Annual Quality Management Plan
Calendar Year 2022

Approved on 04/26/2022 HS

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Section 1: INTRODUCTION

As a Ryan White Part A (RWPA) recipient, Clark County manages a Clinical Quality Management (CQM) program that develops and oversees the CQI plan to ensure that HIV health services are consistent with the most recent Health and Human Services (HHS) Guidelines and clinical practice standards. This plan is considered a "living" document intended to be modified and updated as part of the RWPA clinical quality improvement process.

Section 2: QUALITY STATEMENT

Shared Mission

The mission of the RWPA CQM program is to implement a proactive process that can positively impact health outcomes of people accessing core medical and support services.

Shared Vision

RWPA creates an annual integrated CQI plan and quality improvement system to support subrecipients so they can deliver optimal care services and quality of care that will make a positive difference in the lives of persons infected and affected by HIV.

Section 3: ANNUAL QUALITY GOALS

The Annual Quality Management Plan outlines how the Clinical Quality Management (CQM) program will be implemented for the current calendar year, including a clear indication of roles, responsibilities, accountability, performance measurement strategies, annual quality goals, a workplan, a timeline for quality activities, data collection strategies, reporting mechanisms, and the elaboration of processes for ongoing evaluation and assessment of the program. The Clinical Quality Improvement (CQI) Advisory Committee and designated Single Points of Contacts (SPOCs) from each agency will guide the review, revision, and implementation of the annual quality plan. The final approval will be granted by the Grant Administrator.

Goal 1: Promote continuous quality improvement initiatives across the TGA.
Goal 2: Improve the quality of core medical and support services provided by TGA.
Goal 3: Improve the performance measurement system to appropriately assess outcomes for people with HIV.
Goal 4: Ensure the comprehensive involvement of people with HIV in the quality improvement process.

Section 4: QUALITY INFRASTRUCTURE

Clinical Quality Improvement (CQI) Advisory Committee

A description of the CQI Advisory Committee consists of several essential individuals that work together in a synchronized and ongoing manner, to improve **P**atient **C**are, **H**ealth **O**utcomes, and **P**atient **S**atisfaction (PCHOPS). A list of the committee's roles and responsibilities is defined on the table below. The committee will be responsible for participating in quarterly meetings to review performance measures and system-wide challenges. Participation is a Part A program requirement, not an option (see Section F of the National Monitoring Standards).

Clinical Quality Improvement Advisory Committee		
Representative	**Roles**	**Responsibilities**
Part A Heather Shoop	Ryan White Program Manager	• Endorses, champions, and promotes the CQI program and approves the CQI plan • Raises the visibility of the CQI program and activities • Has final accountability of the CQI program • Provides overarching leadership and support
Part A Jessica Rios	Quality Manager	• Chairs, oversees, and facilitates the quarterly CQI committee meetings (March, June, September, and December) • Starts and ends meetings on time and moves the agenda forward • Encourages committee participation • Responsible for writing and implementing the CQI annual plan and related activities • Provides one on one training to subrecipients and shares resources for capacity building purposes • Disseminates programmatic activities and accomplishments • Communicates systematic updates to the service providers, consumers, Planning Council, and community at large
Part A Staff Tiffany Evans Tony Garcia Vanessa Cruz (Ad-Hoc) Octavio Posada (Ad-Hoc)	Committee Members	• Provides guidance in the selection and implementation of Quality Improvement projects based on trends and needs of the service delivery system. Posts CQI agenda, meeting minutes, and resources to the LVTGA website • Provides guidance directed at policies, procedures, and the compliance component of the CQI program • Provides support to the CQI program in relation to EHE Initiatives
Part A Subrecipients	Committee Members	• Provides guidance for QI projects • Accountable for entering current and consistent, service data for collection and reporting purposes • Conducts consumer satisfaction surveys to measure the impact of the RWPA Program • Actively participates and collaborates as subject matter experts • Are involved in every aspect of the CQI plan and drives QI in a proactive manner • Meets contract deliverables, participates in conducting PDSA cycles

