Annual Quality Plan

Ryan White Part A Las Vegas TGA

Grant Year 2011

March 1, 2011-February 28, 2012

Ryan White Part A HIV/AIDS Program
Las Vegas Transitional Grant Area
Clark County Social Services
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Las Vegas TGA Ryan White Part A HIV/AIDS Program

SECTOION 1: INTRODUCTION

Legislative Requirements

The Ryan White Treatment Extension Act of 2009 requires Part A TGA's to establish a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service Guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

Annual Quality Plan

The Las Vegas TGA Ryan White Part A Programs Quality Management (QM) C.O.R.E. Team has outlined this document. It is considered a "living" document and will continue to develop and expand to continually measure the quality of services delivered for people living with HIV/AIDS (PLWH/A) in the area. The overall purpose of quality management in the TGA is to;

- Support the development of high quality care for PLWH/A
- Enhance the quality of services, client outcomes, and ensure accountability
- Provide improved access to and retention in care for PLWH/A
- Identify and justify vital program activities and resources required to meet changing needs
- Link support services to medical services to improve client outcomes
- Enable sub-grantee's to perform with greater efficiency through streamlined processes
- Provide meaningful data for priority setting and resource allocation processes

This Annual Quality Plan outlines how the quality management program will be implemented for the current grant year, including a clear indication of responsibilities and accountability, performance measurement strategies, annual quality goals, a timeline for quality activities, data collection strategies, reporting mechanisms, and elaboration of processes for ongoing evaluation and assessment of the program. The QM C.O.R.E. Team will guide the review, revision, and implementation of the annual quality plan, final approval will be given by the Grant Administrator. This Annual Quality Plan is effective March 1, 2010 through February 28, 2011.

SECTION 2: QUALITY STATEMENT

Definition of Quality

The Health and Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB) administers the Ryan White Program. HAB defines quality as "the degree to which a health or social service meets or exceeds established professional standards and user expectations."

Shared Vision

To have a completely accessible continuum of high quality care and support to aid in the elimination of health disparities among people living with HIV/AIDS in the Las Vegas region.

Shared Mission

To continuously monitor and improve HIV/AIDS service delivery processes through an annual implementation plan in order to provide tangible benefits and a unified system of quality medical care and supportive services for people living with HIV/AIDS in the Las Vegas TGA.

SECTION 3: QUALITY INFRASTRUCTURE

Leadership

The Las Vegas TGA Program Administrator has the overall administrative responsibility and accountability for the quality of care and services delivered. The Program Administrator is also responsible for reporting the progress of QM activities and performance measures to Clark County Management and the Health Resources and Services Administration (HRSA).

Quality Committee Structure

The purpose of the QM C.O.R.E. (Continuous Organizational Review and Evaluation) Team is to provide a mechanism for the objective review, evaluation, and continuing improvement of the quality management system. It is also responsible for guiding the direction of quality improvement projects, forming quality improvement committees when necessary, documenting improvements, results, and guiding the implementation of successful practices TGA wide. The C.O.R.E. Team will also be responsible for guiding the review, revision, and implementation of the Annual Quality Plan. The QM Coordinator will guide the QM C.O.R.E. Team and manage quality management activities.

The QM C.O.R.E. Team will include the following members:

- The Part A Quality Management Coordinator,
- Ryan White Part A Data Manager, and
- The Quality Manager of each Ryan White Part A funded agency or their designee.

Figure 1. Quality Management C.O.R.E. Team March 1, 2011-February 28, 2012

NAME	AGENCY	REPRESENTATION
JeKeissa Mosley/Sunny Russell	AFAN	Lead Case Manager/Lead Social Worker
Bonnie Carlisle/Josefa Ozaeta	COMC	Clinical Coordinator/Case Manager
Aaronell Matta	CCC	Internal Program Analyst
Christine Bronston	Mohave County	Nursing Manager
Shirley Trummell	Nye County	Senior Eligibility Specialist
Sabrina Hagan-Finks	SNHD	Grant Analyst
Patricia Thomas	UMC	Program Coordinator
Shayla Streiff	Ryan White Part A	Quality Management Coordinator
Alisha Campbell	Ryan White Part A	CAREWare Data Manager

Roles and Responsibilities

The QM C.O.R.E. Team has the following annual responsibilities;

- Meet at least quarterly
- Develop and coordinate implementation of the annual quality plan and work plan
- Identify areas for improvement projects
    - Organize quality improvement teams when necessary
- Conduct and evaluate improvement projects
    - Continually monitor the status of those projects
- Document improvement projects and results
- Utilize the PDSA (plan, do, study, act) cycle for small tests of change (pilot tests)
    - Documents results of pilot tests and communicates them to key stakeholders
- Systematizes changes if appropriate

- Provide recommendations to the Planning Council for the improvement of service delivery in the TGA based on findings

QM Staff will support the C.O.R.E. Team and QM program through the following responsibilities;

