

# **CLINICAL QUALITY MANAGEMENT PLAN 2015 – 2017 PHOENIX ELIGIBLE METROPOLITAN AREA**



## **MARICOPA COUNTY RYAN WHITE PART A PROGRAM**

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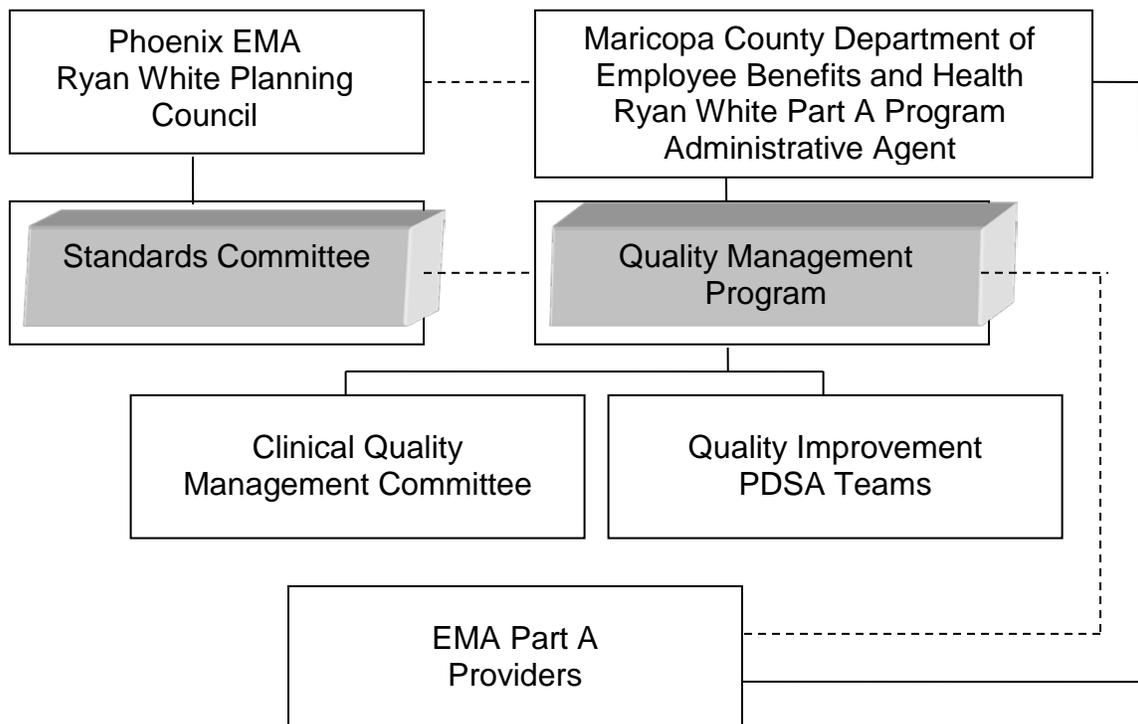
## Quality Statement

The Clinical Quality Management (CQM) program shall be a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to people living with HIV/AIDS (PLWH/A) throughout the Phoenix Eligible Metropolitan Area (EMA). The Ryan White Part A Program Administrative Agent (AA) will develop strategies to ensure that the delivery of services to all Ryan White Part A Program eligible PLWH/A is equitable and adheres to the most recent National Public Health Performance Standards (NPHPS) guidelines and clinical practice standards.

The purpose of the Quality Management (QM) Plan is to:

- Promote a commitment to quality of care throughout the Ryan White Continuum of Care
- Describe the EMA's QM infrastructure
- Identify strategic goals for each component of the Ryan White Part A QM program
- Guide the development of structured activities that will enhance the delivery of services to PLWH/A receiving care from all Ryan White Part A Program funded sub-recipients
- Communicate the roles, responsibilities, and expectations of the Ryan White Part A Program Administrative Agent staff and quality-related activities

