

**BALTIMORE-TOWSON EMA PART A QUALITY
MANAGEMENT PLAN
2015-2017**



I. Introduction

The Baltimore City Health Department (BCHD) is designated the Ryan White Part A Grantee and manages the Clinical Quality Management Program (CQM) for the Baltimore Eligible Metropolitan Area (EMA). The Baltimore EMA is comprised of 38 sub-recipients who help people living with HIV/AIDS (PLWHA) by providing medical and supportive services.

BCHD's vision is:

To make Baltimore a city where all residents realize their full health potential.

The overall mission of BCHD is:

To advocate, lead, and provide services of the highest quality in order to promote and protect the health of the residents of Baltimore City.

Quality Statement

CQM's mission is to ensure the provision of high quality HIV care at Part A and Minority AIDS Initiative (MAI) funded Primary Care and Support Service agencies serving HIV-infected and affected persons who are uninsured, under-insured, or persons who are not able to obtain needed services through other funding streams.

This document describes the organizational structure, goals, performance measurement strategies and processes used to implement a quality management program for the Baltimore EMA.

Legislative Authority

Section 2604(h)(5)(A) of Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that “..the Chief Elected Official of an eligible area that receives a grant under this subpart shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.”

Section 2604 (c) (5) (B) also provides for funding of quality management activities. It states that in addition the 5 percent of funding allocated for administrative costs, the EMA may use for quality management activities not more than the less or “5 percent of amounts received under the grant; or \$3,000,000. Further, that the costs of a clinical quality management program described under subparagraph (A) may not be considered administrative expenses.

The activities of the Quality Management Program are legally protected. The law protects those who participate in quality of care or utilization review. It provides further that ‘neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired.’ All copies of minutes, reports, worksheets and other data are stored in a manner ensuring strict confidentiality.

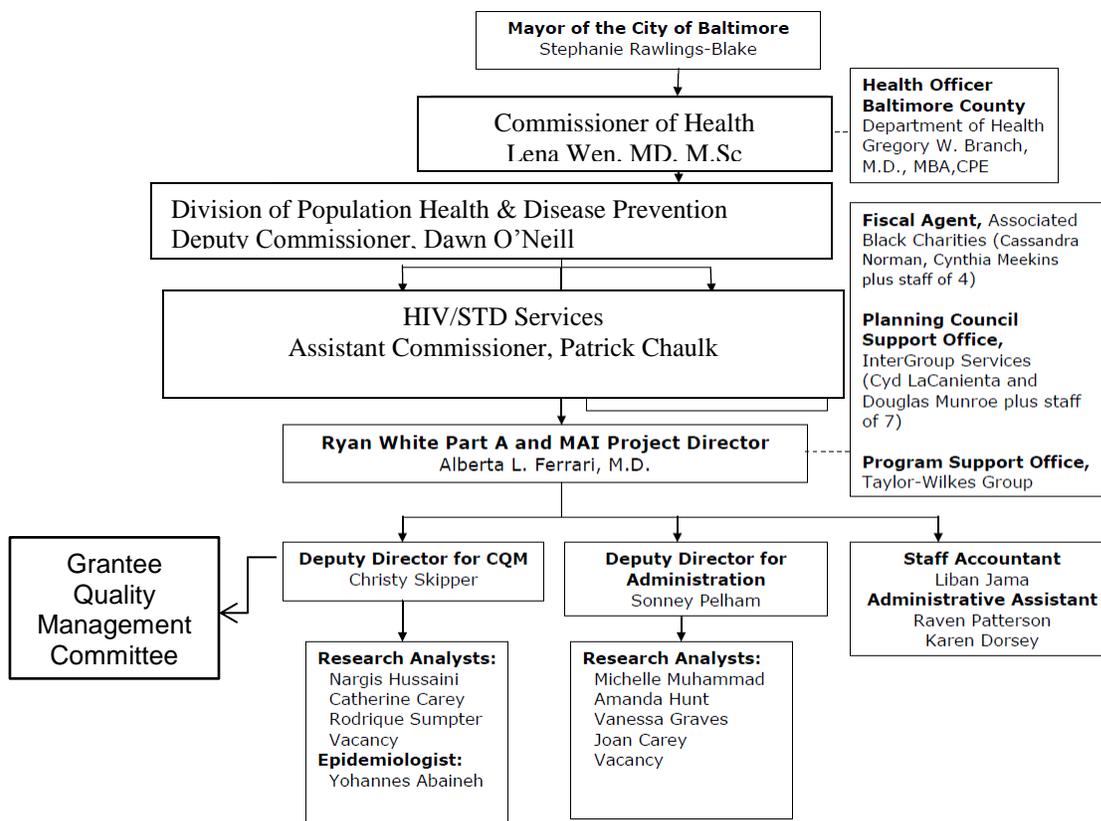
Scope of Ryan White Part A Funded Services

The Mayor of Baltimore, the city’s Chief Executive Official (CEO), delegated administrative responsibility for the Ryan White Program to the Commissioner, Baltimore City Health Department.

Part A services are provided directly by hospitals, clinics, local health departments, and community partners selected through a competitive selection process. Eligible persons have access to a continuum of HIV medical care programs and varied supportive services through multiple points of entry. The planning and allocation of Part A services are coordinated with Parts B, C, D, as well as Housing Opportunities for Persons with AIDS (HOPWA) and other governmental funding sources. The Baltimore EMA Ryan White Part A Program serves HIV-positive persons residing in Baltimore City and 6 surrounding counties including Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's.

