South Carolina Ryan White Quality Management Plan

Department of Health and Environmental Control
Division of STD/HIV and Viral Hepatitis

2018

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Introduction

The Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau in coordination with HRSA's Office of Performance Review aligned quality measures with performance measures to identify priority quality measures for grantees. These measures are consistent with measures selected by stakeholders of all HIV programs in the state. The goal of the Quality Management Plan, as outlined in the following pages, is to improve the quality of care for people living with HIV in South Carolina. An effective quality management plan will directly support quality improvement activities in the state and assist in the development of a supporting infrastructure across the defined service area consistent with legislative requirements and expectations for all Parts of the Ryan White HIV/AIDS Treatment Modernization Act.

A. Ryan White Background and History

The Ryan White HIV Program is the largest federal program focused exclusively on HIV/AIDS care. The program is for individuals living with HIV/AIDS who do not have sufficient health care coverage or financial resources. Ryan White fills gaps in care not covered by other sources. The United States Congress enacted the Ryan White program in 1990. The program has been reauthorized in 1996, 2000, 2006, and 2009 with each reauthorization accommodating new and emerging needs. The goal is to improve the quality and availability of care for individuals infected with HIV and those families affected by HIV disease by providing emergency assistance to regions most severely affected by the HIV epidemic. Since 2000, the Ryan White legislation has included specific provisions directing grantees to establish, implement and sustain quality management programs, which includes monitoring of the quality of medical care and services provided to ensure that People Living with HIV (PLWH) who are eligible for treatment will receive it.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB).

B. Quality Statement

The goal to improve access to quality healthcare and support services is fundamental to the mission, values, and strategic plan for South Carolina Department of Health and Environmental Control (DHEC). The Ryan White (RW) quality management program utilizes an interdisciplinary approach working collaboratively with all stakeholders. The quality management program functions to ensure continuous monitoring, evaluation and process improvement within the DHEC, STD/HIV and Viral Hepatitis Division, and HIV Care and Support Programs. The mission of the RW HIV Quality Management Program

and the STD/HIV and Viral Hepatitis Division is to ensure that all PLWH in South Carolina receive quality medical care and support services to improve health outcomes. The key components of the Ryan White Quality Management Program are:

- Performance and Outcome Measurement.
- Data Analysis, Presentation and Evaluation.
- Identification and utilization of Continuous Quality Improvement (CQI) strategies
- Implementation of CQI initiatives.
- Monitoring adherence to established HIV clinical practice standards and Public Health Services (PHS) Guidelines.
- Coordination of data collection for the agency's review of outside organizations.
- Identification and implementation of solutions for improvement in processes and outcomes.

C. Mission Statement

The mission of the Ryan White (RW) Quality Management (QM) Program is to ensure that quality medical care and supportive services are provided to PLWH. This will be accomplished through the development of a comprehensive quality management plan utilizing outcome and epidemiological data to ensure the delivery of the highest quality of care and services provided to PLWH in SC by: continuously monitoring the quality of care and support services provided, improving processes and systems to reduce variation in the provision of care and services, and identifying, prioritizing and implementing quality improvement activities.

D. Purpose

The purpose of the SC RW Part B QM program is to systemically monitor, evaluate, and implement process improvement strategies. The quality management program will provide a mechanism for objective review, continuous monitoring and evaluation in order to enhance the quality of medical care and support services provided to PLWH in South Carolina, through all sources of Ryan White funding including Part A, B including AIDS Drug Assistance Program (ADAP), C, D, F, Minority AIDS Initiative (MAI) and Emerging Communities by:

- Working collaboratively with direct service providers, funded through Ryan White, to ensure that providers adhere to the established HIV clinical practice standards and Public Health Services (PHS) Guidelines.
- Utilizing continuous quality improvement strategies, including vital health-related supportive services, to improve access to and retention in HIV medical care and improve treatment adherence.
- Utilizing available demographic, clinical and outcomes data to monitor emerging trends and identified needs along the HIV care continuum.

E. Ryan White Expectations

A major focus of the Ryan White program is to eliminate barriers to accessing care and to continuously improve the quality of care and services received by Ryan White clients. Requirements direct grantees to:

- Ensure that service providers adhere to established HIV clinical practices and PHS guidelines;
- Ensure that quality improvement strategies include support services to assist clients in receiving appropriate HIV care (e.g., transportation assistance, medical case management, case management) and treatment;
- Ensure that trends are monitored and identified along points of care on the HIV care continuum through the utilization of demographic, clinical, and performance data for HIV related illnesses.

Emphasized in the Ryan White Program expectations, quality management programs are pivotal in addressing the following key themes:

- Ensuring improved linkage and access to medical care and support services for HIV+ individuals aware of their status.
- Enhancing the quality of services and outcomes.
- Linking medical services and social support services.
- Making changes within programs to align with identified trends/needs of the evolving epidemic.
- Utilizing quality, epidemiological, and outcome data to establish priorities.
- Ensuring accountability (resources, responsibility, implementation, etc.).

F. Definition of Quality

Quality is defined by HRSA's HIV/AIDS Bureau/Division of Service Systems as the degree to which a health or social service meets or exceeds established professional standards and user expectations. In order to continuously improve systems of care for individuals and populations, evaluation of the quality of care should consider:

- The quality of inputs.
- The quality of the service delivery process.
- The quality of outcomes.

Quality Infrastructure

A. Leadership and Accountability

Ryan White Program staff provide oversight and management of the RW Part B grants. Staff monitors all Ryan White funds and grantees to ensure that Ryan White funds are the

payer of last resort. The Division leadership is dedicated to the quality improvement process and guides the quality management plan.

