HIV Care & Treatment
QUALITY MANAGEMENT PLAN

2022-2023
Last revision: 07/13/2022

QUALITY STATEMENT

The Oregon HIV Care and Treatment Program (HCT) is committed to developing, evaluating and continually improving a statewide, quality continuum of HIV care, treatment and support services that meets the identified needs of persons living with HIV and their families, ensures equitable access and decreases health disparities.

The HCT supports this mission by gathering data and information about the services delivered by HCT and its contractors, analyzing this information to measure outcomes and quality of services, reporting this analysis in order to identify areas requiring needed planning, and implementing improvement activities in order to meet program goals.

QUALITY MANAGEMENT INFRASTRUCTURE

The HCT is comprised of the HIV Community Services Program and CAREAssist, the state's AIDS Drug Assistance Program, and supervised by the HCT Program manager. The HCT program managers are responsible for providing staff management and program oversight to ensure quality management activities are implemented per the program's annual Quality Management Plan (QMP) and ensures quality assurance and improvement activities meet the expectations of funders. The coordinator of the quality management program, the HIV Quality Improvement Strategist, is responsible for convening the program's Quality Management Committee (QMC), participating in statewide quality improvement planning, implementing the program's QMP, monitoring and presenting outcomes and recommending improvement strategies. In addition, this position is responsible for coordinating contractor monitoring activities to include conducting site reviews, reviewing and following up on contractor reports and monitoring data quality. The HCT CAREAssist and HIV Community Services Coordinators are responsible for participating as members of the program's quality management committee to ensure program activities are aligned with the HCT program's QMP. In addition, these positions and the HIV Care and Treatment Data Analyst participate in contractor compliance activities, quality assurance, and quality improvement related training and technical assistance. The HCT's Financial Operations Analyst is responsible for monitoring fiscal compliance, to include monitoring budgets, expenditures and conducting financial site reviews.

Coordination of QMP activities also occurs with other Oregon Ryan White grantees through the Statewide Quality Management Committee (SQMC), as explained below.

Quality Management Committees

The HCT QMC membership is comprised of individuals who have different responsibilities in the development, implementation, evaluation and support of the QMP. Each member serves an important role in helping ensure accountability and standardization of efforts, identifying gaps in care and fostering collaboration and sharing of knowledge. Members of the QMC are expected to participate in at least quarterly meetings.

The following table describes the current and potential membership of the QM Committee.

Program Representation/Role	Resource/Area of Expertise	Current Status
HIV/STD/TB Section Manager	Oversight and responsible for supervision of HIV, STD, TB programs in State of OR Public Health Department.	Participates as needed/requested
HCT (CAREAssist and HIV Community Services) Program Managers	Oversight and responsible for supervision of the HIV Care and Treatment Program, State of OR Public Health Department (CAREAssist ADAP and HIV Community Services).	Participating.
HIV Quality Improvement Strategist	Quality management, compliance, data quality, and contract monitoring for the HCT program. Conducts site visits for the HIV Community Services (HCS) Ryan White Part B subrecipient and service contractors.	Participating.
HIV Community Services Coordinator	HCS client services (HIV Case Management Standards of Services and support services guidance), special projects, contractor training and education, report submission.	Participating.
CAREAssist Coordinator and Program Analyst	CAREAssist policies and procedures, data collection, special projects, contractor training and education.	Participating.
HIV Care and Treatment Data Analyst	CAREWare database administration and generating reports.	Participating.
Oregon Housing Opportunities Program (OHOP) Housing Coordinator	Ryan White Part B Programs Housing Programs services and ServicePoint data collection and reporting	Participates in workgroups and on QMC as needed/requested.

OHOP Support Specialist	OHOP data collection and reporting.	Participates as needed/requested.
Financial Operations Analyst	Fiscal compliance including monitoring, analyzing and reporting of budgets and expenditures. Conducts contractor financial site reviews.	Participates in contract workgroup as needed and in QMC as needed/requested.
Information Technology Dept. (OIS)	Database support for CAREWare and CAREAssist database.	Participates as needed/requested.
Program Liaison, Program Design & Evaluation Services	Provides evaluation and reporting for the HCT program.	Participates in workgroups and in QMC as needed/requested.
HIV Surveillance	Compile lab files for uploads into database systems (CAREWare and CAREAssist), as well as provides Surveillance data and reports annually and as requested.	Participates in workgroups and QMC as needed/requested.
HIV Consumer Representative	Person/s living with HIV/AIDS.	Participates in the End HIV/STI Oregon Statewide Planning Group (formerly known as IPG), and the CAREAssist Advisory Board (CAB).

Oregon HIV Statewide Quality Management Committee (SQMC)

After much discussion over three months in latter 2021 with Part A and Part B leadership and SQMC representatives, SQMC decided to shift committee structure and focus, revising the charter and membership. Starting with the March 2022 meeting, SQMC now focuses solely on quality management activities among Ryan White (RW) funded programs. This narrower SQMC focus and membership allows us to better concentrate and move forward improvement planning efforts within our HIV care service programs. We hope that by maintaining our excellent individual relationships and coordination efforts with Prevention, EISO, Surveillance, Integrated Planning, End HIV, and other community partners, we will continue to align SQMC's RW quality improvement goals with those that support the End HIV Oregon vision of the health of our clients and communities.

SQMC Purpose: To provide a forum for collaboration among Ryan White HIV services programs on quality management metrics, measurement, policies, procedures, and programs, supporting Oregon's End HIV goals.

SQMC Responsibilities: The HIV Statewide Quality Management Committee (SQMC) helps guide individual Ryan White HIV services programs in developing, implementing, and monitoring the Ryan White quality management activities to support shared, statewide End HIV Oregon goals. Specific activities include:

- Share information about the quality management activities of individual Ryan White programs in Oregon.
- Discuss, develop, and monitor shared Ryan White metrics for measuring progress, goals, objectives, and activities.
- Share information on best practices for gathering and reporting on measurement data.
- Provide expertise and information about emerging trends related to HIV care and treatment and quality improvement initiatives.
- Contribute data for a Ryan White cross- part quality management report and share cross-part Ryan White data and/or information with community partners.

SQMC Membership:

- The group will be co-chaired by Ryan White Part A and Part B Quality Management staff.
- Members will primarily include those responsible for quality management activities in their respective agencies. Others with interest in or experience with performance management/measurement may be included, at the discretion of the Committee Chairs.
- Members will be representative of at least Part A, Part B, and Part C/D programs. Additional members or participants may include Surveillance, HIV prevention, Part F (AETC), and other key partners, as needed.

SQMC Meeting Schedule/Time Commitment:

- Quarterly 2-hour meetings
- Additional ad hoc meetings and project work, as needed (e.g., quality improvement project participation, data analysis, and other training opportunities)

SQMC Deliverables:

- Deliverables will be established annually.

SQMC QI Collaborative

Although care provider agencies (Ryan White subrecipients/subcontractors) and SQMC agency leadership had agreed to participate in a SQMC supported QI collaborative based on survey results from November-December 2020, providers do not currently have the ability to participate due to staffing capacity issues and most case management agencies just now returning to the office due to the COVID

pandemic. SQMC therefore decided to continue to engage our providers and re-evaluate their capacity to participate in the QI Collaborative in 2023. SQMC further agreed to the following:

- Postponement of a cross-Part collaborative does not preclude any Part or Ryan White provider/program from piloting QI project(s) related to Social Determinants of Health (e.g., improving client food/housing security) in 2022, if applicable.
- All agreed this timeline will also allow more time for the End HIV Oregon goals to be established and/or strategies identified regarding food security and housing.
- The Part B Case Management Task Force will meet in Spring 2023 and may have further suggestions regarding the July 2022 addition of food security questions to client forms and planned trainings. The new timeline will align with these efforts.
- While no formal consensus reached, general agreement that a minimum number of QI Collaborative participants would best support the effort of developing and initiating a formal QI Collaborative. However, SQMC could still provide support and technical assistance in a less formalized structure to providers, if that is what best fit need and capacity in 2023.

The following SQMC performance measures were revised June 22, 2022 to better align with SQMC's new charter.

- Performance Measure outcomes are compiled by the State of Oregon Public Health HIV Surveillance team annually in June
- SQMC reviews annual performance measure data in the summer quarterly meeting.

Oregon HIV Statewide Quality Management Committee (SQMC) – **PERFORMANCE MEASURES**

DIAGNOSED		LINKED TO CARE	RETAINED IN CARE	VIRALLY SUPPRESSED
PM 1: **Goal: 15%** **Late – Delayed HIV Diagnosis** (HIV Diagnosis and time to AIDS) *Numerator*: Number of people with late diagnosed HIV in CY in the jurisdiction based on residence at time of diagnosis. *Denominator*: Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining conditions <= 3 months (90 days) after a diagnosis of HIV infection. Note: calculating delayed diagnosis, don't include day 0- the day of diagnosis, count the day after Dx: within 1-30 days or 0-90 days.	NEWLY DIAGNOSED	**PM 2** (*formerly PM 3*)**:** **Goal: 95% (by 2025)** **Newly diagnosed PLWH are in care within 30 days, as defined as having CD4 or VL test after date of diagnosis.** *Numerator*: The number of individuals diagnosed with HIV in the past year with 1 CD4 or VL test at least 1 day after their diagnosis date that is within 30 days of their diagnosis date. *Denominator*: The number of all newly diagnosed individuals with HIV (DX code=900) in the CY, as indicated in ORPHEUS. **PM 3** (formerly PM 4): **Goal: 100% (BY 2025)** **Newly diagnosed PLWH are in care within 90 days, as defined as having a CD4 or VL after date of diagnosis.** *Numerator*: The number of individuals diagnosed with HIV in the past year with at least 1 CD4 or VL test after their diagnosis date that is within 90 days of their diagnosis date. *Denominator*: The number of individuals diagnosed with HIV (dx code=900) in the CY, as indicated in ORPHEUS.	**PM 5:** **Goal: 90%** **Newly diagnosed PLWH with at least one VL or CD4 count within 12 months after first CD4 or VL test after diagnosis.** *Numerator*: The number of individuals diagnosed with at least 1 CD4 or VL test within 12 months after their 1st CD4 or VL test after diagnosis in CY. *Denominator*: The number of individuals diagnosed with HIV (dx code=900) in the CY, as indicated in ORPHEUS.	**PM 7** (*formerly PM 9*)**:** **Goal: 80%** **# of newly diagnosed PLWH in the CY whose most recent VL result is suppressed (under 200).** *Numerator*: The number of individuals diagnosed in the CY whose most recent viral load result within 12 months is <200 copies per ml (suppressed) *Denominator*: The number of people who are diagnosed with HIV past year and believed to be living in Oregon.
	ALL PLWH	**PM 4:** **Goal: XX%** **Out of Care – Linkage to Care** *Numerator*: *Denominator*: Challenges to identifying the N/D: • What is the definition for falling out of/not in care? • We will discuss/decide this PM later, once the above question has been determined.	**PM 6:** **Goal: 100% by 2025** **# of PLWH with at least 1 VL or CD4 test in the past year.** *Numerator*: The number of individuals that have had at least 1 VL or CD4 count within 12 months. *Denominator*: The number of people who are diagnosed with HIV and believed to be living in Oregon.	**PM 8** (*formerly PM 10*)**:** **Goal: 95% by 2025** **# of PLWH whose most recent VL result is suppressed (under 200).** *Numerator*: The number of individuals whose most recent viral load result in the calendar year is <200 copies per ml (suppressed) *Denominator*: The number of people who are diagnosed with HIV and believed to be living in Oregon.

