Hartford Transitional Grant Area (TGA)

Quality Management Plan

2015-2017

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I. Overview

The Greater Hartford Transitional Grant Area (TGA) supports HIV/AIDS services in three counties: Hartford, Middlesex, and Tolland. Approximately 3,562 People with HIV/AIDS live in the three counties with 91% of the HIV/AIDS cases in Hartford County, 6 % in Middlesex County and 3% of the cases in Tolland County. Of these individuals infected with HIV/AIDS, 39.2% are Hispanic, 31.9% Caucasian and 28.9% Black. The route of transmission of the disease include: injective drug users (IDU) accounting for 38%; Men who have sex with men (MSM) 24%; Heterosexual 21%; 14% other/unknown, 2% MSM/IDU and 1% Perinatal. 68% male and 32% female makes up the HIV/AIDS population within the TGA. According to the 2012 American Community Survey estimates, 10.9 percent of the general population in the TGA has incomes below the federal poverty level. According to Needs Assessment and CAREWare data, more than 50 percent of persons with HIV/AIDS live below the federal poverty level.

A. Mission

The mission of the Hartford TGA's QM program is to continually improve the quality of services for persons living with HIV/AIDS. The goals of the program include:

1. Insure that services are delivered in accordance with Department of Health and Human Services' HIV/AIDS treatment guidelines and the TGA's standard of care
2. Build and support the development of the quality management capacity at the sub-contractor level based on need
3. Collect and report performance measurement data to identify improvement areas and to trend data for benchmarking within the TGA and Statewide.
4. Promote quality improvement and quality management accountability at sub-contractor agencies
5. Refine as necessary standards of care and monitor program adherence to determine where technical assistance or other action is required
6. Expand quality management culture across the TGA

B. Core Values

The Hartford TGA is committed to the following core values:

1. Care services are readily available
2. The system of care focuses on the needs of persons living with HIV/AIDS in the Greater Hartford area
3. Patients enter into care as early as possible after diagnosis and remain in care.
4. HIV/AIDS care is of the highest quality
5. A strong commitment to consumer involvement in their care and in quality management.
6. The Greater Hartford Planning Council is an effective and efficient council

C. Purpose

The purpose of the Hartford TGA Quality Management, (QM) Program is to continuously promote improvement in processes of care – clinical and non-clinical throughout the TGA to achieve desired client-level health outcomes. The Quality Management Program is defined by quantifiable Standards of Care that are reported in CAREWare, a software program provided and supported by HRSA/HAB to Ryan White providers.

II. Quality Improvements Directions

For 2015-2017, the City of Hartford TGA has aligned its quality management and improvement goals with national, state, and city initiatives. These initiatives are: the National HIV/AIDS Strategy, Office of the President; the CT Cross Parts Collaborative; the Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR); and Hartford specific improvement needs based on performance measurement and epidemiology data.

A. National HIV/AIDS Strategy, (NHAS) for the United States

The Ryan White Part A Quality Management program is dedicated to working with local, state, and federal entities to better serve those living with HIV/AIDS as well as reduce the numbers of those infected. The program has aligned its strategies with those of the NHAS to incorporate the following goals:

1. Reduce the number of people who become infected with HIV
2. Increase access to care and improve health outcomes for people living with HIV
3. Reduce HIV-related health disparities.

B. Connecticut Cross Parts Collaborative

The Ryan White Part A Quality Management program has been an active participant of the CT Cross Parts Initiative since its inception in 2008. The CT Cross Parts Collaborative identifies low performing measures based on results of a statewide quality of care report using the HRSA/HAB measures. Each Part is responsible for initiating a quality improvement project to increase the measures. The current quality improvement projects are:

1. To improve hepatitis B vaccination
2. To increase oral health screening
3. To increase cervical cancer screening

C. Connecticut HIV Planning Consortium

The Connecticut HIV Planning Consortium (CHPC) is a comprehensive body which integrates HIV Care and Prevention. The collaborative effort includes active participation by Connecticut's two Ryan White Part A Programs (the Greater Hartford TGA and the New Haven/Fairfield EMA), funded statewide care and prevention service providers, PLWHA, representatives from Ryan White Parts C, D and F (Connecticut AIDS Education and Training Center) and other state department agencies (Department of Correction, Department of Social Services, and Department of Mental Health and Addiction Services).

