinic had 140 patients linked to care through the Rapid Linkage Program; 95 (67.8%) of those who initiated care attended their second medical appointment, and 91 (65%) who initiated care also attended their third medical appointment (65%). In total, 115

patients who initiated care through the Rapid Linkage Program attended at least a second medical appointment (82%).

Engagement in care is dependent on a number of factors, such as patient readiness and the ability to take time away from work for an appointment. Because of this, not all persons identified were linked within 72 hours; however, there has been a significant decrease in time to care for patients diagnosed within the local FQHC system. In January 2018, the average time to care was 21 days; in December 2018, the average decreased to 4 days.

Since implementing the Rapid Linkage Program, there also has been a decrease in time to viral suppression. Prior to launching rapid linkage and rapid start, a patient diagnosed in January 2018 took an average of 91 days to achieve viral suppression. As of December 2018, viral suppression was achieved in 31 days.

A Rapid Linkage Program improvement planned for 2019 is the hiring of a Sexual Health Coordinator who will navigate care for all patients diagnosed through routine and targeted testing programs. This staff person also will link patients to STD testing and treatment, PrEP, and Hepatitis C treatment.

Retention in Care

The Return-to-Care (RTC) Program is operated by the Ryan White outpatient medical care clinic in cooperation with its clinic-based social workers and external case management providers. The focus is on medical patients who are at high 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 for follow-up to Austin Public Health Department disease intervention specialists (DIS) and/or Early Intervention Services staff. Using these criteria, at-risk data are being pulled monthly. Information is collected on reasons for out-of-care status, such as relocated out of area, transferred care, incarcerated, and refused care. Information on barriers to care also is collected and includes issues such as insurance, homelessness, incarceration, and health literacy.

Between April 1, 2018 and March 31, 2019, the clinic identified 725 unduplicated patients at risk for out-of-care. Eighteen (18) of these patients were unreachable, i.e., no working phone, no voicemail, returned mail, and unable to contact the third-party emergency or other contact persons listed on file. Two hundred and fifteen (215) patients contacted through RTC efforts have successfully attended a medical appointment; 33 currently have pending appointments. This accounts for 45.34% of the number of patients who have not moved, transferred care, are incarcerated, or died. (547).

While there has been success with efforts to re-engage patients through the RTC program, there is a need to better target those not regularly attending appointments. According to ARIES HAB data, only 78.7% of Outpatient Ambulatory Health Care patients are meeting the HAB medical visit frequency measure, with 441 patients not attending their medical visits twice a year at least 60 days apart over a twenty-four month period. Looking at patients that fail to meet the HAB measure provides a broader scope than the current RTC program. In 2019, staff will develop improved strategies for engaging these patients, so that they remain in medical care.

Improving Quality of Care

Ryan White HIV outpatient medical clinic staff are working with the CommUnityCare (FQHC system) data analytics team to hone data reporting and depictions tools that will aid in the assessment and improvement of HIV care. To date, the analytics team has developed the following Tableau Dashboards:

- HIV Care Continuum
- Time to Viral Suppression Tracker
- HAB Core and Clinical Measures

All dashboards allow filtering by site, provider, payer, and patient demographics. The Tableau Dashboards are being used by medical providers and medical leadership to assess the quality of care for patients living with HIV. Further enhancement of these tools in 2019 will be instrumental in refining the clinic's ability to ensure accurate performance reporting in ARIES.

Access to Care Pilot Program

The Early Intervention Services (EIS) team has implemented a pilot program to provide cell phones to clients who do not have any way of communicating with case managers or medical providers. The team had noticed that clients who were experiencing homelessness were more likely to be lost to care because there was no way for the EIS staff to get in contact with them about their care or to schedule appointments. When the team was able to provide a temporary cell phone for clients, this significantly improved the linkage to care rate. An EIS staff member assessed a client's need for a phone at their intake appointment. If the need was present and the client was interested, the staff member then explained the expectations. The client signed a document agreeing to the terms of the program and agreed to return the phone after 30 days of use. The EIS staff member and the client would then schedule a time to meet again within a day or so for the staff member to deliver the phone. For the next 30 days, the client is able to use the cell phone to make medical appointments, call their EIS Specialist, look for employment, or receive calls from other service providers. The EIS Specialist is able to stay in frequent contact with the client. In FY 2017, only 63% of the out-of-care clients who completed an intake with EIS were linked to medical care. With the ability to provide phones to those most vulnerable, the EIS team linked 90% of all out-of-care clients to medical care in FY 2018.