Oregon HIV Statewide Quality Management Committee (SQMC)

Agenda Meeting Cycle 2022-2023

Purpose: this agenda meeting cycle provides structure, coordination, and consistency and ensures topics for the year for each quarterly meeting are agreed upon and approved by SQMC prior to the meetings.

Meeting Timelines	Agenda Items	SQMC Meeting Outcomes/Purpose	SQMC Roles & Responsibilities: New Charter Alignment
Summer 2022 (end of July)	• Cross Parts and State SQMC Performance Data Review ○ Key community partner annual dissemination report out points w/PM • Current QI initiatives to address trends • Set cross-part improvement priorities for the year	• Identify any upwards and/or downward PM trends within the RW care continuum • Discuss any QI efforts within RW programs to address trends and where/if there is alignment across any CQM plans or initiatives to consider • Discuss any potential future improvement efforts necessary to impact trends • Develop annual report key points with PMs	• Contribute data/information for a Ryan White cross- part quality management report • Discuss and develop shared Ryan White metrics for measuring progress • Share information about quality management activities
Fall 2022 (end of Oct)	• Current RW QI initiative and/or quarterly data progress updates from individual programs ○ What's been working and what hasn't • Any cross-Parts QI initiatives alignment or collaboration considerations • Any additional CQM resource needs, training, and/or guest speakers (e.g., CQII, consumer involvement, etc.)	• Discuss progression on individual RW Parts CQM Plans • Share expertise and advice around challenges and successes • Identify improvement efforts that could be made more robust with additional collaboration between RW Parts • Identify additional cross Parts CQM areas that could be strengthened (e.g., consumer involvement/feedback, etc.)	• Share information about quality management activities • Provide expertise and information about emerging trends related to HIV care and treatment and quality improvement initiatives • Share information on best practices

Meeting Timelines	Agenda Items	SQMC Meeting Outcomes/Purpose	SQMC Roles & Responsibilities: New Charter Alignment

Winter 2023 (end of Jan)	• Guest Speakers to promote further CQM alignment:
	  ○ Comprehensive Plan/End HIV Oregon (Food or Housing Security focus)
	  ○ CQII
	  ○ Clients/Consumers
	  ○ RW program providers
	• Discuss any future Best Practices or different strategies for consideration
	• Discuss Moving QI Collaborative Efforts Forward
	  ○ Finalize plans if proceeding
		• Learn from experts in the field and develop a better understanding of CQM
		• Promote opportunities to hear directly from service providers and consumers about improvement strategies/efforts that best fit the need they observe and experience
		• Better align CQM strategies with best practices
			• Provide expertise and information about emerging trends related to HIV care and treatment and quality improvement initiatives
			• Share information on best practices

Spring 2023 (end of April)	• Reconfirm SQMC PMs are relevant and measurable, before analysis • Report out on end-year individual Parts CQM initiatives ○ What's worked/what hasn't/future planning • Key community partner annual dissemination report out points w/QI • *Potential agenda item: Updates on initial collaborative start, if proceeding*	• Ensure analysis requests for next meeting • Discuss progression on individual RW Parts CQM Plans • Develop annual report key points with CQI activities	• Contribute data/information for a Ryan White cross- part quality management report • Share information about quality management activities • Discuss and develop shared Ryan White metrics
• Approved by SQMC: 4/13/2022			

INFLUENCE OF THE NATIONAL HIV/AIDS STRATEGY

The updated National HIV/AIDS Strategy (NHAS) for 2022-2025 is the nation's third national HIV strategy and updates the HIV National Strategic Plan (2021). The **Strategy** incorporates the latest epidemiological data and biomedical prevention science on HIV and includes support for harm reduction services and syringe service programs (SSPs). Additionally, the **Strategy** encourages reform of state HIV criminalization laws and includes a greater focus on addressing the social determinants of health, and includes the following:

- Four main Goals (which includes 21 objectives and 78 strategies):
  - Goal 1: Prevent New HIV Infections
  - Goal 2: Improve HIV-Related Health Outcomes of People with HIV
  - Goal 3: Reduce HIV-Related Disparities and Health Inequities
  - Goal 4: Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties
- Five priority populations
- Nine core indicators to monitor national progress
  - Establishes a disparity indicator stratified by the priority populations to measure progress toward reducing significant HIV-related disparities
  - Quality of life for people with HIV was designated as the subject for a developmental indicator, meaning that data sources, measures, and targets will be identified, and progress monitored thereafter

The Health Resources and Services Administration (HRSA) plays a critical role in achieving the goals identified in the Strategy by helping to stop the disease through a comprehensive system of HIV care and treatment led by the Ryan White HIV/AIDS Program.

Our Ryan White Part B HIV Care and Treatment has membership on the End HIV/STI Oregon Statewide Planning Group, which includes representatives of Ryan White Parts A, B, C, D, and F, HIV Prevention, HOPWA Programs, Hepatitis Prevention Programs, Department of Corrections, the STI Prevention Program, the AIDS Education and Training Center, and community-based AIDS Service Organizations. Notably, 40% of End HIV/STI Oregon Statewide Planning Group members identify as people living with HIV (PLWH). The End HIV/STI Oregon Statewide Planning Group, in collaboration with these partners, released the statewide End HIV Oregon five-year initiative on World's AIDS Day on December 1, 2016, which strives to meet the National Strategy goals.

The End HIV Oregon initiative also focuses on a statewide response in support of the Strategy's focus:

- Widespread testing and linkage to care, enabling PLWH to access treatment early;

- Broad support for PLWH to remain engaged in comprehensive care, including support for treatment adherence
- Universal viral suppression among PLWH; and
- Full access to comprehensive pre-exposure prophylaxis (PrEP) services for those to whom it is appropriate and desired, and support for medication adherence for those using PrEP.

The HIV Care Continuum consists of a series of steps PLWH take from initial diagnosis to achieving the goal of viral suppression. This program reviews trended data on clients engaged at each stage on the continuum in order to identify where gaps may exist in order to determine service and system intervention and improvement opportunities for better client health outcomes, with the ultimate goal of viral suppression.

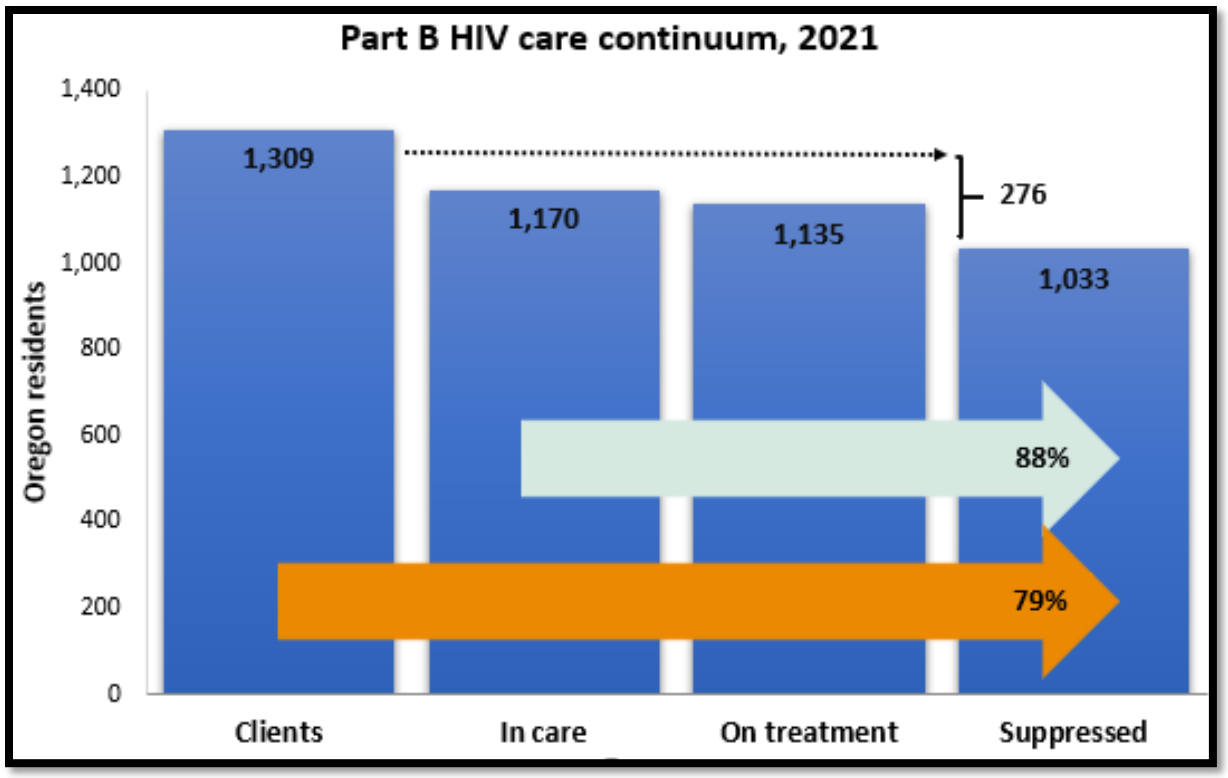
At the state and local levels, jurisdictions use the HIV care continuum – compiled using local data – to determine where improvements are most needed and target resources accordingly.[1] Client participation in HIV care falls along a continuum from not being involved in care to full participation, with periods of time inconsistent engagement in care. A wide range of interventions can be used to encourage, support and enhance engagement in care.[2]

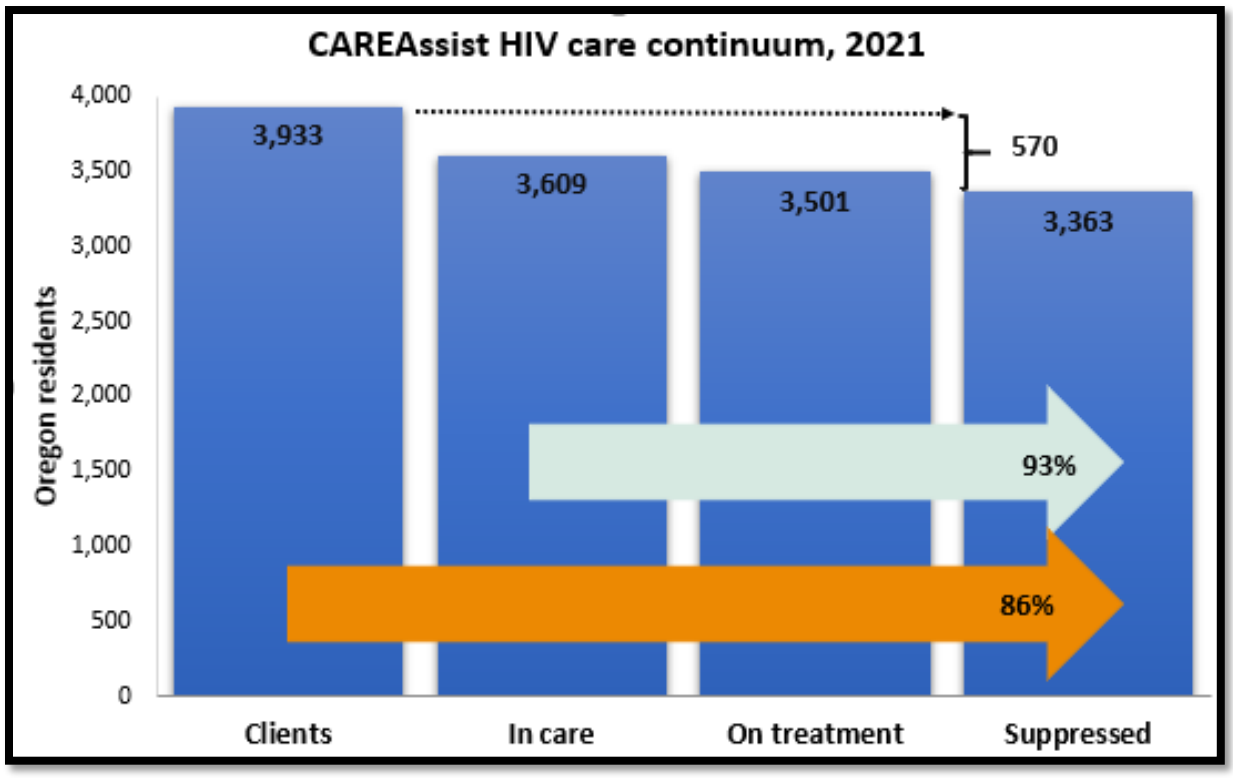
The Program's HIV Care Continuum consists of the following::