D. City: Hartford TGA

The city of Hartford will also align its quality management program as it's related to Early Identification of Individual with HIV/AIDS (EIIHA) with Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR). CHAIR is committed to:

1. Develop and coordinate state and local strategies to identify people who are unaware of their HIV positive status and link them to care
2. Foster collaboration between Ryan White A and B and Prevention
3. Coordinate data collection, identify data needs, and evaluate approaches for identifying people who are unaware of their status and link them and their patient level data with community viral load

Additionally, the TGA will expand its own HIV QM program across service categories and is committed to:

1. Monitor the HRSA/HAB measures on an ongoing basis.
2. Monitor the revised local measures on an ongoing basis.
3. Assist providers with quality improvement activities to improve low performance measures.

III. Evaluation, Assessment, Results (Core Services)

The results in the following sections comprise of data that reflect the ambulatory care services in the Hartford TGA. Table 1, identifies the 23 HAB measures and the trends within the TGA over the previous 5 years. In the 2014 column, the measures are color coded according to performance: green/excellent, yellow/very good, grey/fair, and red/poor. HRSA/HAB retired several of these measures leaving it is to the digression of the providers to continue omit the measure or continue collecting data, the measures will remain in CAREWare.

A. TGA Results

The table below represents the TGA's aggregate data set for the 23 HAB over a five-year period.

TABLE 1: HRSA HAB Measures 2010 -2014

HAB Performance Measures	2010	2011	2012	2013	2014
HAB01 Two Primary Care Visits (Retired)	86.02%	90.55%	88%	88.37%	90%
HAB02 >=2 CD4 Count	76.19%	84.50%	81.37%	78.47%	82%
HAB03 CD4 <200 with PCP Prophylaxis	53.03%	85.91%	87.19%	77.17%	79%
HAB04 AIDS Client on HAART (Retired)	95.07%	96.55%	92.04%	92.06%	85%
HAB05 Percentage of Pregnant Women on ART (Retired)	*CHS only Provider-100%	*CHS only Provider-100%	*CHS only Provider-100%	100%	100%
HAB06 Adherence Assessment (Retired)	44.54%	70.44%	64.68%	69.95%	72%
HAB07 Cervical Cancer Screening	33.53%	30.38%	29.39%	30.73%	43%
HAB08 Hepatitis B Vaccination	35.31%	50.06%	53.68%	61.65%	60%
HAB09 Hepatitis C Screening	79.79%	94.98%	90.51%	92.94%	87%
HAB10 HIV Risk Counseling	63.59%	82.84%	85.47%	87.27%	75%

HAB11 Lipid Screening (Retired)	43.09%	61.58%	69.52%	74.57%	78%
HAB12 Oral Exam	34.80%	44.50%	14.52%	24.50%	33%
HAB13 Syphilis Screening	66.26%	76.98%	77.10%	70.17%	77%
HAB 14 TB Screening	58.26%	86.24%	72.58%	84.52%	83%
HAB 15 Chlamydia Screening (Retired)	34.14%	39.02	51.46%	60.08%	53%
HAB 16 Gonorrhea Screening(Retired)	33.44%	38.03	49.38%	58.57%	52%
HAB 17 Hepatitis B Screening	45%	57.74%	61.37%	73.89%	75%
HAB 18 Hepatitis/HIV Alcohol Counseling (Retired)	n/a	n/a	n/a	n/a	n/a
HAB 19 Influenza Vaccination (Retired)	21.90%	33.55%	44.18%	41.37%	49%
HAB 20 MAC Prophylaxis (Retired)	16.07%	43.92%	50.95%	48.87%	60%
HAB 21 Mental Health Screening	51.73%	70.12%	68.13%	83.79%	65%
HAB 22 Pneumonia Vaccination (Retired)	54%	54.86%	73.42%	77.61%	71%
HAB 23 Substance Abuse Screening	51.21%	66.48%	82.12%	82.33%	74%
HAB 24 Tobacco Cessation Counseling (Retired)	n/a	n/a	n/a	n/a	n/a
HAB 25 Toxoplasma Screening (Retired)	36.82%	45.45%	72.26%	81.70%	81%

