Bergen-Passaic TGA
RYAN WHITE PART A
PROGRAM

QUALITY MANAGEMENT PLAN 2015

Adopted: March 16, 2015

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

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BERGEN-PASSAIC TGA
RYAN WHITE PART A PROGRAM
2015 QUALITY MANAGEMENT PLAN

I. INTRODUCTION AND QUALITY STATEMENT

The Bergen-Passaic Ryan White Part A Program is committed to providing the highest level of care for persons living with HIV/AIDS in the two-county region. Its Continuous Quality Management (CQM) Program is designed to carry out this commitment through monitoring, evaluation and improvement of the quality of clinical services provided in the Bergen-Passaic Transitional Grant Area (TGA). Authority is granted by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and the Ryan White HIV/AIDS Treatment Extension Act of 2009 as administered by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program.

Mission Statement

The mission of the Bergen-Passaic Ryan White Continuous Quality Management Program is to provide a *framework for excellence* in the care and treatment of persons living with HIV/AIDS in Bergen and Passaic counties.

The *aim* of the CQM Program is expressed in the mission statement and five long range goals that describe the desired future state of HIV/AIDS care within the Ryan White Part A Program. The first is to achieve the highest possible level of durable viral suppression for HIV/AIDS patients through successful identification, linkage, engagement, and retention in medical care. The second is to establish a commitment to measurement and process improvement as the ongoing approach to quality care. Cultural competencies and professional capacities are additional themes articulated in the long range goals. Finally, the long range goals speak to national and international directives to optimize the care and treatment of all PLWHA and are consistent with national strategies articulated by HRSA, the Centers for Disease Control and Prevention and internationally by the World Health Organization.

The 2015 Quality Management Plan is a blueprint for realizing the aim of the QM Program. The Plan identifies priorities, objectives and actions – all of which clearly direct the activities that cumulatively strengthen patient care in the Bergen-Passaic TGA.

LONG RANGE GOALS

I. To eliminate outflow within the HIV care continuum by maximizing the number of persons who are aware of their HIV status, are in care and have achieved durable viral suppression.

II. To track, measure and optimize the clinical performance and outcomes indicators identified by national and state quality organizations.

III. To demonstrate proficiency with quality improvement processes for the purpose of achieving optimal quality care.

IV. To monitor and facilitate the application of clinical and cultural competency standards in accordance with national and state policy.

V. To embrace the March to Zero by achieving zero new infections, zero AIDS-related deaths and zero discrimination.

II. ANNUAL QUALITY GOALS

Annual quality goals are the endpoints that direct the efforts of the 2015 QM Plan. They differ from long range goals inasmuch as they are time limited and quantified. The annual goals do not attempt to accomplish all aspects of the long range goals; rather, they articulate achievable initiatives that will contribute to accomplishing the aim of the QM Program and its future direction.

The first annual goal focuses on the clinical process indicators associated with attaining durable viral suppression along with specific quality improvement processes that will be undertaken in 2015 to support viral suppression. The second annual goal monitors selected process and health status indicators to assure continued high quality of care for Ryan White patients. The third addresses unfettered access to care through application of case management, effective referrals, patient satisfaction and cultural competency. The fourth seeks to facilitate identification of persons with HIV/AIDS, linkage and early engagement in medical care. The fifth annual goal expands use of the *e*2 system to create a regional system of care that reduces the outflow of patients in the HIV Care Continuum. Annual Goals One, Two and Three are under direct responsibility of the Quality Management Team. Annual Goal Four is assigned to the Bergen-Passaic Linkage to Care Cross-Collaboration and to the EIS/Outreach Work Group, both under the purview of the Planning Council. Goal Five pertains to the SPNS Initiative with responsibility assigned to a separately identified SPNS Team. Although specific tasks of the QM Team pertain largely to Goals One, Two, and Three, the QM Team expects to be involved with all five annual goals through ongoing collaboration.

2015 ANNUAL QUALITY GOALS

I. To systematically facilitate application of four clinical quality performance indicators relative to reducing the outflow of the care continuum and achieving durable viral suppression.
II. To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.
III. To support unfettered access to care as measured by adherence to case management quality indicators, patient satisfaction, cultural competency, effective referrals and consumer involvement.
IV. To support efforts to expand HIV screening, linkage, engagement and retention in medical care.
V. To expand the capacity of health information technology in the Bergen-Passaic TGA in support of efforts to reduce the outflow of patients in the HIV Care Continuum.

III. QUALITY INFRASTRUCTURE

The CQM Program, in place since 2003, consists of a Quality Management (QM) Team supported by the Office of the Grantee and Ryan White Part A and MAI providers. The QM Team was convened in 2005 to assist the Program Director with the development of a QM Plan and in carrying out its directives. The Team is comprised of clinicians, mental health and substance abuse professionals, and case managers. In 2014, oral health providers and three consumers were added to the team. Support for QM is funded by the Ryan White Part A Program.

