FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Quality Management Committee Meeting

Monday, May 19, 2025, 12:30 p.m.

Meeting Location: Broward Regional Health Planning Council Conference Room

Join the meeting now
https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2U5MDc5ZjItOGVhNy00MzQ3LWJmNzMtZGE0YjVhNDU1OGM5%40thread.v2/0?context=%7b%22Tid%22%3a%220dd42165-bf27-4e00-9f50-1f4dff8a73f8%22%2c%22Oid%22%3a%22df400b73-e09f-4638-a7b6-0750be4ecb25%22%7d
Meeting ID: 253 807 535 170
Passcode: W5un64Pm
Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore

This meeting is audio and video recorded.

The purpose of the Quality Management Program for Ryan White Part A in the Broward County EMA is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all clients receiving Ryan White Part A and Minority AIDS Initiative (MAI) funded services in Broward County.

Quorum for this meeting is 5

DRAFT AGENDA

ORDER OF BUSINESS

1. Call to Order/Establishment of Quorum
2. Welcome from the Chair
    a. Meeting Ground Rules
    b. Statement of Sunshine
    c. Introductions & Abstentions
    d. Moment of Silence
3. Public Comment
4. **ACTION:** Approval of Agenda for May 19, 2025
5. **ACTION:** Approval of Minutes from April 21, 2025 **(Handout A)**
6. Discussion Items:
    a. **Action**:
7. Old Business:
    a. None
8. New Business
    a. **Review:** Quality Management Workplan **(Handout B)**
    Work Plan Activity 2.5: 2.5 Conduct quarterly reviews of the QMC Annual Workplan.

b. **Presentation:** Updates to the Quality Improvement Project (QIP) Toolkit **(Handout C)**
Work Plan Activity 2.3: Receive presentations on Quality Improvement Projects (QIPs) taking place among RW Part A service providers.

c. **Presentation**: HIV Care Continuum Data **(Handout D)**
Work Plan Activity 1.2: Identify and analyze health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC and PSRA Committee.

9. Recipient's Report
10. Data Request
11. Public Comment
12. Agenda Items for Next Meeting
    a. To Be Determined
    b. **Next Meeting Date: June 16, 2025, 12:30 p.m**. via Microsoft Teams Videoconference and at BRHPC
13. Announcements
14. Adjournment

For a detailed discussion on any of the above items, please refer to the minutes available at:
HIV Planning Council Website

Please complete the meeting evaluation.

Three Guiding Principles of the Broward County HIV Health Services Planning Council
• Linkage to Care • Retention in Care • Viral Load Suppression •

Vision: To ensure the delivery of high-quality, comprehensive HIV/AIDS services to low-income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high-quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: (1) Foster the substantive involvement of the HIV-affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care, (2) Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments, (3) Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

May 2025

Broward HIV Health Services Planning Council Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	All events listed on this calendar are free and open to the public. Meeting dates and times are subject to change. Please contact support staff at hivpc@brhpc.org or (954) 561-9681 ext. 1244/1343. Visit HIV Health Service Planning Council for updates.					
				1 System of Care Committee Meeting (SOC) 9:30AM – 11:30AM Location: BRHPC/MS Teams	2 Medical Case Management Network 2:30PM-3:45PM	3
4	5	6 Community Empowerment Committee Meeting (CEC) 3:00PM– 5:00PM Location: BRHPC/MS Teams	7	8	9	10
11 	12	13 Minority AIDS Initiative Subcommittee Meeting 12:30PM – 2:30PM Locations: BRHPC/MS Teams	14	15 Priority Setting and Resource Allocation Committee Meeting 9:30AM – 11:30AM Location: BRHPC/MS Teams Executive Committee Meeting 12:45PM – 2:45PM Location: BRHPC/MS Teams	16	17
18  	19 Quality Management Meeting (QMC) 12:30PM– 2:30PM Location: BRHPC/MS Teams	20	21 Quality Network Meeting (CQM) 9:00AM-10:15AM	22 HIV Planning Council Meeting 9:30AM – 11:30AM Locations: BRHPC/MS Teams	23	24
25	26	27	28	29	30	31 

Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020
Links are active and lead to meetings or Awareness Day Information. **Information is subject to change.**

Meetings in **RED** are canceled. Meetings in **BLUE** are for the HIV Planning Council Committees. Meetings in **GREEN** are for the Provider Network.
Holidays and meetings outside of the HIV Planning Council are in **BLACK**.

May 2025

Broward HIV Health Services Planning Council Calendar

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TODOS ESTAN BIENVENIDOS!	ALL ARE WELCOME!	BON VINI!
A menos que se anote de forma diferente en el calendario, todas las reuniones se realizarán en: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Para confirmar información acerca de la reunión de Consejo de Planeación HIV, o confirmar la reserva de servicios especiales tales como: Traducción Inglés a Español o a Criollo (Haitiano), servicios para discapacitados en visión o audición, por favor llame con 48 horas de antelación para que puedan hacerse los arreglos necesarios.	Unless otherwise noted on the calendar, all meetings are held at: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 To confirm HIV Planning Council meeting information, or reserve special needs services such as Translation from English to Spanish or Creole, or are hearing or visually impaired, please call 48 hours in advance so that arrangements can be made for you.	Sòf si yo ta ekri yon lòt bagay nan almanak-la, tout rankont-yo ap fét: Location: Broward Regional Health Planning Council (BRHPC): 200 Oakwood Lane, Suite #100, Hollywood, FL 33020 Pou konfime enfòmasyon ou resevwa sou rankont Konsèy Planifikasyon HIV-a, oswa pou rezève sèvis pou bezwen Espesyal tankou: Tradiksyon angle an panyòl oswa kreyol; oswa, si ou gen pwoblèm wè oswa tande, rele 48 tè alavans pou yo ka fè aranjman pou ou.

HIVPC Committee Descriptions

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and ser- vices provided to all patients receiving Part A and MAI-funded services.

Executive Committee - Sets agenda for Council meetings, addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.

Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.

Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system-based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.

Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.

Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes. Function as a primary level of appeal for unresolved grievances relative to the Council's decisions regarding Ryan White Part A funding.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWHA in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

June 2025

Broward HIV Health Services Planning Council Calendar

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1	2	3 **Support Services Network** **9:00AM-10:15AM** **Community Empowerment Committee Meeting (CEC)** **3:00PM– 5:00PM** **Location: BRHPC/MS Teams**	4	5 **System of Care Committee Meeting (SOC)** **9:30AM – 11:30AM** **Location: BRHPC/MS Teams** **HIV Long-Term Survivors Awareness Day**	6	7
8	9	10	11	12	13	14
15	16 **Quality Management Meeting (QMC)** **12:30PM– 2:30PM** **Location: BRHPC/MS Teams**	17	18 **Quality Network Meeting (CQM)** **9:00AM-10:15AM**	19	20	21
22	23	24	25	26 **HIV Planning Council Meeting** **5:30PM – 7:30PM** **Locations: Broward Government Center/MS Teams**	27 National HIV TESTING Day JUNE 27	28 GET CARE BROWARD TREAT HIV | BEAT HIV RYAN WHITE | PART A
29	30					

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Version 04/28/21 Information on this calendar is subject to change.

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Handout A

FORT LAUDERDALE/BROWARD EMA
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200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Quality Management Committee Meeting
Monday, April 21, 2025 – 12:30 PM
Meeting Location: Broward Regional Health Planning Council Conference Room and via Microsoft Teams

Microsoft Teams Meeting Information:
Join on your computer, mobile app, or room device: Click here to join the meeting
Meeting ID: 253 807 535 170 Passcode: W5un64Pm
Or call in (audio only): +1 469-998-5921 Phone Conference ID 226 656 416#

MINUTES

Chair: Bisiola Fortune-Evans • Vice Chair: Franchesca D'Amore

QMC Members Present: R. Jimenez, S. McLeod, V. Biggs, F. D'Amore, B. Fortune-Evans, J. De La Nuez,

Ryan White Part A Recipient Staff Present: T. Thompson, B. Miller, R. Pena, W. Cius

Planning Council Support Staff Present: D. Liao, S Isidore, M. Lacroix, G. Berkeley-Martinez, J. Beal, D. Cestaro-Seifer

Guest Present: B. Mester, C. Williams, O. Desinor, J. Rogers, J. Shirley, R. Louis XVI, J. Rodriguez

1. **Call to Order, Welcome & Public Record Requirements**

   The *QMC Vice-Chair* called the meeting to order at **12:35 p.m.** The *QMC Vice-Chair* welcomed all meeting attendees who were present. Attendees were notified that the QMC meeting is based on Florida's "Government-in-the-Sunshine Law" and the meeting reporting requirements, including the recording of minutes. In addition, it was stated that the acknowledgment of HIV status is not required but is subject to public record if it is disclosed. The PCS staff led roll calls and introductions for the committee members, Recipient staff, PCS staff, and guests. Lastly, a moment of silence was observed.

2. **Public Comment**

The Public Comment portion of the meeting is intended to allow the public to express opinions about items on the meeting agenda or to discuss other matters about HIV/AIDS services in Broward County.

No public comments were made.

3. **Meeting Approvals**

The approval for the agenda of the April 21, 2025, Quality Management Committee meeting was proposed by **R. Jimenez** This was seconded by **F. D'Amore** and passed unanimously.

The approval for minutes of the March 17, 2025, Quality Management Committee meeting was proposed by **R. Jimenez** This was seconded by **V. Biggs** and passed unanimously.

Motion #1: R. Jiminez, on behalf of QMC, made a motion to approve the April 21, 2025 Quality Management Committee agenda and seconded by F. D'Amore. The motion was adopted unanimously.

Motion #2: F. D'Amore, on behalf of QMC, made a motion to approve the March 17, 2025 meeting minutes, and seconded by V. Biggs. The motion was adopted unanimously.

4. **Discussion Items**
   a. **Action**: Review PSRA Scorecard Template—provide recommended changes to the PSRA Committee

M. Lacroix, PCS Staff, began the discussion by explaining the committee's purpose of reviewing the scorecard template. She referenced the previous Priority Setting & Resource Allocation (PSRA) meeting, where it was noted that the current scorecards lack data on individuals aged 50 and older. As a result, the committee recommended that the Quality Management Committee (QMC) evaluate the scorecard template and associated criteria during their April meeting, with the intent of providing feedback and recommendations to the Clinical Quality Management (CQM) Support Staff.

D. Liao, representing the CQM Support Staff, guided the committee through the FY2023-2024 Scorecard: Part A Overall. Following the presentation, the committee engaged in a discussion about potential improvements.

V. Biggs highlighted the importance of updating the age categories to better represent individuals aged 64 and older, particularly those transitioning into Medicare. V. Biggs proposed new age brackets: 59–63, 64, and 65+, as the current structure does not allow for adequate analysis of this population's needs.

J. Beal, Clinical Support Consultant, encouraged the committee to review how other Eligible Metropolitan Areas (EMAs) structure their scorecards. He cited Miami's EMA as an example, noting that its detailed scorecards stimulate site-level competition and accountability. J. Beal also pointed out a notable discrepancy in viral suppression rates within Broward's Medicaid population compared to those with Medicare, private insurance, or Ryan White coverage. While the current scorecard identifies insurance

categories, it does not effectively link them to care outcomes, such as viral suppression, which are critical for local Ending the HIV Epidemic (EHE) efforts.

F. D'Amore raised a concern about the terminology used in the scorecard's gender section. She questioned whether the term "other," used in the race category, could also be applied to gender, or if a more appropriate term should be used. After a brief discussion, the committee agreed to adopt "unspecified" as the preferred term.

V. Biggs also inquired whether private insurance data includes coverage through the Affordable Care Act (ACA), and if so, whether ACA coverage could be distinguished from other private plans. T. Thompson acknowledged that there is a field for ACA data but noted uncertainty about its consistency in reporting. J. Shirley explained that the data collection form includes dropdown options for ACA exchange, private non-ACA, and employer-sponsored insurance. Thompson added that while the data could be extracted, it would require a manual process due to the absence of an automated report.

Lastly, Biggs suggested including data on viral suppression rates specifically for Ryan White clients aged 59 and older. By breaking down suppression rates by age group, the committee could identify which segments face the greatest challenges.

The committee concluded by reviewing all suggestions and recommendations to be presented to PSRA, and a motion was made accordingly.

QMC Scorecard Recommendations to PSRA:

1. Following the Executive orders enacted earlier this year, adopt an alternative term for the blackened-out portion under the gender category. The recommended term to use is "Unspecified."
2. Break down the private insurance category into: ACA, Employer-Sponsored, and Private Non-ACA
3. The age categories for individuals aged 59 and above are divided as follows: 59-63, 64, and 65 and over.
4. In the Virally Suppressed section, include a section for the overall N for each subcategory. Note that the percentage will be adjusted accordingly. The numerator will be those who are virally suppressed, while the denominator will represent the overall count for each subcategory.

Motion #3: V. Biggs, on behalf of the QMC, made a motion to approve the recommendations put forth by the committee. These recommendations include updating the redacted portion of the gender category to read "unspecified," breaking down the private insurance category into ACA, Employer-Sponsored, and Private Non-ACA, adjusting the age categories for individuals aged 59 and older to 59–63, 64, and 65 and over, and adding the overall "N" for each subcategory in the Virally Suppressed section. The motion was seconded by F. D'Amore and was adopted unanimously.