In accordance with current resource allocations approved by the Greater Baltimore HIV Health Services Planning Council (PC), Part A funds are allocated to 8 core medical and 9 support service categories.

II. QUALITY INFRASTRUCTURE



To fulfill the legislative requirements for a quality management program, the Baltimore EMA Clinical Quality Management Program (CQM) involves the Grantee, which supports the Quality Management Program within the Baltimore City Health Department (BCHD) and the EMA Planning Council. Some structure, roles and responsibilities are outlined below:

Resources, Roles and Responsibilities

Resources

The resources available for the Clinical Quality Management program include the Ryan White Program Staff, information technology, and other infrastructural resources. A key resource for the program is the client level data, a custom Excel template collecting service level data on each client receiving Part A funded medical or support care in the Baltimore Towson EMA. This system allows the EMA to satisfy the annual Ryan White Services Report (RSR) and provides a complete set of data for program and quality analysis. The HRSA HIV/AIDS Bureau and the National Quality Center are technical assistance resources for the EMA.

Roles and Responsibilities

A. Mayor of Baltimore

- Serves as the CEO to apply for and to receive the Ryan White Part A grant.
- Establishes the Planning Council and appoints members.
- Designates BCHD as the **GRANTEE FOR RYAN WHITE PART A PROGRAMS**. BCHD also manages the **CLINICAL QUALITY MANAGEMENT PROGRAM** for the Part A and MAI grants.
- Establishes the intergovernmental agreements with other jurisdictions in the EMA as required.

B. Part A and MAI ADMINISTRATION – BALTIMORE CITY HEALTH DEPARTMENT

The Deputy Director for Clinical Quality Management is responsible for leading the coordination and implementation of the Baltimore EMA Quality Management Program.

Deputy Director for CQM – QM Roles and Responsibilities

- Oversees the Baltimore Towson EMA's quality related activities
- Developing and coordinating implementation of the Quality Management Plan and Annual Work Plan.
- Establishing annual QI goals and indicators for the EMA and identifies trends in clinical performance and related health outcomes.
- Developing quality indicators based on the approved Standards of Care, HRSA measures and guidance from other sources (e.g., NHAS, NQC).
- Delineating quality management requirements and expectations in procurement documents (i.e., RFPs and contracts).
- Works closely with primary medical sites in conducting onsite performance reviews, identifying practice areas in need of improvement, and guiding quality improvement teams using QI methodologies such as PDSA, Ishikawa and workflow diagrams.
- Facilitating collaboration and coordination among funded agencies to enhance the quality of care throughout the EMA.
- Collaborating with other Ryan White Grantees in the region, including parts B and C.
- Providing recommendations to the Planning Council for the improvement of service delivery in the EMA based on quality management program findings.
- The final interpretation and reporting of QM data to the RW Program Director, Planning Council and providers.

- Provides and facilitates system-wide and individual technical assistance to funded agencies.

General Roles and Responsibilities:

- Ensures the delivery and availability of high quality services regardless of a clients' ability to pay to all RW eligible persons including women, infants, children and youth with HIV disease.
- Ensures that Ryan White funds are the payer of last resort.
- Prepares and submits the annual HRSA application for Part A funding.
- Limits the Grantee and provider administrative costs at 10% as established by HRSA and the Ryan White HIV/AIDS Treatment Modernization Act of 2006.
- Assures compliance with all Conditions of Award related to the Part A and MAI grants.
- Participates in local needs assessment and comprehensive planning activities conducted by the Planning Council.
- Manages procurement of RW funds, distributing funds according to priorities established by the Planning Council.
- Oversees timely contracting and payment of agencies. Contracting and payments are conducted through the Fiscal Agent, Associated Black Charities, Inc.
- Provides periodic reports and service utilization to the Planning Council and HRSA.

Research Analysts – QM Roles and Responsibilities:

- Conducts site visits on an annual basis (or as triggered by ongoing monitoring of quality of care) of funded agencies and identifies areas for improvement, as needed through assessment of performance on select indicators.
- The oversight of quality management at their respective primary medical or supportive service care site and are responsible for collecting and reporting data on performance indicators specific to their assigned providers' service areas.
- Provides and facilitates system-wide and individual technical assistance to funded agencies across categories.
- Reports findings to the Planning Council, Administrative partners and sub-recipients at a minimum on an annual basis.
- Requests and collects corrective action plans (CAP) and provides feedback or recommendations on the CAP on an a quarterly basis
- Serves as liaison to the Planning Council and the Planning Council sub-committees.
- Other duties as assigned related to the overall functioning, operation and mandates of the Baltimore EMA Ryan White Part A Office
- Ensures inclusion of performance measure in sub-recipients' work plans (Program Officers)
- Stays abreast of QM activities and priorities (Program Officers)
- Participates in at least two 1-hour long QI training each fiscal year (Program Officers)

QM Committee – QM roles and Responsibilities

The QM committee is responsible for providing oversight of the QM program, and to oversee, guide, assess and improve the quality of HIV services provided by sub-recipients. The QM committee membership will include all Part A CQM staff, including the epidemiologist and two representatives from the planning council (at least one member will

be a person living with HIV/AIDS). QM committee meetings will initially be held every other month either in person, via webinar or conference call.

