

**DC CROSS-PART COLLABORATIVE
2011
HIV QUALITY MANAGEMENT PLAN**



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INTRODUCTION

The Health, Resources and Services Administration (HRSA) of the HIV/AIDS Bureau (HAB) sponsored the development of the DC Eligible Metropolitan Area (DC EMA) Quality Management (QM) Cross-Part Collaborative (the Collaborative) to strengthen the regional capacity for collaboration across Ryan White (RW) HIV/AIDS Program Parts (Parts A, B, C, D and F) and for alignment of QM goals to jointly meet the RW HIV/AIDS Program legislative mandates, and to implement quality improvement (QI) activities to jointly advance the quality of care for people living with HIV/AIDS (PLWHA) across jurisdictions within the Area DC EMA and to coordinate HIV services seamlessly across Parts.

The various Parts were created by HRSA, each with a specific grant structure and reporting requirements in response to the Ryan White HIV/AIDS Treatment Modernization Act of 2006. Grantees, administrative agents, HIV care providers, and consumers representing each of the Parts and other stakeholders from the DC EMA came together to form the Collaborative. A complete listing of the Collaborative membership and their affiliation with the RW Program Parts can be found in Appendix A. The Parts and their grantees within the DC EMA are listed below.

PART A: Grants to Eligible Metropolitan Areas and Transitional Grant Areas

Part A provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. Part A funds are used for PLWHA who are uninsured, underinsured or underserved to ensure access to core medical and support health services that enhance access to care; maintain clients in care, particularly primary care services; and ensure continuity of care.

The DC EMA, the District's Department of Health (DOH) HIV/AIDS, Hepatitis, STD and TB Administration's (HAHSTA) Care Bureau is the designated DC EMA grantee. HAHSTA provides oversight to DC and West Virginia (WVa) providers directly. In Maryland (MD) and North Virginia (NVa), HAHSTA contracts with the Suburban Maryland and Administrative Agency (SMAA) within the Prince George's County Health Department and the Northern Virginia Regional Commission (NVRC) respectively to provide oversight to providers serving their jurisdictions. Providers offering Outpatient/Ambulatory Medical Care (Medical Care) and Medical Case Management (MCM) services throughout the DC EMA were invited to attend the Collaborative. DC, WVa, MD and NVa are currently represented.

PART B: Grants to States and Territories

Part B provides grants including a base grant to supplement core medical and support services, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants and grants to States for Emerging Communities (EC). The DOHs within each of the four jurisdictions of the DC EMA are the grantees for their State/District's Part B funds which include the counties, cities and the District within the DC EMA. Each DOH receives a base grant, ADAP and ADAP supplemental grants. In Maryland, their ADAP is known as MADAP. WVa also receives EC grant. The grantees can choose to provide services directly through their local health departments or a consortium. All four of the DOHs are participating in the Collaborative along with some of their Medical Care Providers.

In addition, Minority AIDS Initiative (MAI) grants are provided to address HIV/AIDS care needs under Parts A, B, C and D to address the HIV/AIDS care needs of African Americans and other disproportionately impacted communities. In the DC EMA, MAI funds are provided to the grantees under Parts A and B to DC, MD and VA.

PART C: Early Intervention Services

Part C provides grants directly to service providers such as ambulatory medical clinics to support outpatient Early Intervention Services (EIS) and ambulatory care for services at their facility location. The Part C grantees participating in the Collaborative represent federally qualified health centers (FQHCs), community-based organizations (CBOs), other medical clinics and a research institute.

PART D: Services for Women, Infants, Children, Youth and Families

Part D provides grants for family-centered primary medical care involving outpatient or ambulatory care (directly, through contracts or through memoranda of understanding) for women, infants, children, and youth with HIV/AIDS. Part D funds primary medical care, treatment and support services to improve access to health care. Two (2) Part D grantees, Children's National Medical Center (CNMC) located in DC and Inova Juniper Program in NVa are participating in the Collaborative.

PART F: AIDS Education and Training Centers Program and Dental Reimbursement Program

Provides grants to support the AIDS Education and Training Centers (AETC) Program and the Dental Reimbursement Program (DRP). The AETC conducts targeted, multidisciplinary education and training programs for health care providers treating PLWHA. The Pennsylvania/MidAtlantic (PA/MA) AETC serves Delaware, DC, MD, Ohio, Pennsylvania, VA, and WV. Currently, the VA and DC Local Performance Sites (LPS) of the PA/MA AETC are participating in the Collaborative. The MD site has been invited, but has not joined.

The DRP funds institutions that have dental or dental hygiene education programs to improve access to oral health care services for PLWHA while simultaneously educating dental hygiene students and residents about comprehensive care specific to HIV/AIDS. Only Howard University's Dental Program in the District receives DRP funds to serve the DC EMA.

Demographics of the Population in the DC EMA:

General:

The general population is racially, ethnically and linguistically diverse. The following number posted in the document is population data estimations based on 2009 US Census Data. The total population of the DC region is 5,529,547 with 52.5% White, 25.1% Black, 12.0% Hispanic/Latino, 8.3% Asian, 0.3% American Indian/Alaska Native and 0.1% Native Hawaiian/Pacific Islander. Nearly 22% of the DC region population is foreign-born, and 27% have limited English proficiency. This region has significant numbers of people moving here for its economic opportunities.

The DC EMA operations are composed of four separate jurisdictions. The four (4) jurisdictions are identified as the four quadrants of Washington DC, five counties located in Suburban Maryland, eleven counties and six cities located in Northern Virginia, and two counties located in West Virginia.

HIV/AIDS:

Of the 5, 529,547 people living in the DC region, 45,971 people were reported living with HIV/AIDS as of December 31, 2009, which represented 0.8% of the region's residents.

- People of color are disproportionately impacted by HIV/AIDS in the DC region.
 - Racial and ethnic minorities make up 36.9% (N=2,040,403) of region's residents, yet they account for an astounding 80.1% of the estimated living HIV/AIDS cases.
Blacks account for only 26% (N=1,437,682) of the region's population, but they comprise 70% of the estimated living HIV/AIDS cases in the region.
 - Approximately thirty percent (30%) (N= 13,791 number corrected) of the HIV/AIDS cases are female.
- The top four (4) reported exposure categories among the cumulative HIV/AIDS diagnoses were male to male sex 37.4%, heterosexual transmission 26.7%; risk either not reported or not identified 20.5%, and injection drug use 12.3%.
- Men who have sex with men who also inject drugs account for an additional 2.7% of HIV/AIDS diagnoses in the region.
- Although residents of Washington DC only represent 10.6% (N=586,132 number added) of the total DC region's population, they accounted for 65.1% of HIV/AIDS cases.
- The nation's capital is the epicenter of the epidemic in the region and has a higher number of HIV/AIDS diagnoses than ever before. Its prevalence rate is more than twelve times that of the rest of the nation.
- In the region, 58% of HIV/AIDS cases have incomes at, or below, the federal poverty level (FPL) and an additional 20% have incomes below 300% FPL. (We need to verify these numbers where possible for accuracy)

The DC Cross-Part Collaborative's HIV QM Plan reflects a continuous process which improves, evaluates and informs the delivery system of measurable outcomes and demonstrates a commitment to quality services for consumers served within the DC EMA's RW Program Parts' (A,B,C,D, and F) provider network. A timeline for annual implementation, revision, and evaluation of the plan is included in this document.

Structure of the HIV QM Plan

The overall purpose of the Quality Management plan is to have a unified document that grantees, each jurisdictional agency, and RW sub-grantees can use to build and strengthen their systems and program services to ultimately improve quality of care to clients. To accomplish this, the DC Cross-Part Collaborative QM Response Team has identified the following areas that must be addressed in the development of the QM Plan:

- A. Quality Statement;
Vision, Purpose, AIMS
- B. Definitions of Quality
- C. Quality Management Infrastructure;
- D. Goals and Implementation Plan;
- E. Capacity Building
- F. Performance Measurements;
- G. Participation and Communication with Stakeholders;
- H. Quality Management Plan;
- I. QMP Work Plan
Process to Update the QM Plan; and
- J. Communication Processes.
- K. Limitations

This QM Plan has been prepared by a Sub-committee of the DC Cross-Part Response Team under the leadership of Safere Diawara, QM Coordinator with the Virginia Department of Health (VDH). The HIV QM Plan sub-committee is an interdisciplinary team who has been reviewing literature and samples of QM Plans and conferring for several months to develop drafts of the QM Plan. The drafts were reviewed and discussed at different levels of the Collaborative before final approval for publication. This final approved document will be shared with all stakeholders and healthcare providers who care for PLWHA in the DC EMA. The Plan is available in print and on the following websites:

- <http://nationalqualitycenter.org/index.cfm/17112/38159>
- www.doh.dc.gov/dcqc

The DC Cross-Part Collaborative Quality Management Plan

A. QUALITY STATEMENT

VISION:

The Collaborative's well-defined network of community partners and resources will provide seamless accessibility to quality HIV-related care and services for all RW consumers in the DC EMA.