5. Old Business

a. **Data Request**: Health disparities along age in the care continuum

T. Thompson from the Part A Office delivered a presentation on health disparities by age across the HIV care continuum. Throughout the presentation, committee members and guests engaged in an active and thoughtful discussion about the data and its implications.

O. Desinor observed that, interestingly, males tend to have higher retention in care compared to females across most gender and race categories. He noted that this trend appears consistent, except within the Haitian population, where the pattern does not align as closely. He suggested that this discrepancy warrants further exploration to better understand why males are being retained in care at higher rates than females.

In response, B. Fortune-Evans offered a perspective on the challenges faced by women, noting that they are often the central caregivers in their families. As a result, women may prioritize the needs of others—particularly children and financial responsibilities—above their own health, which can negatively impact their engagement in care.

When the presentation moved to viral suppression data, B. Mester asked about the criteria used to define retention in care. T. Thompson explained that, according to HRSA, retention is defined as having at least two medical appointments spaced 90 days apart. He added that the County also considers other indicators such as medication pickups, copayment assistance for medical visits, and documented lab values.

At the conclusion of the presentation, B. Fortune-Evans, QMC Chair, expressed appreciation to T. Thompson for delivering a thorough and insightful overview of the data.

6. New Business

a. None.

7. Recipient Report

T. Thompson provided a brief verbal update, stating that the County is expected to receive an additional partial grant award. According to the Project Officer, the Ryan White budget has been fully approved by Congress. However, it is still unclear what the implications of that approval will be for the County's specific funding.

7. Data Request

a. None

8. Public Comment

The Public Comment portion of the meeting is intended to allow the public to express opinions about items on the meeting agenda or to discuss other matters about HIV/AIDS services in Broward County**.** No public comments were made.

9. Agenda Items/Tasks for Next Meeting

The next QMC meeting will be held on May 19, 2025, at 12:30PM at BRHPC.

10. Announcements

- None.

11. Adjournment

There being no further business, the meeting was adjourned at **2:10PM.**

QMC Attendance for CY 2025

Count	Meeting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
	Meeting Date	21	C	17	21									
1	Biggs, V.	X	C	X	X									
2	D'Amore, F., V. Chair	X	C	X	X									
3	Fortune-Evans, B., Chair	X	C	E	X									
4	Jimenez, R.	X	C	X	X									
5	Julio De La Nuez	X	C	A	X									
6	McLeod, S.	X	C	X	X									
	Quorum = 4	6	C	4	6									

Legend:	
X - present	N - newly appointed
A - absent	Z - resigned
E - excused	C - canceled
NQA - no quorum absent	W - warning letter
NQX - no quorum present	Z - resigned
CX - canceled due to quorum	R - removal letter

Quality Management Committee Minutes – April 21, 2025 Minutes prepared by PCS Staff

Handout B

Quality Management Committee (QMC) Work Plan FY2025-2026

The work plan is intended to help guide the work of the committee and to assist the Quality Management Committee in achieving its objectives in the coming year. For each activity, the time period of activity is highlighted in blue and the completion date is noted with an "X".

GOAL: By February 2026, systematically monitor, evaluate, and continuously recommend improvements to the quality of HIV care and services provided to all clients receiving Ryan White Part A and Minority AIDS Initiative (MAI) funded services in Broward County.

Objective 1: Use client-level demographic, clinical, and utilization data to assess quality of care, identify health disparities, gaps in care, and integration of services.

Activities	Responsible Party	Outcomes	Action Steps	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
1.1 Review and analyze findings from the annual needs assessment including focus groups, client and provider surveys, and network member evaluations and recommendations.	CQM Staff, QMC, Quality Network	Increase understanding of needs assesment process	Develop Committee knowledge of Needs Assessment purpose and process.												
1.2 Identify and analyze health disparities and gaps among stages of the HIV Care Continuum and make recommendations to HIVPC and PSRA Committee.	CQM Staff, QMC, Quality Network	Increase access to care and improve health outcomes	Idenitify underserved populations (such as the 50+ community, people moving into Medicare, people moving into ACA, and the LGBTQ community) and review client-level data (Care Continuum and Broward Outcomes and Indicators) to identify gaps in care and health disparities. (Integrated Plan 2022-2026, Goal 2, Strategy 2.4)		x										

Objective 2: Implement quality improvement activities that enhance systemwide service delivery and improve client treatment, care, health outcomes, and satisfaction.

Activities	Responsible Party	Outcomes	Action Steps	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2.1 Receive presentation(s) on targeted strategies and interventions for vulnerable populations who may not seek care or who may have fallen out of care.	QMC,SOC, PCS, and CQM Team	Increase access to care and improve health outcomes	Identify ways to engage/ reengage PWH who are not in care or are not virally suppressed and provide recommendations to the QMC and the Ryan White Part A Office. (Integrated Plan 2022-2026, Strategy 2.1.3)												
2.2 Review Service Delivery Models as part of the system-wide Quality Improvement Project (QIP) and ensure standards of care are consistent with current HIV clinical practice standards and PHS guidelines.	CQM Staff, QMC, Networks	Increase access to care and improve health outcomes	Perform annual review and make modifications when indicated on the following SDMs: a. Universal Standards b. Legal Services c. Health Insurance Premium & Cost Shairng Assistance - HICP d. Medical Case Management - MCM e. Integrated Primary Care & Behavioral Health -IPCBH f. Non-Medical Case Management g. Food Bank h. Substance Abuse (Outpatient) i. Mental Health Services j. Centralized Intake Eligibility Determination - CIED k. Emergency Financial Assistance - EFA l. AIDS Pharmaceutical Assistance (Local Pharmacy) m. Medical Nutrition Therapy												
2.3 Receive presentations on Quality Improvement Projects (QIPs) taking place among RW Part A service providers.	QMC and SOC	Increase knowledge of Ryan White Part A's system of care	Receive presentations regarding QIPs and if required, make recommendations to improve health outcomes for RWPA clients.	x											
2.4 Develop annual QMC goals and identify objectives, strategies/action steps to achieve goals.	QMC	Completed annual QMC Workplan	Recommend improvement to QMC activities.												
2.5 Conduct quarterly reviews of the QMC Annual Workplan.	QMC	Track Progress of the QMC in completed activities	Assess progress on completing QMC activities.												

Objective 3: Routinely evaluate the CQM Program and identify areas for improvement.

Activities	Responsible Party	Outcomes	Action Steps	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
3.1 Review progress made on completing the CQM Annual Work Plan and achieving annual CQM Program goals.	QMC and CQM team	Identify goals and objectives for upcoming year	Review CQM Workplan every quarter and provide reccomendations to achieve Workplan goals	x											

LEGEND: **"X"** =Action Completed; **Blue** = Planned

Handout C

QI TOOLKIT QUICK GUIDE

FY 2025-2026

BROWARD COUNTY
RYAN WHITE PART A QI
TOOLKIT QUICK GUIDE

GET CARE
BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

Overview of the *Broward EMA Ryan White Part A QI Toolkit Quick Guide*

The Broward EMA Ryan White Part A QI Toolkit Quick Guide is designed as a tool to support the timely execution of necessary steps that support the Plan Do Study Act (PDSA) quality improvement model. Using the QI Toolkit Quick Guide provides structure to Ryan White agencies completing their Quality Improvement Projects (QIPs). The contents include: QIP planner and seven Checkpoint Activities with examples to support QIP completion.

The ***Broward EMA Ryan White Part A QI Toolkit Quick Guide*** was developed to:

- Present examples curated by CQM Support staff to illustrate the best practices
- Offer a streamlined, user-friendly version of the comprehensive toolkit manual
- Break down complex information into practical, actionable steps
- Serve as a template for onboarding new QI champions and reinforcing the quality improvement process for all Ryan White subrecipient agencies

The QI Toolkit Quick Guide is a companion to the *Broward EMA Ryan White Part A QI Toolkit*. The QI Toolkit is a quality resource informed by evidence, designed to cultivate a proficient and enduring network of Quality Improvement leaders. This toolkit provides a framework with designated checkpoints starting with the data analysis process, leading to the construction of a formal AIM statement. Building upon this infrastructure, QI teams can conduct PDSA cycles that support improvement in client health outcomes and service-delivery processes. The QI Toolkit should be used as a reference manual to support a deeper dive into the PDSA quality improvement process model.

Checkpoint Activities

- □ Checkpoint 1: Identify Focus Areas for Quality Improvement Projects (Step 1)
- □ Checkpoint 2: Driver Diagram (Step 2)
- □ Checkpoint 3: AIM Statement (Step 3)
- □ Checkpoint 4: Drivers/ Contributing Factors (Step 3)
- □ Checkpoint 5: PDSA Cycle Planning Form (Step 4)
- □ Checkpoint 6: Preliminary Data Review and Evaluation (Step 5)
- □ Checkpoint 7: QIP Poster (Step 6)

QIP PLANNER 2025-2026

This planner is a recommended timeline for deliverables related to the QIP process.

Checkpoint check-ins are one-on-one virtual check-ins and provide an opportunity to check in with the CQM team. Time slots are available from 10 am to 3 pm.

QIP PHASE	STARTING	ENDING
STEP 1: GEARING UP FOR QIPS	3/1/2025	4/30/2025
STEP 2: IDENTIFYING THE OPPORTUNITY	5/1/2025	5/28/2025
STEP 3: AIM STATEMENTS	5/29/2025	7/2/2025
STEP 4: PDSA CYCLES	7/3/2025	11/5/2025
STEP 5: PRELIMINARY DATA REVIEW AND EVALUATION	11/6/2025	1/7/2026
STEP 6: QIP POSTER	1/8/2026	2/282026

CHECKPOINT DUE DATES	DATE
Build an Agency QIP Team to Identify Areas for Improvement	5/7/25
Data Stratification	5/28/25
Problem Statement and AIM Statement	6/11/25
PDSA Pre-Planning and Quality Measures	7/2/25
PDSA Cycle Planning Form	8/20,9/24,11/5
Preliminary Data Review and Evaluation	1/7/26
QIP Poster	2/4/26

MARCH

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

APRIL

M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

MAY

M	T	W	T	F	S	S
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5	6	(7)	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	(28)	29	30	31	

JUNE

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						1
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9	10	(11)	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

JULY

M	T	W	T	F	S	S
	1	(2)	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

AUGUST

M	T	W	T	F	S	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
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25	26	27	28	29	30	31

SEPTEMBER

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8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	(24)	25	26	27	28
29	30					

OCTOBER

M	T	W	T	F	S	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER

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3	4	(5)	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

DECEMBER

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JANUARY

M	T	W	T	F	S	S
			1	2	3	4
5	6	(7)	8	9	10	11
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19	20	21	22	23	24	25
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FEBRUARY

M	T	W	T	F	S	S
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9	10	11	12	13	14	15
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23	24	25	26	27	28	

Checkpoint 1: Build an Agency QIP Team to Identify Areas for Improvement

Agency Name:			
QIP leader:	**Role/Title:**	**QIP Co-leader:**	**Role/Title:**

Include the name and current title/role of your CQM team below. (Example: nurse, front desk staff, peer counselor, administrator, medical practitioner, and counselor).

Team Members' Name	Title/Role

As a QIP team, talk to your clinical and support staff, including consumers, to inform the ideas you list below. Document your top two current ideas that will impact changes in client outcomes, client satisfaction, and/or service delivery. Please indicate which theme it falls under.

Change Ideas	Client Outcomes	Client Satisfaction	Service Delivery
	☐	☐	☐
	☐	☐	☐

Checkpoint 1 Example: Build an Agency QIP Team to Identify Areas for Improvement

Agency Name: Health First Clinic			
QIP leader: Anthony Best	**Role/Title:** QI Leader/Psycologist	**QIP Co-leader:** Aisha Henry	**Role/Title:** MCM

Include the name and current title/role of your CQM team below. (Example: nurse, front desk staff, peer counselor, administrator, medical practitioner, and counselor).

Team Members' Name	Title/Role
Jason Smart, Maria Martinez, Sandy Cohen, Marcus Thompson	Peer Counselor/Certified Peer in HIV
Tabitha Mussington	ARNP
Robert McWilliams	IT Specialst
Anita Roberts,Daniel Williams, Brittany Lewis, Suzanne Bailey	NMCM
Theresa Montalvo	Front Desk Staff Supervisor
Pamela Barrett,Joseph Brown	MCM

As a QIP team, talk to your clinical and support staff, including consumers, to inform the ideas you list below. Document your top two current ideas that will impact changes in client outcomes, client satisfaction, and/or service delivery. Please indicate which theme it falls under.

Change Ideas	Client Outcomes	Client Satisfaction	Service Delivery
Develop a multidisciplinary approach to linking clients to HIV treatment and care at our agency.	☐	☐	☑
Develop an intervention that increases the number of appointments kept by our patients with HIV.	☑	☑	☐

Checkpoint 2: Data Drill Down and Analysis Action Plan

Agency Name:	
Start Date:	**End Date:**

Data Stratification Observation, Goal, and Importance

Observation Our QI Team has observed that:	
Goal Our QI Team wants to:	
Importance This is important because:	

Checkpoint 2: Data Drill Down and Analysis Action Plan

Data Drill Down Action Steps

Please fill out the form below and attach your agencies' stratified data report(s). Reminder: De- identified data only (examples of data that should not be included are PE number, DOB, social security, and clinic number).