- Developing and overseeing internal QI activities (refer to the work plan on page 13)
- Discuss performance measurement data to identify priorities for quality improvement projects at the systems or sub-recipient level
- Monitors system wide or sub-recipient level quality improvement projects
- Provides recommendations and updates to the planning council regarding quality improvement projects

C. GREATER BALTIMORE HIV HEALTH SERVICES PLANNING COUNCIL

Quality Management Roles and Responsibilities:

- Through the Continuum of Care Committee, (1) develops and enhances standards of care for the provision of core medical and support services, (2) provides technical input and recommendations to the planning council on the service delivery of core medical and support services
- Through the Comprehensive Planning Committee, (1) collects, analyzes and reports data related to the Baltimore EMA to identify trends and needs to be addressed in planning, (2) oversees procedures and develops recommendations for the prioritizing of HIV services and the allocation of funds
- Reviews the QM Program Annual Quality Management Report for use in priority setting and resource allocation.
- Participates in quality management related trainings and presentations.
- Provides representation from the planning council on the QM Committee

D. RYAN WHITE FUNDED SUBRECIPIENTS

Ryan White funded subcontractors are generally public and private, non-profit agencies contracted to provide the range of allowable core medical and supportive services.

Quality Management Roles and Responsibilities:

- Participates in quality management activities conducted by the Ryan White office Clinical Quality Management Program in accordance with the QM Plan and contractual requirements
- Provide services in accordance with EMA Standards of Care
- Develop and implement an agency-specific quality management plan for Ryan White funded services that includes:
 - Quality Mission Statement
 - Quality Program Infrastructure
 - Annual Quality Goals
 - Capacity Building
 - Performance Measurement
 - Quality Improvement
 - Participation of Stakeholders
 - Work Plan
 - Evaluation
 - Procedures for updating QM Plan
 - Communication
- Conducts quality improvement projects at the agency level both independently and in coordination with the Clinical Quality Management program

- Reports quality management activities and data (including but not limited to client level data) to the Clinical Quality Management program for analysis and identification of system wide or sub-recipient level quality improvement projects on a quarterly basis.
- Requests and receives technical assistance, training and supported, as indicated, from the Clinical Quality Management program
- Maintains involvement with consumers through a consumer advisory board, satisfaction surveys, focus groups or another mechanism for them to have a voice in the program

III. ANNUAL QUALITY GOALS

Internal Quality Goals

The following goals were developed after receiving technical assistance from the National Quality Center. Progress toward achieving these goals will be monitored by the CQM program and will be modified during the annual update to this plan. Please refer to the work plan on page 13.

Goal 1: Establish an internal QM committee and hold regular meetings to provide oversight of the quality program, and to oversee, guide, assess, and improve the quality of HIV services provided by sub-recipients

- Share results of OA with QM committee
- Discuss goals and objectives of the QM plan
- Set a regular meeting schedule to provide the platform for providing oversight of the EMA wide QM program
- Select performance measures for the EMA

Goal 2: Update the QM plan with all components listed in A3 and additionally include: The process and timeline to review the sub-recipient QI data; The process and time line for reporting back data findings to sub-recipients and recommendations of QI activities based on data; The process and time line for reviewing CAPs and to make recommendations from the CAPs

- Review OA, incorporate recommendations into QM plan and begin implementation of recommendation s
- Share revised QM plan with sub-recipients and Planning Council

Goal 3: Standardize the use of quality indicators for PMC and support services based on the HRSA/HAB core indicators

- Include quality indicators with benchmarks for PMC, Co Morbidity and Medical Case Management into RFPs
- Recommend for PMC providers to collect and report data on all 4 HRSA/HAB core indicators
- Develop a survey for sub-recipients to determine which of the core indicators will be used for support services. (Recommend gap in medical visits and medical visit frequency. Also, recommend the consideration of the Systems-Level indicator-Linkage to HIV Medical Care.)

Goal 4: Review sub-recipient client level data submissions

- Use CLD to evaluate provider performance and to identify sub-recipient QI activities

- Report data back to the sub-recipients with recommendations for QI based on their data in a timely manner. (Ideally no later than one month after submission.)
- Continue to require CAPs for providers performing less than optimally
- Respond to CAPs with recommendations in a timely manner (Ideally no later than one month after submission.)

Goal 5: Use sub-recipient data to determine and establish EMA QI goals

- Trend and compare sub-recipient data to a larger aggregate data set-i.e.: HRSA or HIVQUAL
- Set benchmarks for viral load suppression and retention in care

Goal 6: Develop a process and procedures for evaluating the BCHD and sub-recipient QI activities to determine on-going improvement needs and facilitate planning for the next year.

Sub-recipient Goals

The following goals were developed for sub-recipients:

Goal 1: Ensure that each sub-recipient has a written quality management plan

- Review all sub-recipient's quality management plans and assess according to the HAB and NQC requirements
- Report findings back to sub-recipients and QM committee on an annual basis
- Provide training and support to sub-recipients that need to revise their QM plans

Goal 2: Aid in the development of performance measures and performance targets

- Participate in CQM trainings to develop performance measures and targets
- Adopt performance measures for at least one category into annual QM plan

Goal 3: Implement applicable FY15 performance measures

Goal 4: Submit quality improvement plans and projects for low performing areas found during the FY14 site visits.

- Develop and submit a quality improvement plan that documents the strategy, timeline and implementation of a quality improvement project

8. Participate in capacity building and quality improvement activities provided by the CQM Program

IV. PERFORMANCE MEASUREMENT

The Baltimore EMA has adopted the HRSA HAB Performance measures for Primary Medical Care, Oral Health Care and Medical Case Management. These measures are available online (<http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html>) and will be collected on an annual basis by the Grantee via client level data, medical record abstraction or a combination of the two methods.

The Ryan White Part A sub-recipients established the measures for the remaining categories. See the Appendix for a listing of all performance measures.

