Oregon Health Authority
HIV Care & Treatment
QUALITY MANAGEMENT PLAN
CY 2017
January 1-December 31, 2017
Revised: 10/05/2017

QUALITY STATEMENT

The Oregon HIV Care and Treatment Program (HCT) is committed to developing, evaluating and continually improving a statewide, quality continuum of HIV care, treatment and supportive services that meets the identified needs of persons living with HIV and their families, ensures equitable access and decreases health disparities.

The HCT supports this mission by gathering data and information about the services delivered by HCT and its contractors, analyzing this information to measure outcomes and quality of services, reporting this analysis in order to identify areas requiring needed planning, and implementing improvement activities in order to meet program goals.

QUALITY MANAGEMENT INFRASTRUCTURE

The HCT is comprised of the HIV Community Services Program and CAREAssist, the State's AIDS Drug Assistance Program, and supervised by the HCT Program manager. The HCT program manager is responsible for providing staff management and program oversight to ensure quality management activities are implemented per the program's annual Quality Management Plan (QMP), and ensures quality assurance and improvement activities meet the expectations of funders. The Quality and Compliance Coordinator is responsible for convening the program's Quality Management Committee (QMC), participating in statewide quality improvement planning, implementing the program's QMP, monitoring and presenting outcomes and recommending improvement strategies. In addition, this position is responsible for coordinating contractor monitoring activities to include conducting site reviews, reviewing and following up on contractor reports and monitoring data quality. The HCT HIV Services Coordinator is responsible for participating as a member of the program's quality management committee to ensure program activities are aligned with the program's QMP. In addition, this position participates in contractor compliance activities and provides quality assurance and quality improvement related training and technical assistance. The HCT's Financial Operations Analyst

is responsible for monitoring fiscal compliance, to include monitoring budgets, expenditures and conducting financial site reviews.

Coordination of QMP activities also occurs with other Ryan White grantees in the State through the Quality Improvement Collaborative (QIC). The QIC is a committee that shares and coordinates quality management efforts across all Ryan White programs in Oregon. The collaborative includes representatives from Ryan White Part A, B, C and D programs, consumers, and key stakeholders from the Ryan White Part A and B planning groups. The committee was meeting quarterly to share information and provide input on quality improvement planning and initiatives undertaken. In order to better align with the HIV Prevention and Care Implementation Plan QI activities, the QIC is in the process of being reorganized and will reconvene in 2017 with a new charter.

HIV Care and Treatment Program Quality Management Committee

The HCT QMC membership is comprised of individuals who have different responsibilities in the development, implementation, evaluation and support of the QMP. Each member serves an important role in helping ensure accountability and standardization of efforts, identifying gaps in care and fostering collaboration and sharing of knowledge. Members of the QMC are expected to participate in at least quarterly meetings.

The following table describes the current and potential membership of the QM Committee.

Program Representation/Role	Resource/Area of Expertise	Current Status
HIV/STD/TB Section Manager	Oversight and responsible for supervision of HIV, STD, TB programs in State of OR Public Health Department	Participating
HCT (CAREAssist and HIV Community Services) Program Manager	Oversight and responsible for supervision of the HIV Care and Treatment Program, State of OR Public Health Department (CAREAssist ADAP and HIV Community Services)	Participating
HCT Quality & Compliance Coordinator	Quality management, compliance, data quality, and contract monitoring for the HCT program. Conducts site visits for the HIV Community Services (HCS) Ryan White Part B subrecipients.	Participating
HCT HIV Services Coordinator	HCS client services, special projects, contractor training and education, report submission	Participating
CAREAssist Coordinator	CAREAssist policies and procedures, data collection	Participating

Oregon Housing Opportunities Program (OHOP) Housing Coordinator	Ryan White Part B Programs Housing Programs services and ServicePoint data collection and reporting	Participates in workgroups and on QMC as needed/requested
CAREWare Database Specialist	CAREWare database administration and generating reports	Participates as needed/requested
OHOP Support Specialist	OHOP data collection and reporting	Participates as needed/requested
Financial Operations Analyst	Fiscal compliance including monitoring, analyzing and reporting of budgets and expenditures. Conducts contractor financial site reviews.	Participates in contract workgroup as needed and in QMC as needed/requested
Information Technology Dept.	Database support for CAREWare, CAREAssist, and ServicePoint	Participates as needed/requested
Program Liaison, Program Design & Evaluation Services	Provides evaluation and reporting for the HCT program.	Participates in workgroups and in QMC as needed/requested
HIV Surveillance	Lab uploads into database system, as well as Surveillance data and reports for the State of Oregon	Participates in workgroups and QMC as needed/requested
HIV Consumer Representative	Person/s living with HIV/AIDS	Participates in the Integrated Planning Group (IPG)

INFLUENCE OF THE NATIONAL HIV/AIDS STRATEGY

In 2010, the White House released the first National HIV/AIDS Strategy (NHAS). In July 2015, the National HIV/AIDS Strategy for the United States: Updated to 2020 was revised. The strategy focuses on a number of goals which aim to reduce new HIV infections, increase access to care, improve health outcomes for people living with HIV, and reduce HIV-related health disparities. The Health Resources and Services Administration (HRSA) plays a critical role in achieving the goals identified in the strategy by helping to stop the disease through a comprehensive system of HIV care and treatment led by the Ryan White HIV/AIDS Program. Our Ryan White Part B HIV Care and Treatment has membership on the Integrated Planning Group (IPG), which includes representatives of Ryan White Parts A, B, C, D, and F, HIV Prevention, HOPWA Programs, Hepatitis Prevention Programs, Department of Corrections, the STI Prevention Program, the AIDS Education and Training Center, and community based AIDS Service Organizations. Notably, 40% of IPG members identify as people living with HIV (PLWH). The IPG, in collaboration with these partners, released the statewide End HIV Oregon

five-year initiative on World's AIDS Day on December 1, 2016, which strives to meet the four primary National Strategy goals:

- Reduce new HIV infections;
- Increase access to care and optimize health outcomes for people living with HIV (PLWH);
- Reduce HIV-related health disparities and health inequities; and
- Achieve a more coordinated statewide response to the HIV epidemic.

The End HIV Oregon initiative also focuses on a statewide response the National Strategy's four areas of critical focus:

- Widespread testing and linkage to care, enabling PLWH to access treatment early;
- Broad support for PLWH to remain engaged in comprehensive care, including support for treatment adherence;
- Universal viral suppression among PLWH; and
- Full access to comprehensive pre-exposure prophylaxis (PrEP) services for those to whom it is appropriate and desired, and support for medication adherence for those using PrEP.

The HIV Care Continuum consists of a series of steps PLWH take from initial diagnosis to achieving the goal of viral suppression. This program reviews trended data on clients engaged at each stage on the continuum in order to identify where gaps may exist in order to determine service and system intervention and improvement opportunities for better client health outcomes, with the ultimate goal of viral suppression.