PURPOSE:

The Collaborative will systematically monitor, evaluate and continuously improve the quality of HIV care and services provided to all RW consumers in the DC EMA through the collaborative efforts of community partners and key stakeholders from all HIV/AIDS Program Parts. All comprehensive HIV care must be provided according to the HHS guidelines for the treatment of HIV disease and related opportunistic infections, formerly the Public Health Service (PHS) guidelines. The key focus of the Collaborative is on changes that demonstrate and improve measurable outcomes of clinical performances.

AIMS:

At the end of this Collaborative, the following will have been achieved:

- Strengthened partnerships across all RW Parts in the DC EMA as evidenced by established communication strategies for the purpose of collaboration for QM; region-wide QM priorities; and joint training opportunities.
- Expanded consumer involvement in quality activities to improve HIV care.
- Collection and synthesis of a portfolio of performance measures that reflect the required HAB measures will be used for the coordination of QI activities, development of best practices and standards, and the implementation of key activities that will minimize and/or eliminate barriers of impeded communication between regional providers and consumers.
- The unified, regional DC Cross-Part Collaborative's HIV QM Plan for all RW funded providers, supported by a work plan and developed by September 2011 will have been fully implemented throughout the DC EMA;
- At least two joint QI projects will be initiated and each grantee will contribute to the success by submitting data bi-monthly based on standardized data collection methodologies.
 - Improving patient/consumer Syphilis Screening rates to 90% (improvement of 25% over baseline) by May, 2012; and
 - Defining a new patient/consumer retention measure by September, 2011 with hopes to improve patient Retention in Care rate.
- Project objectives will be updated at least annually.

B. DEFINITION OF QUALITY

The following definitions can be found in the QM Technical Assistance (TA) manuals developed by HRSA and the National Quality Center (NQC).

a. Indicator:

A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or the level of quality achieved. Indicators serve as an interim step toward achieving a performance measure and are also referred to as activities.

b. Performance Measure:

Performance measure is a quantitative tool that provides an indication of the quality of a service or process. It is a number assigned to an object or event that quantifies the actual output and quality of work performed.

c. Plan-Do-Study-Act (PDSA) Cycles:

The Collaborative QI process is based on the PDSA Cycle methodology. This model for performance improvement will be used for all QI activities:

- **PLAN** – Identify and analyze what you intend to improve, looking for areas that hold opportunities for change;
- **DO** – Carry out the change or test on a small scale (if possible);
- **STUDY** – What was learned? What went wrong? Did the change lead to improvements in the way you had hoped?; and
- **ACT** – Adopt the change, abandon it, or run through the cycle again.

d. Quality:

Quality is the degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider: the quality of the inputs, the quality of the service delivery process, and the quality of life outcomes.

e. Quality Assurance (QA):

QA refers to a broad spectrum of ongoing/continuous evaluation activities design to ensure compliance with minimum quality standards. An ongoing monitoring of services for compliance with the most recent HHS guidelines for the treatment of HIV disease and related opportunistic infections, and adherence to grantee, and federal, state and local laws, rules, and regulations.

f. Quality Improvement (QI):

QI is generally used to describe the ongoing monitoring, evaluation, and improvement process. It includes a client/consumer-driven philosophy and process that focuses on preventing problems and maximizing quality of care. This focus is a means for measuring improvement to access and the quality of HIV services.

g. Quality Management (QM):

QM is a larger concept, encompassing continuous QI activities and the management of systems that foster such activities: communication, education, and commitment of resources. The integration of quality throughout the organization of the agency is referred to as QM. The QM Program embraces QA and QI functions.

h. Outcomes:

Results achieved for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, conditions or health status.

i. Outcome Indicator:

Specific item of information that track a program's success (or failure) on outcomes. They describe observable, measurable characteristics or changes that represent the product of an outcome.

C. QUALITY MANAGEMENT INFRASTRUCTURE

a. The development of the Collaborative was initiated by HRSA HAB.

The NQC, with support from HAB, has helped to guide the efforts of the Collaborative. NQC's responsibilities over the course of the Collaborative:

- Facilitate four Learning Sessions;
- Provide a standard monthly data reporting template;
- Meet jointly to review all reports submitted and send feedback;
- Launch ProjectSpace;
- Launch a listserv; and

- Summarize progress and best practices from this Collaborative, and develop a final report.

b. The leadership of the Collaborative comes from the Response Team.

Membership on the Response Team is optional and open to anyone in the Collaborative. The Response Team provides oversight and support of the Collaborative and works with other Collaborative members to set the goals for the QM Plan, determine priorities and provide technical support necessary to implement identified quality initiatives. In addition, the Response Team will collaborate on a regular basis to ensure that clinical QM activities and actions are integrated appropriately throughout the DC EMA. Each member of the Response Team will perform different roles in the development, implementation, training, evaluation, and support of the HIV QM Plan and written Work Plan over the next 12-18 months.

Response Team Responsibilities:

- Define the structure and framework for QM and performance monitoring activities within the Collaborative;
- Oversee the implementation of the HIV QM Plan;
- Ensure that adequate resources are made readily available to successfully implement the annual Work Plan;
- Oversee and approve quality initiatives from a planning, monitoring, analysis, identification of recommendations and implementation perspective;
- Ensure that consumers are represented in all Collaborative activities;
- Engage key stakeholders in the QI activities;
- Identify and prioritize key QI project measure indicators;
- Oversee the data analysis and reporting activities for the Collaborative; and
- Provide expertise for the development of learning sessions for Collaborative members; and
- Participate in monthly face to face meetings, conference calls, and quarterly Collaborative-wide meetings over the next 12-18 months.

Sub-committees

The Response Team will accomplish its work through close and constant interaction with other Collaborative members through a sub-committee structure. The following standing Sub-committees have been established for the Response Team.

1. QI Projects Sub-committee

Responsibilities:

- Lead the Collaborative in dialogue regarding project improvement activities;
- Provide TA and other supports around those activities;
- Set Collaborative goals for each improvement project; and
- Manage the effective communication of best practices related to the project among Collaborative members.

2. Data Management Sub-committee

Responsibilities:

- Assist the Collaborative with identifying potential data improvement projects;
- Advise the Collaborative on the development of improvements to the data collection system and performance monitoring initiatives;
- Review data over time for trends in program outputs and data validity;
- Request performance measures data from providers per schedule;
- Develop recommendations on how to improve data; and
- Share findings with stakeholders.

3. HIV QM Plan Sub-committee

Responsibilities:

- Develop and implement the HIV QM Plan and gathering needed information from various sources;
- Review the HIV QM Plan, for promoting collaboration among all participants;
- Establish shared measures and standards whenever possible; and
- Report the HIV QM Plan implementation outcomes to both the Response Team and to the stakeholders in a feedback mechanism that, not only holds the DC EMA accountable for implementing the plan, but provides good input and advice from the entire region across all Parts.

4. Provider Capacity Development Sub-committee

Responsibilities:

- Support the development of DC Cross-Part QI activities by linking training and TA to all stakeholders;
- Develop and implement QM training opportunities based on identified needs; and
- Facilitate providers and consumers ability to conduct QM activities as well as their knowledge about QI concepts.

5. Consumer Capacity Development Sub-committee

Responsibilities:

- Providing an effective means of QI communication to the consumers;
- Serving in an advisory capacity and making recommendations to the Response Team and stakeholders; and
- Increasing public awareness of the status of the Collaborative activities; and providing input into identified QM Programs.