Green – excellent; Yellow- very good; Grey- fair; Red- poor. HAB measures from each category of measures are further explained at: - http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Data Analysis: Quality strengths and improvements

Currently as a TGA we have excelled (90% - 100%) in two of the twenty-three HAB measures, thirteen measures fell in the very good range, (70%-89%) five scored fair (50%-69%)while the remaining three fell below 50% range (49% and below). To address these measures that are performing fair/poor the TGA has set goals for 2015 to improve these measures.

Table 2: 2014 Core Benchmarks

Core Measures	TGA	Statewide
Core 1: Viral load suppression	78%	82%
Core 2: Prescription of antiretroviral therapy	89%	93%
Core 3:HIV medical visit frequency	84%	73%
Core 4: Gap in HIV medical visits	9%	12.5%

Data Analysis: Introduction

The core measures were previously known as the In+Care Campaign measures. The Campaign was a quality improvement initiative focusing on improving lives and the health of our communities by retaining patients in HIV care and preventing them from failing out of care. The measures were introduced to TGA in the spring of 2014, the benchmarks is as of June 30, 2014. The QM team will continue to monitor the data as a TGA and statewide.

B. Early Identification of Individuals with HIV AIDS (EIIHA)

The TGA's strategy to identify individuals with HIV entails:

1. Prioritizing and funding Early Intervention Services
2. Expanding collaborations with HIV identification and engagement services, such as Partner Notification
3. Improving coordination with other HIV counseling and testing programs
4. Employing contract language and Part A reporting requirements to establish programs and implement protocols to identify persons with HIV
5. Participating in the development of an integrated statewide effort to identify individuals with HIV

Goals

The goals of the strategy are to:

1. Identify those that ae considered high risk.
2. Increase the percentage of persons with HIV in the TGA who know their Serostatus
3. Get persons with HIV into care in the early stages of infection
4. Improve health outcomes of individuals with HIV and reduce disparities in access to care
5. Reduce HIV incidence, and
6. Educate the public about HIV and HIV testing

TABLE 3: 2015 EIIHA Tables (No data at this time)

Performance Measure	Men Who Have Sex with Men	Individuals Over 50	Black Heterosexuals	Hispanic Heterosexuals	West Indians
1. Identify					
2. Inform					
3. Refer					
4. Link					

The TGA's new EIIHA population includes; men who have sex with men, individuals over 50, black heterosexuals, Hispanic heterosexuals and West Indians. The updates were changed in CAREWare and data collection will begin in January.

IV. Quality Management Goals and Projects for 2015-2017

A. Monitor quality reports to sustain gains >90% on performance measures semi-annually.
B. Continue QI projects for cervical cancer screening, hepatitis vaccination and oral health screening.
C. Review EIHHA baseline data to determine additional QI projects.

TABLE 4: HAB Measures Statewide/TGA Percentages and Goals (FY 13/14)

HAB Measures	Statewide RW Parts	TGA	2012 Goals	2013 Goals
Cervical Cancer (7)	39%	30.38%	49%	50%
Hepatitis B vaccination (8)	34%	50.06%	60%	70%
Oral screening (12)	41.3%	14.52%	25%	50%
Influenza vaccine (19)	43.9%	44.18%	60%	N/A
MAC prophylaxis(20)	49.4%	50.95%	60%	N/A

The quality improvement goals for 2012-2014 are outlined in Table 4. Cervical cancer screening, hepatitis B vaccination and oral health continue to be a challenge for the TGA for this reason they remain as a quality improvement goal for **2015**.