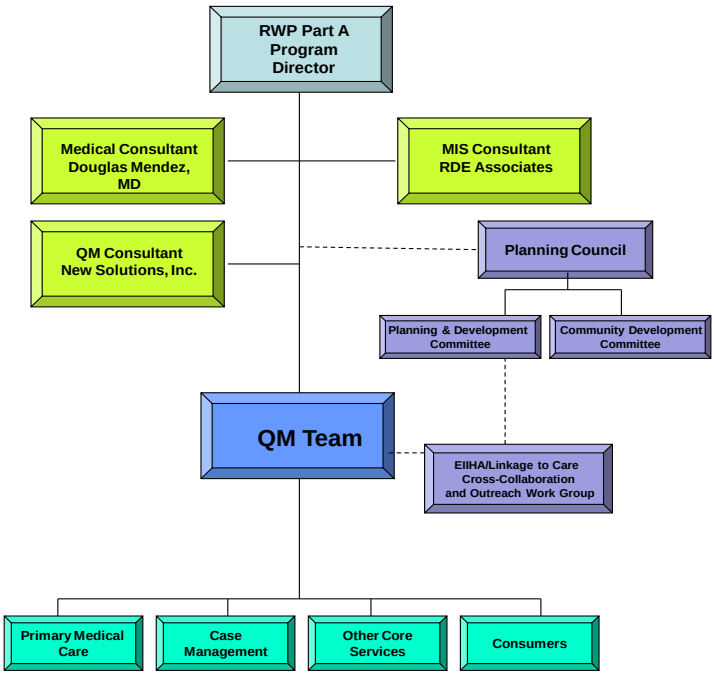
The Ryan White Part A CQM Program staff consists of the Program Director, consultants and support personnel from the Ryan White Part A staff. In lieu of a full time Quality Management Coordinator, the organizational structure benefits from the ongoing support and expertise of three consultants. Dr. Douglas Mendez, Quality Coordinator and Medical Consultant, joined the team in 2009 and has since functioned as a clinical resource responsible for monitoring delivery of Part A clinical care and for coordination with quality improvement activities. The Quality Consultant, Dr. Patricia H. Virga, has been involved with the Ryan White Program since its inception in 1994, playing a critical role in the development of the outcomes evaluation program and providing assistance into the development of the QM Plan and evaluation activities. Third, RDE Systems, an MIS consultant, works closely with the Quality Management Team and the Program Director to facilitate implementation of quality management activities. See Figure 1.

While all staff report to the Division Director, CQM is conceived as a *collaborative* effort involving each participant equally. This basic philosophy of stakeholder involvement with *all* participants *throughout* the process is fundamental to successfully implementing the Quality Management Plan and ultimately improving care for persons living with HIV/AIDS in the region.

Quality management also includes involvement of the Paterson-Passaic County – Bergen County HIV Health Services Planning Council ("the Planning Council") which oversees development of standards, planning and policy. Through its committee structure, which includes consumer participation, members of the Council also add input into the development of the QM Plan which is then incorporated into the Regional Comprehensive HIV Health Services Plan.

In 2013, the Bergen-Passaic Linkage to Care Cross-Collaboration was formed under the direction of the Planning Council to implement the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan. This interdisciplinary Collaboration, consisting of providers across the HIV Continuum of Care, includes outreach, early intervention, testing, linkage and engagement. Consumers also participate in the Collaboration. A second collaboration, the Part A EIS/Outreach Work Group, also identified in the EIIHA Plan, was initiated in 2014 and works in tandem with the Collaboration and the QM Team. While the 2015 QM Plan does not *directly* involve the Collaboration and EIS/Outreach Work Group, the relationship among them is fully recognized and articulated in the Regional Comprehensive HIV Health Services Plan.

Bergen-Passaic Ryan White Part A
Quality Management Program



IV. CAPACITY BUILDING

A process is in place for QM capacity building and the acceptance of structured performance measurement. Opportunities for learning about quality improvement and effective interventions are incorporated into each QM Team meeting in the form of peer learning networks. Presentations from the agency representatives provide effective communication and opportunities for sharing best practices. Providers are required to participate in capacity building activities in accordance with contracted conditions of award.

Additionally, the QM Team works with the New Jersey Cross-Part Collaborative (NJ-CPC) and the National Quality Center (NQC) to build capacity. Quality management technical assistance programs are offered regularly by both entities, and all opportunities for capacity building are offered to the QM Team. The QM Coordinator attends the Cross-Part Collaborative meetings, participates in the NQC HIV Cross-Part Care Continuum Collaborative (H4C) H4C Initiative as a member of the response team, and provides technical assistance to QM Team members supported by NJ-CPC and NQC.

Targeted provider trainings planned in 2015 include case management trainings, *e*2 system technical assistance and on-site collaboration with the clinical teams and the medical consultant. This represents a significant commitment to expanding and maintaining provider capacity for quality improvement.

V. PERFORMANCE MEASUREMENT

Clinical performance measures are selected by the QM Team with each iteration of the Quality Management Plan. The QM Team identifies performance measures for primary medical care, case management, treatment adherence and oral health care. Outcome indicators specified by the QM Team are also measured.

The 2015 QM Plan continues the direction and initiatives of the previous plans by maintaining the clinical process indicators under review, placing greater emphasis on tracking of viral suppression, introducing oral health for quality monitoring, and monitoring of selected process indicators to maintain quality of care. Linkage to care, unfettered access, the electronic exchange of health information and a monitored referral system are given greater clarity in the 2012-2015 Comprehensive HIV Health Services Plan.

Clinical indicators. In 2015, the QM Team elected to maintain many performance indicators selected in prior years. Priority is given to those directly associated with viral suppression in coordination with NJ-CPC and NQC. Data are collected and reported bi-monthly and reviewed by the QM Team at each of its quarterly meetings.