Membership on the Response Team is open to all members of the collaborative. Participating members who wish to serve on the response team must submit a letter of interest and Response Team Membership Application form to the Response Team Chairperson. The

Response Team will review all applications and selections will be made based on availability and experience. A copy of the form is included as Appendix A.

c. **The Collaborative is a group of internal stakeholders made up of grantees, RW providers, and consumers.**

Grantees and DC EMA RW Providers:

The grantees and RW providers are a network of administrators and HIV healthcare providers that include physicians, mid-level practitioners, dietitians, dentists, nurses, phlebotomists, pharmacists, mental health counselors, medical case managers, quality managers, and others who are awarded RW funding directly or through a sub-contract to monitor and/or provide HIV-related services to PLWHA in the DC EMA.

Someone with signatory authority from each grantee and RW provider agency will be asked to review and agree to implementation of this HIV QM Plan within their specific program to achieve the vision of the Collaborative. Throughout the process, they will need to complete annual QM Self-Assessment; monitor and report on specific outcomes bi-monthly and participate in the regularly scheduled meetings.

Consumers:

Consumers are equal partners in the QI process and as such are sought as active members of any QI initiative related to the Collaborative. Consumers of all HIV-related services are the primary driving force behind the need for continual monitoring, re-evaluations and improvement of those services, the Collaborative includes consumer representation to advise other members on QI processes. Meaningful consumer involvement reflects an integrated process rather than parallel consumer improvement activities. To that end, the Collaborative felt the need and saw value in the inclusion of consumer representation from the inception of the Collaborative and moving forward.

External Stakeholders:

External stakeholders are interested in seeing the quality efforts of the Collaborative succeed but may not be actively participating in the activities of the Collaborative. External stakeholders may include caregivers; Advocacy groups, AIDS or health care focused policy committees, the Metropolitan Washington Regional HIV Health Services Planning Council, the Regional Advisory Committees; non-Ryan White providers of HIV Care in the DC EMA; and other funders, such as medical insurers (Medicaid, Medicare, and the Veterans Administration, etc). They should be kept informed of the Collaborative's efforts and called upon as needed to support the Collaborative.

Membership:

The attached Appendix B provides information about the current and potential membership of the DC Cross-Part Collaborative.

Meeting schedule:

The Collaborative is expected to be working together for 12-18 months. The Collaborative will meet quarterly at a centralized location to be determined by NQC. Members of the

Response Team are expected to also participate in monthly face-to-face meetings and/or conference calls.

d. Resources:

QM resources provided by the following organizations are consulted frequently:

- HRSA HAB
(<http://hab.hrsa.gov/special/qualitycare.htm/>)
- NQC (<http://nationalqualitycenter.org/QualityAcademy/>)
- Institute for Healthcare Improvement (<http://www.ihl.org/IHI/Topics/HIVAIDS/>)

D. GOALS AND IMPLEMENTATION PLAN

Health outcome goals are based on HAB's HIV Performance Measures for Core Clinical, ADAP and Pediatric Services. Currently, the QA process evaluation goals are set by HRSA with one optional goal selected by the Collaborative.

QA/process evaluation goals include:

1. Strengthening the existing HIV QM Infrastructure within RW Programs across all Parts to support QI activities throughout the DC EMA;
2. The development and implementation of the DC Cross-Part Collaborative HIV QM Plan;
3. Assuring QM alignment and integration throughout the DC EMA at the local levels;
4. The development and implementation of outcome and performance measures;
5. Providing TA and training on an ongoing basis;
6. Ensuring that ambulatory/outpatient centers, primary care and health-related support services adhere to the most recent HHS guidelines, as well as federal, state, local and grantee regulations;
7. Developing, implementing, and reporting on identified specific QI projects;
8. Facilitating the active involvement of provider agencies in the implementation of multidisciplinary data driven QI projects; and
9. Ensuring that the goals for consumer involvement include the participation of a diverse group of PLWHA in QI activities, including but not limited to:
 - a. Providing consumer perspectives, outreach, and as community liaisons;
 - b. Helping with needs assessments for QM and identifying service barriers;
 - c. Functioning as trainers for QM; and
 - d. Acting as a resource pool for various skill sets needed at agencies for QM.

Implementation Timeline:

Year One 2011:

- Initiate collection, synthesis and analysis of the Collaborative's performance measures;
- Set project goal for syphilis screening across Collaborative participants;

- Share best practices surrounding syphilis screening improvement projects to achieve project goal across the Collaborative; and
- Define retention measure for use in future years.

Year Two 2012:

- Continue collection, synthesis and analysis of the Collaborative's performance measures, including newly defined retention measure;
- Continue sharing best practices surrounding syphilis screening improvement projects to achieve project goal of 90% across the Collaborative;
- Establish and set project goal for retention across the Collaborative; and
- Begin sharing best practices surrounding retention improvement projects to achieve project goal across the Collaborative.

Year Three 2013:

- Continue collection, synthesis and analysis of the Collaborative's performance measures, including retention measure;
- Continue sharing best practices surrounding retention improvement projects to achieve project goal across the DC EMA ; and
- Set project goal for Year Four focus across the DC EMA.

The attached Appendix C provides information about the three-year strategic plan.

Quality Management Program Work Plan, 2011 – 2012

GOALS include:

1. Establishing a QM structure within the Collaborative that supports QI activities throughout the DC EMA.
2. The development and implementation of measurable outcomes and performance measures at all levels.
3. To provide ongoing TA and trainings when necessary.
4. Encourage Collaborative participants to achieve goals for each QI Project.
 - Increase the percentage of HIV patients who have been screened for syphilis within the measurement year across Collaborative participants to 90% by April 2012.
 - Increase the percentage of HIV patients who are retained in primary HIV healthcare within the measurement year across Collaborative participants to a mutually agreed upon goal to be determined.

The attached Appendix D provides information about the implementation/work plan.

Accomplishing the activities within this plan will require coordinated teamwork efforts throughout the DC EMA. All RW programs should become an integral component in conducting activities to accomplish the comprehensive QM Plan objectives and key activities.

E. CAPACITY BUILDING

The Collaborative will continue to build QI capacity through providing training, TA, and technology transfer. Capacity building needs will be determined through organizational assessments, QM surveys and focus groups.

Training will involve the development and delivery of curriculum and the coordination of training activities to increase the knowledge, skills and abilities of trainers, HIV service providers and consumers. Collaborative members trained by NQC, or trainers from LPS of PA/MA AETC and Howard University's Dental Program will provide QM training opportunities for members of the Collaborative as well as the DC EMA.

TA will be provided or facilitated through culturally relevant and expert programmatic and technical advice (mentoring/coaching) with support from the NQC. TA is also provided in areas such as organizational infrastructure development, program implementation, QI, and evaluation via self-study QM tutorial through the NQC's Quality Academy
<http://nationalqualitycenter.org/index.cfm/5847/8860>.

Technology transfer will occur when innovations are diffused among HIV providers to improve effectiveness and are translate into programs and practice. Newsletters and a Consumer Information Center will be utilized in this process.

The attached Appendix E provides information about the planned capacity building activities.

F. PERFORMANCE MEASUREMENT

The attached Appendix F provides information about the current available data that is being tracked and reported for selected clinical services in the DC EMA to address HAB's Performance Measures. The Collaborative chose some of the Core Clinical Measures to focus on for their QI projects. Data will be collected from a variety of sources and, to the extent possible, existing data sources will be utilized including the eClinical Works, General Electric (GE) Centricity, Virginia Client Reporting System (VACRS), CAREWare, Cross Program Reporting and Evaluation System (XPRES)/MAVEN, custom agency databases in Access or Excel, and other transportable data sources.

Findings for QM activities will be reported only in the aggregate. Client-level data will not be reported or made available. Program-specific data reports may be directly provided to each provider for the purpose of enhancing their QM Program.

Performance measurement is a central component of the QM Program. The Collaborative will use performance measurement data to identify and prioritize QI projects, to routinely monitor the quality of care provided to consumers, and to evaluate the impact of changes made to improve the quality and systems of HIV care.