Service Category Evaluation Procedures

The Ryan White Clinical Quality Management Program is responsible for the regular collection, analysis and reporting of quality management data and provision of technical assistance. These data include, but are not limited to: medical records (paper or electronic), client level data submissions, and client/staff interviews.

Annually, the CQM team will analyze client level data submission from selected providers or across selected categories in 3 month intervals. Reports will be generated per provider, across categories and measures. A quality improvement project will be required if:

- performance is off by more than 5% on a performance measure;
- if performance has declined by more than 5%;
- or if a provider is one of the 5 lowest performers.

Alternatively, medical record reviews will be conducted from sub-recipients annually to complete quality checks, gather benchmark data and/or to provide technical assistance. Data collection will be implemented utilizing appropriate sampling methodology and will include a review of services currently provided. Service categories to be reviewed will be selected in consultation with the QM committee. For each data collection activity scheduled in the QM Work plan, a data collection plan will be developed with input from the QM Committee that specifies:

- The service category to be reviewed
- The measures to be collected
- The frequency by which the measures are to be collected
- The methods used to collect the data
- The methods used to analyze the data
- The methods for data security (including issues relating to confidentiality of client-specific data, how long the data and instruments will be stored and how they will be stored)
- How and to whom the findings will be reported

All data collection efforts should place as minimal burden as possible on the sub-recipients and should minimize any interference with the routine operations of the agencies. Where deficiencies or areas for improvement are identified, technical assistance will be provided.

The development of new data collection instruments should follow standard survey research practices: planning, pretesting, revision and instrument finalization. Persons involved with the data collection will be bound by agency, local, state and federal regulations regarding confidentiality. Individuals involved in data collection will receive appropriate training regarding their role, the confidentiality and security of data, and other ethical issues.

V. CAPACITY BUILDING

To ensure that RW Grantee staff and sub-recipients understand quality management and are aware of the need for continuous improvement, regular education and training will be provided. All stakeholders will have access to the EMA's Quality Management plan, accessible on the Baltimore City Health Department's website.

Internal Capacity Building:

RW Grantee staff will stay abreast of QM activities and priorities through participating in trainings, webinars and other capacity building activities sponsored through HAB, the National Quality Center. These include trainings such as:

- Training of the Trainers
- Training on Coaching Basics
- Training of Quality Leaders
- Monthly webinars through the NQC
- Participation in the Maryland Regional Group
- Other Health Department, Bureau or QM sponsored trainings

Staff are also encouraged to undertake personal projects for submission to the Grantee administration, planning council, QM committee, relevant professional conferences and others.

Technical assistance will be requested as needed from HAB, National Quality Center and other partners deemed appropriate to address capacity building needs.

Sub-Recipient Capacity Building:

Sub-recipients will participate in a minimum of 3 trainings or webinars related to quality management and quality improvement activities. They will be invited to participate in HAB/NQC sponsored webinars. By contract, they are required to participate in all QM activities. Technical assistance will be provided by the Grantee or other partners as needed or as requested by sub-recipients.

VI. QUALITY IMPROVEMENT

In order to provide training and practice in quality management methodology, the Grantee will work with sub-recipients to reinforce knowledge and practical skills for performance improvement.

QI Methodology & Project Implementation

Use of causal analysis, work flow diagrams, and Plan-Do-Study-Act cycles will be used to identify and implement quality improvement projects in the EMA and at the sub-recipient level. Service category specific areas for improvement will be prioritized through the QM committee and with the planning council.

Service providers will be expected to implement no more than 4 QI projects in a fiscal year, this includes any system wide QI projects. If a service provider is performing at goal for all service funded categories, then the service provider may select a QI project on any other measure of interest. As stated above, a quality improvement plan will be required if performance is off by more than 5%, has declined by 5% or if a provider is one of the lowest 5 performers on a measure. Feedback and recommendations on quality improvement projects/plans will be provided within 30 days after receiving the plan.

QI project teams are established by the Ryan White Office CQM Program to work on specific quality improvement projects with sub-recipients. The composition of the teams will change based on the

nature of the project, the service category or sub-recipient. Roles and responsibilities for the Internal QI Project Teams and sub-recipient project teams are as follows:

Internal QI Project Teams:

- Identifies the area for improvement that will be the basis of the QI project
- Works with the sub-recipients to delineate goals for the project and develop a timeline for implementation
- Delineate responsibilities to the sub-recipients (e.g., development of the improvement project/PDSA test cycles)
- Develops a data collection plan with the sub-recipient for each project
- Identify potential solutions to make improvement on performance measures
- Report to Grantee Administration and QM Committee on progress (sub-recipient programs will not be identified but their progress on a project will be)
- Monitor sub-recipient project teams

Sub-recipient Project Teams:

- Sub-recipients determine the root causes of the problem
- Completes a PDSA project cycle
- Document and track progress on the project
- Shares progress on the project with the Internal QI Project Team Leader
- Develop long term plans to maintain the QI project

VII. COMMUNICATION

Communication with key stakeholders in the EMA will include email correspondence, on site training, presentations at Part A provider meetings or other regional meetings, planning council committees, QM committee meetings, webinars and conference calls.

Findings from quality management activities will be reported only in the aggregate. Service category data will be provided in aggregate. CQM may provide agency-specific data reports directly to each sub-recipient for the purpose of enhancing their quality management program one month after each three month interval (e.g. data submitted March through May will be reported in July). Aggregate level performance will be shared quarterly with the planning council members and key stakeholders. The QM program's Annual Quality Management Report to the planning council will summarize the findings and results from the activities conducted by CQM.