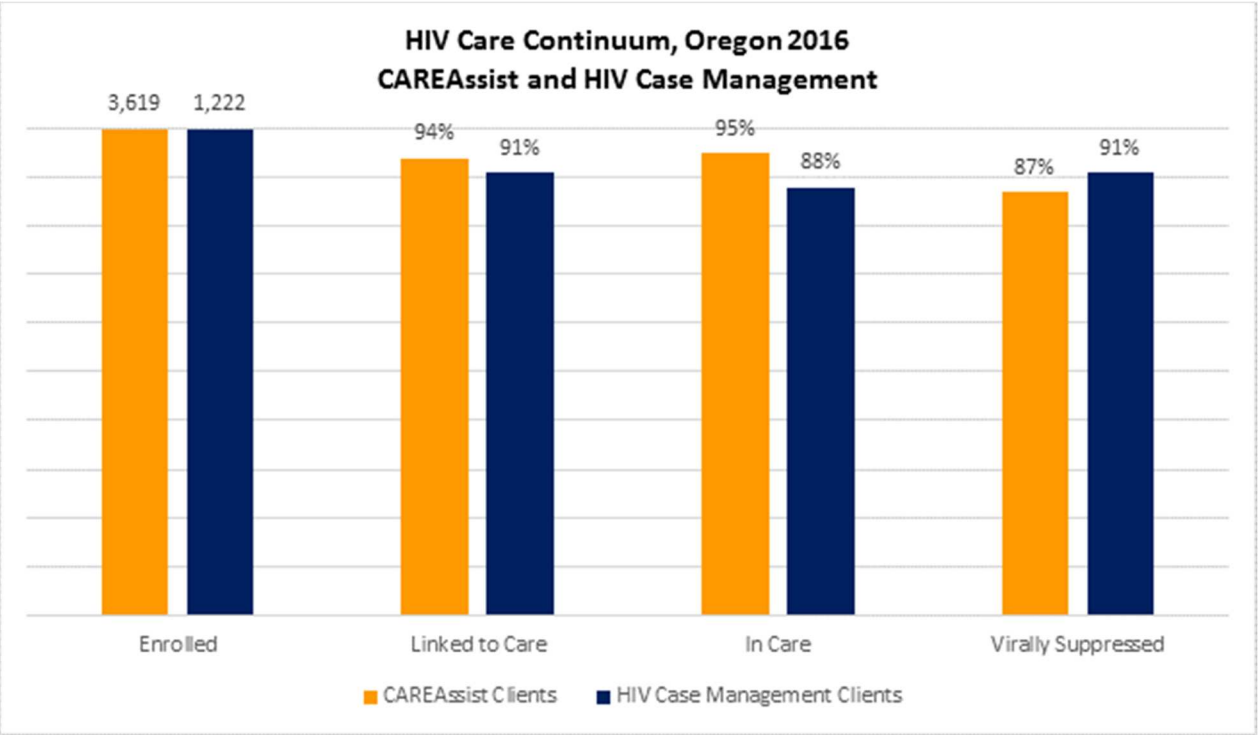
At the state and local levels, jurisdictions use the HIV care continuum – compiled using local data – to determine where improvements are most needed and target resources accordingly.[1] Client participation in HIV care falls along a continuum , from not being involved in care to full participation, with periods of time inconsistent engagement in care. A wide range of interventions can be used to encourage, support and enhance engagement in care.[2]

The Program's HIV Care Continuum consists of the following steps:

- Enrolled clients diagnosed with HIV infection
- Linked to care
- In care
- Viral Suppression

[1] CDC.Understanding the HIV Care Continuum. [Fact sheet] December 2014. Available at: http://www.cdc.gov/hiv/pdf/DHAP_Continuum.pdf#page=1&zoom=auto,-99,792. Accessed from HAB Information Email, Volume 18, Issue 1,January 8, 2015

[2]Topic: Engagement in Care. HRSA/HAB Technical Assistance Resources, Guidance, Education & Training (TARGET).website. Accessed January 8, 2015 at: https://careacttarget.org/category/topics/engagement-care.



Oregon HIV Care and Treatment program—HIV Care Continuum definitions:

Enrolled: Actively enrolled HIV clients in Calendar Year (CY)

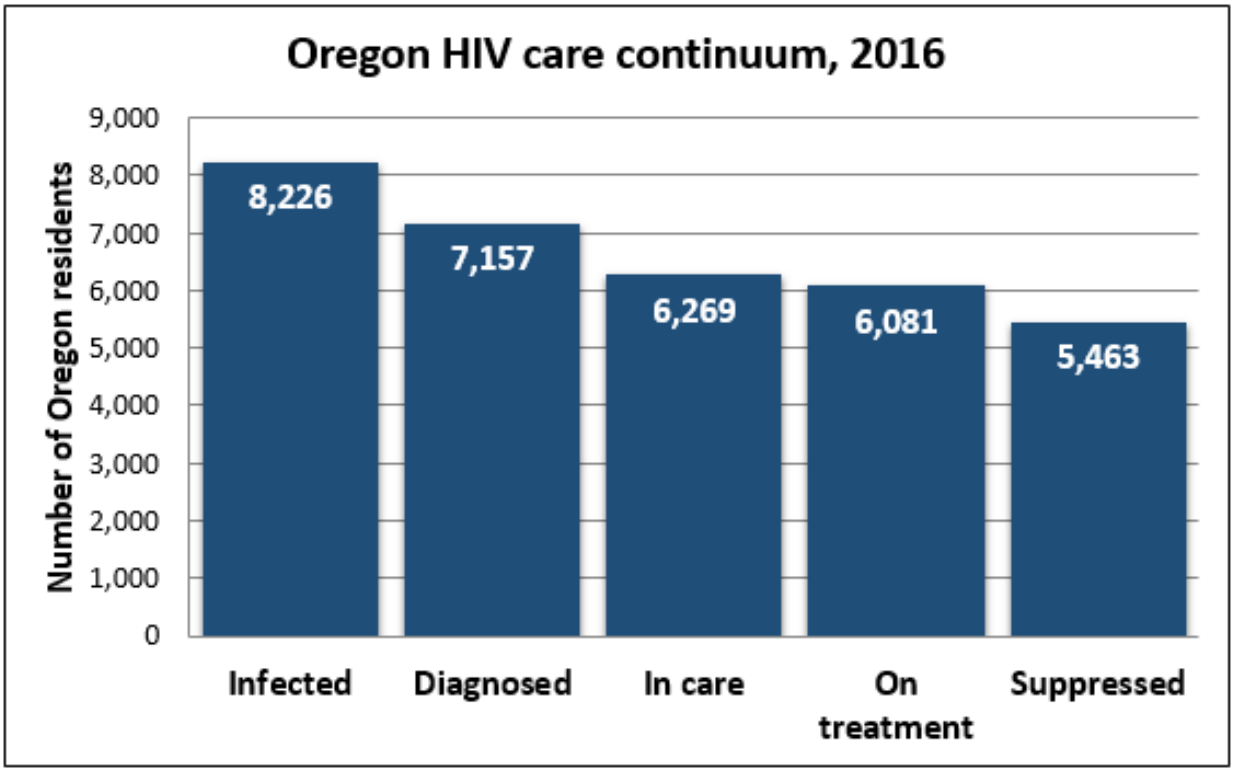
Linked to Care: Clients diagnosed with HIV in CY2015, who had at least one HIV medical care visit within 3 months of diagnosis (as measured by a viral load or CD4 test).