Data Drill Down Action Steps	Start Date	Date Completed	Results, Findings, & Comments
Review the list of active patients/ clients for whom there is a health outcome concern. What are your findings?			
List the criteria that will assist the team in drilling down the findings to meet the team's goal (Criteria include demographics, diagnosis, service utilization, and health literacy).			
Run reports using the listed criteria to stratify or drill down your data.			
Organize and analyze the reported stratified data. Discuss findings**.**			
What are your next steps? Be specific and create a list (For example, add another criterion OR conduct a root cause analysis using an Ishikawa fishbone diagram, Pareto Chart, or asking the Five Whys).			

Checkpoint 2 Example: Data Drill Down and Analysis Action Plan

Agency Name: Health First Clinic	
Start Date: 5/1/25	**End Date:** 11/21/2025

Data Stratification Observation, Goal, and Importance

Observation Our QI Team has observed that:	Clients are missing appointments for medical, lab and non-medical case management appointments which interferes with their ability to learn about HIV and attain viral suppression at 6 months following linkage and/or re-engagment in HIV treatment and care.
Goal Our QI Team wants to:	Create a plan to encourage clients to stay connected to the HIV treatment and care team while focusing on attaining viral suppression within 6 months of linking or re-engaging in HIV care.
Importance This is important because:	Clients will feel better and do better if they become virally suppressed or undetectable. Accompany benefits to viral suppression are decreasing HIV transmission to sexual and needle-sharing partners.

Checkpoint 2: Data Drill Down and Analysis Action Plan

Data Drill Down Action Steps

Please fill out the form below and attach your agencies' stratified data report(s). Reminder: De- identified data only (examples of data that should not be included are PE number, DOB, social security, and clinic number).

Data Drill Down Action Steps	Start Date	Date Completed	Results, Findings, & Comments
Review the list of active patients/ clients for whom there is a health outcome concern. What are your observations?	5/7/25	5/7/25	We had 35 patients in the last six months who were newly diagnosed with HIV and/or reengaging in HIV Care. This group of clients missed approximately 48-100% of the medical, laboratory or non-medical case management appointments for which they were scheduled at our clinic began receiving services with our agency following a treatment/care gap.
List the criteria that will assist the team in drilling down the observation to meet the team's goal (Criteria include demographics, diagnosis, service utilization, and health literacy).	5/7/25	5/12/25	We want to know the following demographics about all 35 clients: Age, gender, race, housing status, pharmacy name, educational level, and primary language spoken. and mental health screening results (PHQ2, GAD, PHQ4 and/or PHQ9). We also want to know any co-morbidities the clients have in addition to all viral load results, CD4 and mental health screening results (PHQ2, GAD, PHQ4 and/or PHQ9) for each client during the last 6 months.
Run reports using the listed criteria to stratify or drill down your data.	5/15/25	5/22/25	Data "drill down" report attached to this checkpoint submission
Organize and analyze the reported stratified data. Discuss findings	5/26/25	5/28/25	Clients are not receiving the same re-engagement/on-boarding experience because the non-medical case manager and peers and medical practitioner do not have a documented pathway or protocol showing how clients are oriented to the agency, and the management of HIV with clinic appointment expectations.
What are your next steps? Be specific and create a list (For Example, add another criterion OR conduct a root cause analysis using an Ishikawa fishbone diagram, Pareto Chart, or asking the Five Whys).	6/2/25	6/4/25	NMCMS, Peers and MCMs do not a formal process for working together with the ARNP during or following the medical linkage to care appointment with the client. We completed a fishbone diagram (see attached) and learned that clients are not given a person-centered orientation to the RW services that are available to them. In addition, the team does not hold an initial meeting to discuss the client's assessments and care plan goals. We believe that clients should be referred to a MCM automatically if they miss their 8 week viral load lab appointment. Most of the clients we reviewed were working with a NMCM only and we believe the acuity level of the clients' needs warrant that a MCM and peer be working with the client.

Client ID	Age	Gender	Primary Language	Education	Race	Comorbidities	Housing Type	Intial Viral load	PHQ4 Screening	Kept Appointments	
1010	20	female	English	9th Grade to 12th Grade	Black	2	Permanent	>100,000 copies/ml	4	0%	
1111	36	male	English	8th Grade or Less	Black	Unknown	Permanent	>100,000 copies/ml		25%	
1212	45	male	Creole	9th Grade to 12th Grade	Black	1	Permanent	>100,000 copies/ml	2	0%	
1313	32	female	Spanish	9th Grade to 12th Grade	Hispanic	Unknown	Permanent	>100,000 copies/ml		0%	
1414	28	male	English	9th Grade to 12th Grade	Hispanic	1	Permanent	>100,000 copies/ml	2	0%	
1515	24	male	English	8th Grade or Less	White	Unknown	Permanent	5,000-100,000 copies/ml	2	25%	
1616	30	male	Creole	College	Black	1	Permanent	5,000-100,000 copies/ml		0%	
1717	40	male	English	9th Grade to 12th Grade	Black	0	Permanent	5,000-100,000 copies/ml		0%	
1818	23	transgender	English	8th Grade or Less	Hispanic	1	Non-Permanent	5,000-100,000 copies/ml	4	0%	
1919	41	male	Spanish	8th Grade or Less	Hispanic	Unknown	Non-Permanent	5,000-100,000 copies/ml		0%	
2020	35	male	English	8th Grade or Less	White	2	Permanent	5,000-100,000 copies/ml		0%	
2121	27	male	English	8th Grade or Less	Black	0	Permanent	5,000-100,000 copies/ml	1	0%	
2222	55	female	Creole	8th Grade or Less	Black	2	Permanent	5,000-100,000 copies/ml	0	25%	
2323	34	female	English	8th Grade or Less	White	0	Permanent	5,000-100,000 copies/ml	1	0%	
2424	65	male	English	9th Grade to 12th Grade	Hispanic	5	Permanent	5,000-100,000 copies/ml		0%	
2525	23	male	Spanish	College	Hispanic	1	Permanent	5,000-100,000 copies/ml		0%	
2626	34	female	English	9th Grade to 12th Grade	Black	Unknown	Permanent	5,000-100,000 copies/ml	0	33%	
2727	72	male	English	8th Grade or Less	White	4	Permanent	5,000-100,000 copies/ml		0%	
2828	33	female	English	College	Black	Unknown	Permanent	5,000-100,000 copies/ml		0%	
2929	52	female	Creole	9th Grade to 12th Grade	Black	2	Permanent	5,000-100,000 copies/ml		0%	
3030	45	male	English	8th Grade or Less	White	0	Permanent	1,000-4,999 copies/ml	0	0%	
3131	62	male	English	9th Grade to 12th Grade	White	3	Permanent	1,000-4,999 copies/ml	3	33%	
3232	45	male	English	College	Black	2	Permanent	1,000-4,999 copies/ml		0%	
3333	26	female	Creole	8th Grade or Less	Black	1	Permanent	1,000-4,999 copies/ml	2	33%	
3434	32	male	Creole	9th Grade to 12th Grade	Black	Unknown	Non-Permanent	1,000-4,999 copies/ml		0%	
3535	27	male	English	8th Grade or Less	Black	1	Permanent	1,000-4,999 copies/ml	1	25%	
3636	41	female	English	8th Grade or Less	Black	2	Permanent	1,000-4,999 copies/ml		25%	
3737	24	male	Spanish	College	Hispanic	0	Permanent	1,000-4,999 copies/ml		0%	
3838	20	female	English	8th Grade or Less	White	2	Permanent	1,000-4,999 copies/ml		0%	
3939	31	female	English	9th Grade to 12th Grade	Black	0	Permanent	1,000-4,999 copies/ml	0	0%	
4040	66	male	English	8th Grade or Less	White	2	Permanent	1,000-4,999 copies/ml		0%	
4141	36	male	English	College	White	1	Permanent	1,000-4,999 copies/ml		33%	
4242	71	female	English	9th Grade to 12th Grade	Black	3	Permanent	1,000-4,999 copies/ml	3	0%	
4343	32	male	English	9th Grade to 12th Grade	White	0	Permanent	1,000-4,999 copies/ml	0	25%	
4444	41	male	Creole	9th Grade to 12th Grade	Black	1	Non-Permanent	1,000-4,999 copies/ml	2	25%	

Legend

Group 1

Group 2

Group 3

Comorbidities

Diabetes

CVD

Mental Health

Kidney Disease

Hepatitis

Dementia

Cancer

Quality Tools

Cause and Effect Diagram

Description

This template illustrates a Cause and Effect Diagram, also called a Fishbone or Ishikawa Diagram. A detailed discussion of Cause and Effect Diagrams can be found at www.ASQ.org

Learn About C and E Diagrams

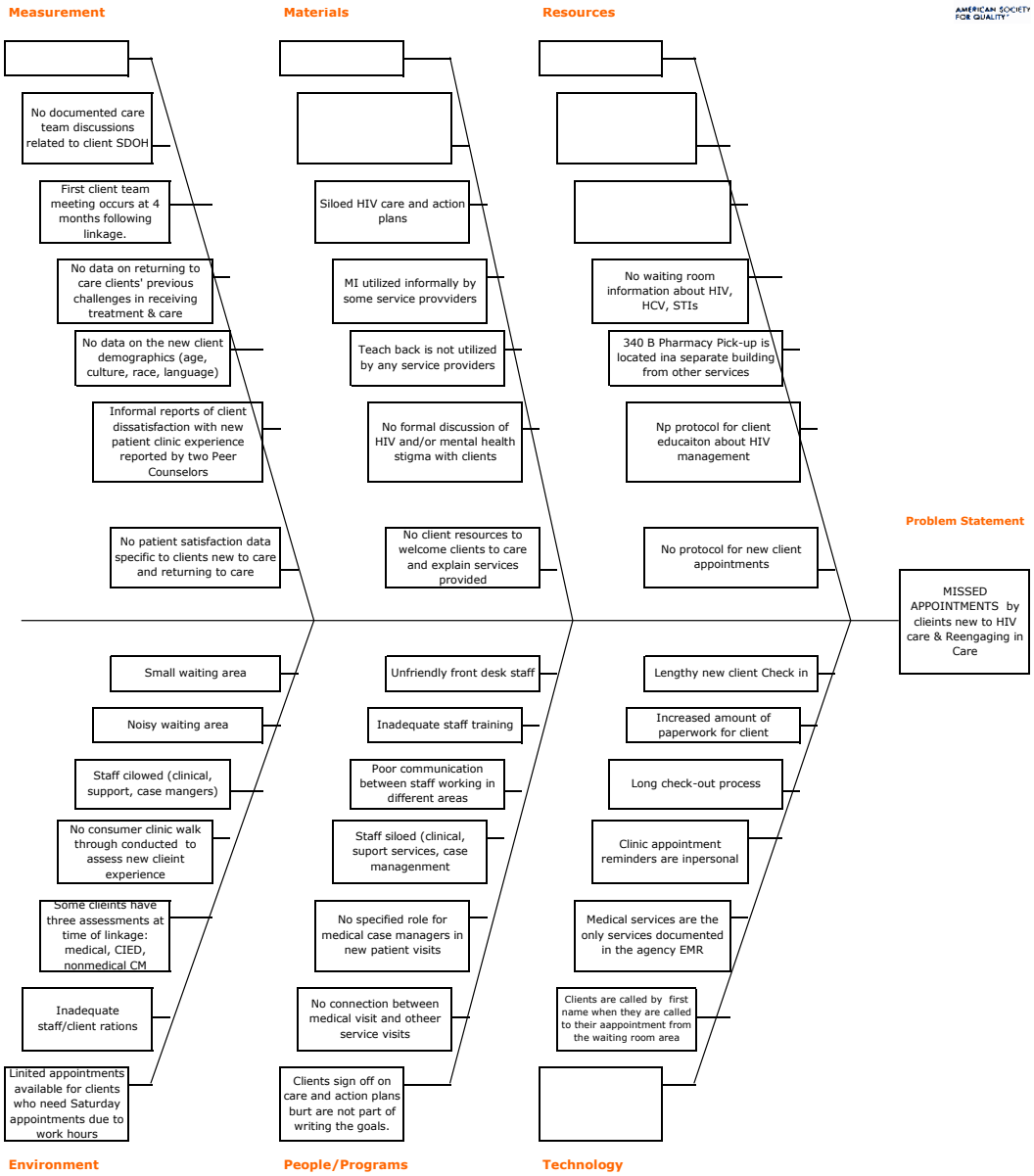
Instructions

- Enter the Problem Statement in box provided.
- Brainstorm the major categories of the problem. Generic headings are provided.
- Write the categories of causes as branches from the main arrow.

Learn More

To learn more about other quality tools, visit the ASQ Learn About Quality web site.

Learn About Quality



Checkpoint 3: Opportunity/Problem Statement and AIM Statement

What are you trying to accomplish?

- Fill in the blanks below to focus on the problem/issue your agency is addressing:

The current situation is		(problem/issue)
leading to		(undesirable event)

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well defined, and, at a minimum, describe the target population, the desired improvement, and the targeted timeframe.

Use the following table to put together your aim statement.

To increase/ decrease		(process/outcome)
from		(baseline %, rate, #, etc.)
to		(goal/target %, rate, #, etc.)
by		(date, 3–5-month timeframe)
in		(population impacted)

Checkpoint 3 Example: Opportunity/Problem Statement and AIM Statement

What are you trying to accomplish?