Increase in Medication Adherence and Viral Suppression

The Positive Living through Understanding and Support (PLUS) program serves high-acuity Medical Case Management (MCM) clients. The PLUS team and MCM staff conducted a pilot study to determine MCM impact on medication adherence and viral load suppression. A total of 29 case managed clients participated. Clients were administered a medication adherence survey at pre-test and again at post-test. The average time between pre-test and post-test was 5.2 months. This time frame was designed to correspond with the course of the MCM care plan, which is reevaluated at least every six (6) months. Study administrators also recorded clients' viral loads pre-intervention and post-intervention to determine trends.

Of the 29 client participants, 11 clients were closed or graduated by the end of the study and did not participate in a post-test. For the remaining clients, medication adherence measured during the previous 7 days improved from an average of 67% at pre-test to an average of 95% at post-

test. Client viral load decreased from an average of 10,501 copies/mL to 358 copies/mL, with the percent of virally suppressed clients (viral load <200 copies/mL) increasing from 66% to 86%.

Study results demonstrated the efficacy of the PLUS MCM intervention, particularly in relation to viral suppression. Within a six-month relationship with their medical case manager, there were significant improvements in individuals' viral loads and viral suppression of the cohort. This indicates the PLUS program is effectively enrolling out-of-care clients into the primary care system and addressing barriers that widen health disparities and interfere with clients' consistent engagement in care. The pilot study aggregated qualitative data that is helpful to medical case managers designing best practices for improving quality of client care and determining how to maintain those clients in care. The most common reasons for clients to miss medications were: forgetting, running out, being too busy to take medications, and lack of medications due to prescription or insurance.

The PLUS team is using these data to take a closer look at clients' relationships with their pharmacies and insurance, enrolling patients in delivery programs and automatic refills, and referring them to ACA enrollment or the Health Insurance Assistance Program, as appropriate, for co-pay or insurance premium support. The most successful medication adherence interventions during the measurement period were: use of a pill box, keeping medicines in sight, using social support network, and combining medications with a daily routine task. When a client expresses difficulty with medication adherence, PLUS staff are using these data to suggest different adherence strategies and incorporate them into the client's care plan.

Training

A three-hour training on Protected Health Information Security and HIPAA was presented to Ryan White service providers in April 2019.

A training on awareness of transgender health issues, *PrEParing for Transgender Persons*, will be offered to service providers in July 2019. Topics will include: transgender data, an overview of gender identity, gender expression, and sexual orientation; trans-competent care needed to support optimal health outcomes; and the cultural humility approach for working with marginalized communities.

Action Plan with Timeline and Responsible Parties

Goal 1: Increase quality improvement activities			
Objective	**Time Frame/ Completion Date**	**Person(s) Responsible**	**Progress/Comments**
a. Complete and submit to HRAU the agency's 2019 QM/QI Plan	May 30, 2019	Provider organization staff	
b. Participate actively in CQM Committee bimonthly meetings and related activities	Every two months commencing February 2019	CQM Committee members	
c. Participate on CQM issue-focused subcommittees	Ad hoc as needed	CQM Committee members	
d. Convene Recipient's HRAU CQM Leadership Team meetings	Every two months commencing January 2019	QM Coordinator, Program Manager, and Data Manager	
e. Submit and analyze service outcomes data quarterly; incorporate service improvements in response to data	July, October, and January 2019; April 2020	QM Coordinator and Provider organization staff	
f. Present service outcomes reports to Planning Council at two meetings each year	May 2019 and November 2019	QM Coordinator	
g. Conduct subrecipient site visits at least annually to discuss CQM issues	August 15, 2019	QM Coordinator and Provider organization staff	
h. Provide at least two QI training opportunities for service providers and CQM Committee members	April and July 2019	QM Coordinator	
i. Schedule training in QI methodologies	December 2019	Program Manager	
j. Design and implement one TGA-wide QI project	February 29, 2020	QM Coordinator	