In Care: Clients who had at least one HIV medical care visit (as measured by a viral load or CD4 test) during CY

Viral Suppression: Clients whose most recent HIV viral load was less than 200 copies/mL in CY

The state of Oregon's HIV Care Continuum consists of the following steps:

- Infected
- Diagnosed
- In Care
- On Treatment
- Suppressed



Oregon—HIV Care Continuum definitions:

Infected: Total HIV-infected in Oregon, diagnosed and not diagnosed
Diagnosed: Confirmed HIV cases living in Oregon
In Care: One or more CD4 or Viral load result reported in 2016
On treatment: Medical Monitoring Project estimate of 97% of in-care patients on ARVs
Suppressed: Percent of resident HIV cases whose last viral load in 2016 was < 200 copies/mL

Focus on Viral Suppression

The HIV Care and Treatment Program has been engaged in a number of efforts aimed at improving HIV viral suppression:

- Beginning in 2011, the program has worked to improve access to accurate and complete lab data by partnering with the State HIV Surveillance program to develop a mechanism to import Viral Load and CD4 data directly into CAREWare and CAREAssist databases. Currently, the program is importing data monthly that can be accessed by Medical Case

Managers and CAREAssist case workers to help them monitor health outcomes and improve targeted follow-up for those clients who are not virally suppressed.

- VL suppression has been a key Performance Measure since FY2015 for all CAREAssist, Base and Supplemental funded programs.
- HIV Case Management Task Force meeting was held in FY2015 and made changes starting January 1, 2016 to the Standards of Service to focus specifically on targeting actions and resources to persons who are not virally suppressed.
- The Integrated Planning Group has addressed how the HIV care and prevention programs can further support medication adherence for people who are not suppressed in the recently submitted Integrated HIV Prevention and Care Plan.
- The program worked with State HIV Surveillance to identify persons who were disengaged from HIV care. This work will continue through implementation of an expanded Patient Navigation program for persons believed to be out of care as identified in Surveillance data and new Early Intervention Services and Outreach contracts that will be completed in 2018.
- Additional Part B Supplemental funding was obtained to provide Patient Navigator services to persons with co-occurring HIV and mental health and/or substance use issues who are experiencing multiple barriers to accessing and retaining HIV care. Clients with an unsuppressed viral load are identified as a priority population and will provide a variety of services to include, but not be limited to, health education, information and referral, health care navigation and health literacy education.
- Additional funding was prioritized in CY 2015 to expand housing services for persons who are virally unsuppressed or medically unstable.
- Since 2016, Part B subrecipients have been engaged in a Quality Improvement Viral suppression study with the goal of increasing HIV medical visits in order to increase viral suppression.

PERFORMANCE MEASUREMENT

Performance Measure data is collected and analyzed for health disparities across different target populations by the HIV Care and Treatment program. Sub recipient Agency providers analyze this data and provide a performance measure narrative semi-annually with a plan for meeting unmet goals.

2017 Performance Measures

1. All HIV Care and Treatment clients (CAREAssist and HIV Community Services) who received at least one service in Calendar Year (CY), regardless of funding source:

a. **Viral Load Suppression**: 100%[3] of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.
b. **No Gap in HIV Medical Care**: 90% of clients will have a medical visit in the last 6 months of the year.
c. HIV Community Services Medical Case Management clients only:
MCM Care Plan: 90% of medical case management (MCM) clients will have a MCM care plan developed and/or updated 2 or more times a year

2. HIV Community Services clients who received at least one Ryan White grant funded Case Management (Non-Medical) service in CY:
   a. **Viral Load Suppression**: 100% of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.
   b. **Stable Housing**: 95% of clients will have stable housing.

3. CAREAssist (ADAP) clients who are active and received at least one Ryan White grant service in CY:
   a. **Viral Load Suppression**: 100% of clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.
   b. Application Determination: 95% of ADAP applications approved/denied for new CA/ADAP enrollment within 14 days of ADAP receiving complete application in the year.
   c. **Eligibility Recertification:** 95% of CA/ADAP enrollees reviewed for continued CA/ADAP eligibility 2 or more times a year

Performance Measures definitions:

Active CAREAssist Client:
- *Client enrolled in CAREAssist program at any point during the reporting period, unless otherwise specified*

Active Part B Client:
- *Client enrolled into Part B program at any point during the reporting period, unless otherwise specified*
- *Client receives at least one funded service during reporting period*

[3] End HIV OR goal

≥ ***18 Definition:***

- *Client meets active client definition*
- *Client is 18 years old during the entire 12 months of the calendar year*

Medical Visit Definition:

- *A viral load and/or CD4 lab test entered in to the CAREWare database will be used as a proxy for a medical visit*

Measurement Year:

- *The reporting time period is from January 1 to December 31*

Viral Suppression:

- *most recent viral load in 2016 was less than 200 copies/mL*

Frequency of performance measure data collection

Contractors providing HIV case management services are required to enter client level data in the centralized CAREWare database. Contractors are also required to submit a semi-annual progress report that includes a performance measure narrative based on data provided by HCS program.

HCT compiles quarterly quality management tracking and performance measure data from various sources, to include CAREWare, the CAREAssist database, HIV surveillance and the CAREAssist Pharmacy Benefits Management contractor, in order for the HCT program and QMC to analyze this data. HCS provides subrecipients quarterly data for the HIV Care Continuum, the current program Quality Improvement project, and Performance Measures, in an excel worksheet. HCT, HCS and Subrecipients analyze this quarterly data, in addition to trended performance measure outcomes over three years in order to identify trends over time.

The following summarize the HCT program's Performance Measures and outcomes for calendar years 2014-2016.