- Establish content of and scheduling of meetings
- Research on best practices
- Quarterly reports on projects and progress to the grantee, sub-grantee's and to the planning council
- Facilitate consumer involvement on quality improvement and program planning
- Provide instruction on quality improvement principles
- Follow up on suggestions by consumers to improve the care they are receiving
- Provide technical assistance to sub-grantee providers on data collection, performance measures and outcomes or organize a HRSA Technical Assistance Coordinator
- Oversee data collection efforts
- Ensure the development, implementation, and evaluation of the quality management plan and annual quality plan
- Evaluate and guide internal quality procedures
- Serve as the key contact for quality management related activities and questions,
- Conduct chart reviews for core and support services to ensure adherence activities, review performance indicators and progress, and to evaluate adherence to TGA specific Standards of Care
- Attend trainings and conferences to enhance skills in quality management protocols, and
- Overall management of the quality management program

Resources

In addition to a dedicated quality management staff, 5% of the annual Part A grant in the Las Vegas TGA is assigned to quality management activities.

Program Structure

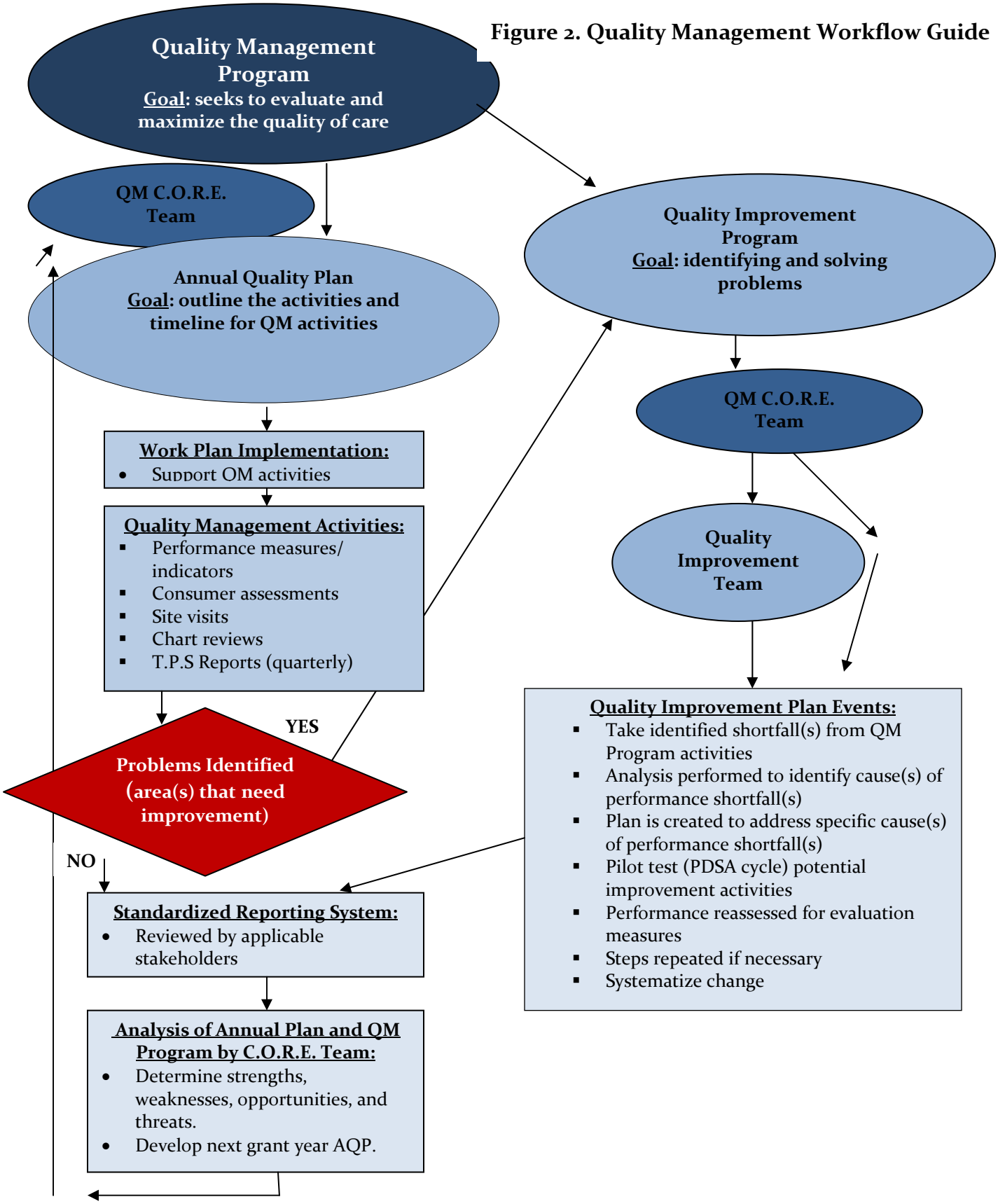
Quality Management Program

The QM Program encompasses all systematic and continuous quality processes, including the formal organizational quality infrastructure and quality improvement related activities consistent with other quality improvement and quality assurance programs. Including identified leadership, accountability and resources to develop a strategy for using and measuring data to determine progress toward evidence-based benchmarks with a focus on linkages and provider and client expectations using data collection practices to ensure that goals are accomplished and result in improved outcomes.