Oregon HIV Care and Treatment program—HIV Care Continuum definitions:
Enrolled: clients who received a service in CY.
In Care: Clients who received at least one service and had at least one CD4 or VL lab reported in CAREWare (CW) in CY. Goal=90%
On treatment: Medical Monitoring Project estimate of 97% of in-care patients on ARVs
Suppressed: Clients who had HIV viral load less than 200 copies/mL at last HIV viral load test in CY. Goal=90%

[1] CDC.Understanding the HIV Care Continuum. [Fact sheet] December 2014. Available at: http://www.cdc.gov/hiv/pdf/DHAP_Continuum.pdf#page=1&zoom=auto,-99,792. Accessed from HAB Information Email, Volume 18, Issue 1,January 8, 2015

[2]Topic: Engagement in Care. HRSA/HAB Technical Assistance Resources, Guidance, Education & Training (TARGET).website. Accessed January 8, 2015 at: https://careacttarget.org/category/topics/engagement-care.

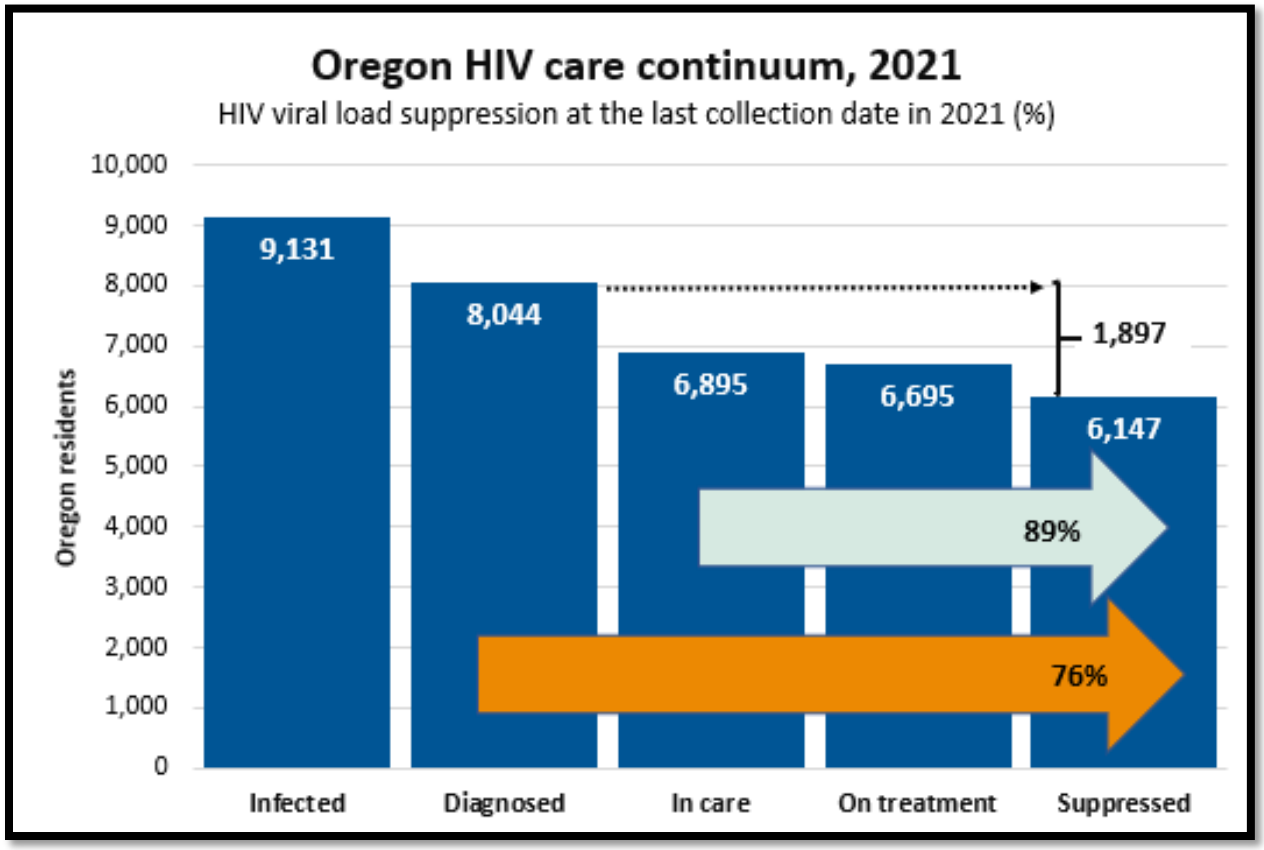

Part B HIV care continuum, 2021
Oregon residents
1,400
1,200
1,000
800
600
400
200
0
1,309
1,170
1,135
1,033
276
88%
79%
Clients
In care
On treatment
Suppressed


CAREAssist HIV care continuum, 2021
Oregon residents
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,933
3,609
3,501
3,363
570
93%
86%
Clients
In care
On treatment
Suppressed

The state of Oregon's HIV Care Continuum consists of the following:

Oregon—HIV Care Continuum definitions:

Infected: Total HIV-infected in Oregon, diagnosed and not diagnosed
Diagnosed: Confirmed HIV cases living in Oregon
In Care: One or more CD4 or Viral load result reported in CY
On treatment: Medical Monitoring Project estimate of 97% of in-care patients on ARVs
Suppressed: Percent of resident HIV cases whose last viral load in CY was < 200 copies/mL



PERFORMANCE MEASUREMENT

Performance measures are selected and regularly reviewed for relevance, need, etc., by the HIV Care and Treatment Quality Management Committee (HIVCAT) based on service utilization, stakeholder and client feedback, and our HIV/STD/TB (HST) section leadership.
Performance measure data are also collected and analyzed for health disparities across target populations on a quarterly basis by the HIV Care and Treatment program. HIV Community Services subrecipient and subcontractor providers analyze this data and provide a semi-annual performance measure narrative plan for meeting unmet goals.

Frequency of performance measure data collection

HIV case management subrecipient and subcontractor providers are required to enter client level data in the centralized CAREWare database. Contractors are also required to submit a semi-annual progress report that includes a performance measure narrative based on data provided by HCS program.

HCT also compiles quarterly quality management tracking and performance measure data from various sources, to include CAREWare, the CAREAssist database, HIV surveillance and the CAREAssist Pharmacy Benefits Management contractor, in order for the HCT program and QMC to analyze this data. HCS provides subrecipients quarterly data for the HIV Care Continuum, the current program Quality Improvement project, and Performance Measures, in an excel worksheet. HCT, HCS and Subrecipients analyze this quarterly data, in addition to trended performance measure outcomes over three years in order to identify trends over time.

Health Equity

The Oregon Health Authority is committed to:

- Eliminating health inequities in Oregon by 2030
- Becoming an anti-racist organization
- Developing and promoting culturally and linguistically appropriate programs, and
- Developing and retaining a diverse, inclusive, and equitable workforce that represents the diversity, cultures, strengths, and values of the people of Oregon.

Our HIV/STD/TB (HST) Section is committed to promoting and achieving health equity in all its work. HST shares the Public Health Division's definition of health equity: **the absence of unfair, avoidable, or remediable difference in health among social groups.** Achieving health equity requires:

- the equitable distribution of resources and power resulting in the elimination of gaps in health outcomes between and within social groups,

- use of an intersectional lens: Intersectionality asserts that multiple social categories used to group people (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism), and
- solutions that look beyond traditional health care and government systems to embrace community wisdom and focus on broader social determinants of health (e.g., education, economic opportunity, transportation, housing).

HST is leading with racial equity. **Racial equity** is the condition that would be achieved if one's racial identity no longer predicted a person's life options and outcomes. Racial equity is one part of racial justice. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them. Racial equity ensures all persons receive what they need to thrive regardless of racial or ethnic identity

In leading with race and ethnicity in our approach to achieving health equity, our new health equity statement will be used alongside our race/ethnicity data with the intent of contextualizing the data, owning that data on race and ethnicity are far from perfect. We acknowledge that until we can find better ways of capturing what race and ethnicity data truly represent, HST will continue to use the data we have with the purpose of moving toward racial health justice.

Our HIV Care and Treatment program has a Health Equity data analysis plan that includes demographic data to be analyzed for our performance measures, which includes stratifying the data to identify health disparities and sharing the data with stakeholders. Our Community Services program provides performance measure data for clients from communities of color to our providers and have added reporting requirements to ensure reporting on specific provider outreach efforts to these communities, in addition to service delivery and program considerations the providers have taken or plan to take to address disparities.

HIV Care and Treatment Program: CAREAssist and HIV Community Services

2022 Performance Measures: All Service Categories, regardless of funding

HIV Care and Treatment clients (CAREAssist and HIV Community Services) who received a service in the Calendar Year (CY), regardless of funding source:

1. **Viral Suppression**: 90%[3] clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

[3] Oregon HIV/STD/TB Program Strategic Plan goal

2. **In Care/Retained in Care**[4]: 90%[5] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

Program: CAREAssist

1. **Application Determination**: 95% of CA applications[6] approved/denied for new CA enrollment within 14 days of CA receiving complete application in the year.
2. **Eligibility Recertification:** 95% of CA enrollees reviewed for continued CA eligibility two or more times a year.

Program: HIV Community Services

1. **MCM Care Plan:** 90% of medical case management (MCM) clients will have a MCM care plan developed and/or updated 2 or more times a year
2. **Stable Housing:** 95% of clients will have stable housing.

Performance measure by HRSA Service Categories[7]

Program: CAREAssist

Service Category: **ADAP**

1. Clients enrolled in CAREAssist (CA) at any point in the calendar year
   1.1. **Viral Suppression**[8]: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.
   1.2 **In Care/Retained in Care**: 90%[9] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).
2. Insured CAREAssist (CA) clients who had one Pharmacy dispensing payment for medication.
   2.1. **Viral Suppression:** 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

[4] In Care is part of HCT Care Continuum and uses the same definition as CDC's HIV Care Continuum "Receipt of Care"
[5] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal
[6] New applications of clients received complete in CY who were never enrolled before
[7] PM's align with HRSA/HAB FY21 PTR Implementation Plan
[8] Part B funding source in addition to all funding sources
[9] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal

3. Uninsured CAREAssist (CA) clients who had one full cost payment for CA-funded medication
   3.1. **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

Program: HIV Community Services

1. Service Category: **Case Management (non-medical)**[10]
   1.1 **Viral Suppression**: 90%[11] clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   1.2 **Stable Housing:** 95% of clients will have stable housing.

2. Service Category: Medical Case Management
   2.1. **MCM Care Plan**: 90% of medical case management (MCM) clients will have a MCM care plan developed and/or updated 2 or more times a year

   2.2. **In Care/Retained in Care**: 90%[12] of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

3. Service Category: Emergency Financial Assistance
   3.1. **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   3.2. **Stable Housing**: 95% of clients will have stable housing.