Clinical performance measures fall into the following categories:

- Four chosen to conform to those of NJ-CPC and the NQC whose focus is achieving durable viral suppression;

- Seven clinical performance measures chosen by the QM Team from previous quality initiatives: STI screening (syphilis, gonorrhea and chlamydia), CD4 and viral load testing, mental health screening, Pap screening, and hepatitis screening and vaccination;
- Three oral health indicators addressing oral exams, health plans and patient education;
- A medical and non-medical case management indicator to monitor the percentage of cases with a completed service coordination plan and six-month update. This indicator is tracked for all case management providers including MAI.
- A treatment adherence performance measure planned by the QM Team and scheduled for roll-out in 2015.
- Three health status indicators: hospitalization and emergency department utilization, CD4 and viral load test results.

These performance indicators will be monitored annually, quarterly or bi-monthly to assure consistency of care. It should be noted that the *e*COMPAS database is in real-time and available directly to the three medical clinics for review at any time.

2015 Indicators Monitored for Outpatient Ambulatory Medical Care, Medical Case Management and Oral Health Care Services

A. Quality Indicators Tracked and Monitored Bi-Monthly with the NJ-CPC and NQC H4C Collaborative
1. % of patients with a viral load less than 200 copies/mL during the measurement year
2. % of patients prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
3. % of patients with at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
4. % of patients who did not have a medical visit in the last six months of the measurement year
B. Medical Performance Measures Tracked and Monitored Annually by the Bergen-Passaic QM Team
1. % adult patients with HIV/AIDS with an annual syphilis screen
1b. % of HIV/AIDS patients with a positive syphilis result for which treatment is needed
1c. % of HIV/AIDS patients testing positive and who were prescribed treatment
2. % adult patients with HIV/AIDS with annual gonorrhea and chlamydia screens
3. % of HIV/AIDS receiving an annual mental health screen
4. % of HIV/AIDS patients receiving an annual Pap screen
5. % HIV/AIDS patients who had 2 or more CD4 tests in the measurement year
6. % of HIV/AIDS patients with lifetime hepatitis a, b and c screening
7. % HIV/AIDS patients who completed the vaccination series for hepatitis a and b
C. Oral Health Performance Measures Tracked and Monitored Quarterly by the Bergen-Passaic QM Team in 2015
1. % HIV/AIDS patients who receive an annual oral health exam by a dentist through the Part A system
2. % HIV/AIDS patients whose care plan is updated at least every six months
3. % HIV/AIDS patients who receive oral health education with each dental visit
D. Case Management Performance Measures Tracked and Monitored Bi-monthly by the Bergen-Passaic QM Team
1. % of clients who had a medical case management care plan developed and/or updated two or more times in the measurement year
2. % of HIV/AIDS patients on HAART receiving treatment assessed and counseled for adherence two or more times in the measurement year.
E. Health Status Indicators Tracked and Monitored Annually by the Bergen-Passaic QM Team
1. % of patients with CD4 Status (<200, 200-500, >500)
2. % of patients with Viral Suppression <200mL (See H4C Indicator 1)
3. % of patients with hospitalization and ED visits
4. % of patients with co-morbid diagnoses: STI, Hepatitis, Tb, Mental Health Disorders

In addition to clinical indicators, the client satisfaction measurement program for *core* and *support* services is well established. All Part A and MAI providers of both core and support

services participate in ongoing client satisfaction surveys. A review of the satisfaction process was recently completed, and new survey instruments were developed by the QM Team. The survey instrument was made easier for consumer comprehension and included questions on outcomes, health status and other important factors in measuring quality. The survey process, administered online, will be streamlined and implemented. Following adoption by the Part A and MAI sub-grantees, the new survey process is planned for 2015.

VI. QUALITY IMPROVEMENT

In 2008, QM Team initiated a process improvement (PI) program that utilizes quality data to document areas where patient care may be improved. The QM Team uses the Plan-Do-Study-Act (PDSA) method recommended by the National Quality Center to implement PI. A PDSA Plan is developed for specific indicators as identified by the QM Team based on review of performance data. The medical consultant works with PI teams at each agency to implement the PDSA Plan. Additionally, the QM Team engages in Peer Learning whereby individual agencies review their PI interventions and results with each other. Thus, the PI process is data driven and results oriented. The PDSA process continues to be utilized as the central mechanism for quality improvement.

Two PI projects are planned for 2015. The first, started in 2014, seeks to improve viral suppression by 20% for all Part A medical patients. This project is undertaken in conjunction with the NJ-CPC and the NQC's H4C Initiative.

The second PI project will begin in 2015 and continue until the stated goal is achieved. This project will focus on age disparities, in particular PLWHA aged 24-45. This cohort was identified during the 2014 reporting process as having below-average retention rates.

VII. STAKEHOLDER PARTICIPATION

The Quality Management Team meets quarterly to review progress with implementing the Plan. The clinical members also meet via teleconference each month.

Efforts to improve HIV viral suppression. The Bergen-Passaic TGA joins with the NJ-CPC in a leadership initiative to improve viral suppression. In tandem with the NJ-CPC, statewide goal of attaining a twenty percent increase of HIV patients with a viral load below 200Ml was adopted by the Bergen-Passaic QM Team in March 2014. To achieve this goal, each medical clinic is undertaking a quality improvement process that includes (1) developing a Plan-Do-Study-Act (PDSA) improvement plan, establishing quantified targets required to achieve the goal, and participation in the H4C Closed Cohort Impact Study. A viral suppression checklist, developed and shared by the NJ-CPC will be incorporated into the PDSA with each clinic modifying it to suite is respective needs. The process is expected to take one year to complete.