Quality Improvement Program

The Quality Improvement (QI) Program involves; 1) taking problems identified within the QM Program activities, 2) pinpointing the cause(s) of those problems, 3) designing activities to overcome these problems, 4) systematizing change and 5) following up to ensure that no new problems have developed and that corrective actions have been effective with the emphasis on meeting PHS Guidelines and TGA specific Standards of Care. Figure 2 illustrates the workflow of the Quality Management program as it relates to the Annual Quality Plan and Quality Improvement Program.

Figure 2. Quality Management Workflow Guide



SECTION4: PERFORMANCE MEASUREMENT

Indicators

Performance indicators quantitatively tell us something important about our services, and the processes that deliver them. They are a tool to help us understand, manage, and improve what our organizations do. Performance indicators let us know;

- How well we are doing,
- If we are meeting our goals,
- If our customers are satisfied,
- If and where improvements are necessary, and
- If our processes are in statistical control.

Our indicators and their respective percentage goals are outlined in the goals section. Data will be collected on an annual basis by grant year and reports provided to each agency in addition to all stakeholders.

Data Collection Strategies

The QM C.O.R.E. Team will use a variety of mechanisms to assess and monitor the quality of HIV services provided by Ryan White Part A funding in the Las Vegas TGA, including:

Chart Reviews

Chart reviews will be conducted at clinical care sites and support service locations to ensure that HIV services meet public health guidelines, standards of care, and evaluate performance measures.

Chart reviews will be conducted by QM staff who have had detailed training in the project and are familiar with standards and processes of HIV/AIDS outpatient care. These reviews will use clinic records including progress notes, flow sheets, laboratory reports and other documentation contained within the record to complete the data collection instrument. Other sources of supporting secondary data (i.e. from information system database or billing information) may also be used to fill in gaps or corroborate chart information if appropriate. Confidentiality agreements will be signed assuring adherence to complete patient privacy protection.

Chart reviews will be conducted on an annual basis at each service provider location and combined by service category for reporting purposes. Chart reviews will be conducted to;

- Ensure that our data in CAREWare is accurate and clean by checking chart data against data in CAREWare.
- Ensure that our performance measures pulled from CAREWare align with what is documented in the client chart.
- Allow us to utilize indicators regarding information that is not tracked in CAREWare.

The NQC's HIVQUAL sample size table will be utilized to sufficiently collect an eligible random sample.

Consumer Assessments

Periodic consumer assessments will be held to focus on client satisfaction including:

- The quality of services
- The role of the service in the consumer's overall healthcare,

- The accessibility of services
- Barriers to accessing care
- Motivations for accessing care

The methodology for which this data will be collected includes:

- Consumer surveys
- Consumer focus groups
- Periodic in-depth interviews
- Suggestion boxes

Review

QM staff is responsible and accountable for collecting performance data results and for the articulation of findings to the QM C.O.R.E. Team. QM staff will present all relevant data to the QM C.O.R.E. Team for analysis and review.

Reporting

QM Tracking Provided Services (T.P.S.) Reports will be utilized as a method of communication from the QM Staff and C.O.R.E. Team to the sub-grantees and the Planning Council by providing collective performance measure reports, relevant needs assessment data, quality management and service utilization data by service category, and reports on quality improvement projects and activities that are upcoming, underway, or are being monitored. Just as service utilization data and needs assessment data should be utilized by the Quality Management Program for use in quality improvement activities, quality management performance measurement data and quality improvement activity outcomes should be utilized by the Planning Council in their priorities and allocations of Part A funding in the Las Vegas TGA. It was created as a means of coordinating the established Planning Council report, additional relevant data and pertinent information for all parties into one informative document. These reports will also be posted on the TGA's website at (www.LasVegasEMA.org).

Data Usage

Data will be used to identify shortfalls, create quality improvement plans, and continually monitor changes to ensure stability and sustainability as seen in the Quality Management Workflow Guide in figure 2.

The QM C.O.R.E. Team is charged with identifying opportunities for improvement and will convene quarterly or more often as necessary to analyze data, processes, and develop improvement plans or appoint a QI Team(s) to do so.

It is vital for QI Teams to include the experts and those affected by the consequences or outcomes, therefore QI Teams will include staff members who are closely associated with the process under study, additional experts in the related field, and members of the C.O.R.E. Team. It is the intent of the QM Program that staff members from the system(s) being assessed work together in teams and are engaged in the quality improvement process when possible. With this method they are more likely to feel ownership in process, generate ideas, and accept changes. Formation of QI Teams can be accomplished by either the C.O.R.E. Team asking additional members to participate with that specific project or by asking a panel of experts to form an Ad-Hoc QI Team. QI Teams aim to identify areas of change, implement pilots to test the change,

review data assessing the change, and ultimately make recommendations about improvements. Therefore it is imperative to have those knowledgeable in that field.