- Fill in the blanks below to focus on the problem/issue your agency is addressing:

The current situation is	Clients newly diagnosed to HIV care and re-engaging in HIV care are missing appointments	(problem/issue)
leading to	poor viral suppression rates within the 6-month critical time period set by the agency.	(undesirable event)

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well defined, and, at a minimum, describe the target population, the desired improvement, and the targeted timeframe.

Use the following table to put together your aim statement.

To increase/ decrease	viral suppression	(process/outcome)
from	0%	(baseline %, rate, #, etc.)
to	25%	(goal/target %, rate, #, etc.)
by	four months(July 15, 2025 through November 21, 2025)	(date, 3–5-month timeframe)
in	35 clients reengaging in HIV care.	(population impacted)

Checkpoint 4: PDSA Pre-Planning and Quality Measures

Aim Statement	

Identify and list below the outcome and process measures that will assist your team in evaluating the effectiveness of your chosen change ideas.

Outcomes Measures:	
Process Measures:	

Rank	Change Idea	Evidence-based or Informed? Y/N Provide Resource	Required Implementation Resources: People, time, space, equipment	Monetary Costs (Y/N)

Checkpoint 4 Example: PDSA Pre-Planning and Quality Measures

Aim Statement	The Health First Clinic will increase viral suppression from 0% to 25% by four months(July 15, 2025 through November 21, 2025) in 35 clients reengaging in HIV care.

Identify and list below the outcome and process measures that will assist your team in evaluating the effectiveness of your chosen change ideas.

Outcomes Measures:	# kept appointments, viral suppression rates
Process Measures:	new protocol/interventions using a multidisciplinary team approach provided to clients newly diagnosed with HIV and clients reengaging in HIV

Rank	Change Idea	Evidence-based or Informed? Y/N Provide Resource	Required Implementation Resources: People, time, space, equipment	Monetary Costs (Y/N)
#1	Refer clients new to HIV care and reengaging in HIV care for MCM services at the time they are linked to HIV care	State of Wisconsin's Linkage to Care Program	Increase in MCM hours to work with clients during the first critical 12 months of new HIV diagnosis or reengaging in HIV care after a gap in care;	Y_$$
#2	Require that all clients new to HIV care and reengaging in HIV care have a Peer counselor to work with for the first 12 month of care	Peer Navigation support client engagement in care	Hire more Peer Counselors who will be supervised by nonmedical CMs to support client retention in care	Y_$
#3	Require that all clients new to HIV care and reengaging in HIV care received mental health support by a counselor monthly for the first 12 months to support retention in care	Mental Health support provides clients with needed support to focus on their adherence to keeping all medical and support service appointments	Hire a mental health counselor or refer clients for monthly mental health appointments for 1 months	Y_$$$$
#4	Adopt the STEPS to Care intervention that requires that clients new to HIV care and reengaging in HIV care meet weekly with a Peer and or non-medical case manager to complete the STEPS to Care Program and client education workbook	STEPS to care is a CDC evidence-based practice	Creating a care team consisting of Peer Counselors, NMCMs and MCMs to implement a modified version of the STEPs tp Care Program will require more work hours from staff and possible hiring of new staff. It would be great to have ipads or chrome books to use when using the tSSTEPS intervention ools with clients. We will also ave coping costs.	Y_$$
#5	Initiate intensive care team meetings with the client and their nmcm, peer and Medical provider at 2 months, 3 months and 5 months of the client being linked to HIV care after a new HIV diagnosis or reengaging in HIV care after a gap.	Intensive case management better supports the needs of clients with high medical and social/emotional needs	Coordination of meeting time; collaboration of services	Y_$

Checkpoint 5: PDSA Cycle Planning Form

PDSA Cycle Tracker

Agency:_____

Use this form to plan and document a PDSA cycle. Additional notes, materials and data can be attached to this sheet.

Intervention: **Cycle #**:

What is your QIP Aim Statement?

What is the outcome you hope to achieve by testing this intervention? How will it help you meet your Aim?

1. Plan

Briefly describe the intervention you plan to test and the process you will utilize: Intervention name and source, client population, staff participation, training/resources, and timeline.

Task(s) to be completed	Person responsible	Task completion date

List the measure of the intervention you plan to test	Is it a process or outcome measure?	Where will you obtain the data to evaluate the measure?	Who will collect the data?

PREDICTION: What do you think will happen (predict the answer to the test. Will it produce a measurable change in the direction of your aim)?

2. Do

What problems or unexpected events did you encounter? What opportunities do you have to make changes?

Feedback and observations from the clients and/or service provider/staff:

What happened? Did you get the data you needed to measure the effectiveness of the intervention?

3. Study

What does the data show? *Please be specific and show your data using a table or chart. Use the QIP Data Excel template tab labeled "PDSA Interventions and Strategies."*

How effective was your intervention? Was your prediction confirmed? Why or why not?

4. Act

Briefly discuss how you will increase the effectiveness of the exact same intervention or adapt a slightly different modified version of the intervention or abandon the intervention completely and try a new intervention.

Following this PDSA cycle, will you: (Check one box)

☐ Adopt (Implement) ☐ Adapt (Refine & Retest) ☐ Abandon Change

What is your plan for the next PDSA cycle to reach your project's aim? Do you require additional resources or technical assistance from our quality consultants at this time?

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Adapted from: *PDSA Cycle Planning Form.* California Institute of Behavioral Health Solutions. Accessible at: https://www.cibhs.org/sites/main/files/file-attachments/ pdsa_cycle_planning_form_final.pdf?1413830469

Checkpoint 5 Example: PDSA Cycle Planning Form

PDSA Cycle Tracker

Agency: Health First Clinic

Use this form to plan and document a PDSA cycle. Additional notes, materials and data can be attached to this sheet.

Intervention: CDC Steps to Care Intervention

Cycle #: 1

What is your QIP Aim Statement?

The Health First Clinic will increase viral suppression from 0% to 25% by four months(July 15, 2025 through November 21, 2025) in 35 clients reengaging in HIV care.

What is the outcome you hope to achieve by testing this intervention? How will it help you meet your Aim?

The outcome we hope to achieve is for 100%(N=5) of the clients who receive an offer to participate in the Step to Care program will accept the offer. Clients who accept the offer to participate are agreeing to a more formal process in learning about HIV chronic disease management that occur during regular scheduled meetings with a peer and case manager.

1. Plan

Briefly describe the intervention you plan to test and the process you will utilize: intervention name and source, client population, staff participation, training/resources, and timeline.

Steps to Care program is an evidenced based intervention developed by the Centers for Disease Control with materials produced specifically for providers and agencies working with individuals diagnosed with HIV. The purpose of the intervention is to improve client health literacy and health outcomes by connecting clients to case management/ peer support team. Clients will be 18 years of age or older and have at least one experienced gap in HIV care lasting more than 30 days. The criteria include having a viral load of 1000 copies. Staff using the intervention require Steps to Care training. Our team decided to implement this intervention over a 1 month period of time. The first group will focus on clients with a viral load greater than 100,000 copies/mL.

Task(s) to be completed	Person responsible	Task completion date
Identify MCM and peer to initiate the program.	QIP leader	5/21/2025
Schedule and conduct AETC training with all agency MCM and peers in attendance	QIP leader & Co-leader	6/4/2025
MCM and peer meet with ARNP and one other medical provider to discuss intervention process.	MCM & peer	6/9/2025
MCM and peer agree on a communication strategy to offer intervention to eligible clients.	IT	6/9/2025
MCM,peer, and IT meet to develop Excel spreadsheet and identify the documentation process of all measures	QIP leader	6/12/2025
MCM, peer, and front desk supervisor discuss the process of scheduling appointments for clients enrolled	Front desk supervisor	6/12/2025
Front Desk supervisor meets with staff to provide guidance on scheduling clients for intervention appointments	Front desk supervisor	6/25/2025

Identify the measure of the intervention you plan to test.	Is it a process or outcome measure?	Where will you obtain the data to evaluate the measure?	Who will collect the data?
1. Client eligibility criteria and number of eligible clients	process	PE and Test and Treat	Peer/MCM/Medical provider
2. Number of intervention offers made to each eligible client	process	Excel Spreadsheet	Peer/MCM/IT
3.Number of client offer acceptances	outcome	Excel Spreadsheet	Peer/MCM/IT
4. Number of labs completed	outcome	PE and EMR	Peer/MCM/IT
5. Number of kept peer scheduled appointment	outcome	EMR	Front desk staff
6. Number of kept peer and MCM combined scheduled appointment	outcome	EMR	Front desk staff
7. Client Perception of Viral Suppression Importance Survey	process	Alchemer	Peer/MCM
8. Number of completed client assessment forms	outcome	Fill-in PDF	Peer/MCM
9. Number of completed adherence assessment forms	outcome	Fill-in PDF	Peer/MCM
10. Number of completed integrated peer and MCM care plans	outcome	Fill-in PDF	Peer/MCM
11. Viral suppression rates/ undetectable status	outcome	PE and EMR	Peer/MCM/IT

PREDICTION: What do you think will happen (predict the answer to the test. Will it produce a measurable change in the direction of your aim)?

We expect that 90% of clients we speak to about this intervention will say "yes" and enroll. Once enrolled, we expect the client to keep 80% of their scheduled appointments with the peer and MCM. We expect 100% completion of labs for each client.

2. Do

What problems or unexpected events did you encounter? What opportunities do you have to make changes?

One of the clients was referred to PROACT. Our team never followed-up with PROACT so we don't know what happen to the individual that was lost to care. There needs to be a better communication system in working with PROACT so that we know when a client is located and returning to care in Broward. There was a time lag in communication between clients being accepted into the program and informing staff . We had to address this in a staff meeting. Behavioral Health counselor was very available to work with clients who needed services but, did not know at what point to meet with clients during this intervention. It was decided that during the making of the offer and acceptance meeting that the peer or MCM would introduce the counselor to the client. We did not offer telehealth appointments and we need to address this in upcoming PDSA cycles.

Feedback and observations from the clients and/or service provider/staff:

MCM and peer enjoyed working together and were effective as a team and individually in keeping the ongoing acceptance of clients into the intervention(making offers, scheduling clients, completing paperwork, etc.). Availability of IT was excellent when MCM and peer needed to make adaptation in the Excel spreadsheet. QIP leader and co-leader were both available to help with communication between MCM/ peer team and medical providers. Medical practitioner mentioned the program when meeting with eligible clients to reinforce the importance of the project.

What happened? Did you get the data you needed to measure the effectiveness of the intervention?

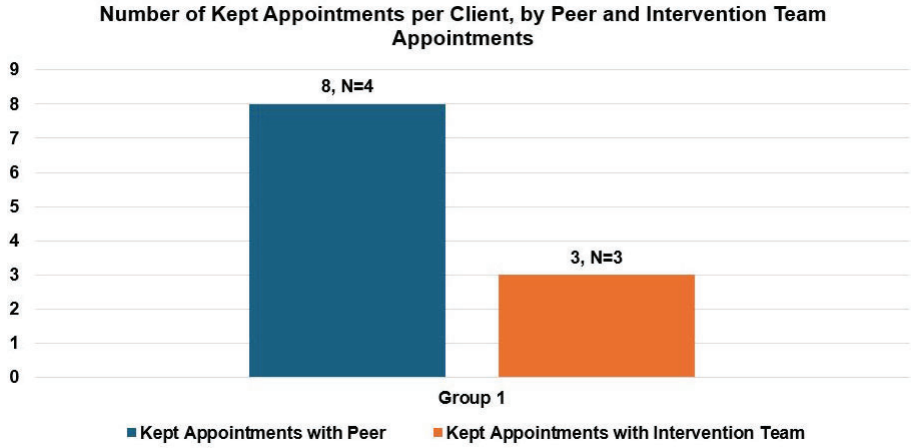
1 client could not be contacted to discuss/start the intervention (referral to PROACT)
4 clients agreed to start the steps to care intervention:
- 2 of the clients had their labs drawn per the medical practitioner's request
- Peer held 2 scheduled appts with each client at a convenient location for the client
- Peer and MCM held 1 scheduled appt at the clinic with 3 out of the 4 clients.

All enrolled clients(N=4) are at different stages with working with their MCM/peer to complete Steps to Care documents/deliverables at the time of this report. Only one client has completed all Steps to Care documents.

3. Study

What does the data show? *Please be specific and show your data using a table or chart. Use the QIP Data Excel template tab labeled "PDSA Interventions and Strategies."*

Client ID	Age	Gender	Primary Language	Education	Race	Comorbidities	Housing Type	Intial Viral load
1010	20	female	English	9th Grade to 12th Grade	Black	2	Permanent	>100,000 copies/ml
1111	36	male	English	8th Grade or Less	Black	Unknown	Permanent	>100,000 copies/ml
1212	45	male	Creole	9th Grade to 12th Grade	Black	1	Permanent	>100,000 copies/ml
1313	32	female	Spanish	9th Grade to 12th Grade	Hispanic	Unknown	Permanent	>100,000 copies/ml
1414	28	male	English	9th Grade to 12th Grade	Hispanic	1	Permanent	>100,000 copies/ml



How effective was your intervention? Was your prediction confirmed? Why or why not?