## Clinical Quality Management Infrastructure



# Ryan White Part A Program Administrative Agent Quality Management Team

**TABLE 1. QM TEAM MEMBERS' POSITIONS AND FUNDING SOURCES**

Position	FUNDING SOURCE	FTE
Program Manager	RW Part A grant (QM)	.5
Grants Administrator	RW Part A grant (QM)	.75
Contract Supervisor	RW Part A grant (QM)	.25
Trainer	RW Part A grant (QM)	1.0
Care Continuum Coordinator	RW Part A grant (QM)	1.0
Program Assistant	RW Part A grant (QM)	.25

### **Program Manager:**

Provides administrative oversight and support to the QM program; The Program Manager is a registered nurse and provides clinical expertise to the QM team

### **Grants Administrator:**

Assists in developing or oversees goals and strategies for the HIV Care Continuum Plan; Development and implementation of metrics, interventions and partnerships for administration and QM; Implements best practices for the improvement of clinical health outcomes; Assists in monitoring sub-recipient compliance; Reviews instruments to ensure the information is collected consistent with sub-recipient contracts.

### **Contracts Supervisor:**

Assists in development of department goals and strategies relative to administration and QM activities; Completes quarterly contractor reviews and assists with annual site visit to ensure contract and sub-recipient compliance.

### **Trainer:**

Conduct onsite program monitoring, chart reviews and desk auditing of funded services to ensure compliance with EMA Standards of Care and other relevant federal, state and local regulations; Analyze chart review and client satisfaction data, analyzes outcomes data and integrates the data into reports; Provide education, training and technical assistance on all QM issues to EMA sub-recipients, Planning Council Members and related committees; Perform data analysis and develops reports to assist Grantee staff and sub-recipients in meeting grant goals and objectives; Handle client complaints to resolve quality of care issues; Coordinate and facilitates CQM meetings

**Care Continuum Coordinator:**

Responsible for developing goals, monitoring outcomes, and reporting on progress across the EMA as it relates to the HIV Care Continuum and the RWPA EIIHA Strategy; Manages the data management systems for RWPA, and provides technical assistance to sub-recipients related to data collection, analysis and reporting.

**Program Assistant:**

Provide clerical support for QM activities

**The CQM (Stakeholders Committee)**

The membership of the CQM Committee reflects the diversity of disciplines involved in the HRSA defined Ryan White Part A Program core and clinically related support services in the EMA. The committee structure consists of:

- (5) Part A Staff: Grants Administrator, Contracts Supervisor, Trainer, Care Continuum Coordinator and Program Assistant;
- (6) Part A Sub-Recipients: Physician (HIV Specialist to serve as Chairperson), Licensed Mental Health Professional, Dentist, Nurse, Nutritionist and Case Manager;
- (11) Part A Sub-Recipients: minimum of 1 representative from each sub-recipient dedicated to QM;
- (2) Part A Consumers: One Planning Council consumer and one community consumer;
- (2) Parts B & D Grantees: One Arizona Department of Health & Human Services Part B grantee & one Part D grantee.

The QM team will be responsible for assisting with the following list of activities:

- Quarterly meetings: to review system-wide CQM issues/challenges and development of strategies to improve care
- Annual meetings to: review site visit data related to quality measures, reports and other relevant data
- Identify EMA-wide quality initiatives and performance indicators and goals
- Review and recommend revisions of measures to reflect current US Health and Human Services (HHS) Treatment guidelines as well as federal and state regulations for HIV care and services,
- Review and revise assessment and data collection tools/protocols as necessary,
- Establish subcommittees as needed to address service specific quality issues,
- Plan and develop educational strategies for Part A-funded sub-recipients which may include grand rounds for HIV care and clinical updates according to HHS guidelines,
- Review and update the QM plan,
- Provide input into an annual evaluation of the HIV QM program conducted by the Grantee.

Distribute updated care continuums by service category and provider on a quarterly basis

The committee working process will be facilitated by the Ryan White Part A Program QM staff. Meeting minutes are recorded by the grantee administrative staff and distributed to all committee members prior to the next meeting.

## **Ryan White Planning Council**

Planning Council members work to set priorities and allocate resources to funded services categories for the Ryan White Part A program in the Phoenix EMA. Council members also evaluate the cost effectiveness and the quality of the services provided based on aggregate Continuum of Care and performance indicator data provided by the QM staff of the AA. The AA provides monthly administrative, fiscal and QM updates to the Planning Council to insure the Planning Council has adequate information for decision making.