B. Roles and Responsibilities of DHEC Staff:

Ryan White Program Services Manager:

The Ryan White Program Services Manager directs and manages the federal Ryan White Part B and Housing Opportunities for Persons with AIDS (HOPWA) programs for the state. These programs include local HIV service providers and short and long-term housing assistance services. The Program Services Manager directs all organizational and operational planning for these statewide programs.

Ryan White ADAP Manager:

The Ryan White ADAP Manager directs all ADAP daily operations including data management and contract monitoring. The ADAP manager tracks and analyzes program financial data to include monitoring ADAP expenditures, projecting medication costs and utilization rates to ensure efficient use of program resources and to maintain continuous access to pharmaceuticals. The ADAP manager prepares reports, as required and works collaboratively with RW providers and contract pharmacies.

Ryan White Quality Management Coordinator:

The Ryan White Quality Management Coordinator analyzes, interprets and evaluates services provided and client level data from a variety of sources, including reports from RW service providers and ADAP. The RW QM Coordinator reviews inappropriate antiretroviral regime alerts from pharmacies and/or providers in coordination with the ADAP Clinical Consultant as indicated. The RW QM Coordinator consults with and provides technical assistance to RW service providers in order to develop an effective CQI program. The RW QM Coordinator also works in collaboration with providers to identify and prioritize opportunities of improvement and to develop an improvement plan of action. The RW QM coordinator also serves as a quality resource for all RW Parts, as well as an agent for referrals to the AIDS Education and Training Center (AETC).

Ryan White Solutions and Integrations Manager:

The Ryan White Solutions and Integration Manager is responsible for interpreting federal and local program guidelines for data requirements in order to effectively collect required data elements necessary to maintain funding. Working as a health information strategist, the Solutions and Integration Manager works closely with RW Part B service providers to ensure all required elements are fully reported and accurately available for evaluation.

Ryan White Part B and HOPWA Coordinator:

The Ryan White Part B and HOPWA coordinator manages the development, coordination and evaluation and conducts routine programmatic monitoring of Ryan White Part B and HOPWA service providers, through site visits and reporting.

Ryan White Medical Case Management Coordinator:
The Ryan White Medical Case Management coordinator serves in a consultant capacity providing programmatic consultation and technical assistance to providers to improve coordination of service delivery.

Ryan White Outreach Coordinator:
The Ryan White Outreach Coordinator is responsible for establishing, monitoring, and improving service outcomes related to Ryan White Outreach services. The RW Outreach Coordinator works in conjunction with medical providers and contractors, in accordance with the National HIV/AIDS Strategy. The RW Outreach Coordinator works collaboratively with care/service providers to assist in the development of processes for identification and location of clients who have fallen out of care, in order to re-engage individuals into care and treatment.

C. Quality Management Steering Committee

The Quality Management (QM) Steering Committee provides guidance, consultation and input regarding the overall Quality Management Program. The QM Steering Committee utilizes a multidisciplinary approach in order to provide objective review and evaluation, as well as continuous improvement of HIV care and support services. The QM Steering Committee reviews performance indicators/measures from the numerous HIV quality initiatives and determines which measures will be included for annual review. The QM Steering Committee members share information regarding quality management plans, best practices, and processes both within the organization and among network partners.

The state membership consists of individuals representing: Ryan White Part A, B (including ADAP), C, D and F programs, as well as DHEC representatives from the Ryan White program, STD/HIV and Viral Hepatitis Prevention Program, Office of Pharmacy and Division of Surveillance and Technical Support. Participation by Part B providers is required under contract with DHEC and providers for Ryan White Parts A, C, D and F are invited. The inclusion of all RW providers (A, B, C, D and F) is essential for statewide coordination and collaboration of care and support services for PLWH. Designees from the following agencies are included in the committee membership: *Affinity Health Center, AID Upstate, AIDS Healthcare Foundation, Beaufort Jasper Hampton Comprehensive Health Services, Caresouth Carolina, CARETEAMPLUS, Charlotte TGA Part A, DHEC, Hope Health Edisto, Hope Health Pee Dee, Hope Health Lower Savannah, Joseph H. Neal Wellness Center, Eau Claire Cooperative Health Centers, Little River Medical Center, Low Country Health Care System, Palmetto Community Care, Medical*

University of SC, MUSC OPAC Pediatrics, New Horizons Family Health Services, Piedmont Care, Roper St. Frances, Sandhill's Medical Foundation, Spartanburg Regional Healthcare System, Sumter Family Health Center, Upper Savannah Care Services, USC Department of Medicine and USC Pediatric Infectious Disease.

Persons living with HIV are included in the committee and other entities may be invited. The Quality Management Steering Committee meetings are scheduled twice annually, which are organized by RW Part B.

The QM Coordinator serves as the DHEC point of contact to the South Carolina Ryan White Quality Management Steering Committee and will schedule, coordinate, plan and chair the QM Steering Committee meetings. A community committee co-chair may be selected to assist with meeting preparation.

D. **Clinical Care Provider Advisory Committee** (formerly Physician Advisory Committee)
The Clinical Care Provider Advisory Committee will work collaboratively with the AIDS Education and Training Center (AETC) as needed.