A. Data Collection

To the extent possible, performance data will be collected from all RW funded agencies within the DC metropolitan area. Providers will use a standardized reporting template and submit their aggregate data through the Collaborative's secured web-based portal, Project Space. The data collection efforts will:

- place as minimal a burden as possible on the sources;
- minimize any interference with the routine operations of provided services; and
- utilize existing data sources (including clinical chart abstraction and consumer interviews)

Persons involved with the collection of data will be bound by their provider, local, state, District and federal regulations regarding confidentiality. Individuals involved in the collection of data should receive appropriate training regarding their role, the confidentiality and security of data, and other ethical issues.

Data collection will include:

- Data to assess the needs of PLWHA in the DC metropolitan area;
- Outcomes data developed for specific program areas;
- Client satisfaction data; and
- Other data as QM activities require or deem necessary.

Strategies

In collaboration with the broader Response Team, the Data Team will coordinate the collection and analysis of data. The Data Sub-committee will:

- Develop and maintain a standardized data reporting template;
- Provide TA and training on data integrity, collection and use;
- Follow-up with non-participating providers to encourage participation,
- Compile and analyze the data,
- Develop and distribute provider performance reports for each data submission, and
- Present the results to the Collaborative.

Data collection will be implemented utilizing appropriate sampling methodology and will include both concurrent and retrospective review. For each data collection activity scheduled in the QM work plan, a data collection plan will be developed that specifies:

- a. The purpose of the data collection activity;
- b. The measures and indicators to be collected;
- c. The instruments and methods to be used to collect the identified data;
- d. The analysis plan for the data;
- e. The methods for maintaining data security; and
- f. How and to whom the findings will be reported.

Data sources

The Collaborative is responsible for the regular collection, analysis and reporting of QM data. This data includes, but is not limited to:

- Chart abstractions from client medical records (paper or electronic);
- Clinical databases;
- Demographic databases;
- XPRES/MAVEN;
- CAREWare;
- ADAP database;
- Administrative/Programmatic monitoring tools;
- Client satisfaction surveys/interviews;
- Focus group summaries; and
- Unmet Needs Assessments.

B. Reporting Mechanisms of Data

Findings for QM activities will be reported in aggregate format, and will not include client-level data. Program-specific data reports may be directly provided to each program for the purpose of enhancing their QM Program and to allow for comparison across the jurisdictions and DC EMA.

The Collaborative utilizes strategies outlined in the HAB's HIV/AIDS Performance Measures for Core Clinical (for Adults and Adolescents), ADAP and Pediatric Services to measure selected key performance indicators for HIV health care. RW grantees, sub-grantees, contractors and subcontractors will be required to report data on these selected key performance indicators. Compiled findings will be shared with HIV providers, the Response Team and HRSA faculty, consumers, grantees, and others, as deemed appropriate. The Response Team will be responsible for oversight and ensuring implementation of the established process.

G. PARTICIPATION OF STAKEHOLDERS

In addition to HRSA and the NQC, several stakeholders are currently involved in the Collaborative's activities.

Goals for Stakeholders are:

1. Make QM a part of the DC EMAs' RW care provision and a part of everyday work activities;
2. Given a clear understanding of their roles in the Cooperative, buy-in to participation in the Collaborative is a welcomed activity;
3. Replicate infrastructures and QM models that work in a similar geographic area and under similar conditions within their own program; and
4. Develop relationships and technical capacity to extract needed QM data.

H. QUALITY MANAGEMENT PROGRAM EVALUATION

The goal of evaluating the QM Program is to determine whether or not programs made an improvement reflected in documented QI activities. The Collaborative requires providers to monitor and report on selected outcome measures bi-monthly.

The Collaborative will evaluate the QM Program on an annual basis, including rating the completeness of goals and key activities undertaken during the year, and results will be used to:

1. Determine the effectiveness of the QM Plan infrastructure and activities;
2. Review annual goals, identify those that have not been met, as well as the reasons these goals were not met, and assess possible strategies to meet them before the next review; and
3. Review the selected quality indicators for appropriateness and continued relevance in order to reach optimal care for consumers.

Based on the findings, the Response Team will refine strategies for the following year. Regular feedback regarding overall QI is critical in sustaining improvements over time. To obtain feedback from stakeholders:

- The Response Team will communicate findings and solicit feedback from key stakeholders on an ongoing basis and data presentations will be made during identified meetings.
- Written reports will be shared with stakeholders who will be given the opportunity to provide feedback on the reports.

I. PROCESS TO UPDATE THE QUALITY MANAGEMENT PLAN

The HIV QM Plan Sub-committee will assess the QM Plan using the NQC Checklist for the Review of an HIV-Specific QM Plan. The NQC checklist will help identify opportunities for improvement to the QM Plan. The results will be shared with the Collaborative during one of the scheduled meetings. By consensus, the Collaborative will identify a new set of quality indicators, establish goals for the upcoming year, and identify and describe specific quality initiatives in the updated QM Plan. A revised QM Plan will be submitted to all the Collaborative's RW participants for approval on an annual basis.

Monitoring review of the implementation process will be conducted by the Response Team on a regular basis. The review will be planned and scheduled every quarter, with a report of progress to the Collaborative and other stakeholders. Monitoring the QM Plan will include reviewing the goals, the objectives and activities listed in the work plan. Frequent monitoring of the plan will allow for early recognition of possible barriers.

J. COMMUNICATION PLAN

Communication will be necessary with the following groups:

- Contract and subcontract HIV service providers;
- Advocacy groups, AIDS or health care focused policy committees, RW leadership, Metropolitan Washington Regional HIV Health Services Planning Council, Regional Advisory Committees, the community at-large, and the press;
- NQC and HRSA staff ; and
- Consumers of RW services, etc.

The purpose of communication will depend upon the group and may include:

- Introduction to the work of the Collaborative;
- Routine meetings to encourage buy-in of non-participating providers to join and provide their data to feed quality measurements;
- Responding to requests for information;
- Data gathering;
- Responding to results of PDSA Cycle and to implementation of other quality processes;
- Press release style updates as the project progresses;
- Reports tied to output or outcomes more than process;
- Routine leadership communication, such as meeting minutes;
- Demonstration of the “process” of development of QM tools, consensus with brief introduction to the work of the Collaborative;
- Highly structured, polished, succinct reporting methods and tools;
- Outcomes of QI activities; and
- Written information for audiences of varying education levels and competencies.

The frequency of communication will depend upon the group and may occur:

- On a routine basis, monthly or bi-monthly; more frequently during PDSA Cycles;
- Prior to subcontractors of Collaborative partners participating in their first collaborative meeting;
- Quarterly in the Collaborative newsletter;
- At local meetings as “news”;
- On a monthly routine basis to describe processes and outcomes, report successes and challenges, and respond to TA needs;
- As needed to share information on outcomes; and
- Bi-monthly for data submission and feedback.

Open Meetings

Highly structured meetings such as the Collaborative Learning Sessions (LS) and QM Summit will be open to all RW providers, consumers and stakeholders and all are encouraged to participate.

K. LIMITATIONS

- All stakeholders are at different levels of implementing QM Plans in their programs;
- The measures selected are the first steps in a multi-year process to improve outcome measurement;
- Information must not be used to compare providers;
- Many interventions can affect outcomes; and
- The services being measured represent only a small part of what may lead to changes.

ACRONYMS

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organization
DC	District of Columbia
DC EMA	DC Eligible Metropolitan Area
DOH	Department of Health
DRP	Dental Reimbursement Program
EC	Emerging Community
EMA	Eligible Metropolitan Area
FMC	Family Medical Center
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GE Centricity	General Electric Centricity
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau
HAHSTA	HIV/AIDS, Hepatitis, STD, and TB Administration
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
LPS of the PA/MA AETC	Local Performance Sites of the Pennsylvania/Mid-Atlantic AIDS Education & Training Center
MADAP	Maryland AIDS Pharmaceutical Program
MAI	Minority AIDS Initiative
MD	Maryland
N	Number
NQC	National Quality Center
NOVA	Northern Virginia
NVRC	Northern Virginia Regional Commission
PDSA Cycle	Plan-Do-Study-Act
PLWHA	People living with HIV/AIDS
QA	Quality Assurance
QI	Improvement
QIP	Quality Improvement Plan
QIPS	Quality Improvement Project Sub-committee
QM	Quality Management
RW	Ryan White
RWPB	Ryan White Part B
SMAA	Suburban Maryland Administrative Agency
TA	Technical Assistance
TOT	Training of Trainers

VA
VACRS
VDH
WV
XPRES

Virginia
Virginia Client Reporting System
Virginia Department of Health
West Virginia
Cross Program Reporting and Evaluation Systems

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The following individuals provided extensive time, effort and dedications to the development of this document.