4. Service Category: **Food Banks/Home Delivered Meals**

   4.1 **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   4.2 **Stable Housing**: 95% of clients will have stable housing.

5. Service Category: **Housing Services**

   5.1 **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

   5.2 **Stable Housing**: 95% of clients will have stable housing.

6. Service Category: **Medical Transportation**

[10] Part B funding source in addition to all funding sources
[11] Oregon HIV/STD/TB Program Strategic Plan goal
[12] Oregon 2017-2021 Integrated HIV Prevention and Care Plan "Retained in Care" goal

6.1 **Viral Suppression**: 90% clients will have a HIV viral load less than 200 copies/mL at last HIV viral load test during the year.

6.2 **In Care/Retained in Care**: 90% of clients will have a HIV medical visit within 12 months (as measured by CD4 or VL Lab).

Service Utilization and Performance Measure (PM) Outcomes – All service providers and funding sources

Calendar Year 2021

HRSA Service Categories[1] requiring a PM based on Service Utilization Client Threshold

		Service Utilization			Performance Measure (PM) Outcomes by Service Utilization				
		N	D	%	Performance Measure	N	D	%	Goal Met?
I. CAREAssist Program		4055	4055	100%	Viral Suppression Goal: 90%	3368	3541	95%	Yes
					In Care / Retained in Care Goal: 90%	3612	4055	89%	No
					Application Determination Goal: 95%	245	245	100%	Yes
					Eligibility Recertification Goal: 95%	3397	4055	84%	No
1.	One Pharmacy dispensing payment for medication (insured)	1264	4055	31%	Viral Suppression Goal: 90%	1109	1145	97%	Yes
2.	One Full cost payment for CAREAssist funded medication (uninsured)	740	4055	18%	Viral Suppression Goal: 90%	652	685	95%	Yes
II. HIV Case Management Program		1420	1420	100%	Viral Suppression Goal: 90%	1064	1160	92%	Yes
					In Care / Retained in Care Goal: 90%	1209	1420	85%	No
					MCM Care Plan Goal: 90%	339	383	89%	No
					Stable Housing Goal: 90%	1193	1420	84%	No

1.	Case Management (non-medical)	1409	1420	99%	Viral Suppression Goal: 90%	1056	1150	92%	Yes
					Stable Housing Goal: 95%	1183	1409	84%	No
2.	Medical Case Management	1148	1420	81%	MCM Care Plan Goal: 90%	339	383	89%	No
					In Care / Retained in Care	961	1148	84%	No
3.	Emergency Financial Assistance	566	1420	40%	Viral Suppression Goal: 90%	442	492	90%	Yes
	COVID Emergency Financial Assistance[5]	75	1420	5%	Viral Suppression Goal: 90%	52	60	87%	No
4.	Food Banks / Home Delivered Meals	638	1420	45%	Viral Suppression Goal: 90%	485	542	89%	No
					In Care / Retained in Care Goal: 90%	565	638	89%	No
5.	Housing	205	1420	14%	Stable Housing Goal: 95%	156	205	76%	No
6.	Medical Transportation	300	1420	21%	In Care / Retained in Care Goal: 90%	267	300	89%	No

[1, 2] Source: HRSA PCN #16-02 Clinical Quality Management Policy

[3] # of PM's needed for each Service Category in CY2022 is based on CY2021 client utilization threshold data.

[4] Thresholds for Performance Measures (PM) are determined by the percentage of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service category (regardless of funding source), as follows:
>=50% utilization=2 PM's; >15% to <50% utilization=1 PM; <=15% utilization =0 PM
Source: HRSA PCN #15-02 Clinical Quality Management Policy

[5] COVID EFA Services included: Food, Housing, Medical Transportation, OTC, Other, and Utilities

Notes:

- Psychosocial Support only funded in 2018 (1 Part B client)
- CAREWare Financial Report, using the following Funding Sources for service category utilization reports= Part B, COVID Part B (2020-2021), OHA Program Income, and Part B Program Income (excludes Non-CARE Act funded and HIVA's Employment Services Program "Other funding" utilization)

HIV Case Management Funded Service Categories NOT requiring a Part B PM[4]		2021 Service Utilization		
		N	D	%
1.	Health Insurance Premium & Cost Sharing	34	1420	2%
2.	Home and Community-based Services	18	1420	1%
3.	Home Health Care	0	1420	N/A
4.	Linguistic Services	23	1420	2%
5.	Medical Nutrition Therapy	1	1420	<1%
6.	Mental Health Services	33	1420	2%
7.	Outpatient/Ambulatory Health Services (Non-CARE Act funded)	66	1420	5%
8.	Oral Health Care	197	1420	13%
9.	Substance Abuse Outpatient Care	0	1420	N/A
10	Substance Abuse Services (residential)	0	1420	N/A

[1, 2] Source: HRSA PCN #16-02 Clinical Quality Management Policy

[3] # of PM's needed for each Service Category in CY2022 is based on CY2021 client utilization threshold data.

[4] Thresholds for Performance Measures (PM) are determined by the percentage of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service category (regardless of funding source), as follows: >=50% utilization=2 PM's; >15% to <50% utilization=1 PM; <=15% utilization =0 PM
Source: HRSA PCN #15-02 Clinical Quality Management Policy

Notes:

- Service Categories in orange indicate a HRSA Core Service.
- CAREWare Financial Report, using the following Funding Sources for service category utilization reports= Part B, COVID Part B (2020-2021), OHA Program Income, and Part B Program Income (excludes Non-CARE Act funded and HIVA's Employment Services Program "Other funding" utilization).

Unfunded HIV Case Management HRSA Service Categories	
For some services, the HRSA RWHAP Parts (i.e., A, B, C, and D) must determine what is feasible and justifiable with limited resources. There is no expectation that a HRSA RWHAP Part recipient would provide all services, but recipients and planning bodies are expected to coordinate service delivery across Parts to ensure that the entire jurisdiction/service area has access to services based on needs assessment[1].	
1.	Early Intervention Services[2]
2.	Hospice Service
3.	Child Care Services
4.	Health Education/Risk-Reduction
5.	Legal Services
6.	Other Professional Services
7.	Outreach Services[3]
8.	Permanency Planning
9.	Psychosocial Support Services
10	Referral for Health Care/Supportive Services
11	Rehabilitation Services
12	Respite Care

[1] Source: PCN #15-02 Clinical Quality Management Policy
[2, 3] End HIV Oregon initiative funded with Ryan White program income
Notes:
- Service Categories in orange indicate a HRSA Core Service.
- Psychosocial Support only funded in 2018 (1 Part B client).

CY2021 Funded HRSA Service Category Utilization and Unfunded Services HIV Care and Treatment - Trended Data for 2019-2021				
Core medical and support service categories are important to assist in the diagnosis of HIV infection, linkage to and entry into care for PLWH, retention in care, and the provision of HIV care and treatment. HRSA RWHAP recipients are encouraged to consider all methods or means by which they can provide services, including use of technology (e.g., telehealth)[1]				
CY2021 Funded HRSA Service Categories[2] Requiring a PM based on utilization[3]		**CY2021** # of clients served	**CY2020** # of clients served	**CY2019** # of clients served
CAREAssist (ADAP) – Service Category Utilization				
1.	ADAP Service Category Number of clients served:	D= 4055	D= 4021	D= 4060
Part B Case Management – Service Category Utilization				
HIV Community Services Program	Number of clients served:	D= 1420	D= 1404	D= 1368
1.	Case Management (non-medical)	N= 1409 99%	N= 1387 99%	N= 1350 99%
2.	Medical Case Management	N= 1148 81%	N= 1130 80%	N= 1102 81%
3.	Emergency Financial Assistance	N= 566 40% COVID EFA N= 75 5%	N=283 20% COVID EFA N=285 20%	N= 436 32%
4.	Food Banks/Home Delivered Meals	638 45%	N= 701 50%	N= 663 48%
5.	Housing	205 14%	N= 176 13%	N= 257 19%
6.	Medical Transportation	300 21%	N= 329 23%	N= 433 32%

Funded Part B Case Management HRSA Service Categories NOT requiring a PM[3]				
11.	Health Insurance Premium & Cost Sharing	N= 34 2%	N= 32 2%	N= 36 3%
12.	Home and Community-based Services	N= 18 1%	N= 23 2%	N= 33 2%
13.	Home Health Care	N= 0	N= 0	N= 1 <1%
14.	Linguistic Services	N= 23 2%	N= 6 <1%	N= 27 2%
15.	Medical Nutrition Therapy	N= 1 <1%	N= 3 <1%	N= 1 <1%
16.	Mental Health Services	N= 33 2%	N= 22 2%	N= 14 1%
17.	Outpatient/Ambulatory Health Services	N= 66 5% (Non-CARE Act funded)	N= 23 2%	N= 102 7%
18.	Oral Health Care	N= 197 13%	N= 8 1%	N= 9 1%
19.	Substance Abuse Outpatient Care	N= 0	N= 0	N= 0
20.	Substance Abuse Services (residential)	N= 0	N= 0	N= 0

[1, 2] Source: HRSA PCN #16-02 Clinical Quality Management Policy

[3] Thresholds for Performance Measures (PM) are determined by the percentage of RWHAP eligible clients receiving at least one unit of service for a RWHAP-funded service category (regardless of funding source), as follows:
>=50% usage=2 PM's; >15% to <50% usage=1 PM; <=15% usage =0 PM

Source: HRSA PCN #15-02 Clinical Quality Management Policy

Notes:

- Service Categories in orange indicate a HRSA Core Service. Psychosocial Support only funded in 2018 (1 Part B client)
- CAREWare Financial Report, using the following Funding Sources for Service Category Usage= Part B, COVID Part B (2020-2021), OHA Program Income, and Part B Program Income (excludes Non-CARE Act funded and HIVA's Employment Services Program "Other funding" utilization)

QUALITY ASSURANCE CONTRACTOR MONITORING

This Contractor Monitoring table lists how contractor service delivery is assessed and monitored:

Activity	Contractor Monitoring	Frequency
Program Progress Report	HIV Case Management subrecipients are required to submit a bi-annual progress report which includes a narrative describing current and future efforts at meeting performance measure goals. Contractors also provide a program narrative to include service successes and barriers, outreach efforts, trauma informed care efforts, and targeted quality management activities. The HIV Quality Improvement Strategist reviews each report and identifies items requiring follow-up. Report information is used for program planning and evaluation purposes. Technical assistance is provided to the contractor as requested.	Bi-annual
Contract Pharmacy Review	Weekly dispense fee invoices, bi-monthly revenue capture invoices, and weekly wholesaler orders from the PBM's PMDC system are used to monitor contracted pharmacies. The Financial Operations Analyst reviews these reports to track spending, revenue capture, and order replenishment. The Financial Operations Analyst meets with CAREAssist management monthly to discuss any fiscal issues and discuss follow up as needed. Quarterly tele-conference meetings are held with the contracted pharmacies to discuss open issues that may affect more than one entity. The ADAP's 340B Program: year one emphasized compliance with 340B, year two emphasized contract compliance. Goal is for a 5-year contract with plan to renew. This audit will review pharmacies, PBM processes, and the CAREAssist 340B Committee oversight/monitoring.	Weekly to Quarterly
Pharmacy Benefits Manager (PBM) data	Contractor submits a quarterly and annual Utilization Management (UM)/MTM report which includes client medication adherence statistics and client level data related to the number of identified inappropriate antiretroviral regimen (ARV) prescriptions resolved, in addition to the outcomes of the MTM program. In addition, contractor provides a Contract Monitoring Performance Measure report to indicate whether they met their identified goals in the following performance areas: turnaround time, help desk telephone response time and abandonment rate, Point-of-Sale data system availability, system change request process, and claims authorization processing. A Plan of Corrective Action is submitted for each outcome that did not meet the goal.	Quarterly and Annual