E. **HIV Planning Council**
The South Carolina HIV Planning Council (HPC) is an active statewide planning body that includes representatives from a wide variety of HIV prevention and care organizations and consumers from around the state. DHEC RW staff attends the HPC meetings. DHEC works in collaboration with the SC HPC committee to address prevention and care needs for PLWH. The RW quality program may present data outcomes for selected performance measures to the HPC committee and the Positive Advocacy subcommittee for review and feedback. The HPC meets five times during the calendar year.

F. **Resources**
Dedicated resources include: DHEC, STD/HIV and Viral Hepatitis Division Director, Infectious Disease Medical Consultants, HIV Care & Support Service Program Director, RW ADAP Coordinator, RW Data Manager, RW Program Manager, HIV Planning Council, RW Part B Coordinator, Surveillance Director, HIV Surveillance Coordinator, DHEC Pharmacy Director, DHEC Tobacco Quitline Program, Viral Hepatitis Coordinator, HIV/Viral Hepatitis Prevention Program Manager, RW QM Coordinator and ADAP Specialty Pharmacy (Panther). Key stakeholders include: Ryan White grantees, HIV Medical Care and Support Service providers and consumers of HIV Health Care and Supportive Services.

South Carolina Ryan White Providers

A. Ryan White Part A Provider

Affinity Health Center funded through Charlotte Mecklenburg TGA.

B. Ryan White Part B Providers (DHEC Contractors)

Affinity Health Center; AIDS Healthcare Foundation; AID Upstate; Beaufort Jasper Hampton Comprehensive Health Services; CARETEAMPLUS; Hope Health-Edisto; Hope Health-Lower Savannah; Hope Health-Pee Dee; Joseph H. Neal Wellness Center; Palmetto Community Care; Medical University of South Carolina; Piedmont Care; University of South Carolina; and Upper Savannah Care Services.

C. Ryan White Part C Providers

*Affinity Health Center; *Beaufort Jasper Hampton Comprehensive Health Services; Caresouth Carolina; Little River Medical Center; Low Country Health Care System Inc.; New Horizon Family Health Services; Eau Claire Cooperative Health Centers, Inc.; Roper St. Francis Foundation; Sandhill's Medical Foundation; Spartanburg Regional Healthcare System; and *Hope Health-Pee Dee. (*Denotes: also Part B provider).

D. Ryan White Part D Provider

Eau Claire Cooperative Health Center

E. Ryan White Part F Provider

AIDS Education and Training Center (AETC)

F. Ryan White ADAP

Program Data

A. Data Overview

The Ryan White HIV/AIDS Program consistently enhances the way in which data are managed and optimized. By utilizing the HIV/AIDS Bureau (HAB) Performance Measures as the measurement framework, the SC QM program converts data statements into questions (i.e. linkage and retention outcomes). The recent enhancements to the HAB Core Performance Measures allow the SC QM program to monitor points in care along the entire HIV Care Continuum in order to identify those individuals who are HIV positive, link HIV positive individuals to care and strive to retain these individuals in care, therefore aiming to achieve the goal of viral suppression. Performance measurement data is fundamental to continuous quality

improvement which allows for continuous measurement and evaluation in how medical care and support services are delivered, treatment is administered and follow up is conducted. The aim of the program is to achieve positive health outcomes for PLWH in SC to include the reduction of new infections, improved rates of viral suppression and retention in care. The program works with service providers to identify areas of high performance and convert those best practices into actionable steps for continuous improvement. The SC RW QM program continues to ensure equal access to quality healthcare services through collaboration with providers, aligning with the goals of the National HIV/AIDS Strategy (NHAS).

B. Data Selection

The SC RW Part B performance measures have been selected by the QM Steering Committee. The various initiatives reviewed for measure selection included HIV performance measures from the In+Care campaign, HIV/AIDS Bureau (HAB) performance measures, and the SC Data to Care campaign; aligning the measures along points of care on the HIV Care Continuum. The performance measures for the SC RW quality program are aligned with the milestones along the HIV Care Continuum, representing key clinical decision points and priorities for care and service delivery for the community and providers. Currently data is not required to be submitted to HAB, however grantees are encouraged to continuously monitor and trend performance data in order to evaluate the quality of care and services provided. The performance measures include the following service categories: ADAP, outpatient/ambulatory medical care, oral health care, health education/risk reduction, mental health, medical case management, non-medical case management, substance abuse services. The RW Part B 2015 performance measures were aligned with the National HIV/AIDS Strategy (NHAS) strategy goals: 1) reduce new infections, 2) increase access to care and improve health outcomes,
3) reduce HIV related health disparities and health inequities, and 4) achieve a more coordinated and collaborative response to the HIV epidemic.

> *Appendix B-SC QM Performance Measures*
> *Appendix C-SC ADAP Performance Measures*
> *Appendix D-Activity Schedule*

C. Data Collection

South Carolina Ryan White providers are using a variety of resources to collect data (*Provide Enterprise*, CAREWare, EMR's, etc.). DHEC continues to work closely with providers providing technical assistance around data management.

- During the fourth quarter of each year, providers are sent a reporting schedule for the upcoming year, to include the due dates of quality reports, Part B activities and other essential projects.

  > *Appendix A-Part B Providers*

- Data sources for the performance indicators/measures are identified to assure

appropriate access to data. The source and placement of information is identified, providers will then develop and/or modify appropriate data collection tools (specific reports) to ensure targeted information is being collected. The agencies' staff develops and communicates a data analysis plan prior to running final reports. The analysis plan will ensure appropriate storage of data in order to prevent inappropriate access, loss or theft through system breakdown. Standards of confidentiality, privacy and security are communicated to all parties involved to ensure security of client data.