In August 2014, the Bergen-Passaic Part A Program was awarded a SPNS grant to expand technical capacity in creating a coordinated system of care with the goal of achieving maximum viral suppression in the region. The program is expected to commence March 1, 2015 and will continue for three years. It is our expectation that the outcome of the program will have a

material effect on quality of care, coordinated care systems and achievement of viral suppression in the region.

Stakeholder involvement. While selection of performance indicators is under the purview of the QM Team, their decisions are routinely influenced by discussions at various meetings of the Part A sub-grantees, the Planning Council and consumers. Several opportunities are available including monthly meetings of the Planning Council, bi-monthly meetings of the EIS/Outreach Work Group and the quarterly meetings of the Bergen-Passaic Linkage to Care Cross-Collaboration. Consumers are present at all such meetings.

The Planning Council uses quality information directly in its priority setting and resource allocation process. Many of the quality reports received by the QM Team are also reviewed by the Planning & Development Committee of the Planning Council. In particular, the Committee reviews reports of unmet need, patients lost to care and newly diagnosed patients to identify characteristics of PLWH/A who should be targeted for additional resources. In addition, annual reports of outcomes evaluations and client satisfaction surveys are provided to the Planning Council. Recommendations from the Planning Council are developed from the reports, the QM Plan, and the Comprehensive HIV Health Services Plan to formulate Directives to the Grantee for funding consideration and recommendations for provider training and quality improvement.

Consumer involvement in CQM takes place at the QM Team meetings. Until recently, despite routine invitations to join the QM Team, consumer recruitment had limited success. In 2014, the NQC sponsored a consumer's technical assistance training in New Jersey, and two consumers from Bergen-Passaic received the NQC training. As of January 2015, three consumers are members of the QM Team.

In 2014, the QM Team began work on a patient portal to allow consumers electronic access to their vital medical information. Two consumers participated in a workshop to provide insight and suggestions for product development. The project, which will directly involve consumer participation, is in the early stages and will be incorporated into the newly awarded Special Projects of National Significance (SPNS) HIV Continuum of Care grant.

VIII. WORK PLAN

The work plan and monthly timetable is presented in Section XII of this narrative.

IX. EVALUATION

Ultimately, accountability for the Quality Management Program resides with the grantee who continuously evaluates the effectiveness of the program infrastructure and QM activities. The quality consultant prepares an annual report itemizing progress with implementation of the QM Plan along with recommendations for improvements. This report is used by both the grantee and the QM Team as they evaluate the annual quality goals, appropriateness of the performance measures and quality improvements.

The annual performance measures defined in the QM Plan are monitored collectively by the Grantee, consultants and the QM Team. The QM Team receives reports at each of its quarterly meetings. Additionally, the Quality Consultant and Medical Consultant review medical records and data reports to assure appropriate interpretation by the QM Team. Findings are articulated based on consensus of all three entities. Data integrity is maintained through client level quality checks embedded in the MIS reporting system. An annual report is prepared, highlighting data and analysis of QM performance results. This report is shared with the Planning Council as part of its annual status report on the Comprehensive HIV Health Services Plan. The QM Plan is further incorporated into the Planning Council's Comprehensive HIV/AIDS Health Services Plan. Sign-off includes approval of the Comprehensive Plan by the Planning Council and the Quality Management Plan by the Division Director.

Reporting and Dissemination of Findings. One of the most important aspects of the QM Program involves the utilization of a web-based MIS reporting system, *e*2. The system allows providers to input relevant quality data as defined by the HRSA and the QM Team. Online reporting is facilitated by *e*2. Again, report formats are designed in accordance with input by the quality consultant, the medical consultant and the recommendations of the QM Team.

Members of the QM Team are provided password protected access to *e*2 where they can view reports on a real-time basis. Reports may be saved and stored for later viewing. This efficiency and ease of use facilitates the QM process quite effectively.

Findings are reviewed by the QM Team and subsequently disseminated to interested parties such as cross-part providers, the Planning Council and the New Jersey State Department of Health and Senior Services Division of HIV/AIDS, TB and STD Services (DHSTS). All Part A providers are encouraged to review the findings within their individual quality improvement programs.

X. UPDATING THE 2015 QM PLAN

The QM Plan is continuously reviewed by the QM Team at each of its regularly scheduled meetings. Additionally, the QM Team meets prior to expiration of the Plan to focus on emerging factors affecting quality management. This information provides the basis for initiating the plan update which is then complemented by interactive discussion and formulation of annual goals and objectives for the coming year.

The QM Plan is further incorporated into the Planning Council's Comprehensive HIV/AIDS Health Services Plan. Sign-off includes approval of the Comprehensive Plan by the Planning Council and the Quality Management Plan by the Program Director.

XI. COMMUNICATION

The 2015 QM Plan will be communicated to the Planning Council and to the public at large through the Planning Council website. Additionally, Bergen-Passaic participates in the NJ-CPC activities and is included in its respective communication plan.

In 2014, the Planning Council received a presentation by the Quality Coordinator on the CQM Program, results and achievements. As part of this presentation, members of the Planning Council received information on the HIV Care Continuum as well as the overarching goal of achieving sustainable viral suppression. Several members of the Planning Council are part of the QM Team and contribute to the discussions. This type of presentation will be repeated in 2015. Further, in 2015, quality management will be placed on the agenda of each Planning Council meeting, providing an update on the activities of the QM Team.

As the SPNS project unfolds, opportunities for presentations and/or workshops at the various HRSA-sponsored venues will be considered and offered as appropriate.