		• Presents PDSA findings at quarterly meetings and / or shares findings to the Planning Council
TriYoung Staff	Data Contractor/Consultant	• Provides statistical reports that consist of tracking clinical behavior in CAREWare to support QI • Collaborates with Quality Manager to track and extract performance measures to identify performance variance, root causes of underperformance, and areas that fall short of QI (PCHOPS) • Imports current VL, CD4s, and other care labs from both local and state health departments to ensure accurate reporting as needed for QI
Part B (Ad-Hoc)	Clinical Quality Manager	• Collaborates with RWPA Quality Manager to align and leverage community-wide efforts aimed at improving PCHOPS • Shares resources, knowledge, and expertise by providing input on CQM activities to be carried out • Requests data from State HIV Surveillance, Office of Public Health and Epidemiology (OPHIE) Program
Part C	Clinical Quality Manager	• Collaborates with the RWPA Quality Manager to align efforts and contribute expertise to QI activities • Shares ideas and results for QI initiatives • Enhances communication, resources, and service implementation across the HIV continuum
Part D (Ad-Hoc)		• Collaborates with RWPA Quality Manager to align and leverage community-wide efforts aimed at improving PCHOPS • Shares resources, knowledge, and expertise by providing input on CQI activities to be carried out
Community Stakeholders		
Internal Stakeholder	**Participation**	**Task**
Part A Planning Council (Ad-Hoc)	• Reviews and utilizes data • Reports as part of the priority setting and resource allocation • Identifies areas for improvement • Provides and periodically updates standards of care for the TGA • Reviews and utilizes service data and reports • Uses quality management data in decision making	• Data Reports: ex: performance measures and service utilization • Monthly meetings • Research best practices and work done by other/similar TGAs

Consumers (Ad-Hoc)	• Participates in the Planning Council committee and CQI committee • Participates in satisfaction surveys and focus groups	• Participate in Surveys • Participate in monthly / quarterly meetings
External Stakeholders	**Participation**	**Task**
HRSA	Establishes guidelines and standards for performance and program compliance	
Pacific AIDS Education and Training Center (PAETC)	AETC provides targeted, multidisciplinary education and training programs for healthcare providers, including presentations on updated clinical guidelines, information, on new pharmaceuticals and chronic disease management	

Section 5: EVALUATION

The Quality Manager updates and evaluates the CQI plan annually with the guidance and support from the LVTGA subrecipients that participate as SPOCs in the CQI advisory committee.

To evaluate our efforts, the Quality Manager collects and analyzes both qualitative and quantitative methods of data. Subrecipients share descriptive qualitative data as a method of inquiry to provide context and a better understanding of what type of care is provided as well as how care is provided to inform health care practices.

SPOCs from each agency complete a Plan, Do, Study, Act (PDSA) template to document and evaluate PDSA cycles on a quarterly basis (April, July, October, and January). The committee also produces an annual report of the monitored performance measures and compares the data to our benchmark and the goal or predicted outcome. Collectively, committee members share what was learned during the PDSA cycle by sharing problems, successes, including surprises. If the committee is not satisfied with the results, we will iterate through the process and repeat the cycle with different strategies until the desired process or outcome is satisfactory.

Section 6: PERFORMANCE MEASUREMENT

Performance measurement is the systematic collection and analysis of data. A successful program translates into viral suppression. Performance measures are required, at minimum for any Service Category utilized by 15% or more of clients in the Las Vegas TGA. Performance measures shall be defined by the COUNTY and included in contracts for subrecipients funded to provide these services that meet this criterion to ensure that we are meeting the minimum required Performance Measures per funded service category as prescribed on page 4 of Policy Clarification Notice (PCN) 15-02.

Performance measurement indicators let us know how we are doing; they also inform us if we met our goals, if improvements are necessary, whether our consumers are satisfied, and if our process aligns with our plan. Since the CAREWare database is "live," the CQI committee SPOCs shall monitor and analyze data over time and every quarter, at minimum (April, July, October, and January). The 2021 LVTGA **Service Utilization Data Report** can be found here.

The Quality Manager and SPOCs collects and analyzes performance measurement data to review and discuss the performance measurement status and progress with the CQI committee members and stakeholders. The LVTGA is currently monitoring the following service categories: Early Intervention Services (EIS), Medical Case Management (MCM), Outpatient Ambulatory Health Services (OAHS). Because a successful program translates into viral suppression, “support service” agencies will also monitor their clients’ viral suppression. The CQI committee will use the performance measurement data to identify, stratify, and prioritize QI projects and goals (Performance Measures are defined are on page 13).