VIII. PARTICIPATION OF STAKEHOLDERS

Consumer Involvement

The consumer voice in the development and planning of the EMA quality management activities is important. The HRSA recommended consumer advisory board is the ideal method to hear the needs and concerns of consumers however this is not required. Other methods of obtaining consumer input include focus groups, suggestion boxes and patient satisfaction surveys. Sub-recipients are encouraged to utilize at least one of these methods to gain consumer input.

At the grantee level, at least one consumer will sit on the QM committee. The consumer will be able to provide their perspective on the development, implementation and evaluation of the EMA's QM program, which guides the quality of programs and services that meet their needs.

Stakeholder Involvement

The Grantee will work with other stakeholders, including other RW Grantees in the region for quality improvement purposes. This will be carried out through participation in the Maryland Regional Group, with representatives from Parts B, C and D. Collaborations on site visits, development of performance measures and regional quality improvement projects are also other ways to involve stakeholders in the QM program.

IV. EVALUATION OF THE QUALITY PROGRAM

Beginning January of each Fiscal Year (i.e., by January 2016 for FY2015), the QM Program and QM Plan will be evaluated for the ability to support and sustain quality improvement activities in the Baltimore EMA.

Evaluation of the QM Program will be led by the Deputy Director for Quality Management with support from CQM Research Analysts and the QM committee on an annual basis. Evaluation will be completed using the Organizational Assessment provided by the National Quality Center Coach and other means such as surveys or other methods deemed appropriate by the QM committee.

The evaluation will include a review of the program's infrastructure, evaluation of quality improvement activities and appropriateness and results of performance measures. The results will be used to plan for future quality activities and shared with the QM committee, Grantee administration and sub-recipients.

Procedures for updating the QM Plan

The quality management plan will be revisited at least annually and will be modified based on:

- Organizational Assessment findings
- Success of annual internal QM goals
- Success of goals set with/for sub-recipients
- Review of the client level data to determine where either EMA wide or sub-recipient level projects is needed
- Success of internal QM Project Teams in moving sub-recipients through QI projects

X. Ryan White Part A Clinical Quality Management Program Work Plan for FY2015

The following work plan has been developed for Fiscal Year 2015. Goals for FY2016 will be developed pending the evaluation of FY2015 goals.

Baltimore EMA Quality Management Program Work Plan 2015			
Goal	Activities	Person(s) Responsible	Timeline
Goal 1. Establish an internal QM committee and hold regular meetings to provide oversight of the quality program, and to oversee, guide, assess, and improve the quality of HIV services provided by sub-recipients	<ul style="list-style-type: none"> i. Share results of OA with committee ii. Discuss goals and objectives of the QM plan iii. Set a regular meeting schedule to provide the platform for providing oversight of the QM program 	Christy Catherine Rodrique Nargis	By April 2015
Goal 2: Update the QM plan with all components listed in A3 and additionally include: a. The process and timeline to review the sub-recipient QI data, b. The process and time line for reporting back data findings to sub-recipients and recommendations of QI activities based on data, c. The process and time line for reviewing CAPs and to make recommendations from the CAPs,	<ul style="list-style-type: none"> i. Review OA, incorporate recommendations into QM plan and begin implementation of recommendation s ii. Share revised QM plan with Sub Grantees and Planning Council 	Christy Catherine Rodrique Nargis	By March 2015
Goal 3: Standardize the use of quality indicators for PMC and support services based on the HRSA/HAB core indicators	<ul style="list-style-type: none"> i. Include quality indicators with benchmarks for PMC, Co Morbidity and Medical Case Management into RFPs ii. Recommend for PMC providers to collect and report data on all 4 HRSA/HAB core indicators iii. Develop a survey for sub-recipients to determine which of the core indicators will be used for support services. 	Christy Sub Grantees	<ul style="list-style-type: none"> i. By Nov. 2014 ii. By Nov.2014 iii. ByMar. 2015
Goal 4: Review sub-recipient data	<ul style="list-style-type: none"> i. Use CLD to evaluate provider performance and to identify sub- 	Christy Catherine	Ongoing beginning June 2015

	<p>recipient QI activities</p> <p>ii. Report data back to the sub-recipients with recommendations for QI based on their data in a timely manner. (Ideally no later than one month after submission.)</p> <p>iii. Continue to require CAPs for providers performing less than optimally</p> <p>iv. Respond to CAPs with recommendations in a timely manner (Ideally no later than one month after submission.)</p>	Rodrique Nargis Yohannes	
Goal 5: Use sub-recipient data to determine and establish EMA QI goals	<p>i. Trend and compare sub-recipient data to a larger aggregate data set-i.e.: HRSA or HIVQUAL</p> <p>ii. Set benchmarks for viral load suppression and retention in care</p>	Christy Yohannes	Ongoing beginning June 2015
Goal 6: Develop a process and procedures for evaluating the BCHD and sub-recipient QI activities to determine on-going improvement needs and facilitate planning for the next year.	<p>i. Develop a performance measure dictionary for all service categories</p> <p>ii. Asses sub-recipients for adherence to standards and to compare chart abstraction/CLD findings to performance measure targets</p>	Christy Catherine Rodrique Nargis Yohannes	By December 2015
Goal 7: Participation in the Maryland Regional Group to increase viral suppression in the state of Maryland	<p>i. Attend all MD RG meetings</p> <p>ii. Provide necessary data and resources to support the MD RG</p>	Christy Lin	By December 2015