<p><u>Amelia Khalil, MA</u> <i>Senior Contract Officer/Quality Manager Northern Virginia Regional Commission</i></p>	<p><u>Angela Fulwood Wood, MSW</u> <i>Chief Operations Officer Family and Medical Counseling Service, Inc.</i></p>
<p><u>Angela Clements, MPH</u> <i>Health Educator INOVA Juniper Program</i></p>	<p><u>Glenn Clarke, MSW</u> <i>Chief, Center for HIV Care Services Former Infectious Disease and Environmental Health Administration Maryland Department of Health and Mental Hygiene</i></p>
<p><u>Jimmy Gathua</u> <i>Data Specialist INOVA Juniper Program</i></p>	<p><u>Justin Britanik</u> <i>Program Compliance Manager Greater Baden Medical Services Inc.</i></p>
<p><u>Lena Lago, MPH</u> <i>Monitoring and Evaluation Manager District of Columbia Department of Health Care, Housing and Support Services Bureau HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)</i></p>	<p><u>Lloyd H. Buckner</u> <i>Executive Director The Carl Vogel Center</i></p>
<p><u>Mrs. Martha Sichone Cameron</u></p>	<p><u>Michael Hager, MPH MA</u></p>

	<i>Former Director of Quality Improvement Whitman-Walker Health (WWH)</i>
<u>Rachel Smith</u> <i>Vice President Greater Baden Medical Services, Inc</i>	<u>Safere Diawara, MPH</u> <i>Quality Management Coordinator Virginia Department of Health (VDH)</i>
<u>Denise Burke</u> <i>Quality Assurance Coordinator Prince George's County Health Department Suburban Maryland Administrative Agency</i>	<u>Brenda Clark</u> <i>Quality Improvement Specialist HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) DC Department of Health</i>
<u>Tarsha Harris Moore, MSW, LICSW</u> <i>Patient Support Services Manager Burgess Clinic, Family Connections, Special Immunology Services Children's National Medical Center</i>	<u>Keli E. Nibblins, RN, BSN</u> <i>Medical Case Coordinator Infectious Disease Associates Mary Washington Healthcare Physicians Group</i>

Appendix A: **DISTRICT OF COLUMBIA • ELIGIBLE METROPOLITAN AREA**

RYAN WHITE CROSS-PART QUALITY IMPROVEMENT COLLABORATIVE

Response Team Membership

The Response Team was assembled to coordinate the Collaborative's activities. This Team is comprised of grantees, sub-grantees, and consumer representatives from the entire EMA. The Response Team accomplishes its work through constant interaction with the broader Collaborative membership via a sub-committee structure. The following standing sub-committees have been established for the Response Team:

Data Management Team

The Data Management Team is responsible for:

- Assisting the Collaborative with identifying potential data improvement projects;
- Advising the Collaborative on the development of improvements to the data collection system and performance monitoring initiatives;
- Reviewing data over time for trends in program outputs and data validity;
- Requesting performance measures data from providers per schedule;
- Developing recommendations on how to improve data; and
- Sharing findings with stakeholders.

Quality Improvement Team

The Quality Improvement Team is responsible for:

- Leading the Collaborative in dialogue regarding project improvement activities;
- Providing TA and other supports around those activities;
- Setting Collaborative goals for each improvement project; and
- Managing the effective communication of best practices related to the project among Collaborative members.

Quality Management Plan Team

The Quality Management Plan Team is responsible for:

- Developing and implementing the HIV QM Plan and gathering needed information from various sources;
- Reviewing the HIV QM Plan, for promoting collaboration among all participants;
- Establishing shared measures and standards whenever possible; and
- Reporting the HIV QM Plan implementation outcomes to both the Response Team and to the stakeholders in a feedback mechanism that, not only holds the DC metropolitan region accountable for implementing the plan, but provides good input and advice from the entire region across all Parts.

Provider Capacity Development Team

The Provider Capacity Development Team is responsible for:

- Supporting the development of DC Cross-Part QI activities by linking training and TA to all stakeholders;
- Developing and implementing QM training opportunities based on identified needs; and
- Facilitating providers and consumers ability to conduct QM activities as well as their knowledge about QI concepts.

Consumer Capacity Development Team

The Consumer Capacity Development Team will be responsible for:

- Providing an effective means of QI communication to the consumers;
- Serving in an advisory capacity and making recommendations to the Response Team and stakeholders; and
- Increasing public awareness of the status of the Collaborative activities; and providing input into identified QM Programs.

In addition to the subcommittees, there are opportunities to support the activities of the Response Team via the individual roles listed below:

Collaborative, Co-Leads

The Collaborative co-leads are responsible for:

- Interfacing with the NQC and HRSA faculty throughout the first 18-months of the project;
- Leading the Response Team in ascertaining and accomplishing goals;
- Identifying key priorities and milestones for the Collaborative; and
- Setting the agenda for the Response Team meetings.

Communicator

The Communicator is responsible for:

- Coordinating all email communication for the Collaborative participants;
- Formatting and editing all Collaborative products developed for distribution; and
- Developing webpage content.

Trainer

The Trainer is responsible for:

- Identifying the need for training;
- Developing in-person, webinar and conference call training agenda; and
- Identifying subject matter experts to address knowledge gaps.

Recorder

The Recorder is responsible for:

- Accurately capturing the ideas discussed and decisions of the Response Team meetings.

Meeting Manager

The Meeting Manager is responsible for:

- Identifying a space for Response Team and Collaborative participant meetings.

Name: _____
Organization: _____
Email: _____
Telephone: _____

I. Overview of Experience and Availability

- Brief description of experience: _____

- List time constraints and availability:

II. Committee and Role

Indicate the committee of interest and your willingness to take a leadership or support role

Leadership (L) or Support (S) Role	Committee / Team
	Data Management
	Quality Improvement
	Quality Management Plan
	Provider Capacity Development
	Consumer Capacity Development
	Co-Lead
	Communicator
	Trainer
	Recorder

	Meetings Manager
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APPENDIX B: COLLABORATIVE MEMBERSHIP

Agency/Part	Participant and Response Team Role	Resource/Area of Expertise	Status as of Today
Ryan White A			
Northern Virginia Regional Commission (NVRC)	Participant <u>Amelia Khalil – Response Team</u>	Part A & Part B Administrative Agent	Participating, Data- N/A
HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)	Participant <u>Lena Lago – Response Team</u>	Part A Grantee/Administrative Agent	Participating, Data-N/A
Prince George's County Health Department (PGCHD)	Participant	Suburban MDRW Part A Administrative Agent	Participating, Data- N/A
Glenridge Medical Center	Participant	Sub-recipient in Suburban MD providing Medical Care and MCM	Participating, Submitting data
AIDS Response Effort, Inc	Participant	Sub-recipient in NOVA providing Medical Care and MCMCM	Participating, Submitting Data
Fredericksburg Area HIV/AIDS Support Services, Inc.	Participant	Sub-recipient in NOVA providing Medical Care and MCMCM	Invited, No data submitted
Loudon County Health Department	Participant	Sub-recipient in NOVA providing Medical Care and MCMCM	Participating, Submitting Data
AIDS Healthcare Foundation	Participant	Sub-recipient in DC providing Medical Care and MCMCM	Invited, No Data Submitted
Andromeda Transcultural MHHC	Participant	Sub-recipient in DC providing Medical Care and MCMCM	Invited, No Data Submitted
Christ House	Participant	Sub-recipient in DC providing Medical Care and MCMCM	Invited, No Data Submitted
Community Family Life Services	Participant	Sub-recipient in DC providing MCMCM	Participating, Submitting Data
La Clinica del Pueblo	Participant	Sub-recipient in DC providing Medical Care and MCMCM serving primarily a Latino/Hispanic population	Participating, Submitted some data
Mary's Center for Maternal and Child Care	Participant	Sub-recipient in DC providing Medical Care	Invited, Not participating or submitting
Regional Addiction Prevention	Participant	Sub-recipient in DC providing Medical Care and MCMCM	Invited, No Data Submitted
The Women's Collective	Participant	Sub-recipient in DC providing Medical Care	Invited, No Data Submitted
Us Helping Us	Participant	Sub-recipient in DC providing Medical Care	Invited, No Data Submitted
Ryan White B			
DC HAHSTA	Participant	ADAP agency	Participating, Submitting ADAP data
Maryland Department of	Participant	ADAP agency	Participating,