HIV Care and Treatment (HCT) Program PERFORMANCE MEASURE OUTCOMES 2014-2016				
Performance Measure	**Goal**	**Outcomes**		
		2014	**2015**	**2016**
CAREAssist (CA): AIDS Drug Assistance Program (ADAP) Services **Funding Source:** Ryan White Part B grant HRSA Service Category: ADAP				
Viral Load Suppression	**90%** of clients have a HIV viral load < 200 copies/mL at last HIV viral load test during the year.	88%	85%	86%
	Numerator: # of CA clients with a HIV viral load < 200 copies/mL at last HIV viral load test during the CY			
	Denominator: # of CA clients with at least one viral load test during the CY			
Application Determination	**95%** of ADAP applications approved/denied for new ADAP enrollment within 14 days of ADAP receiving complete application in the year.	Not measured	99%	98%
	Numerator: # of applications that were approved or denied for new CA enrollment within 14 days (two weeks) of CA receiving a complete application in the CY.			
	Denominator: # of complete CA applications for new CA enrollment received in the CY			
Eligibility Recertification	**95%** of ADAP enrollees reviewed for continued ADAP eligibility 2 or more times a year.	95%	94%	91%
	Numerator: # of CA enrollees who are reviewed for continued CAREAssist eligibility at least two or more times (at least 150 days apart in the CY)			
	Denominator: # of clients enrolled in CA in the CY			
Inappropriate Antiretroviral Regimen	**90%** of identified inappropriate antiretroviral regimen (ARV) prescriptions resolved in the year.	100%	100%	100%
	Numerator: # of antiretroviral (ARV) regimen prescriptions that are resolved by the CA program during the CY			
	Denominator: # of inappropriate ARV regimen prescriptions that are identified by CA during the CY			
HIV Community Services (HCS): Core Medical Services **Funding Source:** Ryan White Part B grant HRSA Service Categories: Home Health Care, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Oral Health Care, Substance Abuse Outpatient Services				

Performance Measure	Goal	2014	2015	2016
Viral Suppression	**90%** of clients have a HIV viral load < 200 copies/mL at last HIV viral load test during the year.	88%*	89%*	91%
	Numerator: # of HCS clients with a HIV viral load < 200 copies/mL at last HIV viral load test during the CY			
	Denominator: # of clients with at least one viral load test during the CY			
No Gap in Medical Visits	**90%** of clients have a medical visit in the last 6 months.	Not measured	74%*	63%
	Numerator: # of clients who have a CD4 or VL lab in CW the last 6 months of CY			
	Denominator: # of clients who had a CD4 or VL lab in CW the first 6 months of CY			
Medical Case Management (MCM) Care Plan	**90%** of MCM clients have a MCM Nurse Care Plan developed and/or updated 2 or more times a year.	Not measured	Not measured	46%
	Numerator: # of clients assigned a high nurse acuity who had a MCM care plan service in CW 2 or more times in the CY			
	Denominator: # of clients assigned a high nurse acuity more than half of the CY			

HIV Community Services (HCS): Support Services

Funding Source: Ryan White Part B grant

HRSA Service Categories: Case Management (non-medical), Emergency Financial Assistance, Housing Services, Linguistics Services, Medical Transportation Services, Psychosocial Support Services, Substance Abuse Residential Services

Performance Measure	Goal	2014	2015	2016
Viral Suppression	**90%** of clients have a HIV viral load < 200 copies/mL at last HIV viral load test during the year.	88%*	89%*	92%
	Numerator: clients with a HIV viral load < 200 copies/mL at last HIV viral load test during the CY			
	Denominator: clients who received at least one Support Service and had at least one viral load test during the CY			
Linkage to HIV Medical Care	**90%** of new clients attend a routine medical visit within 3 months of Diagnosis, as measured by VL (lab test).	Not measured	94%*	91%
	Numerator: clients who have a CD4 or VL lab test within 3 months of HIV diagnosis			
	Denominator: clients who received at least one Support Service and had a new HIV diagnosis during the CY			
Stable Housing	**95%** of clients have stable housing	93%*	84%*	91%
	Numerator: # of clients whose last CW housing status in CY was stable/permanent			
	Denominator: clients who received at least one Support Service and who received an HIV case management service in the CY			

OHOP:

Funding Source: Formula, OHBHI & OSSCR

Performance Measure	Goal	2014	2015	2016
Stable Housing	**80%** of clients successfully accessed or maintained qualification for source of income.	58%	58%	Not available at this

				time
	Numerator: OHOP clients who obtained and maintained a source of income in the CY			
	Denominator: Clients enrolled in OHOP in the CY			
Housing Status	**90%** of clients maintain or obtain housing stability.	92%	92%	Not available at this time
	Numerator: OHOP clients who were not homeless or unstably housed during the CY			
	Denominator: Clients enrolled in OHOP in the CY			
*indicates these outcomes for HCS clients who received Ryan White Part B funding were not separated by HRSA service category—the criteria used at that time: a client must have received at least one service from any HRSA service category in CY. Beginning in 2016, outcomes for Ryan White Part B funding were separated by indicated HRSA service category.				

QUALITY ASSURANCE CONTRACTOR MONITORING

This Contractor Monitoring table lists how contractor service delivery is assessed and monitored:

Activity	**Contractor Monitoring**	Frequency
Program Progress Report	HIV Medical Case Management subrecipients are required to submit a bi-annual progress report which includes a narrative describing current and future efforts at meeting performance measure goals. Contractors also provide a program narrative to include service successes and barriers, outreach efforts, trauma informed care efforts, and targeted quality management activities. The HIV Quality and Compliance Coordinator reviews each report and identifies items requiring follow-up. Report information is used for program planning and evaluation purposes. Technical assistance is provided to the contractor as requested.	Bi-annual
Contract Pharmacy Review	Weekly dispense fee invoices, bi-monthly revenue capture invoices, and weekly wholesaler orders from the PBM's PMDC system are used to monitor contracted pharmacies. The Financial Operations Analyst reviews these reports to track spending, revenue capture, and order replenishment. The Financial Operations Analyst meets with CAREAssist management monthly to discuss any fiscal issues and discuss follow up as needed. Quarterly tele-conference meetings are held with the contracted pharmacies to discuss open issues that may affect more than one entity. Planned audit of ADAP's 340B Program (current RFP in ORPIN): year one emphasizes compliance with 340B, year two emphasizes contract compliance. Goal is for a 5-year contract with plan to renew. This audit will review pharmacies and PBM processes.	Weekly to Quarterly

Pharmacy Benefits Manager data	Contractor submits a Quality Assurance report which includes client medication adherence statistics and client level data related to the number of identified inappropriate antiretroviral regimen (ARV) prescriptions resolved. In addition, contractor provides a Performance Measure report to indicate whether they met their identified goals in the following performance areas: turnaround time, help desk telephone response time and abandonment rate, Point-of-Sale data system availability, system change request process, and claims authorization processing. A Plan of Corrective Action is submitted for each outcome that did not meet the goal.	Quarterly and Annual
Medication Therapy Management (MTM) data	Contractor ensures access to ad-hoc reporting systems and submit financial and performance reports electronically as specified. A report is submitted with the following information: number of MTM clients identified as eligible for service by eligibility criteria, number of MTM encounters delivered, number of Clients enrolled in MTM, number engaged in MTM (appointments scheduled vs. appointments kept), MTM clinical interventions summary data, and documented interventions identifying non-conforming regimes (i.e., does not meet DHHS Guidelines).	Quarterly and Annual
Fiscal Expenditures	Monthly expenditures recorded through the Financial Services Office are monitored by the Financial Operations Analyst to track funded service providers monthly allocations and ensure that subrecipients are receiving their formula distributions. The program Financial Operations Analyst works with the State Financial Services Office to ensure that allocations are current, reports are received and distributions are funded correctly.	Monthly
Fiscal Report	The Administrative Fiscal Form completed by the subrecipient reports on current quarter expenses and year to date expenses as budgeted in the Care Services Budget for each contract agency. The Financial Operations Analyst closely monitors these reports to track spending, ensures that charges are in compliance with state and federal guidelines and assures that subrecipients are providing planned services within the approved budget. These reports are compared to the Quarterly Revenue and Expenditure Reports filed with the Oregon Financial Services Office and the Financial Report generated from CAREWare. If discrepancies are found between these three reports, the Financial Operations Analyst works directly with the contracted agency to correct the discrepancies and request resubmission of any of these reports.	Quarterly