Goal 2: In collaboration with Texas DSHS, improve quality of ARIES data			
Objective	**Time Frame/ Completion Date**	**Person(s) Responsible**	**Progress/Comments**
a. Monitor and document timely input of all required client-level data, with exceptions noted	Ongoing	Provider organization ARIES data staff	
b. Stratify HAB measures outcomes by special population groups, addressing ARIES report issues with DSHS	Quarterly measurement of identified disparities	HRAU Data Manager	
c. Request and/or provide ARIES technical assistance and training for all new ARIES data entry staff.	Ongoing, as needed	Provider organization ARIES data staff and HRAU Data Manager	
d. Train ARIES data staff on how to run various ARIES reports at the provider level	Ongoing, as requested	HRAU Data Manager	
Goal 3: Reduce health outcome disparities			
Objective	**Time Frame/ Completion Date**	**Person(s) Responsible**	**Progress/Comments**
a. Provide and document at least one annual staff training on cultural competency based on CLAS Standards	February 29, 2020	Provider organization staff	
b. Identify service barriers related to language, social determinants, and/or race/ethnicity, and develop written strategies for achieving equity	Ongoing assessment; plans submitted by May 30, 2019	Provider organization staff	
c. Increase capacity for oral and/or written Spanish translation	Ongoing; progress submitted FY19 Closeout Report	Provider organization staff	
d. Provide at least one annual training for provider organizations related to reducing health outcome disparities	February 29, 2020	QM Coordinator	

e. Analyze Consumer Satisfaction Survey (CSS) data, HAB performance measures in ARIES, and other data to identify significant health outcome disparities	August 15, 2019	HRAU CQM Leadership Team	
Goal 4: Rapid linkage to care, retention, reengagement, and viral suppression			
Objective	**Time Frame/ Completion Date**	**Person(s) Responsible**	**Progress/Comments**
a. Continue to improve linkage interval from diagnosis to initiating ART	February 29, 2020		
b. Participate in Return-to-Care efforts by investigating and reporting per established procedures	Monthly	Provider organization staff	
c. Implement and measure results of at least two new return-to-care interventions during FY 2019	February 29, 2020	Provider organization staff	
d. 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	Provider organization staff	
e. Respond to consumers' medical care improvement recommendations in the CSS and other sources,	Ongoing; document in FY19 Closeout Report	Provider organization staff	
f. Utilize findings under Goal 3, Objective e., to develop strategies for increasing viral suppression among identified subpopulations	September through December, 2019	CQM Committee HRAU CQM Leadership Team	
Goal 5: Increase Consumer Involvement			
Objective	**Time Frame/ Completion Date**	**Person(s) Responsible**	**Progress/Comments**
a. Create new or expand upon existing mechanisms for involving consumers in quality of care/services	Ongoing reporting CQM Committee; document in FY19 Closeout Report	Provider organization staff	

b. In partnership with a consumer, co-facilitate, organize and train local consumer advocacy group with focus on quality improvement of services	June 2019	QM Coordinator	
Goal 6: Increase coordination and collaboration across service delivery system			
a. Establish and document referral relationships with new HIV service providers	Plan submitted by May 30, 2019; documented in FY19 Closeout Rpt.	Provider organization staff	
b. Develop mechanisms for following up to increase successful client referrals	Plan submitted by May 30, 2019; documented in FY19 Closeout Rpt.	Provider organization 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 quarterly by the CQM Committee, the Recipient's CQM Leadership Team, subrecipients, staff in the HRAU, and other units in the Austin Public Health Department.