Medication Therapy Management (MTM) data	Contractor ensures access to ad-hoc reporting systems and submits financial and performance reports electronically as specified. A report is submitted with the following information: number of MTM clients identified as eligible for service by eligibility criteria, number of MTM encounters delivered, number of Clients enrolled in MTM, number engaged in MTM (appointments scheduled vs. appointments kept), MTM clinical interventions summary data, and documented interventions identifying non-conforming regimes (i.e., does not meet DHHS Guidelines).	Quarterly and Annual
Fiscal Expenditures	Monthly expenditures recorded through the Financial Services Office are monitored by the Financial Operations Analyst to track funded service providers monthly allocations and ensure that subrecipients are receiving their formula distributions. The program Financial Operations Analyst works with the State Financial Services Office to ensure that allocations are current, reports are received, and distributions are funded correctly.	Monthly
Fiscal Report	The Administrative Fiscal Form completed by the subrecipient reports on current quarter expenses and year to date expenses as budgeted in the Care Services Budget for each contract agency. The Financial Operations Analyst closely monitors these reports to track spending, ensures that charges are in compliance with state and federal guidelines and assures that subrecipients are providing planned services within the approved budget. These reports are compared to the Quarterly Revenue and Expenditure Reports filed with the Oregon Financial Services Office and the Financial Report generated from CAREWare. If discrepancies are found between these three reports, the Financial Operations Analyst works directly with the contracted agency to correct the discrepancies and request resubmission of any of these reports.	Quarterly
CAREWare Financial Report	The Financial Report, generated from CAREWare, provides the program with service utilization and service expenditure data for each contract agency. The HIV Community Services Program Manager and the Financial Operations Analyst closely monitors the financial components of these reports to track spending, ensures that charges are in compliance with state and federal guidelines and assures that subrecipients are providing planned services within the approved budget.	Monthly and Quarterly
Care Services Budget	The program requires that each funded service provider file an annual budget plan prior to the State fiscal cycle. The Financial Operations Analyst reviews and approves each plan to assure compliance with state and federal requirements.	Annually

Local Client File Review	A Local Client File Review is conducted by each county based contract agency delivering medical case management services using a tool developed by HIV Community Services as a condition of contract. Quality indicators are reviewed resulting in a summary report submitted to HIV Community Services. The results are utilized for planning and quality improvement activities. Compliance findings are followed up and may result in a plan to rectify deficiencies, technical assistance or incorporation into the case management training program curriculum to increase statewide compliance.	Annually
Ryan White Services Report (RSR)	Contract agencies enter required data elements into the program's centralized CAREWare database. Data entered includes demographics, service utilization, primary medical and insurance provider information, household status and income data. The HIV Community Services Program provides contract agencies with a detailed data report in January identifying those data elements that are missing or questionable and provides technical assistance to assure accurate information is reported.	Annually
CAREAssist Data Report (ADR)	The CAREAssist program reports outcomes on the CAREAssist Data Report (ADR) according to the guidelines and definitions provided by HAB. All data for the ADR comes from the client level database that also interfaces with databases for the PBM, the HIV Surveillance Program, and state financial management systems.	Annually

Ryan White funded agencies participate in an annual onsite review with HIV Case Management regional community-based organization subrecipient and subcontractor. County based Health Departments are reviewed on a triennial schedule. Public Health Department Triennial site visits are completed by the HIV Care and Treatment Program for Ryan White funded subcontractors under the direction of the Oregon Health Authority, Public Health Department, Public Health Systems Innovation and Partnerships Unit.

Fiscal site visit protocol:

A Fiscal compliance review is conducted to provide assurance that the contractor has an accounting system with proper controls to identify and report revenues, expenditures, and equipment provided by the Department of Health and Humans Services (DHHS) thru the Oregon Health Authority (OHA). The accounting transactions for that period are evaluated for accuracy and compliance with applicable Federal and State regulations and Title XXVI of the Public Health Service Act, 42 U.S.C. (Ryan White Part B). Instances of non-compliance, material discrepancies and other irregularities are considered findings of the review for which

management response and corrective action is required within 60 days upon receipt of the fiscal reports.

Program Site visit protocol:

Ryan White Part B subrecipient site visits include an entrance meeting to identify challenges, successes and barriers providing services. Performance measures and other data outcomes are also provided and discussed. The chart review includes an in-depth review of documentation and data recorded in the client chart and in the CAREWare database. Data collected during these reviews are compiled and presented to the subrecipient identifying successes and areas of improvement, and compliance findings as summarized in site visit report forms. Compliance issues require a written plan of correction within 30 days of receipt of findings and may result in a second site review within 90 days. Quality assurance and improvement recommendations are provided and agency monitoring is documented on their program reports. An on-site review may be implemented at any time for agencies that are experiencing problems identified in any of the monitoring activities listed above.

Improvements and additions to monitoring activities:

HIV Community Services program frequently provides technical assistance and training to contractors to further enhance local quality management planning and activities. Quality improvement is a significant focus of onsite reviews, which includes quality assurance and improvement recommendations provided to contractors based on comprehensive client chart and system delivery review. Site visits also include an offer to the subrecipient to meet with all service delivery staff during the chart review to go over selected charts utilizing the chart review tool and CAREWare data entry.

Ongoing Activities and monitoring include:

- Contractors participate in the HIV Case Management Task Force, which identifies system improvements by reviewing quality trends and provides recommended changes to the standards of service and other program requirements.
- Technical assistance and ongoing training opportunities are available to contractors to ensure program and fiscal compliance, and to assist partners in monitoring quality indicators. In addition, the program provides extensive CAREWare support, which includes developing contractor requested custom reports and locally identified performance measures.
- The program has a Contractor Monitoring workgroup that meets monthly to review contract administration, report and deliverables monitoring and ensures timelines and reports are met.

Contractor Corrective action process

Corrective action requested by the HIV Community Services ranges from informal requests to formal reports submitted to the County or agency Board of Commissioners. Informal requests include Care Services Budget revisions requested by the Financial Operations Analyst due to non-compliance with administrative or other charges. In addition, quarterly CAREWare Financial Reports, Administrative Fiscal reports and Expenditure reports are monitored by the Financial Operations Analyst. Reports are analyzed to ensure accuracy in reporting and service delivery. Reports that require corrective action are sent back to the contractor for explanation and/or revision. Formal corrective action may be requested as a result of the annual Local Client File Review or On-Site Review. If a fiscal or programmatic deficiency is identified that warrants corrective action, HIV Community Services will notify the contract agency in writing. Deficiencies noted will require a Corrective Action Plan submitted by the contractor in writing and include specific descriptions of the items needing correction, the plan for correcting the problem identified, and a timeline for resolution. The program provides technical assistance to assist an agency in reaching compliance expectations as needed and/or requested by the contractor. Corrective Action plans resulting from an onsite review may result in additional site visits to ensure the issues have been rectified.

CAREAssist follows the state contracting division's requirements for corrective action, follow-up and resolution for contractors. Within the contracts division, financial penalties are defined within the contract for specific elements of the scope of work.

CAPACITY BUILDING MONITORING AND ACTIVITIES

Capacity building involves projects to review and enhance systems of care in improvement in the following areas:

1. The capacity to collect accurate data
2. The capacity to meet HRSA reporting requirements
3. The capacity to share data to determine QI needs

The HIV Care and Treatment program's quality management plan and evaluation studies have been instrumental in making program improvements to program design and services. In addition, trended data is used to shape the direction of the program. The program will continue to improve the process of using data to develop multi-year goals associated with viral load suppression and ensure HIV case managers use the available data to develop client level performance measure. HIV Case Managers are encouraged to use this data to determine those clients needing additional follow-up. The program reviews this data for each contractor site in CAREWare, develops standards to enhance service delivery to persons who are in medical care but are not suppressed across programs (CAREAssist, case management, adherence programs), and targets training and

technical assistance for contractors aimed at increasing the overall percent of clients with a suppressed viral load.

The data quality plan identifies reports that need to be generated for the CAREAssist and CAREWare databases and outlining procedures for data collection in these databases. Reports are generated and data completeness checks, validation, and data cleaning occur at least two months prior to annual report submission. Contractors are contacted and provided technical assistance to ensure that their data is accurate and complete prior to submission to reporting agencies. CAREAssist leadership and the Office of Information Services (OIS) has been working on a new database system to expand the data quality plan to include an enhanced CAREAssist database. The expanded database will allow case workers to utilize custom reports to complete a review and clean-up of their data at specified time periods during the year to increase the capacity for the program to collect and report accurate data for HRSA reporting requirements. Currently, CAREAssist leadership reviews database reports quarterly and annually and provides training and direction to caseworkers during staff meetings.

The databases monitored in the Data Quality Plan are as follows:

- CAREAssist, used by the CAREAssist program.
- CAREWare, used by Ryan White Part B contactors
- ServicePoint, used by the housing coordinators.

Capacity Building and Monitoring Activities		
Capacity Building Goal	**Activity**	**Person(s) Responsible**
Data Quality Plan		
New service delivery staff will input service data and charting accurately.	Complete an informal chart review of new service delivery staff within 3 months of hire date.	Contractor Supervisor, and/or HIV Quality Improvement Strategist
Contractors will complete their own data quality activities.	Ensure contractors are running reports and fixing data entry problems annually. Provide technical assistance and training and encourage contractors to identify and fix data entry missing or incorrect fields more frequently, by running quarterly reports.	HIV Quality Improvement Strategist, HIV Services Coordinator, and HIVCAT Data Analyst
The Data Quality Plan (DQP) will be revised to increase the	The DQP will be revised on an ongoing basis to add additional	CAREAssist Coordinator, HIV Quality Improvement

breadth of the plan to include additional monitoring activities.	areas of monitoring service delivery data and aligning the data in the databases with reporting requirements and QI activities.	Strategist; HIV Services Coordinator; IT Data specialist, HIVCAT Data Analyst
Data will be used in reports to identify and guide QI activities and monitoring.	Reports will be generated and reviewed by QMC to identify and/or monitor quality issues/concerns and will result in a QI initiative to address the issue. QMC will prioritize based on previous performance and outcomes. Technical assistance and ongoing training opportunities are available to subrecipients to ensure program and fiscal compliance, and to assist partners in monitoring quality indicators. In addition, the program provides extensive CAREWare support, which includes developing requested custom reports and locally identified performance measures for subrecipients.	CAREAssist Coordinator, HIV Quality Improvement Strategist; QMC, HIVCAT Data Analyst
Annual CAREAssist chart review; identify and make a plan to resolve potential barriers.	CAREAssist Caseworkers will complete an annual chart review. The HIV Quality Improvement Strategist will help to coordinate these activities, along with the CAREAssist Coordinator and Program Analyst.	CAREAssist Coordinator and Program Analyst, HIV Quality Improvement Strategist; QMC
Reporting Requirements Plan		
Changes to funder reporting requirements and revisions made to data entry requirements will be accurately reflected in materials provided to subrecipients and contractors.	HCT staff will participate in funder sponsored webinars and meetings related to reporting and service requirements. User Manuals for all databases will be updated as changes occur and these changes will be communicated to contractors in multiple formats. Reporting	CAREAssist Coordinator, HIV Services Coordinator and HIV Quality Improvement Strategist

	requirements will be reviewed at least annually.	
Ensure accurate subrecipient data is used for the purposes of reporting to HCS and to identify a plan for subrecipients to meet unmet goals.	Performance measure Progress report data will be provided to subrecipients to ensure accurate and consistent data and enable the subrecipient to measure their performance against the Part B service area as a whole.	HIV Quality Improvement Strategist and the HIVCAT Data Analyst
Sharing QI Data Plan		
Improve client outcomes by sharing data necessary for subrecipient to analyze this data for health disparities and service delivery in order for the subrecipient to identify necessary quality improvement activities.	The HIV Community Services provides subrecipients quarterly data for the HIV Care Continuum, the current program Quality Improvement project, and Performance Measures, in an excel worksheet. Subrecipients will be provided TA, training and the tools necessary for the subrecipient to analyze this data and run additional CAREWare reports, as needed, in order to identify health disparities across different demographics; client outreach/referral; service delivery evaluations and/or changes; assessment of barrier; quality improvement projects; and/or request for program TA/training.	HIV Quality Improvement Strategist and the HIVCAT Data Analyst
QMC will review program quarterly data in order to identify necessary QI activities to improve client or service delivery outcomes	HCT will compile quarterly data for the HCT QMC to analyze this data in order to identify health disparities across different demographics. client outreach/referral; service delivery evaluations and/or changes; assessment of barrier. quality improvement projects. and/or request for funder TA/training.	CAREAssist Coordinator, HIV Services Coordinator, HIVCAT Data Analyst, and HIV Quality Improvement Strategist