Quality improvement methodology will be utilized to identify the cause of any shortfalls and may include, but is not limited to, the following:

- **Observational Studies**
  - An investigational method involving description of the associations between interventions and outcomes.

- **Flow Chart Analysis**
  - The purpose of the flowchart is to identify the actual path a process follows and to ultimately have a process that is predictable, consistent, and has minimal waste. By documenting a process in this manner, the team will be able to identify redundancies, inefficiencies, misunderstandings, and waiting loops. The flow chart also allows the team members to gain a better understanding of how a process should be performed.

- **Activity Logs**
  - Tracking log of the daily activities of a department or an individual position.

- **Cause and Effect Diagrams (Fishbone Analysis)**
  - These diagrams are intended to illustrate the range of causes that lead to a particular outcome. The diagram helps a team visualize how the various components relate to one another and highlights specific conditions that require further attention.

- **Brainstorming**
  - A group creativity technique designed to generate a large number of ideas for the solution of a problem.

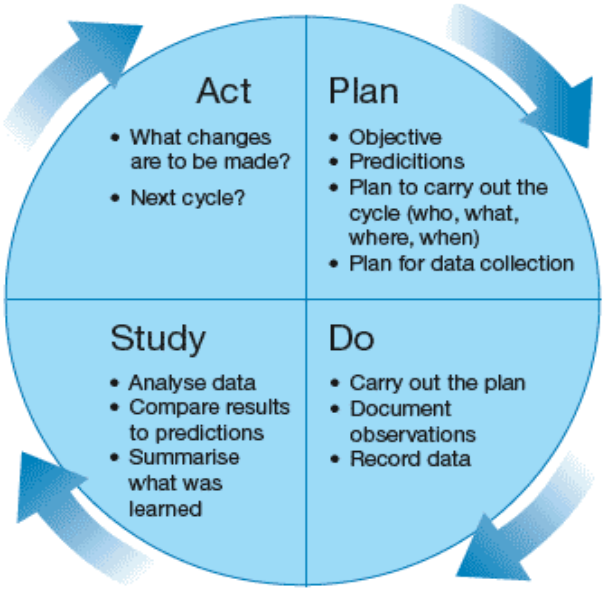
Quality improvement activities for implementation may include, but aren't limited to, the following;

- Education (local and state staff, consumers, stakeholders),
- Program guidelines review, revision or development,
- Procedure and policy development changes,
- Form development or revision,
- The implementation of a flowchart or checklist to guide processes, or
- System change.

The PDSA (Plan, Do, Study, Act) method will be used to guide QI Teams and quality improvement activities. This method is shorthand for testing a change in the real work setting on a smaller scale before implementing it system wide. The steps include;

- **Plan**
  - Plan a change.
- **Do**
  - Test or pilot the change for an appropriate interval.
- **Study**
  - Observe the results (What worked and what didn't? What should be kept and what should change?)
- **Act**
  - Refine the change until it's ready for broader implementation.

Figure 3. PDSA Cycle



SECTION 5: ANNUAL QUALITY GOALS

Quality goals are endpoints or conditions toward which the QM program will direct its efforts and resources during quality improvement work.

Goal #1 Improve the quality of HIV/AIDS core medical and supportive services in the Las Vegas TGA through an effective quality management program.

Supporting Activities:

1.1 Implement an annual quality plan including a work plan of activities and timeline for the current grant year.
1.2 Hold quarterly meetings with the Quality Management Team to review data and initiate quality improvement projects and strategies.
1.3 From progress and outcome reports select at least two areas and develop, implement, and monitor quality improvement activities.
1.4 Ensure that all funded sub-grantees conduct and/or participate in an annual, standardized Las Vegas TGA wide client satisfaction survey/needs assessment.
1.5 Review the agency specific QM annual plans and return evaluations to each agency for the current grant year.
1.6 Utilize HRSA Technical Assistance Coordinators or the local Area Health Education Center to provide guidance on new processes and other relevant training as needed.

Goal #2 To increase awareness of the quality management principles and knowledge of quality improvement processes and opportunities to key stakeholders and Quality Management staff.

Supporting Activities:

2.1 Provide technical assistance on developing quality management plans, documenting outcomes and quality activities to contractors as requested or required.

2.2 Staff to participate in the quality management technical assistance web-cast trainings once a month throughout the grant year and any additional trainings as they arise providing feedback and new techniques to the C.O.R.E. Team and subcontractors.

Goal #3 To improve the effectiveness of the Planning Council's decision-making process for allocations.

Supporting Activities:

3.1 Share success and challenges of quality improvement projects and activities with the Planning Council quarterly through the Tracking Provided Services Report.

3.2 Provide information to the Planning Council on how quality improvement results can be reflected in their annual priority setting and resource allocation process for program changes and improvement of care.

3.3 Provide relevant quality management/improvement data to the Planning Council during their data presentation prior to the priority setting and resource allocation process to aid in decision making that supports a high quality of care.