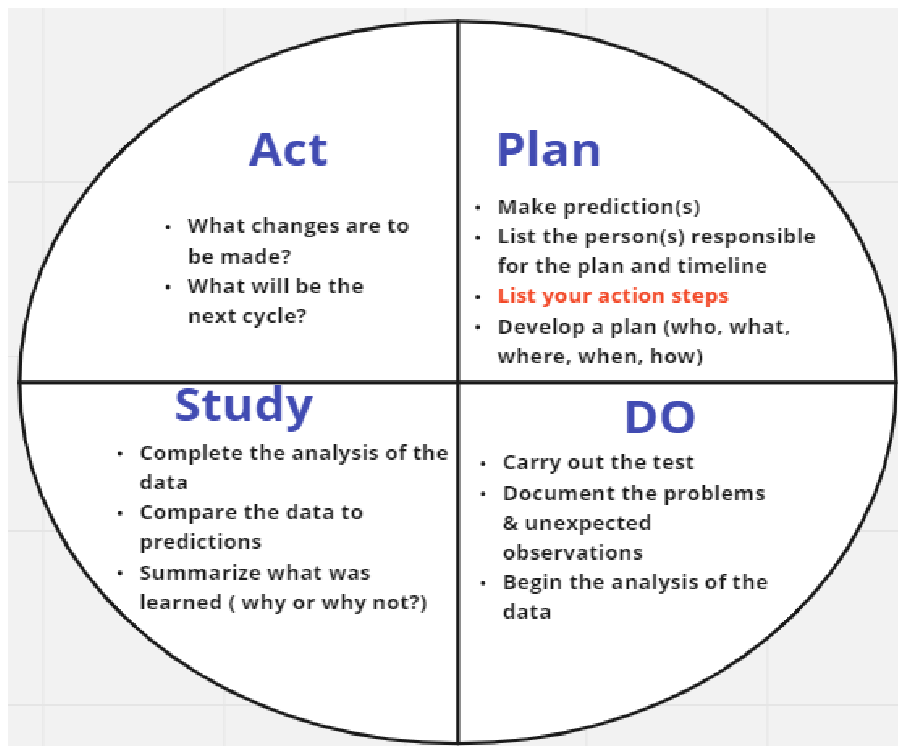
Section 7: QUALITY IMPROVEMENT

The RWPA Quality Manager works with subrecipients to build capacity and provide guidance on prioritizing measures and data collection to identify improvement opportunities and monitor QI activities.

The LVTGA CQI SPOCs will use the Plan, Do, Study, Act (PDSA) model for improvement to learn and build knowledge and expertise overtime as they design a change that will result in improvements. The results from evaluations are used to reevaluate, build, or expand successful activities. If subrecipients have difficulty meeting goals, barriers are addressed, and one on one training is provided. All steps of quality improvement projects are documented by subrecipients on the LVTGA PDSA Form.

The PDSA Methodology is widely utilized in human service fields and is identified as a preferred option by HRSA for RWHAP. The PDSA steps are:

1. **Plan** – Develop an objective with questions and predictions
2. **Do** – Carry out the plan on a small scale and document the process
3. **Study/Check** – Analyze the data, compare to the “Plan” section and document process
4. **Act** – Adapt the new process, abandon it, or revise and begin the cycle again