- South Carolina Ryan White Part B providers and ADAP utilize *Provide Enterprise (PE)* to collect, report, and analyze data. DHEC continuously works closely with each provider to provide technical assistance around data management. *PE* enables providers to run customized Client Level Data Reports and Clinical Report Cards (CRC) that meet the data requirements of the QM program. Reports are run by the provider; the data/report is submitted, via secure portal in *PE*, to the RW Data Manager and QM Coordinator. The performance measures are currently analyzed annually, per calendar year, at the state level. Additional monitoring is on-going at the provider level.

- Data Integrity Call: The Data Integrity session provides support assisting RW Part B providers to identify areas for improvement. Data Integrity calls are scheduled with Part B providers prior to the combined annual RW Part B and HOPWA Programmatic and Quality Management site visit, in order to provide the following: 1) guidance to prepare for the RW/HOPWA/SC QM Combined Site Visit, 2) opportunity to review and interpret programmatic reports to be reviewed during the site visit and 3) opportunity for the Program Data Manager to address questions and issues with data collection and/or reporting. The focus of data support allows providers the opportunity to "fact check" clinical outcomes and review the Clinical Report Card (CRC) and identify issues with CRC results prior to the site visit. Specific client records may be isolated for review with the Program Data Manager. The data session allows providers to identify and target opportunities for improved performance.

- ADAP Data: ADAP monitors adherence and effectiveness of therapy by measuring refill intervals for anti-retroviral therapy (ARV) and identifying inappropriate anti-retroviral regimen. The outcomes from ADAP-related therapy are measured utilizing the Clinical Report Card to evaluate clinical outcomes of PLWH on anti-retroviral therapy. Currently, the quality management program is collecting data for the ADAP performance measure: *Inappropriate Antiretroviral Regimen Components Resolved by ADAP*. The Clinical Review Process for review of inappropriate antiretroviral regimen has been implemented by ADAP. This review process is a collaborative, multidisciplinary approach for the review

of anti-retroviral medications in order to identify inappropriate antiretroviral regimens. When an inappropriate antiretroviral regimen is identified, the QM program is notified by the pharmacy (Panther) and /or RW provider; the ADAP medical consultant is contacted for clinical review of the ARV regimen, which may include contacting the prescribing clinician in order to recommend modifications of the ARV regimen and provide follow up recommendations for resolution. The ADAP program will track the percentage of identified inappropriate antiretroviral regimens that are identified and resolved in order to provide care and treatment consistent with PHS guidelines. The quality management program will plan to collect and report data for HAB ADAP Performance Measures (Application Determination, Eligibility Recertification, & Formulary) in CY 2017.

D. Data Utilization

Performance measurement is the process of collecting, analyzing and reporting data regarding patient care and health outcomes. Performance measurement is a fundamental component of the quality management program and is an essential element of continuous quality improvement process. Performance data will be utilized to monitor quality of care, ensure adherence with best practices/standards of care guidelines and to identify and prioritize quality improvement activities. Data is also used to prioritize projects and evaluate changes in order to improve quality of care and services provided to PLWH.

- Internally, SC QM data is retrieved and analyzed from All Parts to identify opportunities for improvement within the Ryan White program. Emerging trends affecting HIV care and service delivery in South Carolina are addressed. Quality reviews and feedback allow providers and DHEC to prioritize identified needs; therefore, enabling appropriate funding to be budgeted at the local level.
- Externally, Ryan White providers compare their performance results for clinical outcomes against their prior performance, the state benchmark and established targets. This comparative process allows providers to note gains in performance and also to identify gaps/opportunities for improvement. Providers are working to continuously improve the quality and systems of services offered to clients. The measurement and analysis of the SC QM data is pivotal for the evaluation of medical and support care services provided to HIV/AIDS clients. DHEC and RW providers work collaboratively to ensure the delivery of quality medical care and support services to HIV/AIDS clients.

Annual Quality Goals

A. Overall Strategies for Achieving the Goals of the Quality Management Program

A systematic, state-wide process for planning, designing, measuring, assessing, evaluating and improving performance include the following components:

- *Develop a planning mechanism* incorporating baseline data from external and internal sources and input from leadership, staff and clients. Clinical, psychosocial, operational and programmatic aspects of patient care will be reviewed.
- *Emphasize design* needs associated with new and existing services, patient care delivery, work flows and support systems which maximize results and enhance client, physician, and staff satisfaction.
- *Evolve and refine measurement* systems for identifying trends in care by regularly collecting and evaluating patient care data across the continuum.
- *Employ assessment* procedures to determine efficacy and appropriateness of services delivered and whether opportunities for improvement exist.
- *Focus on improving* quality in all dimensions by implementing multidisciplinary, data driven, evidenced based teams and encouraging participatory problem solving.
- *Promote communication*, dialogue and information exchange across the STD/HIV and Viral Hepatitis Division and throughout the state, regarding data findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement.
- *Strive to establish collaborative relationships* with diverse stakeholders and community agencies to collectively promote the health and welfare of the community served.

B. Quality Initiatives

Retention in Care: Hepatitis C

- 95% of HIV patients will have a Hepatitis C (HCV) screening performed at least once since diagnosis of HIV.
- 50% of patients with a diagnosis of HIV and who are identified as high risk (MSM and/or IDU) will have annual Hepatitis C (HCV) screening performed in the measurement year. (New measure and no baseline data).

Viral Suppression

- 85% of patients, over the age of 24 months, with a diagnosis of HIV/AIDS will have a viral load less than 200 copies/mL at last viral load test during the measurement year.