QM Plan data will be reviewed by the HCT program and the QMC.	Monthly, quarterly, and annual data from a variety of sources is collected, analyzed and reviewed as part of the Ryan White Part B Quality Management Plan, including CAREWare, the CAREAssist database, HIV surveillance and the CAREAssist Pharmacy Benefits Management subrecipient.	CAREAssist Coordinator, HIV Services Coordinator, HIVCAT Data Analyst, and HIV Quality Improvement Strategist
Quality care or service concerns will be communicated by/to HCS in order to be reviewed for potential QI activity or project	When routine review of CAREWare and CAREAssist data and chart reviews indicates potential instances of quality care or service concerns, the program follows up with subrecipients as necessary. CAREAssist case workers follow-up with clients and subrecipient case managers as necessary. When it is determined that there are systemic, program, or policy changes that need to occur as a result of these reviews, the program determines whether these changes can wait until the HIV Case Management Task Force convenes or if necessary, changes need to occur more immediately. Quality improvement activities and projects can occur as a result of these reviews, such as the 2016 Quality Improvement project.	CAREAssist Coordinator, HIV Services Coordinator, and HIV Quality Improvement Strategist

QUALITY IMPROVEMENT GOALS

Quality improvement goals are established priorities which the QM program identifies annually to direct its efforts and resources towards. Goals are measurable and realistic and establish a threshold at the beginning of the year for each goal, and QMC determines an action plan for unmet goals, which includes establishing quality goals for the year based on outcomes. The Ryan White Part B program reviews HIV/AIDS Bureau performance measure recommendations annually and compares these to quality-of-care trends as identified by the stakeholders listed in this report. Quality improvement goals are identified based on recommendations from the program's various planning groups and stakeholders, data quality analysis, quality assurance monitoring outcomes, and based on trended performance data. The QMC evaluates the recommendations, reviews the data, and sets the annual QI goals in order to improve previous performance rates and outcomes. QI projects are then identified and prioritized to address the QI annual goals.

Quality improvement activities are formulated to improve provider performance, service delivery, and system-wide capacity, and quality goals are derived from the following sources:

- Subrecipient and service contractors participate in a HIV Case Management Task Force every two years which identifies system improvements by reviewing quality trends.
- Regional subrecipient and service contractor are required to submit an annual Quality Management Plan and required to complete and include at least one annual quality improvement project..
- QA data
- Bi-annual client satisfaction surveys
- Performance measures
- Annual site visit data

QI Projects are developed using a PDSA model of improvement:

1. Plan the test, including a plan for collecting data
   a) State the objective of the test
   b) Make predictions about what will happen and why
   c) Develop a plan to test the change (who, what, when, where, and why)

2. Do
   a) Try the test on a small scale
   b) Document problems and any unexpected outcomes
   c) Begin analysis of the data

3. Study
   a) Complete analysis of the data

b) Compare data to predicted results
c) Summarize what was learned

4. Act
a) Refine the change based on what was learned
b) Determine what changes need to be made
c) Determine next cycle

The following Quality Improvement Projects were selected for calendar year (CY) 2022 as a result of 2021 Performance Measure data and Quality Improvement project outcomes.

2022 Quality Improvement projects

Quality Improvement (QI) projects are planned, coordinated, tracked and monitored, and documented by the HIV Quality Improvement Strategist and reviewed by the HIVCAT QMC and shared with stakeholders such as the CAREAssist Advisory Group.

The following are the 2022 QI Projects.

Program: CAREAssist

CAREAssist Viral Suppression Quality Improvement project 2022: Outreach to Communities of Color

Purpose of this project: Historically, CAREAssist clients who were not virally suppressed and not in case management were often impacted by social determinants of health and racial inequities that create additional barriers to obtaining and maintaining HIV health care and access to ART medications. For this reason, initially the focus of this project was to address potential racial inequities for clients of color, but we only identified nine clients of color who were not virally suppressed and not in HIV case management. We also recognize that all clients in this virally unsuppressed subgroup may need services, so we chose to expand the project to include all CAREAssist clients who are virally unsuppressed (or do not have a viral load lab) and not in case management, as this will provide CAREAssist an opportunity to help all of these clients while also comparing how these clients' experiences might be the same or different across groups.

Subrecient: HIV Alliance 2021-2022 Linkage to Care QI Project

AIM Statement: Identify the barriers for newly diagnosed clients getting into care w/in 30 days and 90 days to improve client Linkage to Care by 5%, from 51% to 56% within 30 days, and from 53% to 58% within 90 days.

Plan: The objective of this QI project was to understand barriers for newly diagnosed clients getting into care within set performance measurement timelines. To determine why the Linkage to Care outcomes have been low, collected in depth data for newly HIV diagnosed clients to be able to answer the following:

- What are the barriers for new diagnosed clients getting into care within 30 or 90 days?
- Why are clients not getting into care within the timeframe?
- Are there health disparities for newly diagnosed clients or specific to clients of Communities of Color?

Do: Data was collected on all newly HIV diagnosed clients in CY2020, and 1st quarter of CY2021, as well as an in-depth review of each clients' chart to answer above questions to identify interventions.

Study: Analyzed newly diagnosed clients enrolled from January 2020 through March 2021, provided by Surveillance (Orpheus database); discovered only 26% of clients during the study period had matching HIV diagnosis dates from Orpheus in CAREWare. Below is a summary of the data analysis.

Act: Continue data analysis in 2022 and conduct a new PDSA cycle by developing and then testing interventions based of the data collected and analyzed in this 2021 QI project.

Goal: improve ≥ 5%	**Linkage in 30 Days** *Goal not met: 2020=51% 2021=51%*			**Linkage in 90 Days** *Goal met: 2020=53% 2021=66%*		
January 2020 – March 2021 Linkage to Care QI Project Data Analysis						
	N	D	%	N	D	%
Communities of Color	3	9	33%	9	11	82%
White	15	20	75%	20	27	74%
TOTAL	18	29	62%	29	38	76%

PARTICIPATION, COMMUNICATION AND SUPPORT WITH STAKEHOLDERS

The following table describes the groups and agency stakeholders currently involved in HIV care activities and in providing data for the QM Committee, as well as the ways in which the HIV Care and Treatment program provides support, technical assistance, training, and guidance related to quality improvement and assurance activities.

QM Stakeholders	QM Participation	QM Data
Consumer (People living with HIV/AIDS)	1. Participate in the CAREAssist Advisory Group and the End HIV/STI Oregon Statewide Planning Group. 2. Participate in Surveys, QI projects, and other special studies.	
HIV Case Management Task Force	1. Identify quality of care issues or concerns in Part B service area. 2. Provides recommendations on standards of service.	PM and CQM data, site visits, chart reviews and CAREWare reports are utilized to recommend improvements to the Standards of Care and statewide data improvement initiatives.
End HIV/STI Oregon Statewide Planning Group	1. Identify HIV related quality care issues or concerns in the State of Oregon. 2. Identify needed services and/or programs. 3. Provide recommendations on program goals and activities.	Data and outcomes data are utilized to develop the HIV/VH/STI Integrated Comprehensive Plan. This includes improvement activities to address identified service needs and gaps, including developing goals and objectives that impact service priorities and resource allocation.
CAREAssist Advisory Group	1. Identify quality care issues. 2. Identify needed services and/or programs. 3. Provide recommendations on program goals and activities.	Quality data is utilized to inform decisions about program and service improvements in CAREAssist.
Oregon HIV Statewide Quality Management Committee (SQMC) (formerly “Quality Improvement Collaborative”)	1. Receive updates pertaining to the QMP.	1. Share general program information across state organizations and agencies pertaining to their Ryan White programs/service delivery. 2. Share ideas for quality improvement initiatives and decide on End HIV Oregon performance measures

		3. Provide a space for innovative collaboration.
RW Subrecipients and subcontractors: • Regional • County	Subrecipients and subcontractors are engaged, supported, and monitored with respect to quality improvement and quality assurance in the following ways: 1. Scheduled monthly to quarterly provider check-in calls. Data is provided during meetings and ways to improve are discussed and monitored. 2. Regional providers submit annual agency QM Plan revisions, including current QI Projects and previous QI project outcomes. The HIV Quality Improvement Strategist reviews submitted plans with providers utilizing a QM Plan review checklist and discuss ways to improve. 3. QI projects processes and outcomes are reported on biannual progress reports. 4. QA: chart review outcomes are reviewed with providers and compliance plans are created, submitted, and monitored until provider meets agreed up completion activities/goals. Stakeholders QM related participation: 1. Data and qualitative summary on service delivery via reporting. 2. Participation in chart review. 3. Participation in QI projects. 4. Ensure service delivery and standards of service according to contract requirements.	Data is provided when requested for technical assistance and training purposes, as well as from chart reviews, site visits, data quality, and feedback from report submissions. Contracted providers are encouraged to use data to identify opportunities for outreach efforts and specific program and clinical interventions for increasing client engagement and retention in care.