XII. TIMELINE

2015 Timeline												
Task	**Month**											
	Jan.	**Feb.**	**March**	**April**	**May**	**June**	**July**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**
QM Team Quarterly Meeting	x			x			x			x		
QM Team Web-conference Meeting		x	x		x	x		x	x		x	
NJ-CPC Meeting	x			x			x			x		
Data Reports to NJ-CPC (H4C/CC)												
- H4C		x		x		x		x		x		x
- Closed Cohort Impact Study		x		x		x		x		x		x
H4C Data Reports to QM Team			x		x		x		x		x	
QM Team Indicator Reports										x		
Hepatitis Indicator Reports to QM Team	x			x			x			x		
Outcomes Reports										x		
Patient/client Satisfaction Review										x		
Adherence Indicator Development				x	x	x	x	x	x	x		
Oral Health Indicator Development	x	x	x	x	x	x	x	x	x	x		
e2 Adherence alert									x			
e2 Oral health alert									x			
VL Suppression PDSA	x	x	x	x	x	x	x	x	x	x		
VL Suppression Age 24-45 PDSA										x	x	x
Future PDSA Planning												
- Case management											x	
- Oral health											x	
- Other indicators											x	
Case management training				x				x				x
Consumer involvement and technical assistance	x	x	x	x	x	x	x	x	x	x	x	x
Cultural Competency Review				x				x				x
*e*2 Referral Module monitoring				x				x				x

BERGEN-PASSAIC TGA
RYAN WHITE PART A PROGRAM
QUALITY MANAGEMENT PLAN 2015

Annual Quality Goals, Objectives and Actions		
I. To systematically facilitate application of four clinical quality performance indicators relative to reducing the outflow of the care continuum and achieving durable viral suppression.	**Report Cycle**	**Baseline**
Objective I.1 Participate in the H4C initiative to track four indicators of the HIV/AIDS Care Continuum with the goal of increasing durable viral suppression by 20%. Actions: 1. Monitor the percentage of patients with a viral load greater than 200 copies/mL, bi-monthly. 2. Monitor the percentage of patients prescribed antiretroviral therapy, bi-monthly. 3. Monitor the percentage of patients with at least one medical visit every six months during the past 24-month period, bi-monthly. 4. Monitor the percentage of patients with a medical visit at least twice per year, bi-monthly. 5. Implement a Plan-Do-Study-Act process improvement project focused on viral load suppression, bi-monthly. 6. Participate in the NQC Closed Cohort Impact Study, bi-monthly. 7. Implement a second Plan-Do-Study-Act process improvement project focused on age cohort 24-45, by third quarter. 8. Utilize the *e*2 alerts to assure at least two medical visits per year, ongoing.	Bi-monthly	86%

II. To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.		
Objective II.1 Continue to monitor the clinical process indicators pertaining to CD4 tests every six months, and meet or exceed the national goal of 90%. Actions: 1. Continue to monitor the frequency of CD4 testing, bi-monthly. 2. Meet or exceed 90% of patients receiving two or more CD4 per year, ongoing. 3. Utilize the *e*2 alerts to assure at least two CD4 T-cell tests per year, ongoing.	Annually	85%
Objective II.2 Continue to monitor annual syphilis screening with a goal of maintaining or exceeding the goal of 85% of all patients screened for syphilis with reporting on an annual basis. Actions: 1. Continue to monitor the number and percentage of patients receiving an annual syphilis screen, annually. 2. Meet or exceed 85% of patients receiving a syphilis screen, ongoing. 3. Continue to review the number and percentage of patients testing positive for syphilis and receiving treatment with a goal of reaching the statewide goal of 100%, annually. 4. Utilize the *e*2 alerts system to track annual syphilis screens, ongoing.	Annually	Screened – 85% Screened, positive and treated – 100%
Objective II.3 Continue to monitor gonorrhea and chlamydia screening with a goal of meeting or exceeding the goal of 75% of all patients screened. 1. Continue to monitor the number and percentage of patients receiving an annual gonorrhea screen, annually. 2. Utilize the *e*2 alerts system to track annual gonorrhea screens, annually. 3. Determine quality improvement steps, as appropriate, for gonorrhea screens, annually.	Annually	75%
Objective II.4 Monitor the percentage of HIV patients with lifetime hepatitis A, B and C screening, with a goal of meeting or exceeding 90% of patients screened. Actions: 1. Continue to monitor and review the number and percentage of HIV patients with hepatitis A, B and C screenings, quarterly. 2. Utilize the *e*2 alerts system to track timely screening, ongoing. 3. Continue to meet or exceed the national goal of 90%, ongoing.	Quarterly	New indicator. Baseline - 90%