C. Planned Activities for CY 2018:

Activity One

Conduct the annual RW Part B Programmatic/HOPWA and the Quality Management Site visits which are combined in order to provide a comprehensive review of care and services that are provided to PLWH in SC. The combined SC RW Part B Programmatic/HOPWA and the Quality Management Site visits will continue for 2018. The RW site visits are conducted annually in order to: assess adherence to established clinical guidelines and standards, monitor health outcomes, monitor performance and assist providers with continuous improvement activities in order to improve care and services provided. Established improvement Plan, Do, Study, Act (PDSA) cycles completed by RW providers will be continuously monitored.

Activity Two

Plan and conduct the Quality Management Steering committee meeting in February 2018 and July 2018.

Activity Three

Continue to utilize the ADAP Clinical Review Process for inappropriate ARV regimens, adverse events, clients identified as pregnant and clients who are incarcerated in jail as indicated.

Activity Four

Continue to implement the RW Part B and Viral Hepatitis Integration Plan.

Activity Five

Utilize the Pre-visit Planning Process to alert providers of missed service(s) as well as assisting the provider to be proactive in preparation for identifying needs and services to be completed. *(SC DHEC-contracted, RW-funded providers are required to create a Medical Encounter and review the Patient Clinical Summary 2-5 days prior to the client visit with a core service provider, including Medical Case Managers. The Pre-visit Process comprises 75% of the time that providers spend ensuring quality during the reporting period. The Pre-visit Process, the Medical Encounter in Provide Enterprise (PE) is an assembly of clinical and service utilization information for each client to include: visit history, refill history from SC ADAP including the Insurance Assistance Program, labs, vaccinations, treatment history including tuberculosis and prophylaxis for opportunistic infections, pap smear and pregnancy monitoring, screenings and referrals. The information is posted to the Medical Encounter from a variety of service disciplines).*

Activity Six

Continue to provide Technical Assistance/training (TA) for the following

- Quality Management Plan
- Organizational Assessment
- Continuous Quality Improvement
- Plan, Do, Study, Act (PDSA) Improvement methodology

Activity Seven

Enhance the medical provider data collection tool and update Patient Clinical Summary in *PE.*

Activity Eight
     Provide ongoing technical assistance to RW providers as indicated and/or requested.

Evaluation

Evaluation

The QM program will evaluate the quality infrastructure and activities to ensure that the quality program aligns with its overall purpose. The program will continuously evaluate strengths, identify opportunities for improvement and implement strategies for improvement as indicated. Based on those findings, organizations will review the annual goals, refine and implement improvement strategies for the following year. Listed below are several evaluation methods that are utilized by the quality management program:

A. Programmatic and Quality Management Part B Site Visits and Clinical Report Card Review

- Annual Programmatic/HOPWA and Quality Management Site visits are conducted in order to ensure adherence to established clinical guidelines and standards, monitor health outcomes, monitor performance and assist providers with continuous improvement activities in order to improve care and service delivery.
- Review Clinical Report Card, comparing provider data to prior performance as well as comparison to the SC state benchmark and established numeric goal/target. The clinical report card enables providers to identify areas for improvement and develop a plan of action for improvement. The data review also allows providers to identify and discuss the strengths of the services delivered, to include discussion of the processes and systems of care currently in place.
- Allow providers to identify and discuss gaps/opportunities for improvement in the delivery of services to include:
  - Define opportunity/opportunities for improvement.
  - Establish goals for improvement.
  - Develop and implement a plan of action for identified improvement opportunities, monitor improvement strategies/interventions and revise as needed.
  - Develop, complete and update the PDSA improvement cycle.
  - Utilize additional continuous quality improvement methodologies to include but not limited to the following:
    - flow chart analysis
    - cause and effect diagram
    - brainstorming

- observational studies
- activity logs
- Encourage and assist providers to become pro-active in the approach to continuous quality improvement:
  - Continuously monitor and evaluate outcome/performance data
  - Develop and implement change strategies for identified improvement opportunities
- Identify training/educational needs:
  - HIV
  - Viral Hepatitis
  - Quality Management Plan
  - Other Technical Assistance as needed

B. ADAP

ADAP works in collaboration with the RW statewide QM Program to ensure that:

- Persons living with HIV/AIDS who are eligible for treatment are receiving those services.
- Treatment paid for by SC ADAP is consistent with PHS Guidelines and adheres to the Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.
- A Clinical Review Process for ADAP was implemented in 2015. The clinical review process is a collaborative, interdisciplinary approach for the review of anti-retroviral medications which includes, but is not limited to following: formulary, prior authorization, dispensing, inappropriate antiretroviral (ARV) regimen, duplication, prescribing/ordering, adverse reaction, and medication interaction.
- DHEC provides training opportunities for medical and support staff and work collaboratively with the AETC to ensure continuous medical education opportunities are available.
- The SC ADAP Medical Consultant also serves a dual role in ADAP, Ryan White Part B, and as an Infectious Disease physician at the Columbia based Ryan White Part B Immunology Center at the University of South Carolina, which is a host site for the AETC. The collaboration between ADAP and the AETC, ensures the provision of continued medical education programs for healthcare practitioners. It also provides a venue for the ADAP Medical Consultant to disseminate information related to clinical best practices to medical care providers.
- Smoking cessation therapies were added to the ADAP formulary in April 2015 to align with the Optional Performance measure O-7.0 (Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months).