## **Standards of Care Committee**

The Standards Committee is a subcommittee of the Ryan White Planning Council and is responsible for development of standards of care for funded Ryan White Part A program service categories. Members of the Standards Committee collaborate with the Ryan White Part A Program QM staff, service area experts and consumers to review aggregate data on clinical outcomes and service quality. This information helps to refine outcome targets defined within the standards of care and monitors service quality in the EMA.

## **Resources**

### **AIDS Education and Training Center (AETC)**

The AETC provides targeted, multi-disciplinary education and training programs for healthcare sub-recipients treating PLWH/A. These trainings include consultation and preceptorships for HIV care sub-recipients, presentations on updated clinical guidelines, information on new pharmaceuticals, and chronic disease management.

### **National Quality Center (NQC)**

The NQC provides focused quality improvement and QM technical assistance to the grantee and Ryan White sub-recipients. These trainings include but are not limited to QM planning, Continuum of Care implementation, assessments, training of trainers for quality improvement principles and quality leadership.

## Performance Measurement

### Compliance with National Public Health Performance Standards (NPHPS)

The goal of the Ryan White Part A Program's QM team is to ensure that PLWH/A in the Phoenix EMA receive the highest quality core and supportive services. To accomplish this, the AA QM team will ensure:

#### Goal:

1. Direct service medical sub-recipients adhere to established practice standards, (NPHPS) Guidelines and Planning Council expectations to the extent possible;
2. HIV-related supportive services focus on retention in care and viral load suppression as defined by the Continuum of Care;
3. Demographic, clinical and health care utilization information, as well as available health outcomes data, performance measures are used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic;
4. The existing QM infrastructure and QM plan are annually revised;
5. Technical assistance is provided to sub-recipients in the development/maintenance of their respective QM plans;
6. Compliance with HRSA/HAB Standards for core and support services;
7. Participation in consumer satisfaction survey by supporting the AA's chosen process; and
8. QA data is collected, maintained and shared with appropriate stakeholders.

**Table 2** provides an overview of the program's general performance measures within the framework. The table lists general performance measures in the column labeled Measurable Items. The information source for each measure is listed under Data Source. Both the AA and sub-recipients have distinct responsibilities in collecting and analyzing performance data. The role of the QM team in analyzing, reviewing, reporting and disseminating results is listed in the following table under Activities. Finally, the table includes the timeline for the activity in the column labeled Timeframe for performance measurement.

Table 2: Quality Management Activities				
General Performance Measurement Area	Data Source	Measurable Items	Activities	Time Frame
HRSA/HAB measures  Planning Council Standards of Care & Sub-recipient commitment and obligations	Annual Site Visit Reviews	one site review is conducted per year by QM team. See <b>Attachment #1</b> for performance measures	QM Team members will conduct site visit review for each category of service provided by each individual service sub-recipients including: Conditions of Award documents, Leadership Interview, QM Plan Assessment, complete agency questions and focused client chart reviews  Follow-up with agencies on findings.	Annually
Maintain Integrity of Quality Assurance Data	Quarterly CQM meetings	Number and type of trainings/technical assistance provided for CAREWare implementation and maintenance.  Number and type of trainings/technical assistance with	QM Team members facilitate contractor meetings where Part A Sub-recipients and the grantee share program updates, information, resources and data.  QM Team members and CAREWare consultant will provide TA on CAREWare	Quarterly
	Technical Assistance Services	Sub-recipients to support routine data collection methods for Part A data in the EMA.	Maintenance and customized data queries and reports, and data collection strategies to Part A sub-recipient.  Follow-up on all meetings and technical assistance as necessary.	Annually-as needed
Maintain and Share Quality Assurance Data	Variance Reports	Reports separated by service category, including: Unduplicated number of clients served; Number of service units provided; Total dollar amount spent.	QM Team produces and reviews reports to assess progress on meeting annual service category goals and budget. Report data to HRSA according to HRSA schedule Provide aggregate reports and recommendations to Planning Council as needed.	Quarterly