II. To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.		
Objective II.5 Monitor the percentage of HIV patients who completed the vaccination series for Hepatitis A and B, with the goal of meeting or exceeding 50% of all eligible patients. Actions: 1. Review the number and percentage of patients completing a Hepatitis A and B vaccination series, quarterly. 2. Meet or exceed 50% of eligible patients who have completed a Hepatitis A and B vaccination series, quarterly. 3. Utilize the *e*2 alerts system to track Hepatitis A and B immunizations, ongoing.	Quarterly	New indicator. Baseline - 50%
Objective 1I.6 Monitor the percentage of HIV patients with an annual mental health screen, with a goal of meeting or exceeding 90%. Actions: 1. Continue to monitor annual mental health screens, annually. 2. Utilize the *e*2 alerts system to track annual mental health screens, ongoing. 3. Continue to meet or exceed the goal of 90%, ongoing.	Annually	86%
Objective II.7 Monitor the percentage of HIV patients receiving an annual Pap screen, with a goal of maintaining or exceeding the statewide goal of 60%. Actions: 1. Continue to monitor the number and percent of female HIV patients receiving an annual Pap test, annually. 2. Utilize the *e*2 alerts system to track annual Pap screens, ongoing. 3. Continue to employ quality improvement efforts when the goal of 60% is not met, ongoing.	Annually	53%
Objective 1I.8 Meet or exceed baseline goals of oral health care quality indicators. Actions: 1. Monitor the percentage of Part A oral health patients who received a dental exam and medical health history by a dentist through the Part A system, quarterly. 2. Monitor the percentage of Part A oral health patients had a dental treatment plan developed and/or updated, quarterly. 3. Monitor the percentage of Part A oral health patients oral health education at least annually 4. Develop *e2* reports on oral health exams, dental treatment plans and patient education, quarterly.	Targeted for first half 2015	New indicator. Baseline to be determined

II. To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.		
5. Consider adding an *e*2 alert for oral health screening exams, dental treatment plans and patient education, by October 2015. 6. Determine the need for quality improvement efforts and implement accordingly, by December 2015.		
Objective II.9 Monitor the other Group 1, 2 and 3 HAB performance measures, and determine the need for process improvement activities. Actions: 1. Review the Group 1, 2 and 3 HAB performance measures of interest to the Quality Management Team, annually. 2. Identify specific HAB performance indicators from Groups 1, 2 and 3 for periodic review and expand the *e*2 clinical module to include data reports for these performance measures, annually. 3. Review the revised HAB performance indicators upon release and assess their application to the Bergen-Passaic Quality Management Program, by March 2014.	Annually	Quality Management Team Planning Council and Planning & Development Committee
Objective II.10 Continue to monitor the traditional clinical outcomes indicators as defined by the Quality Management Team, and identify areas for potential improvement. Actions: 1. Continue monitoring of VL suppression at <200 copies/mL, bi-monthly (see I.1). 2. Continue monitoring of CD4 counts at <200, 200-500 and >500, annually (see I.2). 3. Continue annual monitoring of HIV-related hospitalizations and emergency department visits, annually. 4. Continue annual monitoring of new diagnoses of selected co-morbid conditions and sexually transmitted infections to include: hepatitis a, b and c; syphilis, gonorrhea, chlamydia, HCV HPV, hypertension, diabetes, mental health diagnoses and other diagnoses, annually.	Annually	Baseline not defined.
Objective II.11 Maintain evaluation studies now in progress by the Grantee pertaining to adherence to PHS standards. Actions: 1. Provide an annual report to the Quality Management Team on Part A adherence to PHS standards as found in the grantee performance review, by March 2014. 2. Identify appropriate evidence-based programs that might have a positive impact on Part A quality improvement objectives and report findings to the Quality Management Team.	Ongoing	Grantee

III. To support unfettered access to care as measured by adherence to case management quality indicators, patient/client satisfaction, cultural competency, effective referrals and consumer involvement.		
Objective III.1 Meet the OPR case management objective of increasing the percentage of case managed clients with HIV infection who had a case management care plan documented and updated at least every six months to 84%. Actions: 1. Continue data collection, reporting specifications and monitoring through the *e*2 system to include tracking of initial assessment (intake), care coordination plan and semi-annual care coordination plan update, bi-monthly. 2. Utilize the *e*2 alert system as a reminder tool to maintain the care coordination plan, ongoing. 3. Implement the methods learned at the case management training (Objective III.4), such as Plan-Do-Study-Act, as necessary to meet the stated goal, ongoing.	Bi-monthly	66%
Objective III.2 Monitor the percentage of patients on HAART who were assessed and counseled for adherence with a goal meeting or exceeding 95%. Actions: 1. Develop a report on treatment adherence in the *e*2 system utilizing the HAB definition of assessment and counseling for adherence two or more times in the measurement year, by April 2015. 2. Monitor the results, October 2015 and quarterly thereafter. 3. Consider adding an *e*2 alert for semi-annual adherence and counseling services if the results do not meet the stated goal of 95%, by August 2015. 4. Determine the need for a quality improvement project and implement accordingly, by December 2015.	Quarterly	New indicator. Baseline to be determined
Objective III.3 Review patient/client satisfaction survey results for the core indicators, and identify areas for potential improvement. Actions: 1. Implement the patient/client satisfaction survey during two six-week periods per year. 2. Monitor and review results from eCOMPAS reports, annually. 3. Determine areas in need of improvement, annually. 4. Implement improvement strategies for a minimum of one indicator per service category, annually.	Annually	Baseline varies with service category
Objective III.4	2015	Not applicable