Our initial prediction that 90% of clients offered this intervention would agree and enroll was not met. In reality, 80% (N=4) of the clients re engaged during this PDSA cycle enrolled in the new intervention. All enrolled clients maintained their scheduled appointments with the Peer. However, only 75% of the scheduled appointments with the Intervention team (Peer and MCM) were kept. The Peer met with each client at locations convenient for the clients while the Intervention team appointments were held at the clinic. Location flexibility helped to reduce barriers for clients, such as issues with transportation, time constraints, and discomfort in clinical settings. Peers often shared experiences with clients, which fostered stronger connections. So far, two of the four clients in the intervention had their labs drawn per the medical practitioner's orders. All clients had labs scheduled, but 50%(N=2) clients have yet to complete this activity.

4. Act

Briefly discuss how you will increase the effectiveness of the exact same intervention or adapt a slightly different modified version of the intervention or abandon the intervention completely and try a new intervention.

To enhance the effectiveness of the Steps to Care intervention, all appointments must align with a client-centered approach, similar to the method employed by the peer in the first PDSA cycle. Provide flexible, mobile locations (mobile units) for joint meetings with MCM and peers, including lab appointments. This strategy will help eliminate barriers such as transportation and scheduling challenges. Additionally, consider incorporating lab draws into peer meetings, as this may offer a sense of comfort by having someone accompany them. Explore incentives, such as gift cards, to further increase client adherence to intervention activities.

Following this PDSA cycle, will you: (Check one box)

☐ Adopt (Implement) ☑ Adapt (Refine & Retest) ☐ Abandon Change

What is your plan for the next PDSA cycle to reach your project's aim? Do you require additional resources or technical assistance from our quality consultants at this time?

.

In our next PDSA cycle, we will enroll more clients(N=15) who have viral loads ranging between 5,000 and 100,000 copies/mL and are re-engaging into HIV treatment/care. To provide enhanced support, we will incorporate a NMCM to address health-related social needs, including but not limited to housing and transportation. Additionally, a second peer will join the team. This expanded team approach is designed to improve care coordination and boost appointment adherence to increase our ability to reach our aim to increase viral suppression from 0% to 25% within four months.

Adapted from: *PDSA Cycle Planning Form.* California Institute of Behavioral Health Solutions. Accessible at: https://www.cibhs.org/sites/main/files/file-attachments/ pdsa_cycle_planning_form_final.pdf?1413830469

Checkpoint 6: Preliminary Data Review and Evaluation

Preliminary Data Review & Evaluation

Agency:_____

Aim Statement:

PDSA Cycle Interventions

Please insert all data visuals down below and describe the results of your data collection, observations, or other findings:

INTERPRETING THE RESULTS

1. Does your data show that you reached your project's aim? Yes or No? How do you know this?

2. Did you implement your strategies for improvement (interventions) as originally planned in your PDSA cycles? If not, explain what modifications you made and the rationale behind these changes.

3. Did you experience any barriers in conducting your QIP? If so, what were the barriers to implementation? Were you able to overcome them and if so, how?

4. a. Did one or more of the interventions used during one or more PDSA cycle achieve improvement in patients' viral loads? Yes or No. Use your data to explain how you know this.

   b. Is the improvement in viral load attributable to one or more of your PDSA cycle interventions? Yes or No. Use your data to explain how you know this.

5. a. Did one or more of the interventions used during one or more PDSA cycles achieve improvement in the patient retention in HIV care rate? Yes or No. Use your data to explain how you know this.

b. Is the improvement in retention in care attributable to one or more of your PDSA cycle interventions? Yes or No. Use your data to explain how you know this

6. What additional factors or changes,if any, that occurred at your agency may have affected your PDSA cycle results/data(i.e. staff changes, infrastructure changes, emergency disasters)?

LESSONS LEARNED

7. What lessons did you learn as you reflect on your agency's QIP implementation process?

8. What went right during your QIP? What went wrong? What needs to be improved?

9. List three (3) things you could have done differently during the QIP that may have resulted in better patient outcomes?

NEXT STEPS

10. What are the next steps your agency will take over the next three months to continue to focus on improving patient viral suppression rates?

11. What data measurement/collection needs do you currently have that might improve your agency's QIP work in the future?

12. Will you continue (adopt) one or more of the interventions used in your agency's QIP, or will you modify or add a new intervention to improve viral suppression rates among the patients your agency serves? Discuss in a few sentences your ideas for your agency's follow-up to this QIP.

Checkpoint 6 Example: Preliminary Data Review and Evaluation

Preliminary Data Review & Evaluation

Agency: Health First Clinic

Aim Statement:

The Health First Clinic will increase viral suppression from 0% to 25% by four months(July 15, 2025 through November 21, 2025) in 35 clients reengaging in HIV care.

PDSA Cycle Interventions

CDC Steps to Care Intervention Month July-September

Please insert all data visuals down below and describe the results of your data collection, observations, or other findings:

Figure 1

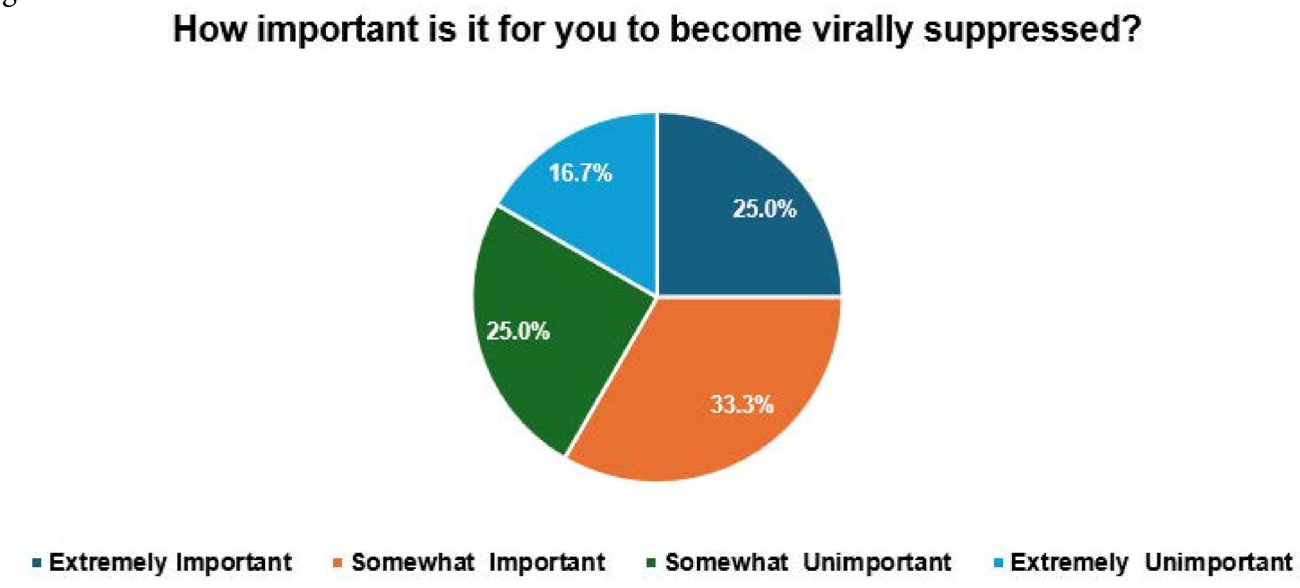


Figure 2

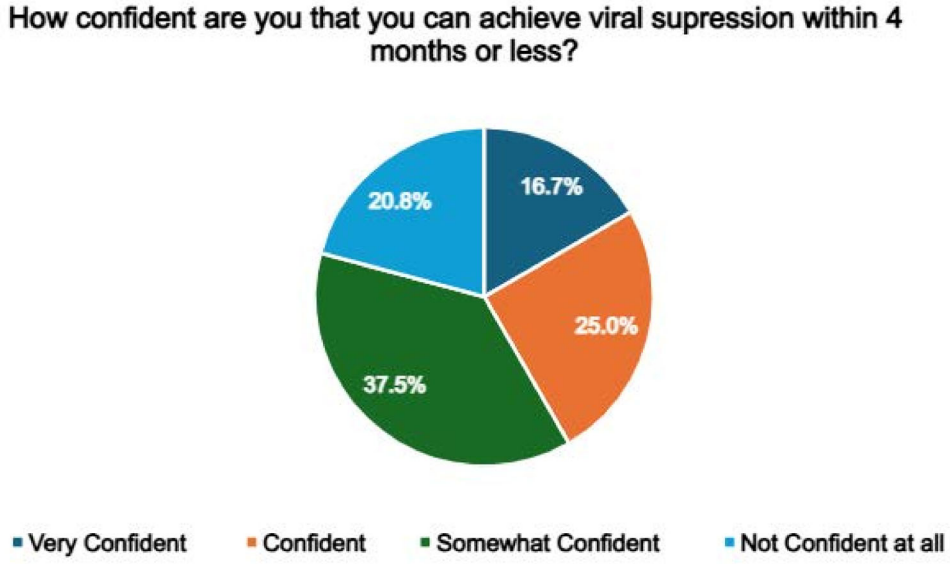


Figure 3

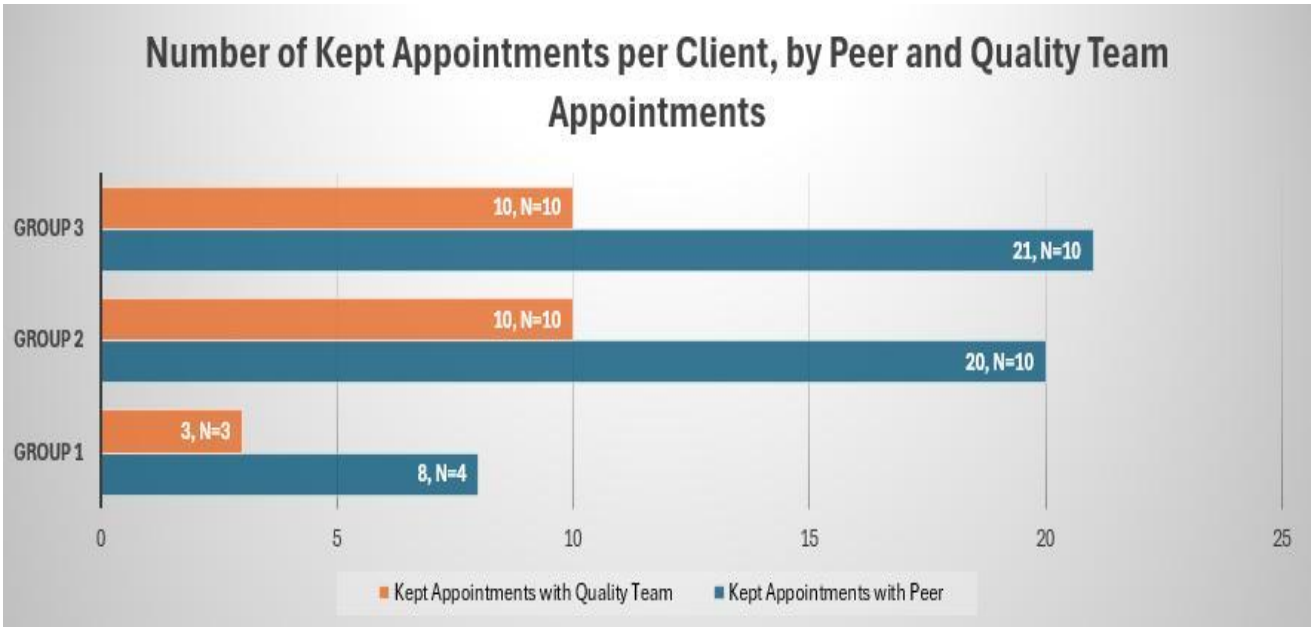


Figure 4

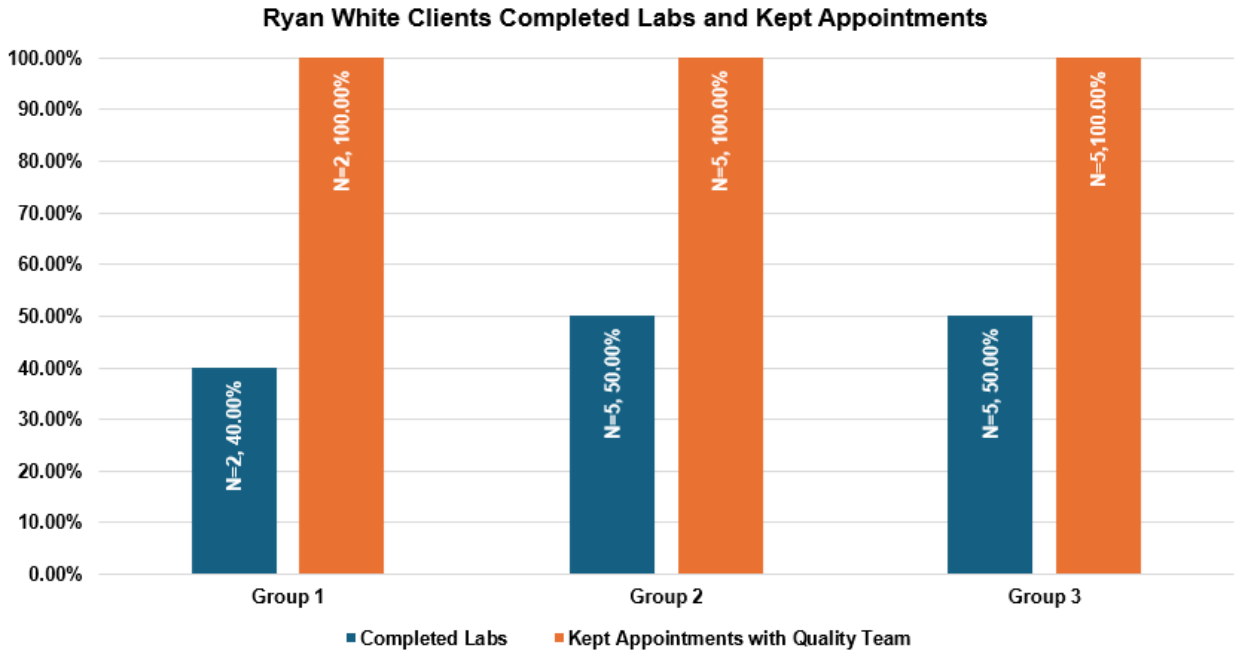


Figure 5

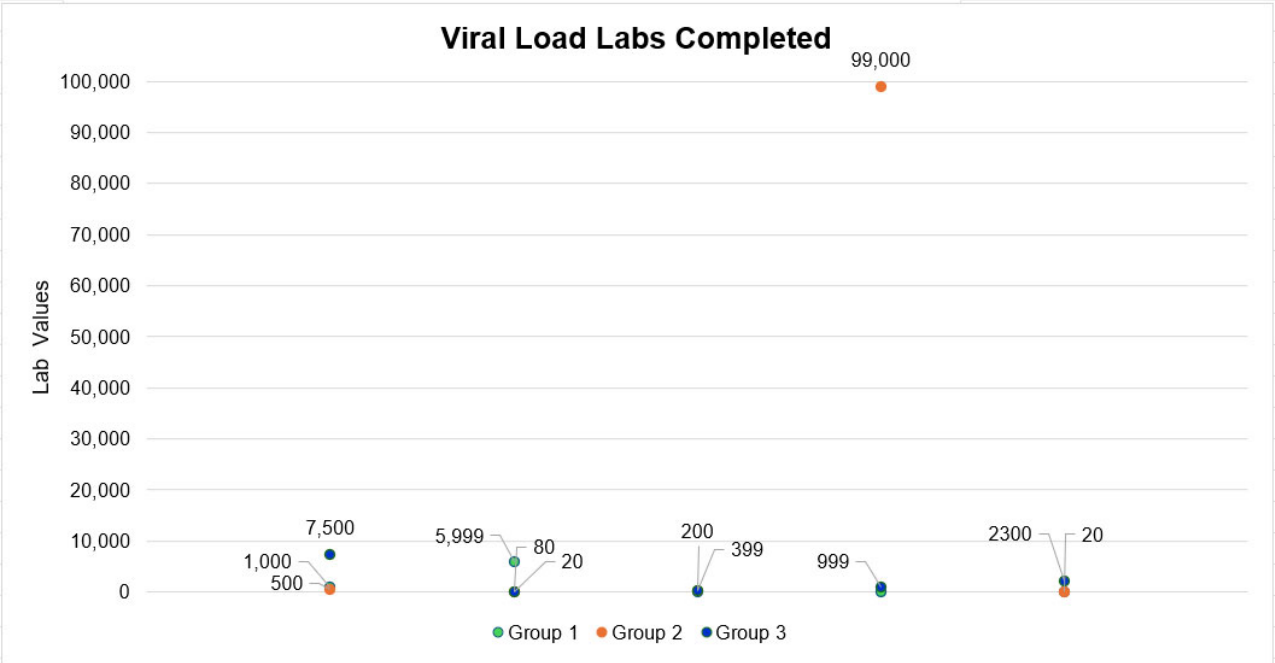


Table 1

Groups	Individual Viral Load Labs Completed
Group 1	1,000 copies/ml
Group 1	5,999 copies/ml
Group 2	500 copies/ml
Group 2	80 copies/ml
Group 2	399 copies/ml
Group 2	99,000 copies/ml
Group 2	<20 copies/ml
Group 3	7,500 copies/ml
Group 3	<20 copies/ml
Group 3	200 copies/ml
Group 3	999 copies/ml
Group 3	2300 copies/ml

INTERPRETING THE RESULTS

1. Does your data show that you reached your project's aim? Yes or No? How do you know this?

   No, the data shows that we did not meet our aim. Of the 35 individuals that we attempted to link to care, 24 clients successfully reentered care. About thirteen percent(N=24) of our clients became virally suppressed during the 6 month project. It's important to note that lab data lags behind our intervention and we will need to continue to monitor the labs to see how much more we improved viral suppression as a result of this QIP.

2. Did you implement your strategies for improvement (interventions) as originally planned in your PDSA cycles? If not, explain what modifications you made and the rationale behind these changes.

   PDSA Cycles. We are fortunate that this did not happen and recognize that we need to have policy and procedures in place in case this happens. We never followed-up with PROACT so we don't know what happen to the people we lost to care. There needs to be a better communication system in working with PROACT so that we know when a client is located and returning to care in Broward.

3. Did you experience any barriers in conducting your QIP? If so, what were the barriers to implementation? Were you able to overcome them and if so, how?

   The intervention did not address the viral suppression needs of individuals who remained unstably housed. When a client is not ready to engage in the intervention, we did not have a sustainable plan to work with individuals who were not ready to participate in the intervention. There was one client that had a barrier to staying connected to case manager services ; however peer was able to sustain limited contact with client.
   Two clients moved to another county for work opportunities. NMCM connected them to Ryan White services in the new county. Clients agreed to stay connected to peers and NMCM during the transition to new services. Clients had 3 months of prescribed ARV to support during the transition.

4. a. Did one or more of the interventions used during one or more PDSA cycle achieve improvement in patients' viral loads? Yes or No. Use your data to explain how you know this.

   Yes, there was improvement in achieving viral suppression in those who completed their labs by utilizing the CDC Steps to Care intervention for those clients returning to care when comparing the baseline data below with the data collected in Table 1. These data can also be seen in Checkpoint 1.

   Baseline Data:
   Group 1 N=5, >100,000 copies/ml

   b. Is the improvement in viral load attributable to one or more of your PDSA cycle interventions? Yes or No. Use your data to explain how you know this.

   All three iterations of the intervention used in our PDSA cycle proved to improve patients' engagement in care and viral load. Clients who kept their lab appointments did show a decrease in their viral load except for one client in Group 2 (99,000 copies/mL) as seen in Figure 5. We will have further discussions with the quality team and the client to understand barriers that may contribute to not achieving viral suppression.

5. a. Did one or more of the interventions used during one or more PDSA cycles achieve improvement in the patient retention in HIV care rate? Yes or No. Use your data to explain how you know this.

   Yes, the CDC Steps to Care intervention improved retention in care for those clients returning to care in this project. As shown in Figure 3, Group 1(N=5) had 4 clients who kept appointments with their peers and 3 clients kept appointments with the quality team (non-medical case managers, disease case managers, and peers). Group 2(N=15) and Group 3(N=15) each had 10 clients who kept all their appointments with both the quality team and their peers. It's important to note that during PDSA Cycles 2 and 3, we increased the frequency of peer interactions with their clients in these two groups. It is possible by increasing the frequency of client-peer interaction in these groups, the clients were more comfortable in attending the quality team meetings.

b. Is the improvement in retention in care attributable to one or more of your PDSA cycle interventions? Yes or No. Use your data to explain how you know this

Yes, those clients who participated in the intervention were retained in care. Of this group, 40%-50% completed their labs as seen in Figure 4.

6. What additional factors or changes,if any, that occurred at your agency may have affected your PDSA cycle results/data(i.e. staff changes, infrastructure changes, emergency disasters)?

We did not have any additional factors or changes that influenced our PDSA Cycles one way or another, but we recognized that any changes can affect our interventions such as weather emergencies and organizational changes. In the future, we need to develop contingencies before implementing interventions that rely on staff involvement and participation. We liked increasing our peer involvement because it fill in gaps when staff were out of office.

LESSONS LEARNED

7. What lessons did you learn as you reflect on your agency's QIP implementation process?

We learned that a barrier that affects some of our clients is unstable housing. As providers, we need to find resources in the community to help our clients either obtain stable or temporary housing until a permanent resolution is available. In addition, we might consider mobile units that could be used to enhance this intervention for people who are living predominately on the streets.

We learned that we need more that one peer and case manager because when they are not there, the clients are less likely engage in care.

Although we did not mention it, during Group 3, we found that it was important that all peers were introduced to all the clients in the group. When this occurred, clients were open to meeting the other peers when their peer was out of the office.

8. What went right during your QIP? What went wrong? What needs to be improved?

What went right: We started small with the QIP so that we could better understand and develop our roles. After doing this, we found it more comfortable to bring more clients into the intervention. Creating a quality team that included peers as the primary contact for the clients enrolled in this program was largely responsible for the improved patient outcomes.

What went wrong: We did not have resources that to support individuals who are living on the streets. The intervention could still work but we need some sort of street medicine approach that might utilize a mobile unit or satellite program(i.e. food bank) that has the ability to draw labs.

What needs to be Improved: We found that there were other important process measures to be considered. In the future, we need to develop contingencies before implementing interventions that rely on staff involvement and participation.

9. List three (3) things you could have done differently during the QIP that may have resulted in better patient outcomes?

We did not investigate other barriers such as education, language, insured, and knowledge of HIV that may have further compromised utilizing this intervention.

We did not look at trauma and substance use in those clients where the intervention was not a good fit.

We did not look at Ryan White clients who were seeing medical practitioners outside of the Ryan White network of providers.

We need to have a way to communicate with the PROACT team so that we could get our clients back into care and in the Steps to Care intervention.

We should have looked at the data pertaining to the number of clients who had AIDS diagnoses. This would have been impactful because by using the intervention to increase viral suppression, we are improving client mortality by helping them sustain a healthy immune system.

NEXT STEPS

10. What are the next steps your agency will take over the next three months to continue to focus on improving patient viral suppression rates?

    We will continue to implement this intervention for people who are returning to care.

    We will develop a protocol for staff changes and natural disasters.

    We need to identify intervention modifications/enhancements to address the needs of clients who would benefit from additional resources and collaborations with other agencies.

11. What data measurement/collection needs do you currently have that might improve your agency's QIP work in the future?

    We need to develop MOU of understanding with key agencies to support data sharing. Obtaining viral load labs was time consuming in some cases where the clients medical practitioner was not a Broward Ryan White Part A Provider.

12. Will you continue (adopt) one or more of the interventions used in your agency's QIP, or will you modify or add a new intervention to improve viral suppression rates among the patients your agency serves? Discuss in a few sentences your ideas for your agency's follow-up to this QIP.

    We will adapt Steps to Care and our process of implementing this evidence-based intervention. We feel that this a very client-centered approach to helping clients reconnect to care going forward. We may want to consider using Steps to Care for those clients new to HIV care.

TITLE

NAME OF PRESENTER, ASSOCIATES, & COLLABORATORS

AGENCY NAME AND YEAR

Add Logo Here

BACKGROUND

- Problem statement
- Why did your agency focus on this?

AIM STATEMENT

[Name of agency] aims to increase [measure] from [baseline] to [goal] through {process] by [goal date].

MEASURES

Process Measures
What data did you use to ensure that your QI process was happening?

Outcome Measures
What data did you use to ensure that your QI process was working?

PDSA CYCLES

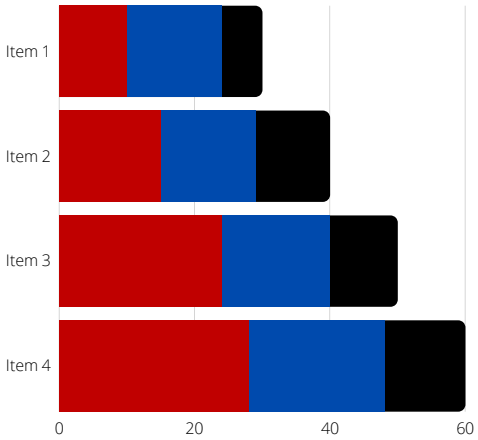
Cycle 1
Plan:
Do:
Study:
Act:

Cycle 2
Plan:
Do:
Study:
Act:

Cycle 3
Plan:
Do:
Study:
Act:

RESULTS

Discuss findings here, include tables, graphs, charts, etc.



Explanation 1

Explanation 2

SUCCESSES, CHALLENGES, & NEXT STEPS

- What went well/as planned?
- What went wrong? Include barriers
- How will you move forward?

ACKNOWLEDGEMENTS

Thank you to.....

Care in Action: Increasing VS with CDC's Steps to Care

Anthony Best and Aisha Henry, & Health First Clinic's Intervention Team

Health First Clinic 2025

Health First

BACKGROUND

Clients newly diagnosed with HIV care and re-engaging in HIV care are missing appointments, leading to poor viral suppression rates within the 6-month critical time period set by the agency.

AIM STATEMENT

The Health First Clinic will increase viral suppression from 0% to 25% by four months(July 15, 2025, through November 21, 2025) in 35 clients reengaging in HIV care.

MEASURES

Process Measures

- Number of intervention offers made to each eligible client and acceptances
- Client Perception of Viral Suppression Importance Survey

Outcome Measures

- Viral suppression rates/ undetectable status
- Number of completed integrated peer and MCM care plans, adherence assessment forms, and client assessment forms

PDSA CYCLES

Cycle 1

Plan: Steps to Care program with 1 MCM, 1 peer

Do: One client was unreachable for intervention discussions. 4 clients agreed to begin the intervention, with 2 having completed lab work. Peers conducted two scheduled appts per client, while the intervention team held one scheduled appt with 3 clients.