CAREWare Financial Report	The Financial Report, generated from CAREWare, provides the program with service utilization and service expenditure data for each contract agency. The Financial Operations Analyst closely monitors the financial components of these reports to track spending, ensures that charges are in compliance with state and federal guidelines and assures that subrecipients are providing planned services within the approved budget.	Quarterly
Care Services Budget	The program requires that each funded service provider file an annual budget plan prior to the State fiscal cycle. The Financial Operations Analyst reviews and approves each plan to assure compliance with state and federal requirements.	Annually
Local Client File Review	A Local Client File Review is conducted by each county based contract agency delivering medical case management services using a tool developed by HIV Community Services as a condition of contract. Quality indicators are reviewed resulting in a summary report submitted to HIV Community Services. The results are compiled into a statewide summary report and are utilized for planning and quality improvement activities. Compliance findings are followed up and may result in a plan to rectify deficiencies, technical assistance or incorporation into the case management training program curriculum to increase statewide compliance.	Annually
Ryan White Services Report (RSR)	Contract agencies enter required data elements into the program's centralized CAREWare database. Data entered includes demographics, service utilization, primary medical and insurance provider information, household status and income data. The HIV Community Services Program provides contract agencies with a detailed data report in January identifying those data elements that are missing or questionable and provides technical assistance to assure accurate information is reported.	Annually
CAREAssist Data Report (ADR)	The CAREAssist program reports outcomes on the CAREAssist Data Report (ADR) according to the guidelines and definitions provided by HAB. All data for the ADR comes from the client level database that also interfaces with databases for the PBM, the HIV Surveillance Program, and state financial management systems.	Annually

Ryan White funded agencies participate in an annual onsite review with regional community based organization subrecipients. County based Health Departments are reviewed on a triennial schedule, as approved by HRSA in the site visit waiver. Public Health Department Triennial site visits are completed by the HIV Care and Treatment Program for Ryan White funded subrecipients under the direction of the Oregon Health Authority, Public Health Department, Public Health Systems Innovation and Partnerships Unit.

Fiscal site visit protocol:

A Fiscal compliance review is conducted to provide assurance that the contractor has an accounting system with proper controls to identify and report revenues, expenditures, and equipment provided by the Department of Health and Humans Services (DHHS) thru the Oregon Health Authority (OHA). The accounting transactions for that period are evaluated for accuracy and compliance with applicable Federal and State regulations and Title XXVI of the Public Health Service Act, 42 U.S.C. (Ryan White Part B). Instances of non-compliance, material discrepancies and other irregularities are considered findings of the review for which management response and corrective action is required within 60 days upon receipt of the fiscal reports.

Program Site visit protocol:

Ryan White Part B subrecipient site visits include an entrance meeting to identify challenges, successes and barriers providing services. Performance measures and other data outcomes are also provided and discussed. The chart review includes an in depth review of documentation and data recorded in the client chart and in the CAREWare database. Data collected during these reviews are compiled and presented to the subrecipient identifying successes and areas of improvement, and compliance findings as summarized in site visit report forms. Compliance issues require a written plan of correction within 30 days of receipt of findings and may result in a second site review within 90 days. Quality assurance and improvement recommendations are provided and agency monitoring is documented on their program reports. An on-site review may be implemented at any time for agencies that are experiencing problems identified in any of the monitoring activities listed above.

Improvements and additions to monitoring activities:

HIV Community Services program frequently provides technical assistance and training to contractors to further enhance local quality management planning and activities. Quality improvement is a significant focus of onsite reviews, which includes quality improvement recommendations provided to contractors based on comprehensive client chart and system delivery review. Site visits also include an offer to the subrecipient to meet with all service delivery staff during the chart review to go over selected charts utilizing the chart review tool and CAREWare data entry.

Ongoing Activities and monitoring include:

- Contractors participate in the HIV Case Management Task Force, which identifies system improvements by reviewing quality trends and provides recommended changes to the standards of service and other program requirements.

- Technical assistance and ongoing training opportunities are available to contractors to ensure program and fiscal compliance, and to assist partners in monitoring quality indicators. In addition, the program provides extensive CAREWare support, which includes developing contractor requested custom reports and locally identified performance measures.
- The program has a Contractor Monitoring workgroup that meets monthly to review contract administration, report and deliverables monitoring and ensures timelines and reports are met.

Contractor Corrective action process

Corrective action requested by the HIV Community Services ranges from informal requests to formal reports submitted to the County or agency Board of Commissioners. Informal requests include Care Services Budget revisions requested by the Financial Operations Analyst due to non-compliance with administrative or other charges. In addition, quarterly CAREWare Financial Reports, Administrative Fiscal reports and Expenditure reports are monitored by the Financial Operations Analyst. Reports are analyzed to ensure accuracy in reporting and service delivery. Reports that require corrective action are sent back to the contractor for explanation and/or revision. Formal corrective action may be requested as a result of the annual Local Client File Review or On-Site Review. If a fiscal or programmatic deficiency is identified that warrants corrective action, HIV Community Services will notify the contract agency in writing. Deficiencies noted will require a Corrective Action Plan submitted by the contractor in writing and include specific descriptions of the items needing correction, the plan for correcting the problem identified, and a timeline for resolution. The program provides technical assistance to assist an agency in reaching compliance expectations as needed and/or requested by the contractor. Corrective Action plans resulting from an onsite review may result in additional site visits to ensure the issues have been rectified.

CAREAssist follows the state contracting division's requirements for corrective action, follow-up and resolution for contractors. Within the contracts division, financial penalties are defined within the contract for specific elements of the scope of work.

CAPACITY BUILDING MONITORING AND ACTIVITIES

Capacity building involves projects to review and enhance systems of care in improvement in the following areas:

1. The capacity to collect accurate data
2. The capacity to meet HRSA reporting requirements
3. The capacity to share data to determine QI needs

The HIV Care and Treatment program's quality management plan and evaluation studies have been instrumental in making program improvements to program design and services. In addition, trended data is used to shape the direction of the program. The program will continue to improve the process of using data to develop multi-year goals associated with viral load suppression and ensure HIV case managers use the available data to develop client level performance measure. Medical Case Managers are encouraged to use this data to determine those clients needing additional follow-up. The program reviews this data for each contractor site in CAREWare, develops standards to enhance service delivery to persons who are in medical care but are not suppressed across programs (CAREAssist, case management, adherence programs), and targets training and technical assistance for contractors aimed at increasing the overall percent of clients with a suppressed viral load.