<b>Table 2: Quality Management Activities</b>				
<b>General Performance Measurement Area</b>	<b>Data Source</b>	<b>Measurable Items</b>	<b>Activities</b>	<b>Time Frame</b>
Maintain and Share Quality Assurance Data	Annual Client Services Data Review	The proportion of clients served and the proportion of services provided equals or exceeds racial/ethnic minority representation in the local epidemic.	QM Team analyzes and produces Annual Client Services Data Report	Annually
	RSR	The proportion of clients served and the proportion of services provided equals or exceeds female representation in the local epidemic.	Report findings are presented to the CQM Committee	
		Clients have demonstrated need (as defined by other client characteristics: %FPL, permanent housing status, insurance status, etc.).	Follow up with sub-recipients as needed.	
		New clients are served in core service areas.	Provider results to PSRA	
Enhance consumer satisfaction	Client Satisfaction Forums and Surveys	Targeted client satisfaction indicators	Client Satisfaction Forums are conducted for service categories by independent sub-recipients.	Annually
		Themes for suggested service changes identified during annual PSRA process.	Identified and acted upon during PSRA Process.	
		Needs Assessments / Special Studies	QM Team conducts analyses, reviews results and provides suggestions/TA for improvement activities for each sub-recipient	

## Participation of Stakeholders

While the CQM committee provides leadership for QM initiatives, the primary goal is to provide a coordinated, comprehensive, and continuous effort to monitor and improve the quality of care provided to PLWH/A throughout the Phoenix EMA; therefore, their input is critical to every stage of planning, implementation and evaluation.

**Table 3** lists the various stakeholders involved in CQI activities, along with the type and level of involvement each has with the CQM process.

Stakeholder	Type of Involvement
Clients	Inform CQM committee make suggestions; evaluate.
Sub-recipients:	<p><i>System wide program</i> Inform, participate in decision making about system-wide improvement.</p> <p><i>Individual contractor initiatives</i> Design own CQI initiatives Meet contract deliverables and PDSAs.</p>
Planning Council	Collaborate with QM Committee, Support the development and approval of Standards of Care.
AZ Regional Quality Group	Collaborate with CQM committee to support system wide initiatives
HRSA	Establish guidelines/standards for performance and program compliance

## Evaluation of Quality Improvement (QI) Activities

The CQM Committee ensures that activities are effective and successfully identify areas in need of improvement, assessment of possible changes, and evaluates the results of those changes in program implementation. The purpose of evaluating QI and QM activities focuses on three areas:

- evaluating the effectiveness of the CQM infrastructure to decide whether process improvement is needed;
- reviewing performance measures to document whether the measures are appropriate to assess clinical and non-clinical HIV care; and
- evaluating CQI activities to determine whether the annual quality goals for QI activities are met.

Several mechanisms, as described below (**Table 4**), are available to evaluate the effectiveness of CQI activities and objectives.

<b>Table 4: Evaluation Clinical Quality Improvement Activities</b>			
<b>Evaluation Area</b>	<b>Activities</b>	<b>Materials</b>	<b>Method/ Timeframe</b>
Assess effectiveness of CQM structure	Assess program based on NQC Quality Management Organizational Assessment	NQC Quality Management Organizational Assessment Tool	Annually
Review Performance Measures	Review CQM Plan with the Clinical Quality Management Committee.	CQM Plan	Annually
Evaluate CQI activities	Review site visit protocols. Review contract language.	Site visit report protocols Site visit reports and follow-up report	Annually

The CQM Committee meets annually to review the CQM plan and set goals and objectives for that year. Prior to this meeting, the committee solicits feedback from local sub-recipients, cross-title administrators and community members in developing clinical and non-clinical measures that best assess the capacity of the Part A continuum to provide quality health and service outcomes for clients. The committee reviews the results, infrastructure and activities from the previous year, as well as any timely literature and HRSA guidance to ensure that the measures selected are sound and meet local and national standards. High-level analytical technical assistance is sought, when needed, from staff from the AETC and NQC to ensure that data collection/analyses methodology reflect the best scientific practice. The committee also identifies the ongoing responsibilities of each committee member to guarantee that the CQM plan can be effectively implemented and identifies any gaps in capacity and assigns duties accordingly.