The Recipient's CQM Leadership Team conducts a formal annual evaluation of the CQM Plan and Program. Evaluation and decisions regarding changes in the CQM Plan and Program are made by the CQM Leadership Team, which meets bimonthly throughout the year and consists of the Program Director, Quality Management Coordinator, and Data Manager. Annual evaluation of the effectiveness of CQM Program activities follows submission of Part A Subrecipient Closeout Reports. The Performance section of the Closeout Report requires quantitative data related to achievement of established outcomes, as well as narrative explanations for significant variances from outcome targets. Subrecipients also provide data and narrative text describing progress on meeting their approved CQM Plan goals and objectives, which are required to align with goals and objectives in the TGA-wide CQM Plan. Other sources of data and information for the annual CQM Program evaluation will include ARIES, the Texas Department of State Health Services (DSHS), the TGA CQM Committee, and other stakeholders such as the Austin Fast Track Cities/Getting to Zero initiative. Subsequently, the CQM Plan will be updated by the Recipient's CQM Leadership Team and identified changes will be implemented in the CQM Program.

TGA-wide evaluation takes place at quarterly meetings of the Recipient's Leadership Team and includes :

- assessment of the effectiveness of the CQM infrastructure;
- assessment of quality and effectiveness of data systems for tracking outcomes;
- review of TGA-wide quality improvement initiatives to determine if progress has been made;
- evaluation of CQM Action Plan objectives to determine if objectives have been achieved;
- review of all performance outcomes reported quarterly;
- review of subrecipient level quality improvement initiatives;
- review of training needs in addition to training scheduled in person or online;
- review of new consumer input data such as focus groups or consumer satisfaction surveys; and
- modification of time frames/completion dates with notation in progress/comments column of CQM Action Plan.

All HRAU staff work together to establish a foundation for program evaluation. Staff develop methods for collecting and processing outcomes performance data, conduct service category monitoring, and submit 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. Quality improvement projects are selected by subrecipients and described in their annual CQM Plan. Subrecipients' quality improvement projects are supported and monitored throughout the year through quarterly progress reports. The Evaluating Your Quality Improvement Project tool on pages 37-38 is offered as an optional framework for evaluating quality improvement projects.

Evaluating Your Quality Improvement Project

Developed by Lori DeLorenzo, MSN

Upon completion of a QI project, it is important to assess the effectiveness of the process, team and outcome. Below are a few key questions that can be used to assess the QI project, the results of which can be used to positively impact future QI projects.
Scale: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree

Question	1	2	3	4	5	Notes
Process						
Did we choose this project based on data? Did we determine, before starting, that the quality concern meets the FIF "test:" • Frequency (problem occurs often) • Impact (can seriously affect patient well-being) • Feasibility (a problem we can do something about)						
Did we clearly articulate the goal and purpose of the QI project; was it sufficiently defined or too large in focus?						
Did we go beyond the targeted timeframe for completion, e.g., did we expect the project to last 6 months and a year later we're still talking about it?						
Were we able to move the project along with regularly scheduled check-in points, e.g., were the meetings regularly cancelled or never scheduled?						
Did we have senior leader support?						
Did we determine the root cause before identifying potential solutions?						
QI Team						
Did we have the right members on the team or did we miss some key players?						
Were the team members actively engaged?						

Did we involve consumer input in a meaningful way?						
Measurement						
Did we set the proper goal, or did we have to refine it over time?						
Did we use the correct performance measure(s)?						
Did we track the results for the individual change ideas/PDSA cycles?						
Were we able to show improvement over time, and were the interventions effective?						
Documentation						
Did we track the change ideas and document what worked and what didn't?						
Did we create a summary of the key change ideas implemented and create a change package (evidence-based set of changes that are critical to the improvement of an identified care process)?						
Sustainability						
Were we able to spread the change ideas to other programs or departments?						
Were processes put into place to institutionalize the change ideas and sustain the efforts over time?						
Information Dissemination						
Did we have opportunities to share information about the project with other team members, and did we take advantage of those opportunities?						
Have we shared the successes and lessons learned with external stakeholders?						

Signature/Title: _____

Dated: _____