Section 8: WORK PLAN

Activity	Action Steps	Responsible Staff	Time Frame	Comments / Outcomes
Goal 1: Promote continuous quality improvement initiatives across the TGA.				
CQI Meetings				
Part A Program Manager, Management Analysts, QM, SPOCs, and community stakeholders meet quarterly to discuss updates, challenges, successes, and quality improvement.		Quality Manager CQI Single Points of Contact (SPOC)	March, June, Sept., Dec. (2022)	Representation includes community partners, clinical, and support staff.
LVTGA CQI SWOT Analysis				
CQI committee participates in a SWOT Analysis of the TGA to share qualitative information about the current CQI program. Analyze and address the Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis of the Las Vegas TGA		Part A Grant Administrator, Quality Manager, Management Analysts, and CQI SPOCs	Jan. 11, 2022	The QM will use this qualitative data to understand and address the needs of the LVTGA.
Conduct an Action Priority Matrix Assessment	After LVTGA CQI SWOT Analysis, the QM will plot the committee's input to pursue action steps for the 2022 CY.	Quality Manager SPOCS	Jan. 31, 2022	The Priority Matrix will help the recipient evaluate the impact and ease of implementation while gaining additional clarity on moving forward with improvements.
CQI Technical Assistance, Training & Capacity Building				
Capacity Building • Review updated PDSA Form • Revisit PM data spreadsheet • Go over quality improvement & teamwork in HIV Care (Tennis Ball Game) • Revisit Performance Measurement Module and PMs for 2022		Quality Manager CQI SPOCS	March 31, 2022	All reporting documents from Capacity Building sessions are linked and attached throughout this plan. QM went over timeline expectations on CQI 2022 Q1 meeting.
Goal 2: Improve the quality of core medical and support services provided by the TGA.				
Identify Service Categories that will be monitored.	Create a 2021 Service Utilization Data Spreadsheet to determine performance measures needed for CY 2022.	Quality Manager	Jan. 11, 2022	EIS, MCM, OAHS & Agencies that provide support services will also monitor their client's viral suppression.
Identify the Performance Measures that will be monitored by the TGA.	Create Custom Reports for tailored Performance Measures	Quality Manager	March 15, 2022	1 PM for EIS 2 PMs for MCM 1 PM for OAHS

Activity	Action Steps	Responsible Staff	Time Frame	Comments / Outcomes
Increase the percentages of virologically suppressed EIS clients from 75.95% to 80%. Increase the percentages of virologically suppressed MCM clients from 83.35% to 86%. Increase the percentages of virologically suppressed OAHS clients from 89.42% to 92%.	Use the PM quarterly data spreadsheet the QM created to pull data on "Data Days." Complete the PDSA Form to document progress, share problems, successes, and surprises. Submit the PDSA Form & PM updated spreadsheet to the QM on the calendared "Reporting Days."	Core Medical AFAN | AHF AHN | CCC COMC | HFC HRC | NARES NCHC | NYE SNHD | UMC Support Services UNLV SDM DH | GR	May 10, 2022 Aug. 10, 2022 Nov. 10, 2022 Feb. 10, 2022	Study the data on a quarterly basis, observe the results and submit reports (PM spreadsheet and PDSA Form) as scheduled on the timeline. OAHS Agencies are highlighted in green. *A Venn Diagram of services can be found here. (Please note that this CQI Plan is a "living document" and this diagram is projected to change.) Agencies that provide support services will also run viral suppression measures: OVS-OHC OVS-MNT OVS-EFA
Increase the percentages of MCM enrolled clients who are **retained in care** from 73.79% to 77%.	Use the PM quarterly data spreadsheet the QM created to pull data on "Data Days." Complete the PDSA Form to document progress, share problems, successes, and surprises. Submit the PDSA Form & PM updated spreadsheet to the QM on the calendared "Reporting Days."	Core Medical AFAN | AHF AHN | CCC COMC | HRC NARES | NCHC NYE | SNHD UMC	May 10, 2022 Aug. 10, 2022 Nov. 10, 2022 Feb. 10, 2020	Study the data on a quarterly basis, observe the results and submit reports (PM spreadsheet and PDSA Form) as scheduled on the timeline.
Assess the e effectiveness of Medical Case Management across the Las Vegas TGA	Conduct review of random sample of files to verify that clients are receiving services identified as a need. Procure consultant to further access Medical Case Management system and make recommendations for improvement.	Program Management Analyst, Consultant TBD, and Collaborative Research	Sept. 30, 2022	The intention is to assess our system-wide efforts.
Goal 3: Improve the performance measurement system to appropriately assess outcomes for people with HIV.				
Lab Data Import Process	The QM created a process map and video to explain the workflow that occurs between the recipients, state, and contractor.	Quality Manager	Jan. 14, 2022	This resource was created to describe how CAREWare Lab Data is as current as the most recent upload. SPOCs are encouraged to reference the timeline for reporting details on page 13.
Create a schedule with Data Days and Reporting Days	Distribute and calendar the timeline with Data Days & Reporting Days.	Quality Manager	Jan. 31 2022	Subrecipients have a clear understanding of when deliverables are due. Calendar invites were sent out on 2.2022