The CQM committee meets quarterly to review progress made on the implementation objectives and performance measures outlined in the current CQM plan. The QM team reports and solicits additional feedback on changes to performance measures at CQM Committee meetings and at Planning Council meetings, sub-recipient meetings, and at other system-level meetings.

The QM team produces an annual report detailing aggregate results of the CQM outcomes and other performance measures.

## **Capacity Building**

The Ryan White Part A Program AA conducts the following capacity building activities:

- Annual completion and reporting of NQC Organizational Assessment Tool results for each sub-recipient (Attachment # 3).
- The QM team participates in the NQC and other Ryan White QM trainings offered for grantees as needed.
- Connection to AETC for any new sub-recipients and/or core service sub-recipients.
- Monthly solicitation of TA needs is gathered in the monthly billing.
- Ongoing CAREWare trainings for all sub-recipients and established protocol for setting up new sub-recipients in CAREWare.

- Quarterly Continuum of Care reports are provided to sub-recipients by service category delivery model improvements which involve representation from multiple contracts and sub-recipients.

## Process for Updating QM Plan

The QM team is responsible for reviewing the CQM plan on an annual basis and updating the plan every two years. Once the team has conducted a thorough evaluation of the previous year's CQM plan (see Evaluation of CQI Activities above), revisions will be made when needed to update the current CQM plan. Consistent feedback provided by key stakeholders to the QM team throughout the course of the year is integral to this process (see Participation of Stakeholders and Communication above). The appropriateness of quality measures, in addition to staff and local sub-recipient capacity and infrastructure are weighed against the need to continue collecting data. Once the current QM plan is updated, this plan is distributed to the CQM Committee for final revisions and endorsement.

## Communication

The QM team believes that the sharing of information serves to strengthen our relationships and helps to provide services more effectively to people affected by HIV/AIDS:

- Reliable data is important because it provides transparency and accountability regarding what services are being offered and how effective the services are.
- The CQM plan ensures that those who provide information should understand how the data is used.

**Table 5** outlines regular communications with stakeholders, the frequency of the communication and the method:

<b>Table 5: Outline of Regular Quality Management Communications</b>			
<b>Information</b>	<b>Stakeholder</b>	<b>Frequency</b>	<b>Method of Sharing Information</b>
QM Plan	HRSA Planning Council Sub-recipients	Annually	Written document and presentation Website publishing
Standards of Care	HRSA Planning Council Sub-recipients Client	Monthly or as needed	Oral and written documents and presentations as appropriate Website publishing
Service-specific Outcome Reports	HRSA Planning Council Sub-recipients Client	Annually	Annual Report
Annual Site Reviews	Sub-recipients HRSA	Annually after review	Annual Report
Monthly Service Reports	HRSA Project Officer	Monthly	Quantitative and narrative reports
Evaluation of Administrative Mechanism	HRSA Planning Council	Annually	Narrative Report

## CQM Plan Implementation/Process

System-wide CQI activities include: CAREWare data collection and distribution of client satisfaction results. The QM team works with individual sub-recipients to develop and implement CQI initiatives, including specific program outcomes. Following the Plan-Do-Study-Act (PDSA) model, sub-recipients provide a narrative that identifies the problem, outlines the QI plan, and explains methods to assess the impact of the change.

Throughout the contract cycle, sub-recipients submit monthly client level service data and invoices. Monthly service utilization reports are then generated, and any concerns with sub-recipients are addressed. Data from these monthly reports facilitate ongoing dialogue about the sub-recipients' progress on meeting their deliverables and their progress on CQI activities. These reports also identify systemic issues that need to be addressed.

**Table 6** provides general information on each activity, including the purpose, plan of action, leadership, timeline, and long-term goal associated with each activity.