ACTION PLAN, TIMELINE, AND RESPONSIBLE PARTIES

The table below lists the QM Plan activities annual schedule and responsible parties:

QM Plan Activities: Action Plan and Responsible Parties		
QM Activity	**Timeline**	**Responsible Party**
QI Project Implementation and Monitoring	CAREAssist and HIV Community Service program QI Projects are monitored weekly during the QI project implementation and then monthly to quarterly by either HIVCAT QMC or a QMC QI project workgroup. The QMC will determine annually which staff need to be on the QI Project workgroup based on the specific project. At least one member of the QMC will be on the QI Project workgroup.	HIVCAT Leadership, HIVCAT Coordinators, HIV Quality Improvement Strategist, and the HIVCAT Data Analyst
QA Data Collection	QA data is collected monthly, quarterly, and annually.	CAREAssist Coordinator, HIV Quality Improvement Strategist, and the HIVCAT Data Analyst
QM Data Collection	QM data is collected quarterly, and annually.	HIV Quality Improvement Strategist, and the HIVCAT Data Analyst
Client Services Satisfaction Survey Implementation, Data Collection, and Analysis	Client Satisfaction Surveys are rotated every year between the OHOP, CAREAssist, and HIV Community Services programs. QMC uses the data from these surveys to determine QI activities.	HIVCAT Leadership, HIVCAT Coordinators, HIV Quality Improvement Strategist, and the HIVCAT Data Analyst
QA and QM Data Analysis	The QA and QM data will be analyzed quarterly and annually to determine if goals were met and where QI activities are needed.	QMC
QM Plan Evaluation	The QM Plan will be evaluated annually at least one month prior to QM plan revision.	QMC
QM Plan Revision	The QM Plan will be revised annually.	QMC

QM Activities **Timeline – (April 2022 – March 2023)**		April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.
QM Data Collection and review	QA CA data												
	CA Chart Review												
	QA CM data &												
	CA PM data												
	CM PM data												
Service/Cost Utilization	CW Financial reports												
QM Meetings	QI Project												
	QA Workgroup (proposed)												
	QMC												
	SQMC												
	QI – Plan: Analyze data and develop intervention or project												
	QI – Do: Test intervention												
	QI – Study and Act: Analyze study results												
QM Plan Revision to Submit to QMC	Evaluation												
	Development												
	Due Date												
Informing Stakeholders	HIV Care and Treatment Staff and CM Providers												
	HRSA Project Officer												
	CAREAssist Advisory Group												
	SQMC												

QUALITY MANAGEMENT PLAN EVALUATION

The QMC will be charged with evaluating the QM Plan (QMP) as follows:

1. Determining the effectiveness of the Quality Management infrastructure to decide whether there is need for improvement in how quality improvement work is accomplished.

2. Reviewing annual QMP goals and identifying outcomes and areas of improvement. Evaluating the QI activities to determine whether the annual QI goals are met.

3. Reviewing whether the performance measures are appropriately identified, and evaluate if new measures should be introduced.

To ensure a useful and current QMP, it is essential to update the plan in a systematic and consistent manner. The process upon which the QMP will be updated is explained in the table below.

QMP Evaluation	Timeline
QI projects, performance measurement goal updates, Data Quality Plan updates, and updates to the QMP will be forwarded to the HIV Quality Improvement Strategist by RW Part B program staff, QMC members, and Stakeholders, and will be shared with the QMC for review, modification, and final QMP approval.	Quarterly Review Annual approval
The QMC will evaluate the QMP by answering the following questions: 1. What QI goals were achieved during the previous measurement year? 2. a) What performance measurement goals were met in previous measurement year? b) Are results in the expected range? If so, how? 3. How were stakeholders informed of performance measure results? 4. a) Did our current QM infrastructure work? b) Where are there areas for improvement in our current infrastructure? 5. a) Did we do what we said we were going to do for each measure and each QI project? b) Why or why not? 6. a) Are our measures meaningful to helping us understand HIV care systems in Ryan White Part B delivery systems in Oregon? b) Are they helping us identify whether or not we need to make changes?	Annual

QUALITY IMPROVEMENT 2021 PROJECT OUTCOMES

CAREAssist and HIV Health Services (Part C) - Rapid ART Start QI Project

Our state's Part C HIV Health Services Center (HSC), managed by the Multnomah County Health Department, coordinated with CAREAssist to provide open access, low barrier HIV care and rapid antiretroviral therapy (ART) and serve newly HIV diagnosed, new to HIV care (already diagnosed with HIV but never started ART), and out of care (no labs or HIV provider access for over 12 months).

AIM: The goal of the Rapid ART Start program was to reduce the time for clients to receive ART from 30 days to within 5 days of initial contact with the ultimate goals to improve client health outcomes and viral suppression, reduce transmission, and improve retention in care.

Plan: HSC serves over 1,500 people living with HIV, offering a full range of primary and specialty HIV care services, medical case management, patient navigation, mental health, and pharmacy services. Many HSC patients face challenges like unstable housing and homelessness, mental health diagnoses, substance use disorders, and income insufficiency. Still, in 2020, 89% received annual HIV labs and 91% were virally suppressed at last test. Wanting to improve these rates even more, HSC initiated a quality improvement project in collaboration with CAREAssist to shorten the time clients had to wait between initial diagnosis, their first appointment with a medical provider, and starting ART.

Do: The team developed clinic processes to shorten the interlude from diagnosis to ART initiation from 4 weeks to within 5 days of first contact with the client; sometimes with clients seen the same day. In 2020, HSC was awarded a three-year HRSA Special Projects of National Significance grant to expand Rapid Start, which is now offered to folks who are newly diagnosed, new to care, and out of care. Clinic staff improved processes to facilitate new clients to receive care quickly, and CAREAssist ensured caseworkers were able to process applications quickly and lines of communication were outlined in order for caseworkers to respond in a timely manner to clinic staff. Case workers prioritized processing Rapid ART client CAREAssist applications, and problem solved insurance and other issues quickly to ensure client access to medication.

Study: The collaboration efforts resulted in developing workflows, protocols, and community partnerships to support the program. As of early 2021, these are the outcomes:

- Increased clients receiving Rapid Start services: from 1-4 clients, to 6-8 clients, and now about 8-9 clients each month, mostly from the tri-county transitional grant area (TGA).
- 91% of clients received ART within 5 days of initial contact.
- newly diagnosed clients linked to care within 30 days grew from 75% in 2018 to 91% in

2019.

- 79% of newly diagnosed clients achieved viral suppression within 60 days.
- CAREAssist approved all eligible Rapid ART Start applications same day and often within minutes to hours after receiving a CAREAssist enrollment application.

Act: HSC's rapid start program has been showcased nationally by the Health Resources & Services Administration as a successful model of innovative HIV care. Future efforts include expansion of Rapid ART Start programs into the balance of state in some capacity and further coordination for linkage to support services and medical care to address client psychosocial needs.

CAREAssist (AIDS Drug Assistance Program)

CAREAssist 2021 QI Project Outcomes and Planned 2022 QI Project: Dental Insurance Improvement Project

AIM Statement: Increase the number of CAREAssist (CA) clients submitting dental insurance applications by 10%.

Plan: Due to the previous years' Part B Case Management dental insurance improvement efforts not hitting the goal, CAREAssist embarked on a first annual Dental Drive, creating a new PDSA improvement cycle focusing on the program's direct outreach to eligible CAREAssist clients and changing the goal to reflect the focus on improving client dental insurance application submissions. CAREAssist also enhanced the information provided to statewide HIV Case Management agencies to aid in their continued client dental insurance outreach efforts.

Do: CAREAssist created and mailed a dental insurance fact sheet along with a dental insurance application to all eligible CAREAssist clients not enrolled in dental insurance. CAREAssist also continued to provide case management agencies monthly dental insurance enrollment data for case managers to be able to identify who is eligible for dental insurance and may need help completing the dental insurance application. In addition, these agencies were provided the materials mailed to clients during the new CAREAssist annual Dental Drive. Our Community Services program continued to work with the Part B subrecipient HIV Alliance dental case management program on ways to enhance dental insurance enrollment.

Study: The client response to the Dental Drive was lower than expected; this could be due to ongoing COVID restrictions or concerns. The outcomes for 2021 after the dental drive: 14% increase in dental insurance applications (enrollment) after the first annual CAREAssist Dental Drive, which exceeded our improvement goal of 10% - see table below.

Act: For the 2022 Dental Drive and new PDSA cycle, we are looking at different ways to engage statewide case management agencies to participate in client outreach at the same time as the Dental (Insurance) Drive. We are also considering ways to increase dental insurance utilization among clients who have dental insurance coverage. With the lifting COVID restrictions will help with an increase in applications and clients not having a barrier in accessing dental care. CAREAssist caseworkers will be including the MODA dental insurance application in client welcome packet for new and returning clients that are eligible for the dental coverage. In order to reduce any barriers with clients mailing paper applications, clients will now have the option to complete a paper or website electronic application. The Dental Drive will occur in July, 2022.

CAREAssist 1st Annual Dental Drive Outcomes
July 2021

CAREAssist QI Project Goal: Increase the number of CAREAssist (CA) clients submitting dental insurance applications by **10%.**

	Eligible & Mailed Dental Insurance Applications	Submitted Dental Insurance Applications	% of Submitted Dental Insurance Applications
2021 Dental Drive TOTAL OUTCOMES:	**1028**	**142**	**13.81% Goal Met**
English	926	132	14.25%
Spanish	96	10	10.42%
Unknown/Other Language	6	3	50.00%
Part A Dental Insurance Applications	**699**	**83**	**11.87%**
English	625	73	11.68%
Spanish	69	7	10.14%
Unknown/Other Language	5	3	60.00%
Part B Dental Insurance Applications	**329**	**59**	**17.93%**
English	301	55	18.27%
Spanish	27	4	14.81%
Other Language	1	0	0.00%

Ryan White Part A has a service jurisdiction managed by Multnomah County Public Health's HIV Grant Administration & Planning program's HIV Case Management subrecients and contractors and includes the following counties: Clackamas, Columbia, Multnomah, Washington, and Yamhill.

Ryan White Part B service jurisdiction covers all other counties in the state of Oregon and is managed by the Oregon Health Authority, Public Health Division's HIV Community Services program's HIV Case Management subrecient and contractors.

CAREAssist 2021 Viral Suppression QI project: Outreach to Communities of Color and other communities

QI Project Purpose: Historically, CAREAssist clients who were not in case management and not virally suppressed are often impacted by social determinants of health and racial inequities that create additional barriers to obtaining and maintaining HIV health care and access to ART medications. For this reason, initially the focus of this project was to address potential racial inequities for clients of color, but only nine clients of color were identified who were not virally suppressed and not in HIV case management. CAREAssist recognized all clients in this virally unsuppressed subgroup may need services, therefore decided to expand the project to include all CAREAssist clients not in case management and not virally suppressed or did not have a viral load lab, to provide CAREAssist an opportunity to help all of these clients while also seeking to better understand client experiences and barriers. Only CAREAssist clients not enrolled in HIV Case Management who either did not have a current viral load lab in the previous twelve months and/or who were not virally suppressed at the last current viral load lab were considered for this project.

Plan: The Plan-Do-Study-Act (PDSA) model of improvement was utilized. Project and call protocol were established by the CAREAssist team and a project tool (21 questions) was created. Also created a "Support Networks and Client Resources" referral sheet (includes crisis, culturally specific services, LGBTQ agencies, and case management resources) for case workers to reference when offering clients resources for an identified need and/or for clients wanting a referral to an HIV Case Management agency in their area. No specific improvement goal was established for this first year's annual project and instead, baseline and project completion data will aid in 2022 goal setting.

Do: Completed PDSA Cycles 1-3**.**

- **PDSA Cycle 1:** Week of April 12, 2021: 43 clients met the criteria and were selected for this project. The CAREAssist Program Coordinator attempted to contact 3 clients (reached 1) to test the effectiveness, flow and process of the protocol, tool and referral sheet. April 29, 2021, was the "Project Kick off" meeting with CA leadership, the data team, and Case Workers. Revised the QI project protocol, tool and referral sheet based on Cycle 1 outcomes.
- **PDSA Cycle 2:** May 1, 2021-June 11,2021: CAREAssist Case Workers attempted to contact the remaining 42 clients. Analyzed the data and tools; reviewed the outcomes and revised the protocol with the CAREAssist Case Workers, ensuring all attempts were documented. Determined another PDSA cycle was needed.

- **PDSA Cycle 3:** August 1-31, 2021: CAREAssist Case Workers attempted to contact the remaining 28 clients who were not reached in Cycle 2 (or were unable to attempt the number of times identified in the protocol). 13 clients were reached during the project.