XI. Ryan White Part A Clinical Quality Management Data Collection Plan 2015-2017

Activity	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
<p>Data Collection via Chart Abstraction and or Client Level Data</p> <p>Develop methodology, pilot data collection plan and instruments</p> <p>Measure quality of care for service categories</p> <p>Develop reports from service categories; Provide to Part A administration, Planning Council and sub-recipients</p>	<p>All Funded Service categories excluding EFA categories. Utilization for EFA categories are reported on monthly to BCHD and the planning council.</p>	<p>TBD</p>	<p>TBD</p>
<p>Implement QI Projects</p>	<ul style="list-style-type: none"> • Coordinate identification and implementation of at least 3 quality improvement projects for service categories reviewed • Coordinate QI project teams at agencies targeted for capacity building • Identify and implement quality improvement projects 	<p>→</p> <p>→</p>	<p>→</p> <p>→</p>
<p>Sub-recipient Level QM Program</p>	<ul style="list-style-type: none"> • Review sub-recipient level quality management plans and activities 	<p>→</p>	<p>→</p>

	<ul style="list-style-type: none"> Assist with implementation of quality improvement projects per agency's quality management plan 		
QM Training	<ul style="list-style-type: none"> Provided a minimum of 3 capacity building/technical assistance trainings to agencies across categories and individually 		

APPENDIX A. FY2015 PERFORMANCE MEASURES DICTIONARY

INTRODUCTION

The Baltimore Towson EMA is comprised of nearly 40 Ryan White Part A sub-recipients who provide core medical and support services to people living with HIV/AIDS (PLWHA). One goal of the Ryan White Quality Management Program is to standardize the use of quality measures for clinical and non-clinical services among the sub-recipients. Since 2009, the Baltimore Towson EMA QM program had implemented the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) performance measures for outpatient ambulatory health services, oral health services and medical case management. Although the EMA had standards of care for support services, there were no performance measures for them.

Following technical assistance from the National Quality Center, the Grantee worked with sub-recipients and members of the PLWHA community to develop performance measures for support service categories. Using the HIV Care Continuum – a model that outlines the sequential stages that PLWHA move through from initial diagnosis of HIV through viral suppression¹ – the EMA developed performance measures that could be linked to each stage of the care continuum. This document outlines the FY2015 performance measures and performance targets for core medical and support service categories.

Clinical performance measures will be updated as they are updated by HRSA HAB. Support service measures and targets will be evaluated for appropriateness and usefulness on an annual basis.

¹ <https://www.aids.gov/federal-resources/policies/care-continuum/>

OUTPATIENT AMBULATORY HEALTH SERVICES INCLUDING CO-MORBIDITY²

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Viral Load Suppression</u> *– the percentage of clients, regardless of age, with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement period	Number of clients with an HIV viral load less than 200 copies/mL at the last test during the measurement period	Number of clients, regardless of age, with at least one medical visit during the measurement period	85%	Client Level Data Chart Abstraction	None
<u>Prescription of ARV Therapy</u> – the percentage of clients, regardless of age, prescribed antiretroviral therapy for the treatment of HIV during the measurement period	Number of clients prescribed ARV therapy during the measurement period	Number of clients, regardless of age, with at least one medical visit during the measurement period	91%	Client Level Data Chart Abstraction	None
<u>HIV Medical Visits Frequency</u>* – the percentage of clients, regardless of age, 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 each visit	Number of clients 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 each visit	Number of clients with at least one medical visit in the first 6 months of the 24 month measurement period	90%	Chart Abstraction	Clients who died during the 24 month measurement period
<u>Gap in Medical Visits</u>*– the percentage of clients, regardless of age, who did not have a medical visit in the last 6 months of the measurement period	Number of clients who did not have a medical visit in the last 6 months of the measurement period	Number of clients who had at least one medical visit in the first 6 months of the measurement period	14%	Chart Abstraction	Clients who died during the 24 month measurement period
<u>PCP Prophylaxis</u> – the percentage of clients, aged 6 weeks or older, who were prescribed PCP	(1) Number of clients who were prescribed PCP within 3 months of CD4 below 200 cells/mm ³ ----- (2) Number of clients aged	(1) Number of clients aged 6 years and older with a CD4 below 200 cells/mm ³ ----- (2) Number of clients aged	87%	Client Level Data Chart Abstraction	(1) Clients with a CD4 above 200 cells/mm ³ during the 3 months after a

² <http://hab.hrsa.gov/deliverhivaidscore/coremeasures.pdf>

(2) Number of clients who were prescribed PCP within 3 months of a CD4 below 500 cells/mm ³	1 through 5 with a CD4 below 500 cells/mm ³	CD4 count below 200 cells/mm ³
(3) Number of clients who were prescribed PCP at the time of HIV diagnosis	(3) Clients aged 6 weeks through 12 months	Clients with a CD4 above 500 cells/mm ³ during the three months after a CD4 count below 500 cells/mm ³