**Table 6. QM Plan Implementation Activities and Timeframe**

Activity	Purpose	Plan of Action	Leadership	Timeframe	Long-Term Goals	GY15	GY16	GY17
6a. Contract negotiation, implementation and review.	<i>Quality Assurance:</i> Contracts and annual budgets are in place and funds are let in a timely manner, ensuring funding allocation to areas of greatest need and non-disruption of service delivery.	Review contractor data, standards and guidance to develop contracts and request for proposals.  Meet with sub-recipients to negotiate annual contracts, based on program reviews.  Produce and review routine financial and service reports and logs to monitor contractor progress in meeting contract requirements.	Program Manager & Supervisors	By the start of the contract year  Follow-up as needed	Establish an efficient contracting process that allocates funds equitably.  Maintain current contract standards that meet professional standards of the service categories.			
6b. Community HIV Planning	<i>Communication:</i> Planning Council is provided with the information needed to make data-driven priority setting and resource allocation decisions.	Participate in PC committee meetings.  Provide PC with timely data through presentation, reports, and ongoing communication.	Program Supervisors, QM Team & Consultants	Monthly	Continue to build a productive relationship with the Planning Council, the community served and sub-recipients through informed, fair, and transparent practices.			
6c. CQM Committee	<i>Evaluation and Communication:</i> The CQM committee will review the progress of the CQM program and approve objectives for future year.	Annually set thresholds for QM goals.  Annually review CQM Plan.	QM Team & Consultants	Annually	Knowledgeable committee that reviews EMA progress analyzes data and determines gaps to focus on.			
6d. Review data points associated with all measures being collected	<i>Quality Improvement:</i> Clear practical and identifiable program activities and accountability are outlined for sub-recipients.	Systematically review data points across all Part A funded service categories.  Research and develop new data points, as needed.	Program Supervisors & QM Team	Quarterly	Clear, concise and current data points are maintained.  Contracts reflect appropriate performance measurements.			

**Table 6. QM Plan Implementation Activities and Timeframe (cont.)**

Activity	Purpose	Plan of Action	Leadership	Timeframe	Timeframe			
					GY15	GY16	GY17	
<b>Long-Term Goals</b>								
6e. Annual Program Assessment	<i>Evaluation and Communication:</i> Planning Council and sub-recipients have access to comprehensive, critical information to use in planning and delivery of Part A services and activities.	Develop and analyze processes and outcome measures for specific programs and across Part A programs.  Review annual program assessment data with CQM Committee	Program Supervisors, QM Team & consultants	Annually	Continue to share timely, relevant information to assist in providing services more effectively to PLWH/A.			
6f. Ryan White Client Level Data Reporting	<i>Quality Improvement and Assurance:</i> Sub-recipients and HIV Care Services have the tools and resources needed to effectively measure program progress and client outcomes.	Install CAREWare at each contractor agency, either as the agency's client management system or as a tool for transferring data from local system.  Provide training or technical assistance as needed.	Program Supervisors, Trainer & consultants	Ongoing	Continuous development and enhancement of web-based data collection system allowing Part A-funded sub-recipients to share client information and promote efficient care coordination.			
6g. PDSAs	<i>Quality Improvement:</i> Sub-recipients are engaging in an activity to enhance the quality of services provided and client outcomes.	Provide technical assistance on the Plan-Do-Study-Act (PDSA) model and QSI development.	Program Supervisors, Trainer	Quarterly	QM tools, such as the use of PDSA cycles are normalized as a part of providing services.			
6h. Site Reviews	<i>Quality Assurance:</i> Sub-recipients are providing high-quality services in accordance with the Part A Planning Council Standards, HRSA Monitoring Standards, and NPHPS Guidelines.	Meet with sub-recipients to conduct site visit review for each category of service provided including: Conditions of Award documents, Leadership Interview, QM Plan Assessment, complete agency questions and focused client chart reviews.  Produce site visit reports to provide sub-recipients with feedback, corrective action plans, and technical assistance.	Program Supervisors & Consultants	Ongoing (according to schedule developed annually)	Ensure that sub-recipients are providing high quality care according to established standards in an efficient manner that provides solid data for measuring quality of care.			

**Table 6. QM Plan Implementation Activities and Timeframe (cont.)**

Activity	Purpose	Plan of Action	Leadership	Timeframe	Long-Term Goals			
					GY15	GY16	GY17	
6i. Client Satisfaction Survey	<i>Quality Improvement.</i> Clients are satisfied with contracted services.	Analyze survey data and compile findings for each sub-recipient to utilize in identifying future QI initiatives.	Program Supervisors, QM Team & Consultants	Annually	Measure client satisfaction across all Part A services and identify areas of improvement and service gaps.			