Goal #4 To improve the quality of HIV/AIDS services and client outcomes for PLWH/A in the Las Vegas TGA in all Ryan White funded service categories through continually tracking performance indicators.

Supporting Activities:

4.1 Continually monitor our indicators on an annual basis through chart reviews and CAREWare to ensure we are meeting our set goals.

Indicators

CORE MEDICAL SERVICES

Ambulatory Outpatient Medical Care

TGA Goal	SERVICE CATEGORY PERFORMANCE INDICATOR
75%	Percent of clients with HIV-infection who have stabilized or increased their CD_4 T-cell count from initial count.
75%	Percent of clients with HIV-infection who had 2 or more CD_4 T-cell counts performed in the measurement year.
75%	Percent of HIV-infected clients who have an undetectable viral load from initial count.
100%	Percent of pregnant women with HIV-infection who were prescribed antiretroviral therapy.
70%	Percent of women with HIV-infection who had a pap screening every 12 months.
60%	Percent of minority clients accessing Ambulatory/Outpatient medical care.
75%	Percent of clients with HIV-infection who had two or more medical visits in an HIV care setting every 12 months.
95%	Percent of clients with AIDS who are prescribed HAART.
80%	Percent of clients who were prescribed HAART and received medication education concurrently.
80%	Percent of clients with HIV-infection and a CD_4 T-cell count below 200 cells/mm^3 who were prescribed PCP Prophylaxis.
85%	Percent of clients with HIV-infection and a CD_4 T-cell count <50 cells/mm^3 who were prescribed Mycobacterium Acium Complex (MAC) prophylaxis.
56%	Percent of clients with HIV-infection on ARV's who were assessed and counseled for adherence two or more times in the measurement year as part of their primary care.

75%	Percent of clients for who Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV infection.
75%	Percent of clients with HIV-infection on HAART who had a fasting lipid panel within the last 12 months.
80%	Percent of adult clients with HIV-infection who had a syphilis test performed within the last 12 months.
75%	Percent of adult clients who received testing for LTBI (latent TB infection) at least once since HIV infection.
70%	Percent of clients with HIV-infection at risk for sexually transmitted infections (STI's) who had a test for Chlamydia within the measurement year.
70%	Percent of clients with HIV-infection at risk for sexually transmitted infections (STI's) who had a test for Gonorrhea performed within the measurement year.
80%	Percent of clients with HIV-infection who have been screened for Hepatitis B virus infection status.
45%	Percent of new clients with HIV-infection who had a mental health screening within 12 months.
80%	Percent of clients with HIV-infection for whom a Toxoplasma screening performed at least once since diagnosis of HIV-infection.
75%	Percent of clients with HIV-infection who have ever received pneumococcal vaccination.
50%	Percent of clients with HIV-infection who have received influenza vaccination within the last 12 months.
45%	Percent of clients with HIV-infection who completed the vaccine series for Hepatitis B.
45%	Percent of new clients with HIV-infection who have been screened for substance use (alcohol and drugs) in the last 12 months.
80%	Percent of clients with HIV-infection who received HIV risk counseling within the last 12 months.
	Medical Case Management
85%	Percent of clients who are in medical care and medical case management services.
75%	Percent of clients in the care system that have at least one medical case management visit within the measurement period.
85%	Percent of clients who have current labs included in their chart dated within the measurement period.
85%	Percent of clients who have a case management care plan documented and updated at least every six months (Moderate MCM Measure).
85%	Percent of clients who have a client acuity documented and updated at least annually (Moderate MCM Measure).
90%	Percent of clients who have a case management care plan documented and updated a minimum of every 2 months (Intensive MCM Measure).
90%	Percent of clients who have a client acuity documented on intake only (Intensive MCM Measure).
75%	Percent of clients will have a stabilized (≥200) or increase their CD4 T-cell count from initial labs on intake to final labs at discharge.
75%	Percent of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs on intake to final labs within the measurement year.
78%	Percent of minority clients accessing medical case management services at least once within the measurement year.
	Mental Health Services
75%	Percent of clients that maintained adherence to ambulatory/outpatient medical visits (2 or more visits at least 3 months apart during the 12 month measurement period).
55%	Percent of clients will have an increase GAF rating from initial GAF to GAF at discharge or final GAF rating within the measurement period if client is still accessing