Note: Measures marked with '*' are also performance measures for Co-Morbidity

ORAL HEALTH SERVICES³

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Dental and Medical History</u>– the percentage of clients who had a dental and medical health history at least once in the measurement period	Number of clients who had a dental and medical health history at least once in the measurement period		75%	Chart Abstraction	
<u>Dental Treatment Plan</u> – the percentage of clients who had a dental treatment plan developed or updated at least once in the measurement period	Number of clients who had a dental treatment plan developed or updated at least once in the measurement period	Number of clients that received a clinical oral evaluation at least once in the measurement period	90%	Chart Abstraction	Clients who had only an evaluation or treatment for dental emergency
<u>Oral Health Education</u> – the percentage of clients who received oral health education at least once in the measurement period	Number of clients who received oral health education at least once in the measurement period		75%	Chart Abstraction	
<u>Phase I Treatment Plan Completion</u> – the percentage of clients, with a Phase I treatment plan completed within 12 months	Number of clients that completed Phase I treatment within 12 months of establishing a treatment plan	Number of clients with a Phase I treatment plan established in the year prior to the measurement period	60%	Chart Abstraction	
<u>Periodontal Screening or Exam</u>– the percentage of clients who had a periodontal screen or exam at least once in the measurement period	Number of clients who had a periodontal screen or exam at least once in the measurement period	Number of clients that received a clinical oral evaluation at least once in the measurement period	55%	Chart Abstraction	Same as above including Edentulist clients

³ <http://hab.hrsa.gov/deliverhivaidscares/oralhealthmeasures.pdf>

MEDICAL CASE MANAGEMENT⁴

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Viral Load Suppression</u> – the percentage of clients, regardless of age, with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement period	Number of clients with an HIV viral load less than 200 copies/mL at the last test during the measurement period	Number of clients, regardless of age, with at least one medical visit during the measurement period	85%	Client Level Data Chart Abstraction	None
<u>HIV Medical Visits Frequency</u> – the percentage of clients, regardless of age, 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 each visit	Number of clients 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 each visit	Number of clients with at least one medical visit in the first 6 months of the 24 month measurement period	90%	Chart Abstraction	Clients who died during the 24 month measurement period
<u>Gap in Medical Visits</u>– the percentage of clients, regardless of age, who did not have a medical visit in the last 6 months of the measurement period	Number of clients who did not have a medical visit in the last 6 months of the measurement period	Number of clients who had at least one medical visit in the first 6 months of the measurement period	14%	Chart Abstraction	Clients who died during the 24 month measurement period
<u>Care Plan</u> – the percentage of clients with a care plan developed or updated 2 more times in the measurement period	Number of clients with a care plan developed or updated 2 or more times in the measurement period	Number of clients with at least 2 MCM visits in the measurement period	85%	Chart Abstraction	None

⁴ <http://hab.hrsa.gov/deliverhivaidscore/medicalcasemanagementmeasures.pdf>

MEDICAL NUTRITION THERAPY

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Care Plan – the percentage of clients with a written care plan in the measurement period	Number of clients with a written care plan in the measurement period	Number of clients with at least 1 MNT visit in the measurement period	85%	Chart Abstraction	Plan must be developed by the 3 rd MNT visit
BIA with Interpretation – the percentage of clients with a BIA completed at intake and annually thereafter in the measurement period	Number of clients with a BIA completed at intake and annually thereafter in the measurement period	Number of clients with at least 1 MNT visit in the measurement period	70%	Chart Abstraction	
Retention in MNT Care– the percentage of clients with at least 1 service visit annually (in addition to the initial service visit) in the measurement period	Number of clients with at least 1 service visit annually (in addition to the initial service visit) in the measurement period	Number of clients with at least 1 MNT visit in the measurement period	90%	Chart Abstraction	Clients new to MNT care in the last 6 mo. of the measurement period
Weight Control – the percentage of clients gaining weight or maintaining weight in the measurement period	Number of clients gaining weight or maintaining weight in the measurement period	Number of clients with at least 1 MNT visit in the measurement period	50%	Chart Abstraction	Clients for whom weight control was not a goal

SUBSTANCE ABUSE OUTPATIENT

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Retention in SA Treatment</u> – the percentage of clients attending at least 2 SA outpatient appointments in the measurement period	Number of clients attending at least 2 SA outpatient appointments in the measurement period	Number of clients with at least 1 SA visit in the measurement period	70%	Chart Abstraction	
<u>Baseline Assessment</u>– the percentage of clients with a comprehensive baseline assessment addressing client’s treatment and social needs in the measurement period	Number of clients with a comprehensive baseline assessment addressing client’s treatment and social needs in the measurement period	Number of clients with at least 1 SA visit in the measurement period	85%	Chart Abstraction	
<u>Care Plan</u>– the percentage of clients with a care plan or at least one care plan update every 90 days in the measurement period	Number of clients with a care plan or at least one care plan update every 90 days in the measurement period	Number of clients with at least 1 SA visit in the measurement period	85%	Chart Abstraction	
<u>Treatment Completion</u> – the percentage of clients completing SA treatment in the measurement period	Number of clients completing SA treatment in the measurement period	Number of clients with at least 1 SA visit in the measurement period	30%	Chart Abstraction	

HEALTH INSURANCE PREMIUMS & COST SHARING ASSISTANCE

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Viral Load Suppression– the percentage of clients with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement period	Number of clients with an HIV viral load less than 200 copies/mL at the last test during the measurement period	Number of clients receiving at least 1 HI assistance during the measurement period	85%	Client Level Data Chart Abstraction	None

HOSPICE

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Baseline Assessment– the percentage of clients on admission assessed for pain, respiratory status, medications, patient preferences and beliefs and values in the measurement period	Number of clients on admission assessed for pain, respiratory status, medications, patient preferences and beliefs and values during the measurement period	Number of clients receiving Hospice service during the measurement period	90%	Chart Abstraction	None