The data quality plan identifies reports that need to be generated for the CAREAssist, CAREWare, and ServicePoint databases and outlining procedures for data collection in these databases. Reports are generated and data completeness checks, validation, and data cleaning occur at least two months prior to annual report submission. Contractors are contacted and provided technical assistance to ensure that their data is accurate and complete prior to submission to reporting agencies. CAREAssist leadership and the Office of Information Services has been working on a new database system to expand the data quality plan to include an enhanced CAREAssist database. The expanded database will allow case workers to utilize custom reports to complete a review and clean-up of their data at specified time periods during the year to increase the capacity for the program to collect and report accurate data for HRSA reporting requirements. Currently, CAREAssist leadership reviews database reports quarterly and annually and provides training and direction to caseworkers during staff meetings.

The databases monitored in the Data Quality Plan are as follows:

- CAREAssist, used by the CAREAssist program.
- CAREWare, used by Ryan White Part B contactors
- ServicePoint, used by the housing coordinators.

Capacity Building and Monitoring Activities		
Capacity Building Goal	**Activity**	**Person(s) Responsible**
Data Quality Plan		
New service delivery staff will input service data and charting accurately.	Complete an informal chart review of new service delivery staff within 3 months of hire date.	Nurse trainer, contractor Supervisor and/or Quality & Compliance Coordinator
Contractors will complete their	Ensure contractors are running	Quality & Compliance

own data quality activities.	reports and fixing data entry problems annually. Provide technical assistance and training, and encourage contractors to identify and fix data entry missing or incorrect fields more frequently, by running quarterly reports.	Coordinator and HIV Services Coordinator
The Data Quality Plan (DQP) will be revised to increase the breadth of the plan to include additional monitoring activities.	The DQP will be revised on an ongoing basis to add additional areas of monitoring service delivery data and aligning the data in the databases with reporting requirements and QI activities.	CAREAssist Coordinator, Quality & Compliance Coordinator; HIV Services Coordinator ; IT Data specialist
Data will be used in reports to identify and guide QI activities and monitoring.	Reports will be generated and reviewed by QMC to identify and/or monitor quality issues/concerns, and will result in a QI initiative to address the issue. QMC will prioritize based on previous performance and outcomes. Technical assistance and ongoing training opportunities are available to subrecipients to ensure program and fiscal compliance, and to assist partners in monitoring quality indicators. In addition, the program provides extensive CAREWare support, which includes developing requested custom reports and locally identified performance measures for subrecipients.	CAREAssist Coordinator, Quality & Compliance Coordinator; QMC
Determine the best process for conducting an annual CAREAssist chart review and identify and make a plan to resolve potential barriers.	CAREAssist completed a preliminary review in 2016. Issues identified that are being addressed with the current and future database include: o Due to the inability to upload documents to the CAREAssist database, both	CAREAssist Coordinator, Quality & Compliance Coordinator; QMC

	the paper chart and the database have to be accessed in order to complete the chart review. o The need for a centrally located eligibility summary and how eligibility was determined. Reviewers were required to look in several places in both the electronic and paper file and overlooked records as a result. o Lack of uniformity when documenting electronically verified, eligibility criteria from state data systems.	
Reporting Requirements Plan		
Changes to funder reporting requirements and revisions made to data entry requirements will be accurately reflected in materials provided to subrecipients and contractors.	HCT staff will participate in funder sponsored webinars and meetings related to reporting and service requirements. User Manuals for all databases will be updated as changes occur and these changes will be communicated to contractors in multiple formats. Reporting requirements will be reviewed at least annually.	CAREAssist Coordinator, HIV Services Coordinator and Quality & Compliance Coordinator
Ensure accurate subrecipient data is used for the purposes of reporting to HCS and to identify a plan for subrecipients to meet unmet goals.	Performance measure Progress report data will be provided to subrecipients to ensure accurate and consistent data, and enable the subrecipient to measure their performance against the Part B service area as a whole.	Quality & Compliance Coordinator
Sharing QI Data Plan		
Improve client outcomes by sharing data necessary for subrecipient to analyze this	The HIV Community Services provides subrecipients quarterly data for the HIV Care	Quality & Compliance Coordinator

data for health disparities and service delivery in order for the subrecipient to identify necessary quality improvement activities.	Continuum, the current program Quality Improvement project, and Performance Measures, in an excel worksheet. Subrecipients will be provided TA, training and the tools necessary for the subrecipient to analyze this data and run additional CAREWare reports, as needed, in order to identify: health disparities across different demographics; client outreach/referral; service delivery evaluations and/or changes; assessment of barrier; quality improvement projects; and/or request for program TA/training.	
QMC will review program quarterly data in order to identify necessary QI activities to improve client or service delivery outcomes	HCT will compile quarterly data for the HCT QMC to analyze this data in order to identify: health disparities across different demographics; client outreach/referral; service delivery evaluations and/or changes; assessment of barrier; quality improvement projects; and/or request for funder TA/training.	CAREAssist Coordinator, HIV Services Coordinator and Quality & Compliance Coordinator
QM Plan data will be reviewed by the HCT program and the QMC.	Monthly, quarterly, and annual data from a variety of sources is collected, analyzed and reviewed as part of the Ryan White Part B Quality Management Plan, including CAREWare, the CAREAssist database, HIV surveillance and the CAREAssist Pharmacy Benefits Management subrecipient.	CAREAssist Coordinator, HIV Services Coordinator and Quality & Compliance Coordinator

Quality care or service concerns will be communicated by/to HCS in order to be reviewed for potential QI activity or project	When routine review of CAREWare and CAREAssist data and chart reviews indicates potential instances of quality care or service concerns, the program follows up with subrecipients as necessary. CAREAssist case workers follow-up with clients and subrecipient case managers as necessary. When it is determined that there are systemic, program, or policy changes that need to occur as a result of these reviews, the program determines whether these changes can wait until the HIV Case Management Task Force convenes or if necessary changes need to occur more immediately. Quality improvement activities and projects can occur as a result of these reviews, such as the 2016 Quality Improvement project.	CAREAssist Coordinator, HIV Services Coordinator and Quality & Compliance Coordinator

QUALITY IMPROVEMENT GOALS

Quality improvement goals are established priorities which the QM program identifies annually to direct its efforts and resources towards. Goals are measurable and realistic and establish a threshold at the beginning of the year for each goal. The Ryan White Part B program reviews HIV/AIDS Bureau performance measure recommendations annually and compares these to quality of care trends as identified by the stakeholders listed in this report. Quality improvement goals are identified based on recommendations from the program's various planning groups and stakeholders, data quality analysis, quality assurance monitoring outcomes, and based on trended performance data. The QMC evaluates the recommendations, reviews the data, and sets the annual QI goals in order to improve previous performance rates and outcomes. QI projects are then identified and prioritized to address the QI annual goals.