C. Clinical Quality Improvement System Upgrades: Provide Enterprise

Provide Enterprise (PE) allows for customization, therefore allowing providers to capture and store the full continuum of medical and support services provided to RW clients. Systematic modifications within *PE* support continuous quality improvement, therefore continuing to meet the evolving changes within the HIV care continuum. Several significant improvements include:

- Medical Encounter Summary
- Patient Clinical Summary
- RSR Completeness Reports
- Clinical Report Card Enhancements
- ADAP Improvements

D. Electronic Health Records Integration/Interface

Technical assistance will be provided to medical care providers who develop a HIV care pre-visit template in the Electronic Health Record.

E. Medical Case Management (MCM) Graduation Module

The MCM Graduation Module will eventually report clients achieving self-sufficiency of their HIV care as they graduate from MCM services.

F. Improvement plans will be communicated to all appropriate staff and if indicated to clients/consumers

G. Process to Update QM Plan

The QM plan is reviewed and updated annually by the quality coordinator in consultation with Ryan White staff and the QM Steering Committee.

H. Communication

Information will be communicated to providers on an ongoing basis, through the Quality Management Steering Committee meetings, STD/HIV and Viral Hepatitis Division - Statewide All Parts meetings with stakeholders, and at the HIV Planning Council meetings.

Capacity Building

Capacity Building

- The STD/HIV and Viral Hepatitis Division, HIV Care & Support Services have received technical assistance from the National Quality Center (NQC) beginning in January 2007. The technical assistance developed the STD/HIV and Viral Hepatitis Division, and the Ryan White Programs' capacity and quality management infrastructure. The Quality Management Coordinator continues to develop the necessary skills to manage the QM program for the Division. The STD/HIV and Viral Hepatitis division also continues to ensure that continuous medical education training opportunities are available, via the AETC, to providers. HRSA's Ryan White HIV/AIDS Program Center for Quality Improvement and Innovation (CQII) will be utilized and referenced as a resource for quality improvement training opportunities.

Acknowledgements

- Health Resources and Services Organization (HRSA)
- HRSA's Ryan White HIV/AIDS Program Center for Quality Improvement and Innovation (CQII)
- South Carolina Department of Health and Environmental Control (DHEC)

APPENDIX A:
2018 Part B Ryan White and HOPWA Reporting Schedule

Due Date	Report Description	Support Provided
12/19/2017-12/20/2017	RSR Error Identification and Correction Technical Assistance with DHEC	Contact Tangee Thomas for questions
01/16/2018	RW/HOPWA/MAI/EC/Special Projects/Rebates/Quarterly Expenditures Report for reporting period: 10/01/2017-12/31/2017	Contact Leigh Oden for questions
	NHAS and NHAS Carryover Expenditure Report for reporting period: 10/01/2017-12/31/2017	
01/19/2018	Begin to work on your RSR in accordance with the RSR TA Plan from DHEC	See RSR Technical Assistance (TA) Plan from DHEC on page 6-7 of this document describing RSR TA & timeline
02/05/2018	*Provide Enterprise* (*PE*) Ryan Services Report (RSR) Completion Reports and RSR Clinical Summary Report (preliminary for technical assistance only) due in the *PE* Secure Portal for reporting period: 01/01/2017-12/31/2017	See RSR Technical Assistance (TA) Plan from DHEC on page 6-7 of this document describing RSR TA & timeline
2/12/2018	RSR Technical Assistance Webinar for Providers (Mandatory participation for each RWB provider who has new staff submitting their RSR report).	Webinar log-in email will be forthcoming
02/12/2018-02/16/2018	RSR Staged Upload in EHB by Provider (Individual TA as needed and/or required) ***Must wait to be cleared to post by DHEC***	See RSR TA Plan from DHEC describing RSR TA process prior to posting and submission to HRSA
2/12/2018-2/16/2018	RSR Client Summary Report and RSR Clinical Summary due to **DHEC** via *PE* Secure Portal for reporting period: 01/01/2017-12/31/2017 (Due on the scheduled RSR Upload date)	Use instructions provided by DHEC and/or GTI
03/02/2018	Final date for RSR Provider Reports and Client Level Upload to be submitted directly to **HRSA** for reporting period: 01/01/2017-12/31/2017	See RSR TA Plan from DHEC describing RSR TA process prior to posting and submission to HRSA
03/15/2018	DHEC HOPWA-funded providers prepare for HOPWA Year-ending for reporting period: 04/01/2017-03/31/2018	HOPWA CAPER TA Plan will be provided from DHEC prior to submission
		Instructions to be provided by DHEC and/or GTI
04/16/2018	RW/EC/Rebate Year-end Programmatic Report and Narrative for reporting period: 04/01/2017-03/31/2018	Instructions to be provided by DHEC and/or GTI
	WICY Year-end Programmatic Report for reporting period: 04/01/2017-03/31/2018	
	RW/EC/Rebate Year-end Implementation Plan Report for reporting period: 04/01/2017-03/31/2018	
	RSR Client Summary Report for reporting period: 04/01/2017-03/31/2018	
04/30/2018	HOPWA CAPER for reporting period: 04/01/2017-03/31/2018	HOPWA CAPER TA Plan for DHEC-funded HOPWA providers will be provided prior to submission
		Instructions to be provided by DHEC and/or GTI