MENTAL HEALTH

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Retention in Mental Health</u> – the percentage of clients attending at least 2 MH appointments during the measurement period	Number of clients attending at least 2 MH appointments in the measurement period	Number of clients with at least 1 MH visit in the measurement period	70%	Chart Abstraction	
<u>Baseline Assessment</u>– the percentage of clients with an initial assessment prior to the initiation of treatment during the measurement period	Number of clients with an initial evaluation prior to the initiation of treatment during the measurement period	Number of clients with at least 1 MH visit in the measurement period	85%	Chart Abstraction	Clients continuing in MH treatment
<u>Care Plan</u>– the percentage of clients with a care plan or at least one care plan update every 6 months in the measurement period	Number of clients with a care plan or at least one care plan update every 6 months in the measurement period	Number of clients with at least 1 MH visit in the measurement period	85%	Chart Abstraction	

MEDICAL TRANSPORTATION

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Retention in Medical Care</u> – the percentage of clients attending at least 2 medical appointments during the measurement period	Number of clients attending at least 2 medical appointments in the measurement period	Number of clients with at least 2 transports/assistances <u>to Medical Care</u> during the measurement period	70%	Chart Abstraction	
<u>Retention in Support Service</u> – the percentage of clients attending at least 2 support appointments during the measurement period	Number of clients attending at least 2 support appointments in the measurement period	Number of clients with at least 2 transports/assistances <u>to Support Services</u> during the measurement period	70%	Chart Abstraction	

CASE MANAGEMENT (NON-MEDICAL)

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Care Plan – the percentage of clients with a written care plan during the measurement period	Number of clients with a written care plan during the measurement period	Number of clients with at least 1 case management visit during the measurement period	80%	Chart Abstractio n	
Access to Support Services – the percentage of clients needing social/community/legal/financial services that obtained these services during the measurement period	Number of clients needing social/community/legal/financial services that obtained these services during the measurement period	Number of clients needing social/community/legal/financial services	85%	Chart Abstractio n	

FOOD BANK/HOME DELIVERED MEALS*

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Care Plan – the percentage of clients with a written care plan in the measurement period	Number of clients with a written care plan in the measurement period	Number of clients with at least 1 food bank service in the measurement period	85%	Chart Abstraction	
Weight Control – the percentage of clients gaining weight or maintaining weight in the measurement period	Number of clients gaining weight or maintaining weight in the measurement period	Number of clients with at least 1 MNT visit in the measurement period	50%	Chart Abstraction	Clients for whom weight control was not a goal

*Does not include Emergency Financial Assistance

PSYCHOSOCIAL

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Retention in Medical Care – the percentage of clients attending at least 2 HIV medical visits during the measurement period	Number of clients attending at least 2 HIV medical visits during the measurement period	Number of clients with at least 1 Psychosocial activity/visit during the measurement period	90%	Chart Abstraction	

HOUSING*

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Permanent Housing – the percentage of clients gaining permanent housing during the measurement period	Number of clients gaining permanent housing during the measurement period	Number of clients with at least 1 Housing service in the measurement period	60%	Chart Abstraction	
Care Plan – the percentage of clients with a written housing plan during the measurement period	Number of clients with a written housing plan during the measurement period	Number of clients with at least 1 Housing service in the measurement period	85%	Chart Abstraction	

*Does not include Emergency Financial Assistance

SUBSTANCE ABUSE RESIDENTIAL

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Baseline Assessment – the percentage of clients with a comprehensive baseline assessment addressing client’s treatment and social needs in the measurement period	Number of clients with a comprehensive baseline assessment addressing client’s treatment and social needs in the measurement period	Number of clients with at least 1 SA visit in the measurement period	85%	Chart Abstraction	
Care Plan – the percentage of clients with a care plan or at least one care plan update during the measurement period	Number of clients with a care plan or at least one care plan update during the measurement period	Number of clients with at least 1 SA visit in the measurement period	85%	Chart Abstraction	
Treatment Completion – the percentage of clients completing residential SA treatment in the measurement period	Number of clients completing residential SA treatment in the measurement period	Number of clients with at least 1 SA visit in the measurement period	30%	Chart Abstraction	

LEGAL SERVICES

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
Access to Entitlement Services – the percentage of clients obtaining entitlement services during the measurement period	Number of clients obtaining entitlement services during the measurement period	Number of clients needing entitlement services during the measurement period	90%	Chart Abstraction	
Baseline Assessment– the percentage of clients with an assessment of the legal situation during the measurement period	Number of clients with an assessment of the legal situation during the measurement period	Number of clients with at least 1 Legal visit/service during the measurement period	85%	Chart Abstraction	
Success of Appeals – the percentage of clients denied SSI/SSDI with successful appeals during the measurement period	Number of clients denied SSI/SSDI <u>who wanted to appeal</u> that had successful appeals during the measurement period	Number of clients denied SSI/SSDI during the measurement period	90%	Chart Abstraction	

OUTREACH SERVICES

Performance Measure	Numerator	Denominator	Target	Data Sources	Exclusions
<u>Linkage to HIV Medical Care</u> – the percentage of clients attending 1 or more HIV medical visits during the measurement period	Number of clients attending 1 or more HIV medical visits during the measurement period	Number of clients encountered by Outreach <u>not currently in HIV medical Care</u>	70%	Chart Abstraction Client Level Data	
<u>Linkage to HIV Medical Care (Newly Diagnosed)</u>– the percentage of clients newly diagnosed with HIV that attended 1 HIV medical visit within 3 months of HIV diagnosis during the measurement period	Number of newly diagnosed clients with HIV that attended 1 HIV medical visit within 3 months of HIV diagnosis during the measurement period	Number of newly diagnosed clients during the measurement period	75%	Chart Abstraction Client Level Data	