I. Evaluation, Assessment, Results (Non-Core Services)

Part of expanding the TGA's quality management plan will be to redevelop the non-core services Standard of Care. These services includes:

i. Medical Transportation
ii. Psychosocial
iii. Non-Medical Case Management
iv. Housing services
v. Food Bank
vi. Emergency Financial Assistance

VI. Overview of the Quality Management Program Accountability Structure

(refer to the Quality Accountability Diagram on the following page.)

A. TGA Leadership Team

QM Program Manager—an experienced registered nurse who has received training from the National Quality Center on quality management and quality improvement. She conducts program evaluation, organizational assessment, and capacity building. She will serve as the quality improvement manager for Ryan White Part A Program service providers and works in close collaboration with funded agencies to build and increase capacity for quality improvement activities. Additional functions of the QM Program Manager include: conducting onsite performance reviews, identifying practice areas in need of improvement, and guiding quality improvement teams using theoretically based models such as clinical quality improvement, PDSA, and the chronic care model. The QM program manager provides support to Ryan White Services Project Manager in setting quality improvement goals and developing clinical and non-clinical performance measures.

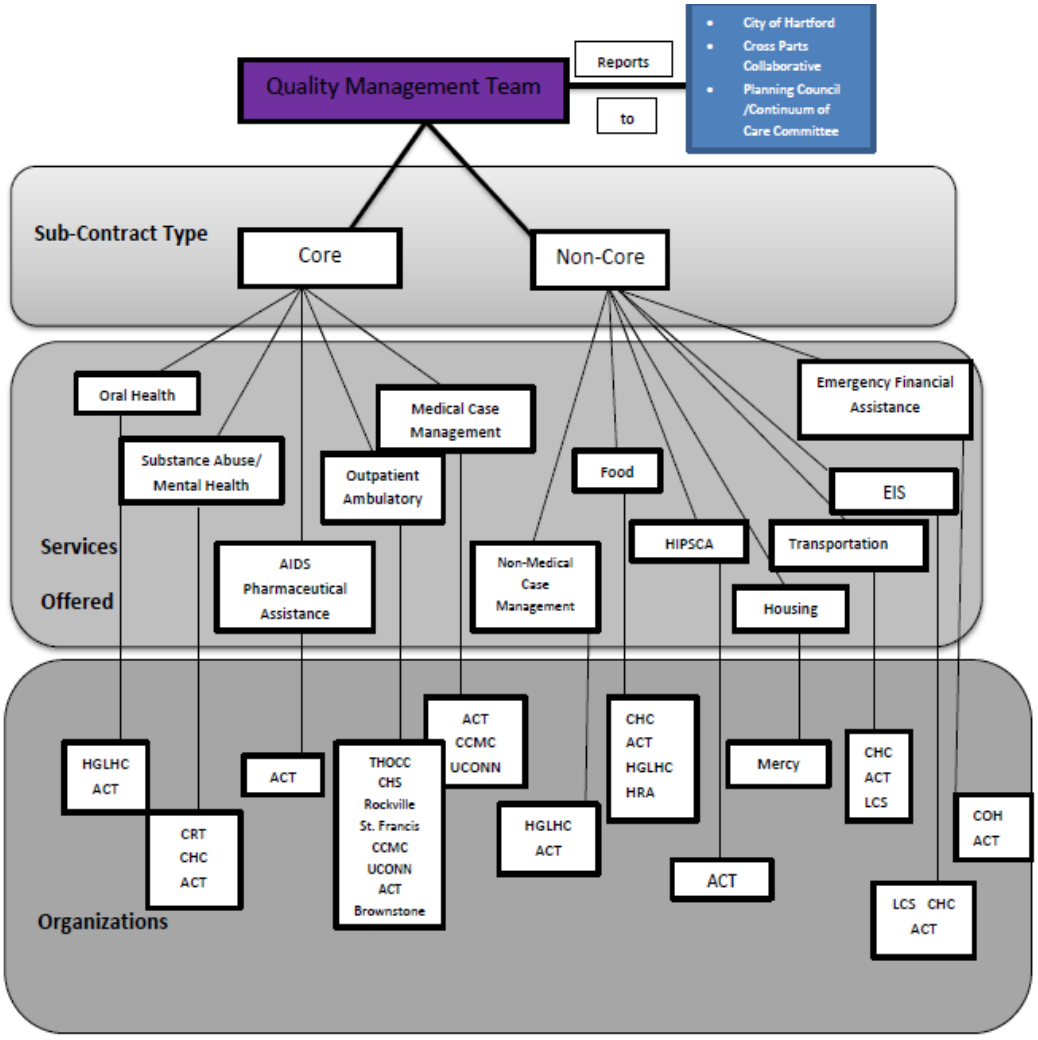
Ryan White Project Manager- has the ultimate responsibility for leadership of the process; is the liaison with the HRSA project officer; issues provider contracts to deliver HIV AIDS services in alignment with approved Standard of Care.