	services.
55%	Percent of clients entering the care system at least 60 days or more prior to the end of the measurement year will remain in care for at least three appointments within the measurement year.
80%	Percent of clients will have a complete Mental Health screening performed and completed within their first three appointments with their Mental Health provider.
80%	Percent of clients will have a DSM-IV diagnosis documented on intake or completed no later than within the first three appointments with their Mental Health provider.
80%	Percent of clients will have a GAF rating documented on intake or completed and documented no later than within the first three appointments with their Mental Health provider.
80%	Percent of clients will have a treatment plan documented on intake or completed no later than within the first three appointments with their Mental Health provider.
80%	Percent of clients will have an updated GAF rating documented at a minimum of every 60 days.
80%	Percent of clients will have progress notes documented at each of their appointments throughout treatment in the measurement year.
95%	Percent of clients exiting Mental Health services will have a discharge plan completed no later than 90 days from the client's last contact/appointment with the service provider.
	Substance Abuse Outpatient Treatment
75%	Percent of clients that maintained adherence to ambulatory/outpatient medical visits (2 or more visits at least 3 months apart during the 12 month measurement period).
55%	Percent of clients will have an increase GAF rating from initial GAF to GAF at discharge or final GAF rating within the measurement period if client is still accessing services.
55%	Percent of clients entering the care system at least 60 days or more prior to the end of the measurement year will remain in care for at least three appointments within the measurement year.
80%	Percent of clients will have a complete Mental Health screening performed and completed within their first three appointments with their Substance Abuse provider.
80%	Percent of clients will have a GAF rating documented on intake or completed and documented no later than within the first three appointments with their Substance Abuse provider.
80%	Percent of clients will have a treatment plan documented on intake or completed no later than within the first three appointments with their Substance Abuse provider.
80%	Percent of clients will have an updated GAF rating documented at a minimum of every 60 days.
80%	Percent of clients will have progress notes documented at each of their appointments throughout treatment in the measurement year.
80%	Percent of clients in individual treatment will have their treatment plan revised and updated at al minimum of every 60 days while the client is in Substance Abuse treatment.
95%	Percent of clients exiting Mental Health services will have a discharge plan completed no later than 90 days from the client's last contact/appointment with the service provider.
	Health Insurance Continuation Services
65%	Percent of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year (documented by CAREWare or current labs).
	Medical Nutrition Therapy
	Percent of HIV-infected clients who had a medical visit with a provider with

65%	prescribing privileges at least once in the measurement yea (documented by CAREWare or current labs).
	SUPPORT SERVICES
	Case Management (non-medical)
65%	Percent of clients who receive case management services that access medical and/or supportive services.
65%	Percent of total service utilization for clients in medical and/or support services in communities of color.
65%	Percent of clients who have a case management care plan documented and updated at least every six months within the measurement period.
65%	Percent of clients who have a client acuity documented and updated at least every six months within the measurement period.
65%	Percent of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year and accessed case management services.
	Emergency Financial Assistance
75%	Percent of clients who received approved EFA payments within 48 hours of request.
65%	Percent of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.
	Food Bank-Home Delivered Meals
65%	Percent of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.
	Housing Services
75%	Percent of clients with a housing payment made within 7 days of approved application.
65%	Percent of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year.
	Client Perspective Issues/Client Satisfaction
75%	Percent of clients indicating being very satisfied or satisfied with the services they received from the Ryan White Program within the last 12 months. (This will be completed in the form of a client satisfaction survey with a minimum of one question related to client satisfaction for each service category funded for that grant year).
	SYSTEMS LEVEL INDICATORS
	Percent of Ryan White Program-funded outpatient/ambulatory care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care.
	Percent of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year.
	Percentage of individuals with an AIDS diagnosis at time of initial outpatient/ambulatory medical care visit in the measurement year.
	Percent of Ryan White Program-funded clinical organizations with an HIV-specific quality management program in the measurement year.

Established Priorities

The annual quality goals and quantifiable goals and benchmarks are established and agreed upon priorities by the Quality Management C.O.R.E. Team and will be utilized to establish quality improvement projects throughout the year.

SECTION 6: PARTICIPATION OF STAKEHOLDERS

Stakeholders and Consumer Representation

Feedback is gathered from internal and external sources involved in the planning, implementation, and evaluation of the quality management program including;

- Consumers through an annual satisfaction survey, focus groups, and interviews. Consumers will also be asked to serve on ad-hoc committees for special projects.
- Members of the community are invited as appropriate to Quality Management related meetings.
- Clinicians, specialty providers, and support/clerical staff are invited to attend quality improvement planning, development, and review meetings as well as participate on relevant quality improvement teams.
- Information technology staff serve on the C.O.R.E. Team to provide support and input for maintaining data integrity, assuring confidentiality and security, and reporting capability.

Continuous quality improvement depends upon the participation of stakeholders to test changes aimed at improving performance and processes. Changes are based on the needs and desires of the clients/patients and health professionals involved in the entire work process. Teams are convened to develop plans and study results to continuously improve. Individuals most closely impacted by the changes and associated with the process should be members of the quality improvement team as the key to improvement is identifying causes affecting performance and changing systems to effect improvements.

Education

As discussed in the goals and activities section Quality Management Staff will attend trainings related to Quality Management sponsored by the National Quality Center (NQC) in addition to participating in monthly web-case trainings and online tutorials. Techniques and knowledge acquired will be brought back to the C.O.R.E. Team in the Las Vegas TGA to further quality improvement efforts and strategies.

Feedback

The C.O.R.E. Team will communicate findings and solicit feedback from both internal and external key stakeholders on an ongoing basis. Presentations and updates of findings will be communicated to the provider community at quarterly Part A meetings as well as the Planning Council at each of their meetings. The C.O.R.E. Team is always willing to listen to suggestions and allow guests at all of their meetings for input and feedback. The QM Coordinator will also ensure that any related feedback from outside parties in the form of email or other means of communication will be provided to the C.O.R.E. Team in a timely manner.