Due Date	Report Description	Support Provided
05/01/2018	RW/MAI/HOPWA/EC/Special Projects/Rebates/ Quarterly Expenditures Report for reporting period: 01/01/2018-03/31/2018	Contact Leigh Oden for questions
	NHAS and NHAS Carryover Quarterly Expenditure Report for reporting period: 01/01/2018-03/31/2018	
	RW/MAI/HOPWA/EC/Special Projects/Rebates Year-end Expenditures Report for reporting period: 04/01/2017-03/31/2018	
	NHAS and NHAS Carryover Year-end Expenditure Report for reporting period: 04/01/2017-03/31/2018	
06/29/2018	MAI Year-end Programmatic Report for reporting period: 04/01/2017-03/31/2018	Christal Davis will run data report and send to providers prior to report submission date
07/16/2018	RW/HOPWA/MAI/EC/Special Projects/Rebates/ Quarterly Expenditures Report for reporting period: 04/01/2018-06/30/2018	Contact Leigh Oden for questions
	NHAS Quarterly Expenditures Report for reporting period: 04/01/2018-06/30/2018	
October 2018 (TBD)	RW Part B Grant Application information due to **DHEC** for reporting period: Application for GY 2018-2019	More details forthcoming from DHEC
10/15/2018	RW/HOPWA/MAI/EC/Special Projects/Rebates/ Quarterly Expenditures Report for reporting period: 07/01/2018-09/30/2018	Contact Leigh Oden with questions
	NHAS Quarterly Expenditure Report for reporting period: 07/01/2018-09/30/2018	
10/31/2018	Annual Client Needs Assessment Survey Summary	Contact Leigh Oden with questions

APPENDIX B:
SC QM Performance Measures

	HIV Care Continuum	Target %	Measure	Numerator	Denominator
1.0	Linkage	30%	Percentage of patients with a diagnosis of Stage 3 HIV (AIDS) within 3 months of diagnosis of HIV	Number of persons with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12-month measurement period	Number of persons with an HIV diagnosis in the 12-month measurement period
2.0	Antiretroviral Therapy (ART)	95%	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year
3.0	Retention (Quality of Care)	95%	Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis (Use the numerator and denominator that reflect patient population.)	Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm	Denominator 1. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm, who had at least two visits during the measurement year, with at least 90 days in between each visit
4.0	Retention (Quality of Care)	65%	Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	Patients for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection. [NOTE: Results from the tuberculin skin test must be interpreted by a health care professional.]	All patients aged 3 months and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days in between each visit.
5.0	Retention (Quality of Care)	90% ongoing patients ———— 95% new HIV diagnosis	Percentage of adult patients with a diagnosis of HIV who had a test for Syphilis performed within the measurement year	Number of patients with a diagnosis of HIV who had a serologic test for Syphilis performed at least once during the measurement year	Number of patients with a diagnosis of HIV who: □ 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
6.0	Retention (Quality of Care)	80% ongoing patients ———— 95% new HIV diagnosis	Percentage of patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for Chlamydia, Gonorrhea & other STIs performed within the measurement year	Number of patients with a diagnosis of HIV who had a test for Chlamydia, Gonorrhea & other STIs performed at least once during the measurement year	Number of patients with a diagnosis of HIV who: □ 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
7.0	Retention (Quality of Care)	95%	Percentage of patients for whom Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV	Number of patients with a diagnosis of HIV who have documented HCV status in chart	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year
8.0	Retention (Quality of Care)	50%	Percentage of patients with a diagnosis of HIV and are high risk (MSM and/or current IDU) who had annual Hepatitis C (HCV) screening performed in the measurement year	Number of patients with a diagnosis of HIV with high risk factors of MSM and/or IDU, who had annual HCV screening performed in the measurement year	Number of patients with a diagnosis of HIV with high risk factors (MSM and/or IDU), who had a medical visit with a provider with prescribing privileges at least once in the measurement year
9.0	Retention (Quality of Care)	50%	Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B *(ever)*	Number of patients with a diagnosis of HIV with documentation of having ever completed the vaccination series for Hepatitis B	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year
10.0	Retention (Quality of Care)	75%	Percent of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year	Number of patients with a diagnosis of HIV who had an oral exam by a dentist during the measurement year, based on patient self-report or other documentation	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year
11.0	Retention (Quality of Care)	85%	Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year	Number of medical case management patients who had a medical case management care plan developed and/or updated two or more times which are at least three months apart in the measurement year	Number of medical case management patients, regardless of age, with a diagnosis of HIV who had at least one medical case management encounter in the measurement year
12.0A	Retention (Quality of Care)	75%	Percentage of patients, over the age of 24 months, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of patients with at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period compared to the last medical visit in the subsequent 6-month period	Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the first 6 months of the 24-month measurement period
12.0B	Retention (Quality of Care)	80%	Percentage of medical case management patients, over the age of 24 months, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of medical case management patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period	Number of medical case management patients, over the age of 24 months, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24-month measurement period

SC QM#	HIV Care Continuum	Target %	Measure	Numerator	Denominator
13.0A	Retention (Quality of Care)	25%	Percentage of patients, over the age of 24 months, with a diagnosis of HIV/AIDS who did not have a medical visit with a provider with prescribing privileges in the last 180 days of the measurement year	Number of patients who had no medical visits in the last 180 days of the measurement year	Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in the first 6 months of the measurement year
13.0B	Retention (Quality of Care)	20%	Percentage of medical case management patients, over the age of 24 months, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	Number of medical case management patients in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of medical case management patients, over the age of 24 months, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year
14.0A	Viral Suppression	85%	Percentage of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year	Number of patients with a viral load less than 200 copies/mL at last viral load test during the measurement year	Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year
14.0B	Viral Suppression	60%	Percentage of patients, over the age of 24 months, with sustained viral suppression (VL <200 for $\geq$ 2 years), who had at least 1 medical visit in the measurement year	Number of patients with most recent viral load test less than 200 copies/mL (VL<200) in the measurement year AND the prior measurement year	Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year
15.0	Antiretroviral Therapy (ART)	100%	Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year
16.0	Retention (Quality of Care)		Percentage of patients, over the age of 24 months of age, who have diagnosis of HIV with at least 2 viral load test during the measurement year	Number of patients who had at least 2 viral load test during the measurement year, including patients who are virally suppressed	Number of patients, over the age of 24 months of age, with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year