Ryan White Data Specialist- informs the QM team of clients who have: (1) incomplete HAB measures; (2) In care campaign data sets; (3) identify CAREWare data training needs; 4) partner notification referral; and (5) data completeness

Health Department Epidemiologist – assist the data specialist to: (1) interpret the data; (2) Provide use friendly data sets to the QM; (3) assist with training provider to interpret and; and of (4) with data on HIV incidence and prevalence.

Ryan White Partners and Quality Management Team-The Ryan White Part C and D program managers, a quality assurance and technical assistance, a consumer, a Data Support specialist from an urban infectious disease clinic and LPN from an infectious disease clinic serve on the QM committee and provide input with regards to performance measures, quality indicators and performance evaluation.

Quality Accountability Diagram (until February 2015)



Key: ACT- AIDS Connecticut; CCMC- Connecticut Children's Medical Center;; LCS- Latino Community Services; CRT Community Renewal Team; THOCC- The Hospital of Central Connecticut; UCONN- University of Connecticut Health Center; APH- AIDS Project Hartford; HGLHC- Hartford Gay & Lesbian Health Collective; CHS- Community Health Services; CHC- Community Health Center

B. QM Site Leaders- QM site leaders are responsible for the oversight of quality management activities for their respective primary medical or supportive service agencies. Agency managers or their designees typically serve as the site leader and key contact for quality management related activities. The QM Manager will identify who these individuals are.

C. Stakeholder Engagement in Quality Management

External stakeholders were selected based on their commitment to improving and ensuring accessing to quality care for all patients living with HIV/AIDS in the Hartford TGA and on their willingness to participate in ongoing quality improvement initiatives. Stakeholders were strategically selected based on their ability to assist the Ryan White grantee in fulfilling the core and supportive service categories

outlined by the Human Resource and Services Administration (HRSA). Internal and external stakeholders are outlined in the table below.

D. Cross Collaborative Activities

The QM Manager and appropriate staff members will continue to attend CT Cross Parts Meetings held monthly to discuss QI activities occurring in the state. This provides the Hartford Part A Grantee perspective on the QI processes taking place in agencies funded by other Ryan White Parts. Information received during the discussions will be shared with QI team and staff.

Stakeholder Matrix

Internal	External
Ryan White Program Staff Ryan White Project Manager Ryan White Part A Quality Program Manager Ryan White Part C Program Director Ryan Part D Program Director Ryan White Infectious Disease Nurse Epidemiologist Minority AIDS Initiative (MAI) Data Coordinator QA & TA manager Ryan White Planning Council member (Continuum of Care committee) Ryan White Consumer	CT State Public Department of Health Program Director HIV/AIDS Surveillance National Quality Center CT Cross Parts Providers Part A (NH) Part D Part B (State) Part Cs

VI. Building TGA Capacity

In 2011-2012 the Hartford TGA will continue to build QM capacity through the activities described below;

1. Establish QM activities in non-core services
2. Promote internal CAREWare and data training within subcontractors agency
3. Continue to train Planning Council member on QM
4. Performance measure and reporting
5. QI Projects (team based) – subcontractor agencies
6. QM plans should be updated regularly at subcontractor level
7. Subcontractors are to conduct PDSAs for local measures that are not at goal
8. Define team roles and responsibilities
9. Continue team meetings
10. Revise of the QM Plan on a regular basis