SECTION 7: EVALUATION

Annual Evaluation

The Las Vegas TGA's QM Annual Quality Plan will be evaluated annually prior to the end of the grant year by QM C.O.R.E. Team. This will be done to assess quality infrastructure and activities to ensure that the quality program is in line with its annual purpose and goals and to determine its strengths and weaknesses to make any needed adjustments. Evaluation will take place using the Quality Plan Review Checklist, which is also utilized to evaluate sub-grantees annual quality plans. Based on evaluative results, the QM C.O.R.E. Team will refine strategies for improvement and implementation for the follow year.

Quality Improvement Activities

Quality improvement activities will be evaluated individually to determine if they meet the expectations for the annual quality goals and to measure the impact they have on improving the health and/or access to care for PLWH/A.

Performance Measures

Performance indicators will be reviewed and evaluated to assess their appropriateness for measuring clinical and non-clinical HIV care by the QM C.O.R.E. Team on an annual basis and additionally by the experts in those fields utilizing ad-hoc standards of care committees.

SECTION 8: CAPACITY BUILDING

Technical Assistance

The QM staff is responsible for providing or coordinating technical assistance training(s) for Ryan White Part A sub grantees and/or providing related materials. Additional training needs will be assessed through monitoring of local QM plans/programs, sub grantee requests, and training evaluations and/or needs assessments.

Training

The QM Coordinator will attend the National Quality Center's (NQC) Training of Quality Leaders Program in January of 2010 as well as the Training of Trainers in June of 2010. The QM Coordinator will participate in all HRSA related quality projects, trainings, and calls and also continue to participate in the following;

- Monthly NQC web-conference calls on best practices and program development,
- NQC quality link which is an online peer learning forum where quality topics can be discussed and shared through a network of quality managers,
- NQC podcasts on quality improvement activities when they become available, and
- NQC's Quality Academy an internet-based modular learning program on quality improvement.

Information from trainings will be shared with the C.O.R.E. Team and utilized to further quality improvement processes in the Las Vegas TGA.

Feedback

All quality improvement activities/reports and annual quality management work plans will be made available to all stakeholders in the TGA for review and will be posted on the TGA's website (www.LasVegasEMA.org). Frequent updates regarding QM activities and outcomes will be given to all program staff during department meetings, all providers during quarterly provider meetings and to the Planning Council on a quarterly basis at their meetings by the Quality Management Coordinator. The purpose of this communication loop is to encourage quality efforts to reflect in Planning Council priority setting and resource allocation processes and additionally in sub-grantee quality improvement projects.

SECTION 9: PROCESS TO UPDATE QUALITY MANAGEMENT PLAN

Updates

The C.O.R.E. Team is responsible for guiding the review, revision, and implementation of the Annual Quality Plan on an annual basis. The review and revision process will begin in February of 2011 prior to the beginning of the grant year and implementation will be March 1, 2011. A presentation will be given to the sub grantee's and the planning council at the beginning of the grant year to discuss any changes to the QM Program, introduce the new grant years Annual Quality Plan, and discuss the new goals and benchmarks, and an outline of processes for that year.

Accountability

The process for updating the plan will be initiated by the QM Coordinator and QM C.O.R.E. Team. Updates and revisions will be finalized by February 28, 2011 for implementation March 1, 2011.

Sign-off Process

The Annual Quality Plan will be agreed upon by the consensus of the QM C.O.R.E. Team and the final approval given by the Program Administrator.

SECTION 10: COMMUNICATION

Sharing Information, Format and Intervals

The QM C.O.R.E. Team will meet at least once quarterly; dates are established in the work plan. Electronic communication and conference calls will be ongoing. NQC Projectspace, an online password protected forum, will be utilized for the C.O.R.E. Team and quality improvement teams to store, share and update tools and materials.

To ensure accuracy and timeliness meeting notes will be generated and distributed within a week of each meeting. This will reinforce the issues discussed; decisions made and inform any team members who were absent. The notes can also serve as a forum to communicate progress to senior leadership and/or sub grantee staff members.

Frequent updates regarding QM activities and outcomes will be given to all program staff during department meetings, all providers during quarterly provider meetings and to the Planning Council on a quarterly basis during their meetings by the Quality Management Coordinator. Again quarterly QM TPS Reports will be in large a method of delivering relevant data to the sub grantee's and Planning Council. Annual quality reports will be developed and disseminated to all stakeholders at the closing of each grant year.

SECTION 11: QUALITY MANAGEMENT PLAN IMPLEMENTATION

Timelines and Accountability

The following work plan outlines the goals and supporting activities for the grant year that will ensure implementation of the program and progress toward quality goals.