Quality improvement activities are formulated to improve provider performance, service delivery, and system-wide capacity, and quality goals are derived from the following sources:

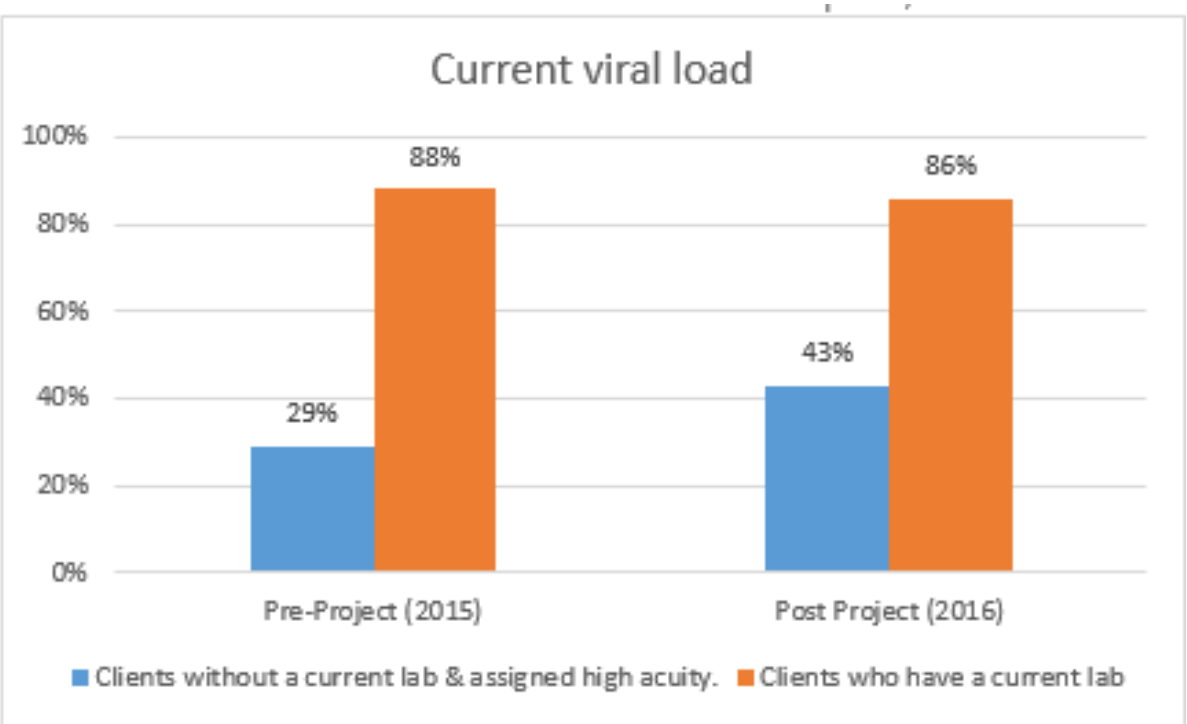
- Subrecipients participated in the HIV Case Management Task Force which identifies system improvements by reviewing quality trends. Recommended changes to the standards of service and other program requirements were implemented in 2016 to support the Quality improvement project of 2016 and 2017 related to viral suppression. The next Task Force is scheduled in FY 2017.
- Regional subrecipients are now required to submit an annual Quality Management Plan and were a major contributor to the program's quality improvement project for 2016. The goal is to include required quality improvement project(s) in the next contract revision.
- Quality Management partnership capacity building goal included the participation of two community based subrecipients in addition to HIV Care and Treatment staff in the Regional Quality Improvement training hosted by the State of Washington Department of Health and facilitated by the National Quality Center (NQC) in February 2017. As a result of this participation, one of the subrecipients was invited to participate in a NQC End+Disparities Learning Exchange and presented, "Stakeholder Engagement with Nontraditional out of Network Centers for Independent Living".

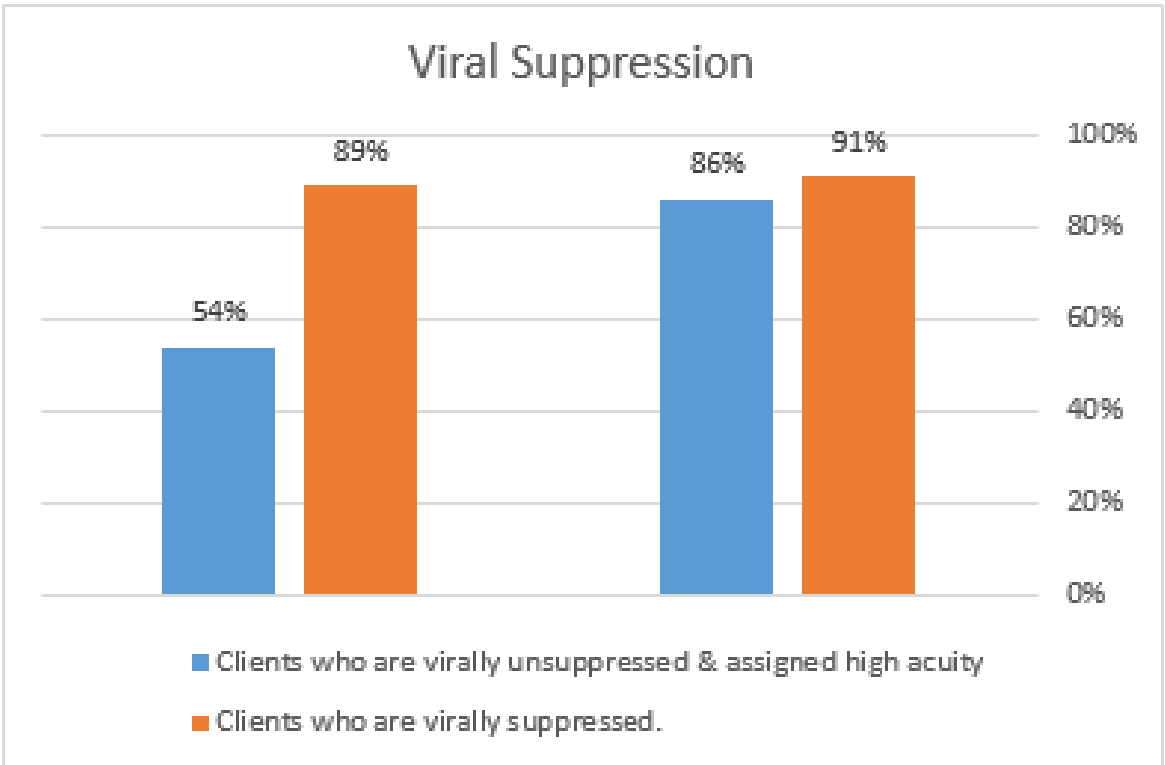
The Quality Improvement Project selected for calendar year 2016 and 2017 was a result of collaboration with subrecipients at the 2015 Task Force meeting. The following is the PDSA cycle for the 2016 Viral Suppression Quality Improvement project:

Plan: In order to increase viral suppression, clients must have current viral load labs to identify those who are not virally suppressed. Quarterly reports were further revised to include performance measurement data specific to viral suppression and collect baseline data starting in 2015. The Standards of Service were revised January 2016 to standardize requirements for clients with no current viral load labs or who are virally unsuppressed.