II. To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.		
Provide for case management trainings in quality management methods. Actions: 1. Participate in NJ-DHSTS training programs for medical case management, ongoing. 2. Implement case management trainings, to be held in a separate setting, and institute Plan-Do-Study-Act methods, by April 2015. 3. Continue trainings every three to six months, initially more often, to review performance data. Initial training would be face-to-face followed by web conference, by December 2015.		
Objective III.4 Continue to implement the Cultural Competency Task Force Recommendations. Actions: 1. Review the CCTF recommendations and determine priorities for 2015, by April 2015. 2. Determine a plan for implementing selected recommendations, by August 2015. 3. Implement selected recommendations, by December 2015.	2015	Baseline to be determined.
Objective III.5 Optimize the capacity and use of the *e*2 referral module, with a goal of reaching 50% of all referrals made and kept. Actions: 1. Enforce the requirement of Part A support service providers to utilize the *e*2 referral module to facilitate and enhance the current fax and phone procedures for making and accepting referrals from other Part A providers, ongoing. 2. Develop an analytic tool for referral monitoring, by October 2015. 3. Monitor performance and determine quality improvement interventions as appropriate, quarterly.	2015	
Objective III.6 Maintain consumer involvement in quality improvement activities and projects. Actions: 1. Maintain consumer membership on the Quality management Team, ongoing. 2. Provide technical assistance to consumer members of the Quality Management Team. 3. Participate in NJ-CPC and NQC consumer training programs as available, ongoing.	Ongoing	Three Consumer QM Team members.
IV. To support efforts to expand HIV screening, linkage, engagement and retention in medical care.		

II.	**To systematically facilitate application of selected clinical quality performance and health status indicators relative to maintaining quality of care.**
Objectives and Activities moved to the Comprehensive HIV/AIDS Health Services Plan 2015. Responsibilities moved to EIIHA, Linkage to Care Cross-Collaboration and EIS/Outreach Work Group	
V.	**To expand the capacity of health information technology in the Bergen-Passaic TGA in support of efforts to reduce the outflow of patients in the HIV Care Continuum.**
Objectives and Activities separately identified in the SPNS work plan.	

APPENDIX B

QUALITY MANAGEMENT TEAM

Marybeth Ali, Hackensack University Medical Center
Mark Anderson, Buddies of New Jersey
Marie Brown, Straight & Narrow
Norberto Colon, Consumer
Maria Cordova, St. Mary's Hospital
Jerry C. Dillard, CAPCO
Thomas Fischetti, Passaic Alliance
Rosalyn Liebhober, Paterson Counseling Center
Troy Love, Hyacinth AIDS Foundation
Michael Marchese, Consumer
Kim Morisco, Paterson Counseling Center
Priscilla Moschella, St. Mary's Hospital
Sandra Murillo, Paterson Counseling Center
Irene Panagiotis, Hackensack University Medical Center
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Gloria Price, Straight & Narrow
Jeanette Rodriguez, St. Mary's Hospital
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Miriam Torres, Passaic Alliance
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Grantee Office:
Milagros Izquierdo, Director, Ryan White Part A Program
Denise Coba, Program Analyst

APPENDIX C

DEFINITIONS

H4C

QM TEAM

ORAL HEALTH

CASE MANAGEMENT

ADHERENCE ASSESSMENT AND COUNSELING

CLOSED COHORT IMPACT STUDY

NJ-CPC REPORTING CYCLES

PERFORMANCE INDICATORS

H4C INDICATORS

Indicator #1 HIV Viral Load Suppression	Numerator: Number of patients in the denominator with HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year
	Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year
Indicator #2 Annual Prescription of HIV Antiretroviral Therapy	Numerator: Number of patients from the denominator prescribed HIV antiretroviral therapy1 during the measurement year
	Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year
Indicator #3 HIV Medical Visit Frequency	Numerator: Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period
	Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period
Indicator #4 Gap in HIV Medical Visits	Numerator: Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year
	Denominator: Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year

QM TEAM 2015 ANNUAL PERFORMANCE INDICATORS

Indicator #1 Annual Syphilis Screen	Numerator: Number of HIV-infected clients $\geq$ 18 years of age, with an annual serologic test for syphilis within the measurement year.
	Denominator: Number of HIV-infected clients who were $\geq$18 years old, and had at least 1 medical visit.
Indicator #2 Annual Chlamydia and Gonorrhea Screen	Numerator: Number of HIV-infected clients $\geq$ 18 years of age, with annual tests for chlamydia and gonorrhea within the measurement year.
	Denominator: Number of HIV-infected clients who were $\geq$18 years old, and had at least 1 medical visit.
Indicator #3 Annual Mental Health Screen	Numerator: Number of HIV-infected clients $\geq$ 18 years of age, with an annual mental health screen within the measurement year.
	Denominator: Number of HIV-infected clients who were $\geq$18 years old, and had at least 1 medical visit.
Indicator #4 Annual Pap Screen	Numerator: Number of HIV-infected females 18 years and older who received an annual Pap within the measurement year
	Denominator: Number of HIV-infected female clients who were $\geq$18 with at least 1 medical visit in the measurement year. Exclude patients for non-dysplasia / non -malignant indications.

Indicator #5 CD4 Test Monitoring	Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year .
	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year
Indicator #6 Lifetime Hepatitis a, b and c Screen	Numerator: Number of patients for whom Hepatitis a, b and c screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity
	Denominator: Number of patients, regardless of age, with a diagnosis of HIV and who had at least two medical visits during the measurement year, with at least 60 days in between each visit
Indicator #7 Hepatitis a and b Vaccination Series	Numerator: Number of patients with a diagnosis of HIV with documentation of having ever completed the vaccination series for Hepatitis a and b
	Denominator: Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges2 at least once in the measurement year

ORAL HEALTH INDICATORS

Performance Measure: Oral Health Services: Dental and Medical History	
Percentage of HIV-infected oral health patients1 who had a dental and medical health history2 (initial or updated) at least once in the measurement year.	
Numerator:	Number of HIV-infected oral health patients who had a dental and medical health history2 (initial or updated) at least once in the measurement year.
Denominator:	Number of HIV-infected oral health patients that received a clinical oral evaluation3 at least once in the measurement year.
Patient Exclusions:	1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.4 2. Patients who were < 12 months old.