Current Grant Year March 2011-February 2012

Goals/Supporting Activities	***Lead***	***Quarter 1***			***Quarter 2***			***Quarter 3***			***Quarter 4***		
		March 2011	April 2011	May 2011	June 2011	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	Feb 2012
GOAL #1-Improve the quality of HIV/AIDS core medical and supportive services in the Las Vegas TGA through an effective quality management program.													
1.1 Implement an annual quality plan including a work plan of activities and timeline for the current grant year.	C.O.R.E. Team	Feb 8th 2011											
1.2 Hold quarterly meetings with the QM Team to review data and initiate quality improvement projects and strategies.	C.O.R.E. Team	Feb 8th 2011					Aug 9th			Nov 8th			Feb 14
1.3 From progress and outcome reports select at least two areas and develop, implement, and monitor quality improvement activities.	C.O.R.E. Team						X	X	X	X			
1.4 Ensure that all funded sub-grantees conduct and/or participate in an annual, standardized Las Vegas TGA wide client satisfaction survey/needs assessment.	QM Staff And C.O.R.E. Team								X	X	X	X	
1.5 Review the agency specific annual QM plans and return evaluations to each agency for the current grant year.	QM Staff	X	X	X									
1.6 Utilize HRSA Technical Assistance Coordinators or the local Area Health Education Center to provide guidance on new processes and other relevant training as needed.	QM Staff	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed

		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Goals/Supporting Activities	***Lead***	March 2011	April 2011	May 2011	June 2011	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	Feb 2012
GOAL #2-To increase awareness of the quality management principles and knowledge of quality improvement processes and opportunities to key stakeholders and Quality Management staff.													
2.1-Provide technical assistance on developing quality management plans, documenting outcomes and quality activities to contractors as requested or required.	QM Staff/ Consultant	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed
2.2 Staff to participate in the quality management technical assistance web-cast trainings once a month throughout the grant year and any additional trainings as they arise providing feedback and new techniques to the C.O.R.E. Team and sub-grantees.	QM Staff	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly	TBD Monthly

		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Goals/Supporting Activities	***Lead***	March 2011	April 2011	May 2011	June 2011	July 2011	August 2011	September 2011	October 2011	November 2011	December 2011	January 2012	Feb 2012
GOAL #3-To improve the effectiveness of the Planning Council's decision-making process for allocations.													
3.1 Share success and challenges of quality improvement projects and activities with the Planning Council quarterly through the TPS Reports.	QM Staff				TPS Report Q1			TPS Report Q2			TPS Report Q3		
3.2 Provide information to the Planning Council on how quality improvement results can be reflected in their annual priority setting and resource allocation process for program changes and improvement of care.	QM Staff/Consultant/C.O.R.E. Team	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed	As Needed

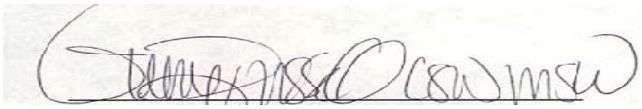
3.3 Provide relevant quality management/improvement data to the Planning Council during their data presentation prior to the priority setting and resource allocation process to aid in decision making that supports a high quality of care.	QM Staff/ C.O.R.E. Team	X	X	X		
GOAL #4- To improve the quality of HIV/AIDS services and client outcomes for PLWH/A in the Las Vegas TGA in all Ryan White funded service categories through continually tracking performance indicators.						
4.1 Continually monitor our indicators on an annual basis through chart reviews and CAREWare to ensure we are meeting our set goals.	QM Staff/ C.O.R.E. Team	Chart Reviews	Chart Reviews	Chart Reviews		

Summary

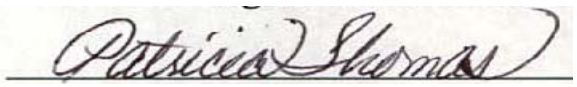
Throughout the year, the QM staff will collaborate with service providers, consumers, the QM C.O.R.E. Team and the Planning Council to continuously analyze data to improve care in order to improve client outcomes, reduce cost, and create more efficient and effective service delivery processes. Everyone plays a valuable and vital role in improving the quality of services provided to people living with HIV/AIDS in the Las Vegas TGA.

Quality Management C.O.R.E. Team and Program Administrator Approval Signatures

Date: 2/8/2011

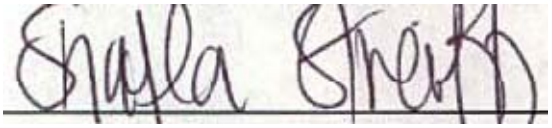


Sunny Russell-AFAN

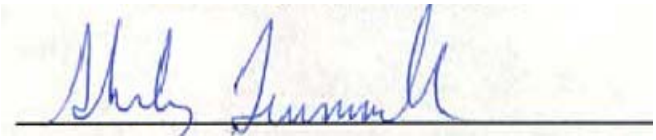


Patricia Thomas-UMC

Josefa Ozaeta-COMC



Shayla Streiff-Part A



Shirley Trummell-Nye County

Alisha Campbell-Part A

Absent

Christine Bronston-Mohave County

Absent

Aaronell Matta-CCC

Absent

SaBrina Hagan-Finks