Health and Mental Hygiene (MD DHMH)	<u>Glenn Clarke – Response Team</u>		No data submitted
Virginia Department of Health (VDH)	Participant <u>Safere Diawara – Response Team</u>	ADAP agency	Participating, Submitting ADAP data
West Virginia Department of Health & Human Resources (WV DHHR)	Participant	ADAP agency	Participating, Submitting ADAP data
Charles County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing MCM.	Invited, No Data Submitted
Frederick County Health Department	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.	Invited, No Data Submitted
Alexandria Neighborhood Health Services	Participant	Part A and Part B sub-recipient in NOVA providing Medical Care and MCM.	Invited, No Data submitted
Montgomery County Department of Health and Human Services	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.	Invited, No Data Submitted
Prince George’s County Department of Health	Participant	Part A and Part B sub-recipient in Suburban MD providing Medical Care and MCM.	Participating, Submitting Data
Building Futures	Participant	Part B sub-recipient providing MCM services in DC	Invited, No Data Submitted
Damien Ministries	Participant	Part B sub-recipient providing MCM services in DC	Invited, No Data Submitted
Homes for Hope	Participant	Part B sub-recipient providing MCM services in DC	Participating, Submitting Data
Joseph’s House	Participant	Part B sub-recipient providing MCM services in DC	Invited, No Data Submitted
Union Temple Baptist Church	Participant	Part B sub-recipient providing MCM services in DC	Invited, No Data Submitted
Shenandoah Valley Medical Systems	Participant	Part B sub-recipient providing outpatient medical care and MCM services in WV	Participating, Submitting Data
Ryan White C			
Greater Baden Medical Services Inc.	Participant <u>Justin Britanik – Response Team</u> <u>Rachel Smith – Response Team</u>	Part A sub-recipient and Part C EIS program grantee in Suburban MD	Participating, Submitting Data
Howard University Hospital Comprehensive Clinic	Participant	Part A sub-recipient and Part C EIS program grantee	Participating, Submitting Data
Carl Vogel Foundation, Inc.	Participant <u>Lloyd Buckner – Response Team</u>	Part A sub-recipient and Part C EIS program grantee	Participating, Submitting data
Medstar Research Institute	Participant	Affiliated with Washington Hospital center, one of two Part C recipients in Suburban MD	Participating, Submitting Data
Whitman-Walker Health	Participant <u>Michael Hager – Response Team</u>	Part A sub-recipient and Part C EIS program grantee	Participating, Submitting Data
Unity Healthcare	Participant	Part A sub-recipient and Part C EIS program grantee	Participating, Submitting Data
Family and Medical Counseling Service	Participant <u>Angela Wood – Response Team</u>	Part A sub-recipient and Part C EIS program grantee	Participating, Submitting Data
Mary Washington Healthcare (formerly known as	Participant	Part A sub-recipient and Part C EIS program grantee in NOVA	Participating, Submitting data

Medicorp)			
Ryan White D			
Children’s National Medical Center	Participant <u>Tarsha Moore – Response Team</u>	Part D Administrative agent, Part A, B, & C funding	Participating, Submitting Data
Inova Juniper Program	Participant <u>Jimmy Gathua – Response Team</u>	Part D Administrative Agent and Part A, B & C Funding	Participating, Submitting Data
Ryan White F AIDS Education Training Center			
Northern Virginia Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant <u>Angela Clements – Response Team</u>	Part F – Clinical Training, TA and consultation	Participating, Data- N/A
Washington, DC Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation	Participating, Data- N/A
Maryland Local Performance Site of the Pennsylvania MidAtlantic AIDS Education & Training Center	Participant	Part F – Clinical Training, TA and consultation	Invited, Data- N/A
Consumer			
Martha Cameron	<u>Martha Cameron – Response Team</u> Consumer Lead	Consumer trained in Quality Management Principles	Participating, Data- N/A
Daryl Williams Washington Healthcare	Consumer	Parts A & C	Participating, Data- N/A

APPENDIX C: THREE-YEAR STRATEGIC PLAN

Domain	Area	2011	2012	2013
Alignment	HIV QM Plan	Develop, implement, and evaluate QM Plan, including a Work Plan.	Review QM Plan; revise as needed, Rewrite Work Plan annually.	Review QM Plan; revise as needed, Rewrite Work Plan annually.
	QM Summit	Hold RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in June 2011.	Hold annual RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in June 2012.	Recommend holding annual RW "All grantees meeting" (which includes grantees and providers from all RW Parts) in June 2013.
	Newsletter	Develop a template. Release new newsletter on a quarterly basis.	Revise and update the template. Release new newsletter on a quarterly basis.	Revise and update the template. Release new newsletter on a quarterly basis.
	QM Self-Assessment	Complete and present report by December 2011.	Complete annually and present report by December 2012.	Complete annually and present report by December 2013.
	Expand the Collaborative to:	Involve all committed RW grantees, providers, consumers and other key stakeholders.	Encourage participation of RW funded agencies in the DC region, that didn’t participate in the first year’s activities.	Encourage participation from non-RW funded providers who provide HIV care in the DC region.

Data	Data Management	Refine data collection process.	Reduce missing data.	Standardize data collection for accuracy and completeness. Ensure maintenance of data status.
		Select specific indicators to be tracked, analyzed, and reported.	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date.	Select specific indicators to be tracked, analyzed, and reported based on cumulative performance data to date.
		Develop a work plan to assess data abstraction barriers.	Update work plan to assess data abstraction barriers.	Update work plan to assess data abstraction barriers.
QI Activities	QM Consultation, Training and Assistance	Provide ongoing TA/consultations to providers in developing QI activities and projects.	Provide ongoing TA/consultations to providers in developing QI activities and projects.	Provide ongoing TA/consultations to providers in developing QI activities and projects.
		Conduct QM and QI trainings across the DC region.	Conduct QM and QI trainings across the DC region.	Conduct QM and QI trainings across the DC region.
	Collaborative Activities	Analysis of Collaborative quality measures every other month. Facilitate best practices dialogue surrounding quality measures across Collaborative	Analysis of Collaborative quality measures every other month. Facilitate best practices dialogue surrounding quality measures across Collaborative	Analysis of Collaborative quality measures every three months. Facilitate best practices dialogue surrounding quality measures across Collaborative
QI Projects	Syphilis Screening	The goal for Syphilis Screening results across Collaborative was set at 90% (improvement of 25% over baseline). Data is being collected, reviewed and shared to improve outcome.	Improve patient/consumer Syphilis Screening rates to 90% (improvement of 25% over baseline) by May, 2012. Share best practices across Collaborative.	Assess need to extend goal for Syphilis Screening.
	Retention in Care	Define QM measure for Retention by September 2011 and add to the list of other Collaborative measures reported every other month.	Monitor retention measure across Collaborative. Share best practices across Collaborative.	Continue to monitor retention measure across Collaborative. Share best practices across Collaborative.
	Expand the QI Projects to other core services and support services	No expansion needed at this time.	Expand the QI Projects to other core services and support services.	Extent the QI Projects to other core services and support services.
Capacity Building	Develop QM Training Team	Develop QM Training Team.	Assess effects of QM Training Team.	Assess effects of QM Training Team.

(Provider and Consumer)	Providers' QM Self-Assessment	Examine results of self-assessment and data reports to determine most critical issues by agency and how performance can best be addressed and improved.	Complete self-assessment annually to measure impact by analyzing assessments and data reports. Perform on-going training and/or TA.	Complete self-assessment annually to measure impact by analyzing assessments and data reports. Perform on-going training and/or TA.
	Developing Training Programs/Tools Accordingly	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.	Schedule, deliver, and evaluate training programs or tools to address performance issues.

The following tables describe the program goals, objectives, and key action steps.