Activity	Action Steps	Responsible Staff	Time Frame	Comments / Outcomes
Individual Capacity Building	Meet in person or online with the Quality Manager to discuss performance measures and PDSA Cycle documentation.	QM & Subrecipients	Ongoing	Trainings will be held in person or online. This is an opportunity for the QM and the SPOCs to discuss and discover opportunities around quality improvement.
Capacity Building **Open Lab Data Days**	Meet online to train SPOCs on how to unpack data and find disparities to maximize quality improvement.	QM Subrecipients	April 27, 2022 May 25, 2022 June 29, 2022	Participants will: ➢ Run custom provider reports. ➢ Dive in and unpack interactive numerical data. ➢ Brainstorm on next steps.
Run service category performance measures on a quarterly basis.	Use the CAREWare6 Performance Measurement Module to run PMs (April, July, October, January).	Subrecipients	Refer to timeline on page 13.	
Report Performance Measurement data to Quality Manager quarterly.	Use the custom-made provider PM spreadsheet.	Subrecipients		
Goal 4: Ensure the comprehensive involvement of people with HIV in the quality improvement process.				
Invite consumers to the CQI meetings for participation.	Determine and document the mechanisms for inviting including clients in CQI activities.	Quality Manager Rapid stART Manager Subrecipients	Ongoing	
English & Spanish content to engage participants Spanish Community Engagement Video English Community Engagement Video	Create, post, and distribute Community Engagement videos in English and Spanish through providers and on the LVTGA website.	Quality Manager	Ongoing	The purpose of these videos is to invite and engage community partners and consumers in the CQI decision-making process at the LVTGA CQI Quarterly Meetings.

Section 9: CAPACITY BUILDING

Capacity Assessment, Information Sharing, and Communication

The Quality Manager shares relevant resources, webinars, articles, and success stories with the CQI committee, consumers, and internal stakeholders. Resources include information from the Center for Quality Improvement and Innovation (CQII) center, HRSA/HAB, Target HIV website, Pacific AIDS Education and Training Center Program (PAETC) and other recognized organizations in HIV care. CQI resources may address quality improvement topics or topics emphasizing gaps in care. In addition, the Quality Manager creates resources (i.e., video tutorials) to build capacity, engage the community, and provide support to subrecipients. Subrecipients shall set time aside on data days to import, log and report quarterly data. The Quality Manager also provides one on one technical assistance to providers on an as-needed basis. The two types of technical assistance provided by the Quality Manager consists of direct in person technical assistance and training or electronic technical assistance and training. The CQI committee believes that sharing information provides transparency and serves to strengthen partnerships within the community. The table below outlines the delivery of communication at the LVTGA.

The Annual Quality Management Plan, CQI agendas and meeting minutes are archived on the Las Vegas TGA website.

OUTLINE OF REGULAR QUALITY MANAGEMENT COMMUNICATIONS			
Information	**Stakeholder**	**Frequency**	**Communication Methodology**
CQI Plan	HRSA Planning Council Subrecipients	Annually	Written document and presentation LV TGA Website publishing
Service Standards	HRSA Planning Council Subrecipients Clients	As needed	Oral and written documents and presentations as appropriate LV TGA Website publishing
Service-specific Outcome Reports	HRSA Planning Council Subrecipients Client	Annually	Annual Report
Annual Site Reviews	Planning Council Subrecipients HRSA	Annually after review	Annual Report
Monthly Service Call & Reports	HRSA Project Officer	Monthly	Quantitative and narrative reports
Evaluation of Administrative Mechanism	HRSA Planning Council	Annually	Narrative Report
CQI Newsletters	CQI Committee	Quarterly	Monthly communication containing updates and meeting information on LVTGA website
Data Days, Reporting Days & Technical Assistance	CQI Committee	Quarterly	Monthly communication containing updates and meeting information on LVTGA website

Commonly Used Acronyms and Definitions in CQM
CAREWare is an electronic health and social support services information system for HRSA's Ryan White HIV/AIDS Program recipients and providers. CAREWare was developed by HRSA's HIV/AIDS Bureau and first released in 2000.
Clinical Quality Management (CQM) encompasses infrastructure, measurement, and improvement. It is also used interchangeably with CQI
Clinical Quality Improvement (CQI) is used interchangeably with CQM
Center for Quality Improvement and Innovation (CQII) a resource that provides technical assistance on quality improvement to Ryan White HIV/AIDS Program recipients.