Do: Clients without a viral load in past 12 months or who are unsuppressed at last lab are assigned a high acuity, requiring monthly contact from the nurse. Services are document, analyzed and reported quarterly.

Study: Sub recipients are ensuring viral load labs in CAREWare are accurate and up to date and running more frequent reports as evidenced by the program receiving increased notification about missing labs or inaccurate data. Among those who are unsuppressed, there was a 32% increase in assigning a high acuity. Overall viral suppression increased by 2% from 89% to 91%.


Current viral load
100%
80%
60%
40%
20%
0%
88%
86%
43%
29%
Pre-Project (2015)
Post Project (2016)
Clients without a current lab & assigned high acuity.
Clients who have a current lab


Viral Suppression
89%
86%
91%
54%
100%
80%
60%
40%
20%
0%
Clients who are virally unsuppressed & assigned high acuity
Clients who are virally suppressed.

Act: This project is continuing through 2017 and will identify further improvement opportunities. For example, the program has been able to investigate lab import issues with the Surveillance Program. Additional changes to the PDSA cycle will be discussed at the forthcoming HIV Case Management Task Force meeting.

The following program and service outcomes are trended and used annually in planning, impacting decisions about program funding, policies/procedures, training program and new services. The following summarize the outcomes for calendar years 2014-2016:

CAREAssist (ADAP) **Quality Management Tracking and Outcomes**	2014	2015	2016
Number enrolled in CAREAssist	3470	3628	3679
Newly Diagnosed HIV clients enrolled in calendar year	Not measured	Not measured	84
Total Applications Received	510	462	657
Percentage of clients who were retained in CAREAssist[4]	91%	88%	86%
Percentage of clients who left CAREAssist for all reasons[5]	9%	12%	14%

[4] Due to Medicaid expansion, once approved for Medicaid, some clients chose not to apply for ongoing assistance because they had no out of pocket medical expenses.
[5] Reasons include: death, moving out of state, received insurance from other source, not paying cost-share, or not recertifying

HIV Case Management Quality Management Tracking and Outcomes	2014	2015	2016
Number enrolled in case management	Not measured	1,178	1,222
Newly Diagnosed HIV clients enrolled in calendar year	Not measured	Not measured	35
Case management clients who are in medical care[6]	88%	91%	88%
Case Management clients who have a current viral load test[7]	Not measured	88%	86%
Case Management clients with no viral load test or viral load test is more than 12 months old and are assigned a high Medical Case Management Acuity.	Not measured	29%[8]	43%
Case Management clients who are virally unsuppressed and assigned a high Medical Case Management Acuity	Not measured	54%[9]	86%

PARTICIPATION AND COMMUNICATION WITH STAKEHOLDERS

The following table describes the groups and agency stakeholders currently involved in HIV care activities and in providing data for the QM Committee.

[6] As indicated by a CD4 or VL reported in CAREWare in the calendar year.
[7] AS indicated by a VL entered in CAREWare in the calendar year.
[8] Baseline data for new standard of service.
[9] Baseline data for new standard of service.

QM Stakeholders	QM Participation	QM Data
Consumer (People living with HIV/AIDS)	1. Participate in QMC, QIC and IPG. 2. Participate in Surveys and other special studies.	
HIV Medical Case Management Task Force	1. Identify quality of care issues or concerns in Part B service area. 2. Provides recommendations on standards of service.	PM and CQM data, site visits, chart reviews and CAREWare reports are utilized to recommend improvements to the Standards of Care and statewide data improvement initiatives.
Integrated Planning Group (IPG)	1. Identify quality care issues or concerns in the State of Oregon. 2. Identify needed services and/or programs. 3. Provide recommendations on program goals and activities.	Data and outcomes data are utilized to develop the HIV/VH/STI Integrated Comprehensive Plan. This includes improvement activities to address identified service needs and gaps, including developing goals and objectives that impact service priorities and resource allocation.
CAREAssist Advisory Group	1. Identify quality care issues. 2. Identify needed services and/or programs. 3. Provide recommendations on program goals and activities.	Quality data is utilized to inform decisions about program and service improvements in CAREAssist.
Oregon HIV Quality Management Committee (formerly "Quality Improvement Collaborative")	1. Receive updates pertaining to the QMP.	1. Share general program information across state organizations and agencies pertaining to the End HIV Oregon initiative 2. Share ideas for quality improvement initiatives and decide on End HIV Oregon performance measures 3. Provide a space for innovative collaboration.
RW Subrecipients : • Regional • County	1. Provide data on services provided via reports. 2. Participate in chart review. 3. Participate in QI projects. 4. Ensure service delivery and standards of service according	Data is provided when requested for technical assistance and training purposes, as well as from chart reviews, site visits, data quality, and feedback from report

	to contract requirements.	submissions. Contracted providers are encouraged to use data to identify opportunities for outreach efforts and specific program and clinical interventions for increasing client engagement and retention in care.

QUALITY MANAGEMENT PLAN EVALUATION

The QMC will be charged with evaluating the QM Plan (QMP) as follows:

1. Determining the effectiveness of the Quality Management infrastructure to decide whether there is need for improvement in how quality improvement work is accomplished.

2. Reviewing annual QMP goals and identifying outcomes and areas of improvement. Evaluating the QI activities to determine whether the annual QI goals are met.

3. Reviewing whether the performance measures are appropriately identified, and evaluate if new measures should be introduced.

To ensure a useful and current QMP, it is essential to update the plan in a systematic and consistent manner. The process upon which the QMP will be updated is explained in the table below.

QMP Evaluation	Timeline
QI projects, performance measurement goal updates, Data Quality Plan updates, and updates to the QMP will be forwarded to the Quality & Compliance Coordinator by RW Part B program staff, QMC members, and Stakeholders, and will be shared with the QMC for review, modification, and final QMP approval.	Quarterly Review Annual approval
The QMC will evaluate the QMP by answering the following questions: 1. What QI goals were achieved during the previous measurement year? 2. a) What performance measurement goals were met in previous measurement year? b) Are results in the expected range? If so, how?	Annual

3. How were stakeholders informed of performance measure results? 4. a) Did our current QM infrastructure work? b) Where are there areas for improvement in our current infrastructure? 5. a) Did we do what we said we were going to do for each measure and each QI project? b) Why or why not? 6. a) Are our measures meaningful to helping us understand HIV care systems in Ryan White Part B delivery systems in Oregon? b) Are they helping us identify whether or not we need to make changes?	