Study: 100% of appts were kept with the peer, and 75% kept appts with the intervention team.

Act: Adapt

Cycle 2

Plan: Steps to Care program with 1 MCM, 1 NMCM, 2 peers

Do: 3 clients couldn't be reached for intervention. 2 clients have unstable housing. 10 clients agreed to start care intervention; 5 completed lab work. Peers had two appts with each client, and the intervention team had one clinic appt with all 10 clients.

Study: 100% appts kept with both peers and intervention team.

Act: Adapt

Cycle 3

Plan: Steps to Care program with 2 MCM, 2 NMCM, 3 peers

Do: 2 clients were unreachable for intervention discussions, and 2 others relocated for jobs. 1 client faced unstable housing. 10 clients agreed to begin care intervention steps. Labs were drawn for 5 clients. Peers conducted 2 appts with each client at convenient locations and held a clinic appt with all 10 clients. Peers facilitated a support group for 4 clients.

Study: 100% appts kept with both peers and intervention team.

Act: Adopt

RESULTS

Groups	Individual Viral Load Labs Completed
Group 1	1,000 copies/ml
Group 1	5,999 copies/ml
Group 2	500 copies/ml
Group 2	80 copies/ml
Group 2	399 copies/ml
Group 2	99,000 copies/ml
Group 2	<20 copies/ml
Group 3	7,500 copies/ml
Group 3	<20 copies/ml
Group 3	200 copies/ml
Group 3	999 copies/ml
Group 3	2300 copies/ml

SUCCESSES, CHALLENGES, & NEXT STEPS

- What went right: We started the QIP on a small scale to better understand and clarify our roles. This made us more comfortable when adding more clients to the intervention.
- What went wrong: Resources are insufficient to aid the homeless effectively. A potential solution could involve a street medicine approach with a mobile unit or satellite program, similar to a food bank, capable of performing lab tests.

ACKNOWLEDGEMENTS

Thank you to the whole Intervention Team at Health First Clinic!

Handout D

Broward EMA Ryan White Part A Program

Health Outcomes Presentation

Quality Management Committee Meeting

May 19, 2025

GET CARE BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

PRESENTED BY
DANIELLE LIAO, MPH

Housekeeping Rules

Mute Microphone

Participants will be automatically muted to limit background noise

Identify Yourself

State your name and agency when speaking

Use the Chat Box

Type in the chat box to identify yourself and agency, ask questions, and request additional clarification

Raise Your Hand

The "raise hand" option will notify the presenter of any questions that may arise

Ask Questions

Please save questions until the end of each slide

HIV Care Continuum Definitions

- **Total Clients:** Clients who are HIV+ and received at least one service from the selected service category(s) in the reporting period.
- **Ever in Care:** HIV+ clients who ever had a medical care service documented.
- **In Care:** HIV+ clients who had a medical care service within the reporting period.
- **Retained in Care:** HIV+ clients who had two or more *medical care services at least 90 days apart in the reporting period.
- **Prescribed Antiretroviral Drugs (ARV):** HIV+ clients who have a documented ARV at any time during the reporting period within HIV history records.
- **Virally Suppressed:** HIV+ clients with most recent viral load less than 200 copies/mL, as of end of the reporting period.

Medical Care Service: Documented viral load or CD4 lab, medical visit, prescription filled and paid by Ryan White, or payment requests for co-pays made by HICP.

HIV Care Continuum Definitions

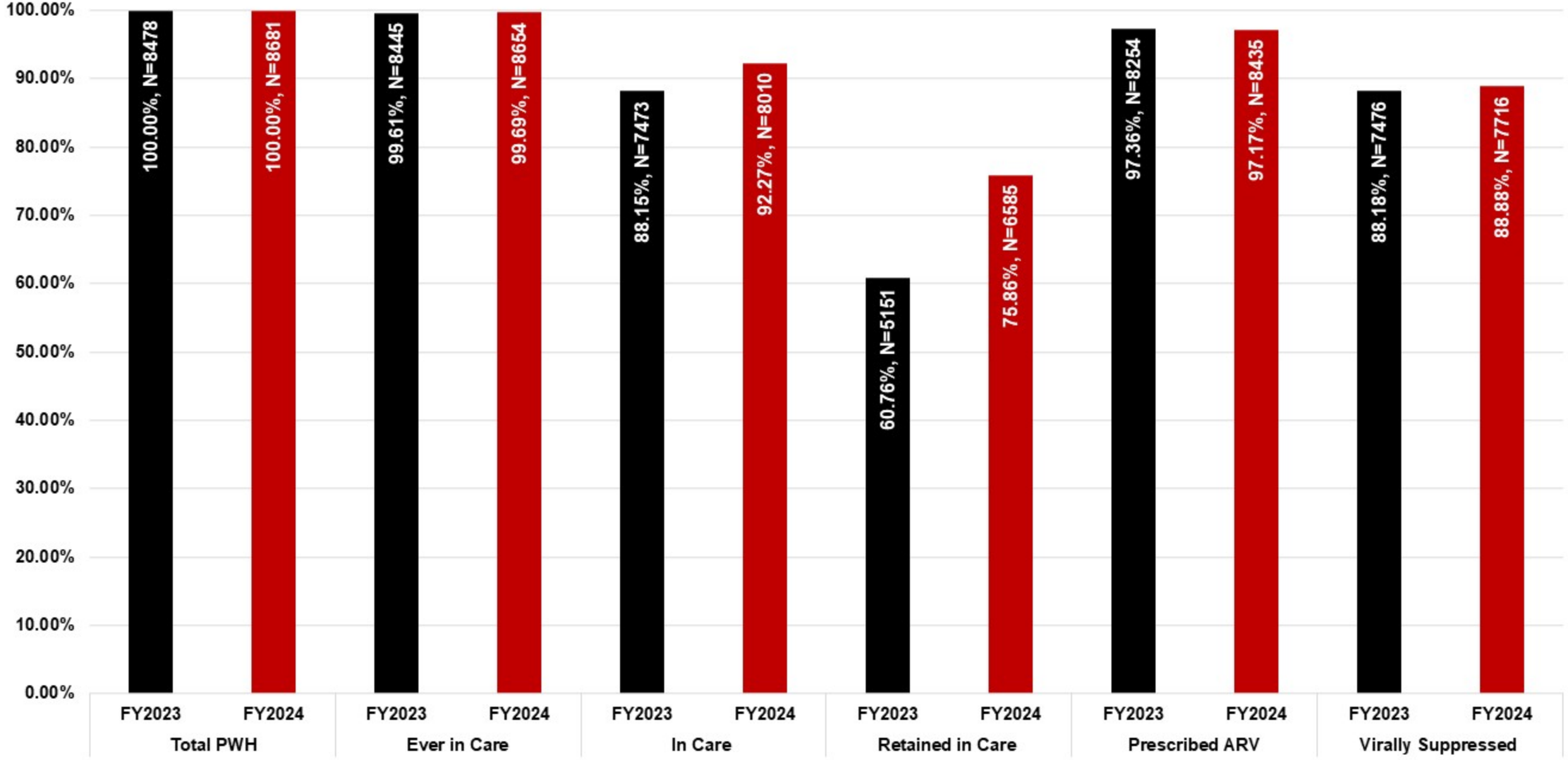
- **Retention in Care:** Measure impact due to limited accountability for information from:
  - Clients who move, are incarcerated, or deceased during the measurement period
  - Clients with private insurance/doctors
  - The strict definition may exclude clients who received clinically indicated medical care during the reporting period
- **On ARV:** Includes self-reported data.

FY 24-25 Annual Data Review

The purpose of this presentation is to review specific data for fiscal year 2024-2025 and discuss opportunities for improvement.

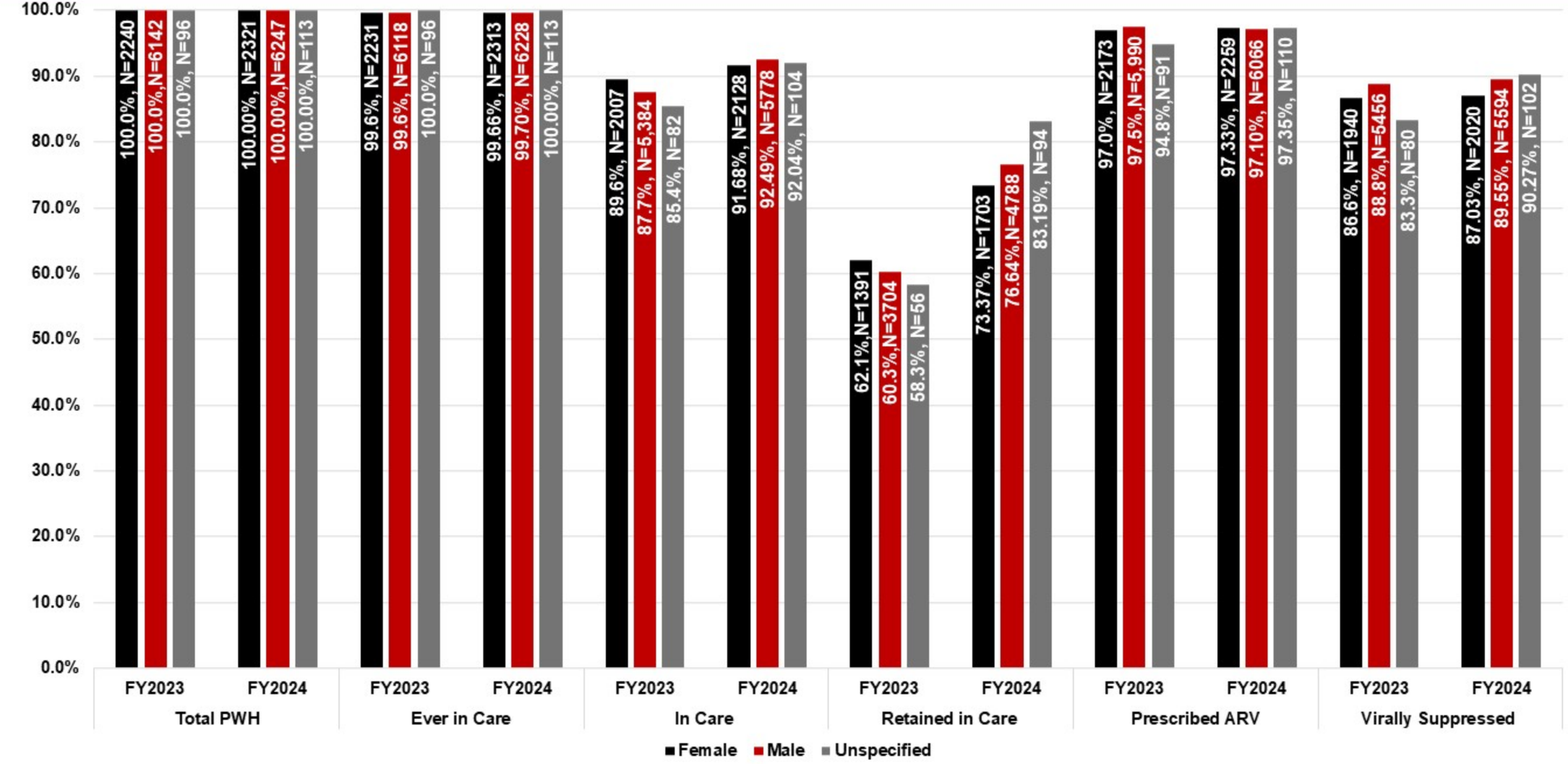
Data presented is based off information entered in Provide Enterprise.