Health and Human Services (HHS) is the U.S. Department of Health and Human Services that enhances the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Health Resources and Services Administration (HRSA) is the agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved.

HIV/ AIDS Bureau (HAB) is the bureau within HRSA of the U.S. Department of Health and Human Services that is responsible for administering the Ryan White HIV/AIDS Program.

Human Immunodeficiency Virus (HIV) is a virus that attacks cells that help the body fight infection, making a person more vulnerable to other infections and diseases. It is spread by contact with certain bodily fluids of a person with HIV, most commonly during unprotected sex (sex without a condom or HIV medicine to prevent or treat HIV), or through sharing injection drug equipment. If left untreated, HIV can lead to the disease AIDS.

PCHOPS – **P**atient **C**are, **H**ealth **O**utcomes, **P**atient **S**atisfaction

Plan, Do, Study, Act (PDSA) Methodology is a four-step process for quality improvement. The first step (plan), develop an objective whit questions and predictions, The second step (do), carry out the plan on a small scale and document the process. The third step (study), analyze the data, compare it to the "plan" section and document the process. The fourth step (act), adapt to the new process, abandon it, or revise and begin the cycle again.

Policy Clarification Notice (PCN) 15-02

Qualitative Data describes qualities or characteristics. It is collected using questionnaires, interviews, or observation, and frequently appears in narrative form.

Quantitative Data is defined as the value of data in the form of counts or numbers where each data-set has a unique numerical value associated with it.

Ryan White HIV / AIDS Program (RWHAP)

Subrecipient includes the terms "provider", "agency", and "organization."

Transitional Grant Area (TGA) are population centers that are the most severely affected by the HIV/AIDS epidemic. To be an eligible TGA, an area must have 1,000 to 1,999 reported AIDS cases in the most recent 5 years.

Quality Improvement (QI) is the framework used to systematically improve the ways care is delivered to patients.

Las Vegas TGA Performance Measures	
0VS-EIS	
Definition	Percentage of EIS clients with HIV whose last viral load in the measurement year is less than 200 copies.
Numerator	No. of persons with HIV whose last viral load in the measurement year is < 200 copies or missing altogether.
Denominator	No. of persons with HIV with at least one medical visit in the measurement year.
0VS-OAHS	
Definition	Percentage of OAHS clients with HIV whose last viral load in the measurement year is less than 200 copies.
Numerator	No. of clients with HIV whose last viral load is <200 copies at the last viral load test during the measurement.
Denominator	No. of persons with HIV with at least one OAHS visit in the measurement year.
0VS-MCM	
Definition	Percentage of MCM clients whose last viral load in the measurement year is less than 200 copies.
Numerator	No. of persons with HIV whose last viral load is < 200 copies at last viral load test during the measurement year.
Denominator	No. of persons with HIV with at least one medical case management visit in the measurement year.
C5 MCM: Retention in Care	
Definition	Percentage of HIV clients with at least two encounters in the year.
Numerator	No. of persons with HIV with at least two visits 90 days apart.
Denominator	No. of persons with HIV with at least one medical visit in the measurement year.
PM Codes: 0VS-EFA / 0VS-MNT / 0VS-OH	
Definition	Percentage of (EFA/MNT/OH) clients with HIV whose last viral load in the measurement year is less than 200 copies.
Numerator	No. of clients with HIV whose last viral load is <200 copies at the last viral load test during the measurement.
Denominator	No. of persons with HIV with at least one OAHS visit in the measurement year.

Timeline for Reporting

*If the data reporting day falls on a weekend or holiday, the data reporting will be due on the last working day before the holiday or weekend.

Performance Measure **As of Date:**	Data Days Providers run CAREWare PMs on or after this date using the "As of Date" on the first column	Data Reporting Providers submit their PM spreadsheets & PDSA Forms to the LVTGA QM
March 31, 2022	April 29, 2022	May 10, 2022
June 30, 2022	July 29, 2022	August 10, 2022
September 30, 2022	October 31, 2022	November 10, 2022
December 31, 2022	January 31, 2023	February 10, 2023