Performance Measure: Oral Health Services: Dental Treatment Plan	
Percentage of HIV-infected oral health patients1 who had a dental treatment plan2 developed and/or updated at least once in the measurement year.	
Numerator:	Number of HIV-infected oral health patients who had a dental treatment plan2 developed and/or updated at least once in the measurement year
Denominator:	Number of HIV-infected oral health patients that received a clinical oral evaluation3 at least once in the measurement year.
Patient Exclusions:	1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.4 2. Patients who were < 12 months old.

Performance Measure: Oral Health Services: Oral Health Education	
Percentage of HIV-infected oral health patients who received oral health education2 at least once in the measurement year.	
Numerator:	Number of HIV-infected oral health patients who received oral health education2 at least once in the measurement year.
Denominator:	Number of HIV-infected oral health patients that received a clinical oral evaluation3 at least once in the measurement year.
Patient Exclusions:	1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.4 2. Patients who were < 12 months old.

Performance Measure: Phase 1 Treatment Plan Completion	
Percentage of HIV-infected oral health patients1 with a Phase 12 treatment plan that is completed within 12 months.	
Numerator:	Number of HIV-infected oral health patients that completed Phase 12 treatment within 12 months of establishing a treatment plan.
Denominator:	Number of HIV-infected oral health patients with a Phase 1 treatment plan established in the year prior to the measurement year3 .
Patient Exclusions:	1. Patients who had only an evaluation or treatment

CASE MANAGEMENT

- Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year

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

- *Denominator:* Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year.

- *Exclusions:*
  - Medical case management clients who initiated medical case management services in the last six months of the measurement year.
  - Medical case management clients who were discharged from medical case management services prior to six months of service in the measurement year.

ADHERENCE ASSESSMENT & COUNSELING

- Percentage of clients with HIV infection on ARVs who were assessed and counseled for adherence two or more times in the measurement year

- *Numerator:* Number of HIV-infected clients, as part of their primary care, who were assessed and counseled for adherence two or more times at least three months apart

- *Denominator:* Number of HIV-infected clients on ARV therapy who had a medical visit with a provider with prescribing privileges at least once in the measurement year

- *Patient Exclusions:* 1. Patients newly enrolled in care during last six months of the year 2. Patients who initiated ARV therapy during last six months

CLOSED COHORT IMPACT STUDY

	Establish cohort: October 2014 data submission	**Update #1: October 2015**	**Update #2: October 2016**
Measurement Period	July 1, 2013 - June 30, 2014	July 1, 2014 - June 30, 2015	July 1, 2015 - June 30, 2016

Establish Cohort: 2014	
Definition of the cohort	Patients, regardless of age, with a diagnosis of HIV with a HIV viral load greater than or equal to 200 copies/mL at last HIV viral load between July 1, 2013 – June 30, 2014
Numerator	Number of patients in the denominator with a HIV viral load greater or equal to than 200 copies/mL at last HIV viral load test during the measurement period between July 1, 2013 – June 30, 2014
Denominator	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit between July 1, 2013 and June 30, 2014
Exclusions	1. Patients who are documented to be deceased during the measurement year 2. Patients who were incarcerated for the greater than 6 months of the measurement year 3. Patients who relocated out of the care site's geographic catchment during the measurement year

Update #1: 2015	
Viral suppression among cohort	Patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load between July 1, 2014 – June 30 , 2015
Numerator	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test between July 1, 2014 and June 30, 2015
Denominator	Number of cohort patients (number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit and not virally suppressed between July 1, 2013 – June 30, 2014)
Exclusions	1. Patients who are documented to be deceased during the measurement year 2. Patients who were incarcerated for the greater than 6 months of the measurement year 3. Patients who relocated out of the care site's geographic catchment during the measurement year

Update #2: 2016	
Viral suppression among cohort	Patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load between July 1, 2015– June 30, 2016
Numerator	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test between July 1, 2015 – June 30, 2016
Denominator	Number of cohort patients (number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit and not virally suppressed between July 1, 2013 –June 30, 2014)
Exclusions	1. Patients who are documented to be deceased during the measurement year 2. Patients who were incarcerated for the greater than 6 months of the measurement year 3. Patients who relocated out of the care site's catchment during the measurement year

NJ-CPC REPORTING CYCLES 2014-2016

CPC Cycle #	Submission Due Date	Measurement Year
1	**4/1/2014**	01/01/2013-12/30/2013
2	**6/2/2014**	03/01/2013-02/28/2014
3	**8/1/2014**	5/1/2013 – 4/30/2014
4	**10/1/2014**	7/1/2013 – 6/30/2014
5	**12/1/2014**	9/1/2013 – 8/31/2014
6	**2/1/2015**	11/1/2013 – 10/31/2013
7	**4/1/2015**	1/1/2014 – 12/31/2014
8	**6/1/2015**	3/1/2014 – 2/28/2015
9	**8/1/2015**	5/1/2014 – 4/30/2015
10	**10/1/2015**	7/1/2014 – 6/30/2015
11	**12/1/2015**	9/1/2014 – 8/31/2015
12	**2/1/2016**	11/1/2014 -10/31/2015
13	**4/1/2016**	1/1/2015 – 12/31/2015
14	**6/1/2016**	3/1/2015 – 2/28/2016