APPENDIX C:
SC QM ADAP Performance Measures

SC ADAP QM#	HIV Care Continuum	Target %	Measure	Numerator	Denominator
A-1.0	Antiretroviral Therapy ART	95%	Percent of SC ADAP applications approved or denied for new SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete application in the measurement year	Number of applications that were approved or denied for new SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete application in the measurement year	Total number of complete SC ADAP applications for new SC ADAP enrollment received in the measurement year
A-1.0a	Antiretroviral Therapy ART	5%	Percent of SC ADAP applications that were incomplete and returned to provider	Number of applications submitted to SC ADAP that were incomplete or incorrectly filled out	Total number of SC ADAP applications (complete or incomplete) for new SC ADAP enrollment received in the measurement year
A-2.0	Retention (Quality of Care)	85%	Percentage of SC ADAP enrollees who are reviewed for continued SC ADAP eligibility two or more times in the measurement year.	Number of SC ADAP enrollees who are reviewed for continued SC ADAP eligibility at least two or more times which are at least 150 days apart in the measurement year.	Number of clients enrolled in SC ADAP in the measurement year.
A-2.0a	Retention (Quality of Care)	5%	Percent of SC ADAP recertification that were incomplete and returned to provider	Number of recertification submitted to SC ADAP that were incomplete or incorrectly filled out	Total number of SC ADAP recertification (complete or incomplete) for continued SC ADAP enrollment received in the measurement year
A-2.0b	Retention (Quality of Care)	95%	Percent of SC ADAP recertification approved or denied for continued SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete recertification in the measurement year	Number of recertification that were approved or denied for continued SC ADAP enrollment within 14 days (two weeks) of SC ADAP receiving a complete recertification in the measurement year	Total number of complete SC ADAP recertification for continued SC ADAP enrollment received in the measurement year
A-2.0c	Retention (Quality of Care)	15%	Percentage SC ADAP enrollees who were closed for "no recertification" in the measurement year	Number of SC ADAP enrollees who were closed for "no recertification" in the measurement year	Number SC ADAP enrollees " in the measurement year
A-3.0	Antiretroviral Therapy ART	100%	Percentage of new anti-retroviral classes that are included in the SC ADAP formulary within 90 days of the date of inclusion of new anti-retroviral classes in the PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents during the measurement year.	Number of new anti-retroviral classes included into the SC ADAP formulary within 90 days of the publication of updated PHS Guidelines for the Use of Antiretroviral Agents in HIV-1-infected Adults and Adolescents that include new anti-retroviral drug class during the measurement year.	Total number of new antiretroviral classes published in updated PHS Guidelines during the measurement year.
A-4.0	Retention (Quality of Care)	100%	Percent of identified inappropriate antiretroviral (ARV) regimen components prescriptions that are resolved by the SC ADAP program during the measurement year.	Number of antiretroviral (ARV) regimen components prescriptions included in the US Public Health Service Guidelines, "Antiretroviral Regimens or Components That Should Not Be Offered At Any Time" and "Antiretroviral Regimens or Components That Should Not Be Offered for Treatment of Human Immunodeficiency Virus (HIV) Infection in Children" that are resolved by the SC ADAP program during the measurement year.	Number of inappropriate antiretroviral (ARV) regimen components prescriptions included in the US Public Health Service Guidelines, "Antiretroviral Regimens or Components That Should Not Be Offered At Any Time" and "Antiretroviral Regimens or Components That Should Not Be Offered for Treatment of Human Immunodeficiency Virus (HIV) Infection in Children" that are identified by SC ADAP

APPENDIX D:
Activity Schedule

Activities	Person Responsible	Frequency
Review QM goals and assess for relevance.	Ryan White Manager, QM Coordinator, ADAP Manager, Data Manager, and QM Steering Committee	Annually
Review mission and vision statement to determine relevance.	Ryan White Manager, QM Coordinator, ADAP Manager, and QM Steering Committee	Every 1-3 years
Approve and finalize QM plan	Ryan White Manager, QM Coordinator, ADAP Manager, and QM Steering Committee	Annually
Evaluate QM program	Ryan White Manager, QM Coordinator, ADAP Manager, Data Manager, and QM Steering Committee	Annually
Review epidemiological data to identify gaps in medical service delivery.	Ryan White Manager, QM Coordinator, Data Manager, and QM Steering Committee	Annually
Conducts needs assessments to identify gaps in supportive service delivery and coordinates these efforts in conjunction with assessments conducted by Part B.	Ryan White Part B Providers	Annually
Conducts client satisfaction surveys to determine quality improvement needs at the service delivery level.	Ryan White Providers	Ongoing
Engage in continuous performance measurement and quality improvement.	Everyone	Every 6-12 months
Review HIV/AIDS treatment guidelines to assure compliance with the best practices and standards of care.	Everyone	Ongoing