Study: Analyzed the final PDSA Cycle 3 data, compiled a summary and outcomes, and presented the closing project outcomes to the following: CAREAssist team, HIV Care and Treatment Quality Management Committee, Ryan White Grant federal Project Officer, CAREAssist Advisory Group. Analyzed lab data at 3- and 6-months post project to determine if the thirteen clients who engaged in the project became enrolled in HIV case management, obtained a viral load lab, and/or became virally suppressed. Also analyzed the data to determine if outreach and offering referrals was an effective intervention leading to improved linkage to care and viral load labs. The final six-month post project data indicates the project was a success, as thirteen clients who participated in the outreach project did show improvement: 54% did enroll in HIV case management, 77% had a current viral load lab, with 78% were virally suppressed.

CAREAssist QI Viral Suppression Project 2021: Outreach to Communities of Color (CoC)

baseline: April 2021	**# of clients in 2021 QI project= 43** CoC clients= 12 (28%) | virally unsuppressed clients=36 (84%) | No VL labs =7 (16%)
project close: 8/31/2021	**# of clients as of 8/31= 31** CoC clients= 4 (13%) | virally unsuppressed clients=19 (61%) | No VL labs =12 (39%)

Post Project Outcomes:*

	Project Close 8/31/2021	3 Month Post 11/30/2021	6 Month Post 2/28/2022
Clients enrolled in Case Management	*5*	*8*	*7*
Clients with a current VL lab in 12 mo	*8*	*10*	***10***
Clients suppressed at last VL lab in 12 mo	*14%*	*78%*	***78%***

PDSA Cycle Outcomes:

	PDSA Cycle 1 Outcome: April 2021	PDSA Cycle 2 Outcome: May/June 2021	PDSA Cycle 3 Outcome August 2021	Overall Project Outcome
Start of PDSA Cycle:	3	42	28	**43**
Clients reached tool completed:	1 CoC: 100% (1/1)	11 (26%) CoC: 27% (3/11)	1 (4%) CoC: 0% (0/1)	**13 (30%)** **CoC: 33% (4/12)**
Clients to contact next PDSA cycle:	42	28	2021 Project Completed	**2021 Project Completed**
Reason unable to complete contact/reach the client:				
Not Attempted: client disenrolled	N/A	1 - include in next PDSA cycle	7	**7**
Attempted: unable to reach	2 - include in next PDSA cycle	9 - include in next PDSA cycle	11	**11**
Three attempts not documented	N/A	19 - include in next PDSA cycle	9	**9**
Contacted: client declined	N/A	3 - do not include in next PDSA cycle	0	**3**

**Analyzed the VL lab completion (in 12 mo) and Viral Suppression of the 13 clients who were reached during the 2021 QI project at the conclusion of the project on 8/31/21, and every 3 months: 11/30/21 and 2/28/22*

Summary

Lessons learned from 2021 project:

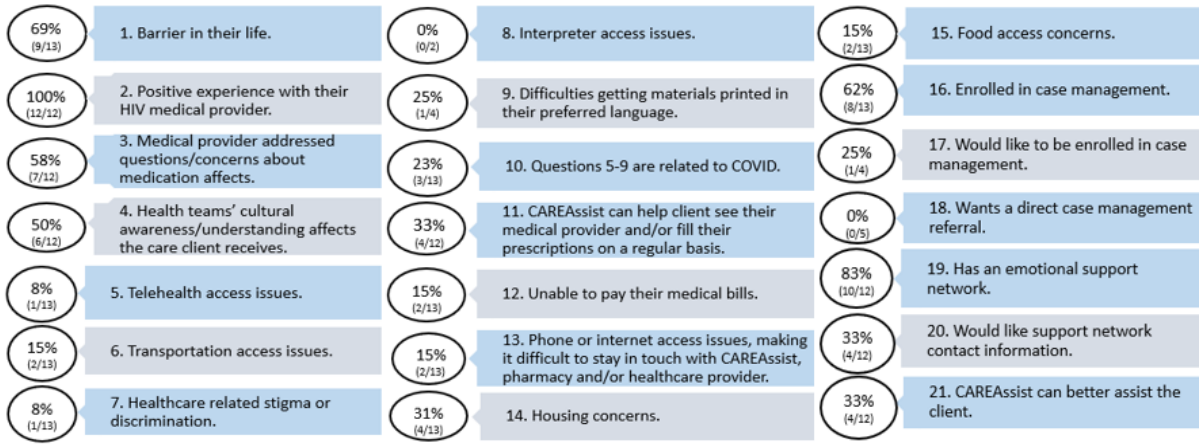
- Will need to expand the reasons why full number of attempts weren't completed. Was client disenrolled or in CM? Add these options to the tool.
- Will need to ensure Caseworkers ask and then fully document on the tool, the reason a client has not obtained a viral load lab (are they linked to a health care provider, do they need help with referral, etc.) or the reason the client believes they are not virally suppressed (what barriers are there, what do they need?).

Overall, the client responses did help the program to gain a better understanding of client barriers to better target interventions to address and improve HIV medical linkage and completion of viral load labs, as shown in the tool responses below, and it was clear by the following comments that some clients did appreciate the Case Worker outreach and information shared at the time of the call:

- *Thanks CAREAssist for everything that you do.*
- *Grateful about the call.*
- *Appreciated it [the call]. Felt like I learned a lot.*
- *Thankful for [the] CAREAssist awesome team and he considers we are doing an excellent job.*
- *Grateful for follow-up and phone call.*
- *Doing well not, facing any barriers at this time and is taking [his] meds.*
- *Struggling with a support network, food, dental and utilities due to covid19.*
- *Client was happy to participate [in outreach call] participate*

Act: The 2022 QI Project will build on the first 2021 project. The project protocol, tool and referral sheet has been revised to determine the best outreach mechanisms for clients who are unreachable during the project and to include the lessons learned from the 2021 project. It is hoped that increased client participation in the project now that COVID-19 restrictions are lifting will facilitate the future development of specific outreach to address identified barriers for clients from Communities of Color (CoC) for clients not engaged in HIV case management. The project will occur in July 2022.

Project Tool Results:



2021 End HIV Oregon Annual Progress Report: HIV Treatment Outcomes

End HIV Oregon is Oregon's initiative to end new HIV infections in our state. It is a collaborative effort between the Oregon Health Authority, the statewide End HIV/STI Oregon Statewide Planning Group including people living with HIV and at risk of HIV infection, and a variety of public and private agencies and community groups across our state. In the 5th year since launching the End HIV Oregon initiative, the Oregon Health Authority (OHA) and its many community partners moved forward towards our shared goal of eliminating new HIV transmissions in Oregon. The report describes some key End HIV Oregon activities, posted on the EndHIVOregon.org website here.

HIV treatment saves lives. People living with HIV (PLWH) who take HIV antiretroviral medicine, as prescribed, and maintain an undetectable viral load live longer, healthier lives, and have no risk of sexually transmitting the virus to an HIV-negative partner. In 2021, we took the following steps to support viral suppression among PLWH:

1. LINKING PEOPLE TO CARE, ACHIEVING VIRAL SUPPRESSION QUICKER: Oregon's Early Intervention Services & Outreach (EISO) Program continues to improve treatment outcomes for people newly diagnosed with HIV: 86% of people newly diagnosed with HIV are now linked to HIV medical care in 30 days or less through EISO compared to 66% from before the program started (2013-2017) and 79% in 2019. The median days to viral load suppression among EISO clients newly diagnosed with HIV is 62 days. Quick achievement of viral suppression means better health for newly diagnosed individuals and zero chance of HIV transmission to their sexual partners.
2. EXPANDING HOUSING OPTIONS FOR PEOPLE LIVING WITH HIV: Unstable housing is a risk factor for HIV transmission and poor mental and physical health outcomes for people living with HIV, including viral nonsuppression. Rising housing costs and low vacancy rates have created a statewide housing crisis. Behavioral health issues, including mental health conditions and addictions, present additional barriers to clients trying to secure and maintain stable housing in an extremely difficult market. Cultivate, administered by Eastern Oregon Center for Independent Living (EOCIL), serves PLWH who have co-occurring behavioral health issues. Cultivate provides rent assistance, housing stability planning, and in-home, intensive case management and behavioral health services to PLWH in rural Eastern Oregon. Cultivate has enrolled 11 clients since it began in January 2021. Staff provide clients with weekly housing inspections, life skills building, behavioral health meetings, and help with budgeting. Despite significant life challenges, Cultivate clients have achieved meaningful success: 100% have applied for Section 8, 90% are actively engaged in medical care and virally suppressed, and 3 are participating in alcohol and drug treatment. EOCIL, through a collaboration with Eastern Oregon Coordinated Care Organization, recently purchased a

7-plex apartment complex in Pendleton to house individuals on the Oregon Health Plan.

3. PROVIDING LIFE-SAVING MEDICINE: The CAREAssist (AIDS Drug Assistance) Program pays for insurance premiums, deductibles, medical co-pays and pharmacy co-pays to ensure that PLWH have medical care and all the medications they need to stay healthy. CAREAssist serves more than 4,000 clients each year and enrollment continues to grow. In 2021, the program increased income eligibility to serve more people. CAREAssist staff are proactive with quality improvement projects to enroll clients in services they may need but are not using. These efforts keep clients connected and may contribute to outstanding program outcomes such as the 96% of program clients virally suppressed in 2021.

Ending Disparities

Testing is easy. Prevention works. Treatment saves lives. But not all Oregonians are benefiting equally from available resources. COVID-19 continues to amplify the devastating effects of health inequities and the need to lead with race in efforts to address systemic barriers. In 2021, OHA worked with community partners to help Oregonians achieve better health and eliminate HIV-related health inequities:

1. CREATING A MORE EQUITABLE PUBLIC HEALTH SYSTEM: In 2021, the Oregon Legislature called out Oregon's racist history, decried the generational legacy of trauma that racism has inflicted on Black, Indigenous, and other people of color in Oregon, and declared racism as a public health crisis. House Resolution 6 codifies the expectation that public health must change policies and systems now to address current and historic inequities. OHA joined with other public health colleagues to support a collaborative funding opportunity for community-based organizations, initiated anti-racism training for staff and contractors, and is working with local public health partners to re-envision how STI services are delivered statewide.
2. SUPPORTING COMMUNITY-IDENTIFIED SOLUTIONS: Since End HIV Oregon began in 2016, OHA has awarded 24 End HIV Oregon project grants to 18 community-based agencies; 42% of these grants have been for projects led by and for communities of color.
3. TRACKING THE METRICS THAT MATTER BY RACE/ETHNICITY: OHA collects a wide range of data related to HIV. We track End HIV Oregon metrics by race, ethnicity, age, HIV transmission risk, gender, region, and other factors, where possible. A 2021 Oregon law (HB 3159, also known as the Data Justice Act) requires healthcare providers to collect and report data on their patients' sexual orientation and gender identity, as well as their race, ethnicity, preferred language, and disabilities. Collecting and reporting on metrics by race/ ethnicity helps everyone involved in ending new HIV transmissions in Oregon measure our progress towards ending inequities.

Progress Towards Viral Suppression & Reductions in Racial/Ethnic Inequities

People with undetectable viral loads cannot transmit HIV to their sex partners: Undetectable = Untransmittable (U=U). Our goal in Oregon is to link people to medical care quickly after HIV diagnosis and provide needed support so people can achieve and maintain viral suppression. Overall, 76.7% of PLWH in Oregon were virally suppressed at last viral load, a much higher rate than seen nationally. Moreover, racial and ethnic inequities in viral suppression rates are closing. Latino/a/x and white Oregonians slightly exceed the overall rate, while all other racial/ethnic groups fell slightly below the overall rate.

Proportion of virally suppressed within twelve months of diagnosis by race/ethnicity, 2020