## **Conclusion**

The purpose of this clinical QM plan is to improve the quality of care provided to PLWH/A in the Phoenix Area EMA. The plan addresses both quality assurance and QI initiatives on the part of the Grantee in our work with sub-recipients, and on the part of sub-recipients in their work with clients. In GYs 2015 – 2017, the Part A QM team will use this plan to guide our work and measure its impact. Upon seeing the results, any necessary changes to the plan or to the measures will be made to ensure that both remain relevant and effective.

## Attachment # 1. 2015 – 2017 Ryan White Part A Quality Management Chart Review Questions and Health Outcomes Program Specific Health Outcomes

*All indicators are HRSA or Planning Council Standards of Care, are measured annually and follow HRSA Guidelines Quality Management review completed during site visit with expected percentage of health outcomes*

<b>SERVICE CATEGORY</b>	<b>QUESTIONS</b>	<b>% of clients</b>
<b>Early Intervention Services (EIS)</b>	01. Documentation of client education provided concerning HIV disease process, risk reduction and maintenance of immune system.	90%
	02. Client had their first medical visit and CE appointment within 90 days of EIS intake.	90%
<b>Food Boxes</b>	01. Food vouchers distributed to client are recorded in the food voucher log.	100%
	02. Client received counseling related to access to other community resources for nutritional support.	90%
	03. Client had at least 1 documented medical visit within 6 months of measurement year.	90%
	04. Client maintained or improved nutritional state.	50%
<b>Health Education/Risk Reduction</b>	01. Client demonstrated higher level of HIV health literacy after completing HERR session.	75%
<b>Health Insurance Premium &amp; Cost Sharing (HIPSCA)</b>	01. Client's benefits were coordinated with 3rd party payer benefits.	100%
<b>Housing</b>	01. Client's rental payment was made to appropriate vendor.	75%
	02. Client's rental check was issued within 7 days of approved request.	75%
<b>Medical Nutrition</b>	01. Completed medical nutrition assessment.	90%

	02. Completed Nutritional Plan.	90%
	03. Updated Nutritional Plan at least annually.	90%
	04. Nutritional plan assessment includes client weight, BIA and dietary intake.	90%
	05. Nutritional plan assessment considers client's individual medical needs.	90%
	06. Maintained or improved BIA.	50%
<b>Psychosocial Services</b>	01. Primary care discussions are included in regularly offered sessions at least quarterly.	75%
	02. Client completed a post session survey after every session,	75%
	03. Support group log reflects documentation of topic with the sign in sheet.	100%
<b>Treatment Adherence</b>	01. Client's viral load decreased after participating in TA services.	75%
<b>Medical Transportation</b>	01. Policies for accessing medical transportation were explained.	90%
	02. Transportation referral completed within 3 business days.	90%
	03. Transportation was provided to client in timely manner and met client's needs.	90%
<b>Oral Health -Dental Insurance</b>	01. Client had a periodontal screen or examination at least once in the grant year.	75%
<b>Oral Health -Direct Dental</b>	01. Baseline health history is documented consistent with ADA guidelines.	75%
	02. At least 1 periodontal screen or exam within the grant year.	75%
	03. Treatment plan initiated within the grant year.	50%
<b>Non-Medical Case Management</b>	01. Completed Intake Assessment ( <i>Central Eligibility only</i> )	90%
	02. Appropriate referrals were made.	90%
	03. Client contacted within 10 days of client request or referral.	90%
	04. If contact did not occur, documentation as to reason for no contact.	90%