Appendix A

Performance Indicators

The following performance indicators are used statewide to monitor the quality of care received by those living with HIV/AIDS in the Hartford TGA. These indicators are provided by HRSA/HAB:

1. ≥ 2 CD4 counts in the measurement year
2. CD4 < 200 with PCP prophylaxis
3. Cervical cancer screening
4. Hepatitis B vaccination
5. Hepatitis C screening
6. HIV Risk Counseling
7. Syphilis screening
8. Tuberculosis screening
9. Hepatitis B screening
10. Mental health screening (revised)
11. Substance abuse assessment
12. HIV risk counseling
13. Viral load suppression (CORE)
14. Prescribed antiretroviral therapy (CORE)
15. Medical visit frequency (CORE)
16. Gap in medical visit (CORE)

Appendix B

Local Performance Measures for FY 2015-2017

Source of information retrieved from Source: Ryan White Service Utilization database.

Housing

80% of HIV-infected housing clients will access affordable housing services

85% of HIV-infected housing clients, *who received* affordable housing, and have at least one HIV medical visits with a provider prescribing privileges at least three months apart within the measurement year

Food Bank /Home-Delivery Meals

80% of HIV-infected food/meals clients will access food/meals services

85% of HIV-infected food/meals clients, who received food/meals, and have at least one HIV medical visits with a provider prescribing privileges at least three months apart within the measurement year

Medical Transportation

80% of HIV-infected medical transportation clients will access medical transportation services

85% of HIV-infected medical transportation clients, *who received* transportation services, will have at least one HIV medical visits with a provider prescribing privileges at least three months apart within the measurement year

Emergency Financial Assistance (EFA)

80% of HIV-infected emergency financial assistance service clients will access emergency financial assistance services

85% of HIV-infected emergency financial assistance service clients, who received emergency financial assistance services will have at least one HIV medical visits with a provider prescribing privileges at least three months apart within the measurement year

Medical Case Management

90% of HIV-infected medical case management clients will have a medical case management care plan developed and/or updated twice at least six months apart in the measurement year

85% of HIV-infected medical case management clients will have one or more medical visits in an HIV care setting in the measurement year

Non-Medical Case Management

90% of HIV infected non-medical case management clients will have a non-medical case management care plan developed and/or updated twice at least six months apart in the measurement year.

85% of HIV-infected non-medical case management clients will have one or more non-medical visits in an HIV care setting in the measurement year

Oral Health

85% of HIV-infected oral health patients will have a dental and medical health history (initial or updated) at least once in the measurement year

Mental Health

80% of HIV-infected mental health service clients will access mental health services

85% of new clients with HIV infection (entering the mental health services for the first time) will have had at least one mental health screening in the measurement year

Substance Abuse

70% of new clients with HIV infection will be screened for substance use (alcohol & drugs) within the measurement year

80% of adult and adolescent clients with a history of substance abuse (6 to 24 months from date of review) with whom relapse prevention is ongoing, will have their substance abuse within the previous 12 months discussed and their treatment plan reviewed and discussed.

Medication Adherence

100% of clients with HIV infection whose last viral load in the measurement year is less than 200 copies

Health Insurance Premium & Cost Sharing Assistance

80% of HIV-infected Health Insurance Premium & Cost Sharing Assistance clients will access Health Insurance Premium & Cost Sharing Assistance services

85% of HIV-infected clients, who received Health Insurance Premium & Cost Sharing, will have at least one HIV medical visits with a provider with prescribing privileges at least three months apart within the measurement year

Early Intervention Services (EIS)

70% of all newly diagnosis HIV-infected clients that have unprotected sex will be referred to Partner Services.

70% of all newly diagnosis HIV-infected or lost to care clients that have needle-sharing partners will be referred to Partner Services.

65% of clients receiving Early Intervention service with an HIV+ diagnosis will have a referral to HIV primary medical care and appropriate support services within the measurement year.

Psychosocial

80% of HIV-infected psychosocial service clients will have access to psychosocial support services

85% of new clients with HIV infection will have had at least one psychosocial support services in the measurement year.