HIV Care Continuum Systemwide, Broward EMA, FY2023 and FY2024



Continuum of Care Report 03/1/2023 – 02/29/2024, 03/1/2024 - 02/28/2025

HIV Care Continuum Sex, Broward EMA, FY2023 and FY2024



Continuum of Care Report 03/1/2023 – 02/29/2024, 03/1/2024 - 02/28/2025

HIV Care Continuum Race/Ethnicity, Broward EMA, FY2023 and FY2024

Race/Ethnicity	FY2023 People Living With HIV	FY2023 Ever in Care	FY2023 In Care	FY2023 Retained in Care	FY2023 Prescribed ARV	FY2023 Virally Suppressed
Black (Non-Hispanic) (N)	4,138	4,124	3,664	2,539	3,997	3,524
Black (Non-Hispanic) %	100.0%	99.7%	88.5%	61.4%	96.6%	85.2%
White (Non-Hispanic) (N)	1,986	1,975	1,706	1,081	1,951	1,802
White (Non-Hispanic) %	100.0%	99.4%	85.9%	54.4%	98.2%	90.7%
Hispanic/Latinx (N)	2,224	2,218	1,991	1,457	2,186	2,036
Hispanic/Latinx %	100.0%	99.7%	89.5%	65.5%	98.3%	91.5%
Other (N)	115	115	101	71	113	105
Other %	100.0%	100.0%	87.8%	61.7%	98.3%	91.3%
Race/Ethnicity	**FY2024 People Living With HIV**	**FY2024 Ever in Care**	**FY2024 In Care**	**FY2024 Retained in Care**	**FY2024 Prescribed ARV**	**FY2024 Virally Suppressed**
Black (Non-Hispanic) (N)	4,308	4,296	3,952	3,168	4,155	3,715
Black (Non-Hispanic) %	100.0%	99.7%	91.7%	73.5%	96.5%	86.2%
White (Non-Hispanic) (N)	1,956	1,945	1,787	1,465	1,919	1,774
White (Non-Hispanic) %	100.0%	99.4%	91.4%	74.9%	98.1%	90.7%
Hispanic/Latinx (N)	2,298	2,294	2,160	1,862	2,250	2,120
Hispanic/Latinx %	100.0%	99.8%	94.0%	81.0%	97.9%	92.3%
Other (N)	106	106	100	87	105	100
Other %	100.0%	100.0%	94.3%	82.1%	99.1%	94.3%

Continuum of Care Report 03/1/2023 – 02/29/2024, 03/1/2024 - 02/28/2025; Other includes Alaskan Native, American Indian, Asian , Native Hawaiian, and Pacific Islander

HIV Care Continuum Age, Broward EMA, FY2023 and FY2024

Age Group	FY2023 People Living With HIV	FY2023 Ever in Care	FY2023 In Care	FY2023 Retained in Care	FY2023 Prescribed ARV	FY2023 Virally Suppressed
18-28 (N)	487	484	428	287	469	391
18-28 %	100.00%	99.38%	87.89%	58.93%	96.30%	80.29%
29-38 (N)	1,672	1,666	1,446	958	1,591	1,395
29-38 %	100.00%	99.64%	86.48%	57.30%	95.16%	83.43%
39-48 (N)	1,623	1,617	1,417	997	1,570	1,401
39-48 %	100.00%	99.63%	87.31%	61.43%	96.73%	86.32%
49-58 (N)	2,083	2,073	1,867	1,330	2,044	1,848
49-58 %	100.00%	99.52%	89.63%	63.85%	98.13%	88.72%
59+ (N)	2,603	2,595	2,306	1,576	2,572	2,434
59+ %	100.00%	99.69%	88.59%	60.55%	98.81%	93.51%
Age Group	**FY2024 People Living With HIV**	**FY2024 Ever in Care**	**FY2024 In Care**	**FY2024 Retained in Care**	**FY2024 Prescribed ARV**	**FY2024 Virally Suppressed**
18-28 (N)	493	491	463	352	460	411
18-28 %	100.00%	99.59%	93.91%	71.40%	93.31%	83.37%
29-38 (N)	1,696	1,693	1,573	1301	1,622	1,448
29-38 %	100.00%	99.82%	92.75%	76.71%	95.64%	85.38%
39-48 (N)	1,720	1,713	1,578	1324	1,647	1,477
39-48 %	100.00%	99.59%	91.74%	76.98%	95.76%	85.87%
49-58 (N)	2,020	2,012	1,875	1,584	1,984	1,814
49-58 %	100.00%	99.60%	92.82%	78.42%	98.22%	89.80%
59+ (N)	2,743	2,737	2,514	2,018	2,716	2,559
59+ %	100.00%	99.78%	91.65%	73.57%	99.02%	93.29%

Continuum of Care Report 03/1/2023 – 02/29/2024, 03/1/2024 - 02/28/2025

Any Questions?

Thank you!

HIV HEALTH SERVICES PLANNING COUNCIL MEETING GROUND RULES

1. The Council, its members, and the public recognize and respect the committee process adopted by this Council. The Council, its members, and the public recognize that full discussion and analysis of issues occurs at the committee level rather than at Council meetings.

2. Before a member can make a motion or speak in debate, the member must be recognized by the Chair as having the exclusive right to be heard at that time.

3. All speakers are expected to address the Council in a respectful manner to respect time limits, to speak briefly and to the point, and to stay on agenda. All other persons in attendance should not interrupt the speaker who is recognized by the Chair as having the floor.

4. If the member who made the motion claims the floor and has not already spoken on the question, that member is entitled to be recognized in preference to other members.

5. No person is entitled to the floor a second time in debate on the same item as long as any other person who desires the floor has not spoken on the item.

6. Speakers should restrict comments and debate to the pending question or motion. Speakers must address their remarks to the Chair and maintain a courteous tone. The Chair may impose time limits on debate or discussion to ensure efficient conduct of Council business.

7. Members should not name service providers and/or persons during any discussion unless the service provider or person is identified in the subject of the motion or agenda item. Specific concerns regarding service providers should be directed towards the Grantee, outside of the meeting.

8. Members of the public may only address the Council upon recognition by the Chair. They are subject to the same rules of conduct expected of Council members.

9. No alcohol or drug use (unless prescribed by a licensed physician), is permitted at Council meetings, grantee or support staff offices.

10. No abusive language, threats of violence, or possession of weapons are permitted in Council meetings, grantee or staff offices.

11. Repeated violation of these meeting rules may result in no further recognition of the offending member or attendee by the Chair at that meeting. Any serious breach of conduct which disrupts the Council's meeting may subject the offender to removal from the meeting, administrative or legal process.

Revised 7/24/14

CONSEJO DE PLANEACIÓN DE SERVICIOS DE SALUD VIH
REGLAS BÁSICAS DE LA REUNIÓN

1. Los miembros deberán aceptar y respetar el proceso de comité adoptado por este Consejo. Las discusiones y el análisis en pleno de los temas tendrán lugar a nivel de comité y no en las reuniones plenarias del Consejo.

2. Antes de que un miembro pueda iniciar una moción o de que una persona pueda hablar en un debate, el Presidente de la reunión deberá reconocer que él o ella tienen el derecho exclusivo de hablar en ese momento dado.

3. Se espera que todos los ponentes se dirijan al Consejo de una manera respetuosa, que no se interrumpa al ponente con derecho al habla en el momento, que cuando se hable se haga de forma clara y concisa, y que se mantenga la agenda.

4. Si el miembro que inicia una moción no ha hablado todavía y reclama su derecho a hablar sobre un asunto, él/ella tendrán el derecho a que con preferencia se les reconozca.

5. Nadie tendrá derecho a reclamar el habla por una segunda vez, en un debate sobre el mismo tema, cuando otra persona que no ha hablado todavía, desea hacerlo.

6. Los debates deben ceñirse a los asuntos o mociones que estén pendientes. Al hablar, los ponentes deben referirse al Presidente, y mantener un tono cortés.

7. Los miembros del público solo podrán dirigirse al Consejo cuando hayan sido reconocidos por el Presidente de la reunión. Estarán sujetos a las mismas reglas de conducta que se esperan de los miembros del Consejo. Se establecerán límites de tiempo según sea necesario para garantizar que los asuntos del Consejo cursen de manera eficiente.

8. Miembros del público sólo podrán dirigir el Consejo a partir del reconocimiento por el Presidente. Están sujetos a las mismas reglas de conducta que se espera de los miembros del Consejo.

9. No estará permitido el uso de bebidas alcohólicas o de drogas en las reuniones del Consejo y tampoco en las oficinas del personal de soporte y donatarios.

10. No está permitido el uso de lenguaje abusivo, amenazas de violencia y posesión de armas en las reuniones del Consejo ni en las oficinas del personal de soporte y donatarios.

11. La repetida violación de estas reglas básicas dará como resultado que el Presidente de la reunión deje de reconocer al derecho a participación del ofensor o miembro de la audiencia. Cualquier violación de conducta grave, que perturbe la reunión de Consejo, terminará en la remoción del ofensor, de la reunión.

Revised 7/24/14

KONSÈY PLANIFIKASYON SÈVIS SANTE POU HIV RÈGLEMAN RANKONT-YO

1. Manm-yo dwe rekonèt epi respekte pwosesis komite-a ke Konsèy-la adopte. Diskisyon ak analiz total pwoblèm-yo fèt nan nivo komite-a; li pa fèt pandan rankont tout Konsèy-la.

2. Anvan yon manm ka fè yon pwopozisyon oswa nenpòt ki moun gen dwa pale pandan yon deba, fòk Prezidan Komite-a bali dwa esklizif pou fè moun tande-li nan moman sa-a.

3. Yo atann-yo aske tout moun k'ap pale ak Konsèy-la fè-li avèk respè, pou pèsonn pa koupe moun ke Konsèy-la bay dwa pale lapawòl, pou moun k'ap pale-a respekte kantite tan yo ba-li pou pale-a, pou li di sa l'ap di-a rapidman epi avèk presizyon, epi pou li respekte ajanda-a.

4. Si manm ki fè pwopozisyon-an mande pou li pale epi si li poko pale sou keksyon-an deja, li gen priyorite sou lòt manm-yo.

5. Pèsonn moun pa gen dwa pran lapawòl de fwa sou yon menm sijè si gen lòt moun ki poko pale epi ki vle esprime tèt-yo.

6. Deba-a dwe rete sou keksyon oswa pwopozisyon k'ap fèt-la. Moun k'ap pale-a dwe adrese sa l'ap di-a bay Prezidan Komite-a epi pale sou yon ton ki make ak respè.

7. Manm piblik-la dwe pale ak Konsèy-la sèlman si Prezidan Konsèy-la bay-yo lapawòl. Yo dwe respektè menm règleman kondwit avèk manm Konsèy-yo. Lè sa nesesè pou zafè Konsèy-la byen mache, yo gen dwa bay-yo yon limit tan pou yo pale.

8. Manm nan piblik la sèlman pou adrese a konsèy sou rekonèsans sou chèz la. Yo ka tonbe anba menm lòd de kondwit ki te espere nan manm konsèy yo.

9. Itilizasyon alkòl ak dwòg (sòf si se yon doktè lisansye ki preskri-li), entèdi nan rankont Konsèy-la oswa nan biwo estaf sipò-a oswa Resevè-a.

10. Vye langaj, menas vyolans, oswa posesyon zam entèdi nan rankont Konsèy-la oswa nan biwo estaf-la oswa Resevè-a.

11. Vyolasyon repete règleman rankont-yo ap lakòz yon manm oswa lòt moun k'ap asiste rankont-lan pa kapab patisipe ankò. Nenpòt ki move kondwit serye ki twouble rankont-la ap lakòz yo mete moun-nan deyò.

Acronym List

ACA: The Patient Protection and Affordable Care Act

ADAP: AIDS Drugs Assistance Program

Administration HUD: U.S Department of Housing and Urban Development

IW: Integrated Workgroup

AETC: AIDS Education and Training Center

AHF: AIDS Health Care Foundation

AIDS: Acquired Immuno-Deficiency Syndrome

ART: Antiretroviral Therapy

ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center

BCFHC: Broward Community and Family Health Centers

BH: Behavioral Health

BRHPC: Broward Regional Health Planning Council, Inc.

CBO: Community-Based Organization

CDC: Centers for Disease Control and Prevention

CDTC: Children's Diagnostic and Treatment Center

CEC: Community Empowerment Committee

CIED: Client Intake and Eligibility Determination

CLD: Client Level Data

CQI: Continuous Quality Improvement

CQM: Clinical Quality Management

CTS: Counseling and Testing Site

eHARS: Electronic HIV/AIDS Reporting System

EIIHA: Early Intervention of Individuals Living with HIV/AIDS

EFA: Emergency Financial Assistance

EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health

FPL: Federal Poverty Level

FQHC: Federally Qualified Health Center

HAB: HIV/AIDS Bureau

HHS: U.S. Department of Health and Human Services

HICP: Health Insurance Continuation Program

HIV: Human Immunodeficiency Virus

HIV HSSS: HIV Human Services Software System

HIVPC: Broward County HIV Health Services Planning Council

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources Services Administration

IDU: Intravenous Drug User

JLP: Jail Linkage Program

LPAP: Local AIDS Pharmaceutical Assistance Program

MAI: Minority AIDS Initiative

MCDC: Membership/Council Development Committee

MCM: Medical Case Management

MH: Mental Health

MNT: Medical Nutrition Therapy

MOU: Memorandum of Understanding

NBHD: North Broward Hospital District (Broward Health)

NGA: Notice of Grant Award

NHAS: National HIV/AIDS Strategy

NMCM: Non-Medical Case Management

NOFO: Notice of Funding Opportunity

nPEP: Non-Occupational Post Exposure Prophylaxis

NSU: Nova Southeastern University

nPEP: Non-occupational Post-Exposure Prophylaxis

OAHS: Outpatient Ambulatory Health Services

OHC: Oral Health Care

PCN: Policy Clarification Notic

PE: Provide Enterprise

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis

PRISM: Patient Reporting Investigating Surveillance System

PROACT: Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH- Broward's treatment adherence program.

PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

QMC: Quality Management Committee

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

RWPA: Ryan White Part A

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children's Health Insurance Program

SDM: Service Delivery Model

SOC: System of Care

SPNS: Special Projects of National Significance

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs

VL: Viral Load

VLS: Viral Load Suppression

WICY: Women, Infants, Children, and Youth

Frequently Used Terms

Recipient: Government department designated to administer Ryan White Part A funds and monitor contracts.

Planning Council Support (PCS) Staff/'Staff': Provides professional staff support, meeting coordination, and information to the HIVPC, its standing and ad-Hoc Committees, Chair, and Recipient.

Clinical Quality Management (CQM) Support Staff: Provides professional support, meeting coordination, and technical assistance to assist the Recipient through analysis of performance measures and other data with the implementation of activities designed to improve patient care, health outcomes, and patient satisfaction throughout the system of care.

Provider/Sub-Recipient: Agencies contracted to provide HIV Core and Support services to consumers.

Consumer/Client/Patient: A person who is an eligible recipient of services under the Ryan White Act.