APPENDIX D: IMPLEMENTATION/WORK PLAN FY2011-2012

Goal A: Implement the DC Cross-Part Collaborative HIV Quality Management Plan						
Domain	Area	Objectives	Key Action Steps	Person/Agency Responsible for Collection	Timeline	Resources
Alignment	Quality Management Plan	Develop the DC Cross-Part HIV QM Plan and Work Plan for 2011-2012.	-Develop draft of the HIV QM Plan - Distribute draft to stakeholders for review - Review and revise Plan at the Collaborative meetings - Finalize plan and post on the different websites.	Collaborative All stakeholders.	July 2011-May 2012	Previous QM Plans NQC /HRSA materials DOHs (in all four jurisdictions) websites
		Implement DC HIV QM Plan across RW agencies in the DC EMA.	- Provide training on QM principles including development of the QM Plan for providers.	QM Training Team All stakeholders	Ongoing	Work plans
		Evaluate and update HIV QM Plan annually	Utilize Cross-Part outcomes evaluation data/information to update QM Plan	Collaborative All stakeholders	May 2013	Data/information from chart review, final year outcomes data report, HRSA and other federal mandates
		Provide QM Training.	Identify topics, dates, and locations for meetings and collaborate with all stakeholders to provide trainings in June 2011.	NQC	June 2011	Written document, face-to-face, telephone, web, and email
		Spread information on Cross-Part activities.	Develop a template, collect information, and release a new Newsletter on a quarterly basis.	Collaborative	Ongoing	Collaborative All other RW providers Other Consumers Any others
		Customize NQC Self-assessment tool to meet Collaborative's needs.	Convene Collaborative meetings Develop and adopt tool Survey, analyze, and report the results.	Response Team.	By December 2011	Written documents, face-to-face, telephone, web, and email

Goal B: Strengthen the existing HIV QM Infrastructure within the DC EMA that supports QI activities.

AREA		Objectives	Key action steps	Person/Agency Responsible for Collection	Method of Reporting/Data Sources	Timeline
Infrastructure	Infrastructure Response Team	Provide leadership and oversight for all QI/management activities.	Work closely with the QM Plan Sub-committee to develop 2011 QM Plan.	Response Team	Approved QM Plan.	December 2011
			Implement the 2011 QM Plan.	All stakeholders	Ongoing reports.	Ongoing
		Strengthen collaboration within DC region to share Programs, policies, and best practices.	Use Established QM infrastructures.	Response Team	Conjoint documents, policies and procedures.	Ongoing
	Response Team Sub- Committee	Provide oversight and facilitation of the Collaborative QM Program.	Develop priorities and set QI goals for 2011.	Response Team QM Plan Sub-Committee	Meetings Written documents Results analysis and different reports.	Ongoing
			Expand membership to include other representatives.	All stakeholders	Membership list Attendance to required activities.	Ongoing
	QI Project Sub-committee(QIPS)	Make improvements in specific aspects of care delivery.		QIPS Members QM in-house teams at RW agencies	QM project reports based on Plan-Do- Study- Act Cycle results.	Ongoing

Goal C: Ensure that primary care and health-related support services adhere to the most recent HHS guidelines.

Domain	Area Objectives	Key Action Steps	Person/Agency Responsible for Collection	Timeline	Data Source(s)
Data Collection	Increase the percentage of pediatric patients with HIV infection who had three or more medical visits in a HIV care setting in the measurement year.	-Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all pediatric provider agencies bi-monthly	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database

Increase the percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had a viral load test performed at least every six months.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all bi-monthly	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of patients, aged 13 years and older, with a diagnosis of HIV/AIDS who had viral load below limits of quantification1 at last test during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical Care provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the number of patients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year at least 6 month apart.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all bi-monthly	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of adult patients with HIV infection who had a test for syphilis performed in the measurement year to 90%.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical care provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all, bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had a viral load test performed at least	Develop data collection methods and tools -Require all RW Parts to report on measures	The Collaborative All stakeholders	Submitted by all MCM provider agencies bi-monthly	XPRES/MAVEN ECW CAREWare Database VACRS

every six months.	- Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly			GE Centricity ADAP database
Increase the percentage of MCM patients, aged 13 years and older, who had a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Collaborative stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all Adolescent/Adult Medical Care provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM clients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all MCM provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all MCM provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted by all pediatric provider agencies bi-monthly.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database
Increase the percentage of ADAP applications approved or denied for new ADAP enrollment ² within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	Develop data collection methods and tools -Require all RW Parts to report on measures - Disseminate results to the Cross-Part stakeholders and agencies -Monitor measures bi-monthly	The Collaborative All stakeholders	Submitted bi-monthly by ADAP providing agencies.	XPRES/MAVEN ECW CAREWare Database VACRS GE Centricity ADAP database

Data Management	Develop data collection plan, methodologies, and instruments.	Develop data collection methodologies and tools.	Collaborative	By May 2011	XPRES/MAVEN ECW VACRS CAREWare
		Gather and interpret needed data.	Collaborative	Ongoing	XPRES/MAVEN ECW VACRS CAREWare
		Present results to the HRSA and the Collaborative.	Collaborative	Ongoing	XPRES/MAVEN ECW VACRS CAREWare
	Data quality assurance	Discover data issues by running report by individual agency.	Collaborative	Ongoing	XPRES/MAVEN ECW VACRS CAREWare
		Evaluate data quality through indicator reports and set action steps to resolve any data issues.	Collaborative	Ongoing	XPRES/MAVEN ECW VACRS CAREWare ADAP Database

Goal D: Quality Improvement Activities and Projects

Domain	Area	Objectives	Key Action Steps	Person/Agency Responsible for Collection	Timeline	Data Source(s)
Quality Improvement Activities and Projects	Syphilis Screening	Increase the percentage of HIV patients who have been screened for syphilis within the measurement year across collaborative participants to 90%.	Collect Collaborative measure data every other month.	Collaborative	Ongoing	VACRS CAREWare XPRES/Maven ECW
			Set Project Goal for Syphilis Screening across Collaborative.	Syphilis Screening subgroup of QI Sub-committee	June 2011	
			Implement improvement projects	Collaborative	May 2011 – December 2012	
			Lead PDSA Cycle process and sharing of best practices across Collaborative participants	Michael Hager, Whitman-Walker Health: QI Lead	May 2011 – December 2012	
	Retention in Care	Increase the percentage of HIV patients who are retained in primary	Define Retention measure.	Retention subgroup of QI Sub-committee.	November 2011	
			Collect Collaborative measure data every other	Collaborative	January 2012 – December 2013	VACRS CAREWare

		HIV healthcare within the measurement year across collaborative participants to a mutually agreed upon goal.	month.			XPRES/Maven eCW
			Set Project Goal for Retention across Collaborative.	Retention subgroup of QI Sub-committee	February 2012	
			Implement improvement projects.	Anne Rhodes, VA DOH: Retention subgroup leader & Michael Hager, Whitman-Walker Health: QI Lead	January 2012 – December 2013	
			Lead PDSA Cycle process and sharing of best practices across Collaborative.		January 2012 – December 2013	

APPENDIX E: CAPACITY BUILDING

Quality Improvement Project	Person/Agency Involved	Method and Frequency of Communication	Use of Data
Develop DC HIV Organizational QM Program self-assessment tool for all RW Part services.	Amelia Khalil/NVRC Cleonia Terry/FMC Martha Sichone-Cameron/Response Team Angela Clements/INOVA Marlene Matosky/HRSA.	The Capacity Building Sub-committee will develop and administer the tool. Completed by December 2011 to be reviewed annually and as needed by the Capacity Building Sub-committee. Agencies will be reassessed annually.	Results will be compiled into a statistical document and distributed to all RW providers in the DC EMA.
Develop and implement a QM training conducted by designated NQC Training of Trainers (TOT) Program.	Amelia Khalil/NVRC Andre Farquaharson/Howard University Dental Program.	Trainings will be conducted throughout the DC EMA in two tiers (basic and advanced). Content for Advanced trainings will be derived from results of Organizational assessments.	Updates will be provided to the DC EMA Collaborative to determine their impact.
Develop and implement QM webinars.	Amelia Khalil/NVRC NOVA/WDC AETC Data Team Leaders.	Webinars will be conducted throughout the DC EMA based on requests for TA as needed.	Updates will be provided to the DC metropolitan Collaborative to determine their impact.
Develop and disseminate DC Cross-Part Newsletter to HIV providers and community at large.	Amelia Khalil/NVRC Newsletter Committee Volunteers.	Newsletter template will be created and content gathered from various collaborative participants. Newsletter will be published quarterly.	Copies to be distributed electronically.
Develop and distribute guidance documents and toolbox resources.	Amelia Khalil/ NVRC NVa/WDC AETC Data Team Leaders	Guidance documents and a resources toolbox will be distributed during the breakout session at NQC Learning Sessions, and in newsletter and webinar.	Updates will be provided to the DC EMA Collaborative to determine their impact