	05. Appropriate encounter documentation.	90%
	06. Supervisor reviewed charts have all required components.	90%
	07. Appropriate documentation of care closure, as appropriate.	90%
<b>Medical Case Management (MCM)</b>	01. Client had medical appointments within 3 months of initial assessment.	90%
	02. Quarterly contact with client is documented by Medical Case Manager.	90%
	03. Treatment Adherence was discussed with client.	80%
	04. Client had comprehensive assessment completed.	90%
	05. A comprehensive individualized care plan was completed.	100%
	06. Clinical Care Team is identified with contact information available.	90%
	07. Medical Case Management contact occurred within 3 business days of referral.	90%
	08. MCM assessment and care plan was completed within 10 days of MCM assignment.	90%
	9. At least one face to face contact annually occurred.	90%
	10. Documentation of contacts with client discuss progress towards goals and status of referrals.	90%
	11. Supervisor reviewed charts have all required components.	90%
	12. Case closures were completed, as appropriate.	90%
<b>Mental Health Services</b>	01. Mental health appointment was scheduled within seven working days of request for services.	70%
	02. Comprehensive assessment initiated within seven days of intake.	70%
	03. Treatment plan was completed within 90 days of first visit.	70%
	04. Progress notes are legible, signed and dated.	70%
	05. Discharge planning was documented within 30 days of treatment goals being met or client contact ended.	70%
	06. If accessing psychiatric care, client is medically adherent and engaged in their psychiatric treatment plan.	70%
	07. Client was assessed and verified for engagement in care initially.	70%
	08. Client was reassessed and verified for engagement in medical care twice annually.	70%

<b>Outpatient Ambulatory Medical Care</b>	01. Client had 2 or more HIV viral loads annually.	75%
	02. Client received health assessment and comprehensive physical exam, including screening for clinical depression and substance use/abuse history.	75%
	03. If newly diagnosed, client received an HIV drug resistance test.	75%
	04. If client meets current guidelines for ART, they were offered and/or prescribed ART.	100%
	05. Client had one medical visit in each 6 month period of the 24-month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequent 6-month period.	75%
	06. If client has CD4 count below 200, they are being recommended and/or prescribed PCP prophylaxis.	75%
	07. If client is on ART, lipid screen was completed annually.	75%
	08. Client was screened for syphilis annually.	75%
	09. Client was screened for chlamydia annually.	75%
	10. Client was screened for gonorrhea annually.	75%
	11. Client was screened for hepatitis A, B, and C, if not immune.	75%
	12. If client is high risk, screening for hepatitis A, B and C completed annually.	75%
	13. Client was screened for TB at least once since diagnosis.	75%
	14. If female, client received annual pap smear.	75%
	15. If client is hepatitis C positive, client has been evaluated or referred for treatment suitability.	75%
	<i>Client has received the following vaccinations or has documented decline on file:</i>	
	16. Influenza.	75%
	17. Pneumococcal, as appropriate.	75%
	18. Completion of hepatitis A vaccine series, unless otherwise documented as immune.	75%
	19. Completion of hepatitis B vaccine series, unless otherwise documented as immune.	75%
	20. Tetanus.	75%

	21. HPV, as appropriate.	75%
	22. Client has assessment of treatment adherence documented at a minimum of twice a year.	75%
	23. If treatment adherence issue is identified, follow-up action is documented.	75%
	24. A risk behavior assessment is on file, along with risk reduction counseling documentation.	75%
	25. Client was screened and received tobacco cessation counseling annually or documented decline of counseling is on file.	75%
<b>Substance Abuse Questions</b>	01. Case conference with members of client's multi-disciplinary team documented in chart.	70%
	02. Appointment scheduled within 7 days of request.	70%
	03. Intake process includes appropriate screening documentation.	70%
	04. Initial assessment completed and provided to the client.	70%
	05. Completed psychosocial history is on file.	70%
	06. Treatment plan completed no later than 7 days after admission.	70%
	07. Updated treatment plans midway through treatment or least every 12 sessions are on file.	70%
	08. If family participation is noted, appropriate documentation of their participation in service planning for the client's needs is on file	70%
	09. Case closure or reason for discharge is on file, as appropriate.	70%

## **Attachment #2– Standards of Care**

*All indicators are HRSA or Planning Council Standards of Care, are measured annually and follow HRSA Guidelines.*

<http://www.maricopa.gov/rwpc/docs/SOC/StandardsOfCarebook.final.2015.pdf>

## **Attachment #3– Organizational Assessment**

*All Sub-recipients are annually required to complete and report their results from the NQC Organizational Assessment Tool.*

<http://nationalqualitycenter.org/files/part-a-oa-rev-14-pdf/>