Develop and facilitate QM trainings/workshops for PLWHA.	Amelia Khalil/NVRC Martha Sichone-Cameron/Response Team Adam Thompson/ NQC Consumer Consultant.	Identify training needs from contents from results of the QM Surveys and Focus Group. Develop curriculum. Provide and evaluate trainings.	Updates will be provided to the DC EMA Collaborative to determine their impact.
Develop and implement specific guidelines for consumer involvement in QM activities.	Amelia Khalil/NVRC Martha Sichone-Cameron/Response Team Adam Thompson/ NQC Consumer Consultant.	Establish a formal program to educate consumers about improving quality of care by increasing self-management practices. Disseminate relevant information on QI activities at consumers' meetings.	Number of training and trainees.
Deliver trainings as needed to the Collaborative.	LPSs of the PA/MA AETC and NQC TOT participants.	Assess the needs of the DC EMA using organizational assessments and deliver training based upon these needs. Trainings will take place quarterly.	Results will compare DC EMA Collaborative participants' competence before training and after.
Develop and implement specific guidelines for consumer involvement in QM activities.	Capacity Building Team and LPSs of the PA/MA AETC.	Establish a formal program to educate consumers about improving quality of care by increasing self-management practices. Trainings provided quarterly. Disseminate relevant information on QI activities at consumer meetings.	Number of training and trainees.

APPENDIX F: PERFORMANCE MEASURES

CORE CLINICAL MEASURES					
Measurement Outcome	Indicator to be Measured	Data Elements used to Measure Indicator	Data Source & Methods	Analyzing & Reviewing Data	Data Usage
Percent of RW pediatric patients with HIV infection who had three or more medical visits in an HIV care setting in the measurement year.	Change in the number of RW pediatric patients with HIV infection who had three or more medical visits in an HIV care setting in the measurement year.	Numerator: Number of HIV-infected pediatric patients who had a medical visit with a provider with prescribing privileges in an HIV care setting three or more times at least three months apart in the measurement year. Denominator: Number of HIV-infected pediatric patients who had a medical visit with a	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Sub-Committee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.

		provider with prescribing privileges in an HIV care setting at least once in the measurement year.			
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	Change in the number of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	<p>Numerator: Number of patients with a viral load test performed at least every 6 months.</p> <p>Denominator: Number of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 60 days between each visit.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of patients, aged 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification ¹ at last test during the measurement year.	Change in the number of patients, age 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	<p>Numerator: Number of patients with viral load below limits of quantification at last test during the measurement year.</p> <p>Denominator: Number of patients who: • were aged 13 years and older with a diagnosis of HIV/AIDS; and • had at least two medical visits during the measurement year with at least 60 days between each visit; and • were prescribed antiretroviral therapy for at least 6 months; and • had a viral load test during the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of patients with HIV infection who had two or more medical visits in an	Change in the number of patients with HIV infection who had two or	<p>Numerator: Number of HIV-infected patients who had a</p>	Providers to supply aggregate performance data on	The Data Subcommittee and NQC are	Provide data to the Response Team and stakeholders to determine:

HIV care setting in the measurement year.	more medical visits in an HIV care setting in the measurement year.	<p>medical visit with a provider with prescribing privileges1, i.e., MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year</p> <p>Denominator: Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>	the selected measures at the NQC Project Space.	responsible for reviewing data and presenting to the stakeholders.	<p>1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.</p>
Percentage of adult patients with HIV infection who had a test for syphilis performed in the measurement year.	Change in the number of adult patients with HIV infection who had a test for syphilis performed in the measurement year.	<p>Numerator: Number of HIV-infected adult patients who had a serologic test for syphilis at least once in the measurement year.</p> <p>Denominator: Number of HIV-infected patients who:</p> <ul style="list-style-type: none"> • were >18 years old in the measurement year or had a history of sexual activity < 18 years, and • had a medical visit with a provider with prescribing privileges at least once in the measurement year. 	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	<p>Provide data to the Response Team and stakeholders to determine:</p> <p>1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.</p>
Percent of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Change in the number of patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	<p>Numerator: Number of patients who had an oral exam by a dentist during the measurement year, based on patient self report or other documentation.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	<p>Provide data to the Response Team and stakeholders to determine:</p> <p>1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement</p>

		<p>Denominator: Number of HIV-infected patients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.</p>			needed improvements.
Percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	Change in the number of MCM patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months.	<p>Numerator: Number of MCM patients with a viral load test performed at least every 6 months that is documented in the MCM record.</p> <p>Denominator: Number of MCM patients, regardless of age, with a diagnosis of HIV/AIDS and had at least one MCM encounter in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM patients, aged 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	Change in the number of MCM patients, age 13 years and older, with a diagnosis of HIV/AIDS with viral load below limits of quantification at last test during the measurement year.	<p>Numerator: Number of MCM patients with a viral load below limits of quantification at last test during the measurement year that is documented in the MCM record.</p> <p>Denominator: Number of MCM patients who: • were age 13 years and older with a diagnosis of HIV/AIDS; and • had at least one MCM encounter in the measurement year; and • were prescribed antiretroviral therapy for at least 6 months; and</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.

		<ul style="list-style-type: none"> • had a viral load test during the measurement year. 			
Percentage of MCM patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	Change in the number of MCM patients with HIV infection who received an oral exam by a dentist at least once during the measurement year.	<p>Numerator: Number of MCM patients who had an oral exam by a dentist during the measurement year, based on client self report or other documentation that is documented in the MCM record.</p> <p>Denominator: Number of MCM patients with HIV infection who had at least one MCM encounter in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	Change in the number of MCM patients, regardless of age, with a diagnosis of HIV/AIDS who had two or more medical visits in an HIV care setting in the measurement year.	<p>Numerator: Number of MCM patients who had a visit with a provider with prescribing privileges two or more times at least three months apart in the measurement year that is documented in the MCM record.</p> <p>Denominator: Number of HIV-infected MCM patients who had at least one MCM encounter in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percentage of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	Change in the number of eligible infants and children with HIV infection who were prescribed PCP prophylaxis in the measurement year.	<p>Numerator: Number of HIV-infected infants or children who were prescribed PCP prophylaxis during the measurement year</p> <p>Denominator: Number of:</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.

		<ul style="list-style-type: none"> • HIV-infected infants or children > 6 weeks of age who meet the following age specific eligibility criteria: • <12 months = All HIV-infected infants regardless of CD4 count • 1-5 yrs = CD4<500 cells/mm³ or CD4%<15% • >6 yrs = CD4<200 cells/mm³ or CD4%<15% AND • had a medical visit with with a provider with prescribing privileges. 			
Percent of ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	Change in the number of ADAP applications approved or denied for new ADAP enrollment within 14 days (two weeks) of ADAP receiving a complete application in the measurement year.	<p>Numerator: Number of HIV-infected patients who have been approved or denied for ADAP services within two weeks of ADAP receiving a complete application.</p> <p>Denominator: Number of HIV-infected patients who have newly applied for ADAP assistance.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: <ol style="list-style-type: none"> 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.
Percent of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.	Change in the number of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.	<p>Numerator: Number of all ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times which are at least 5 months apart in the measurement year.</p> <p>Denominator: Number of patients enrolled in ADAP in the measurement year.</p>	Providers to supply aggregate performance data on the selected measures at the NQC Project Space.	The Data Subcommittee and NQC are responsible for reviewing data and presenting to the stakeholders.	Provide data to the Response Team and stakeholders to determine: <ol style="list-style-type: none"> 1) Was the goal met? 2) Should we continue track this measurement? 3) Identify issues/ challenges and implement needed improvements.