Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

MEETING AGENDA

COMMITTEE: Quality Management Committee
Date/Time: Monday, August 19, 2013 at 12:30 p.m. **Location:** Governmental Center Annex, A337
Claudette Grant, **Chair**

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*

2. **APPROVALS:** 8/19/2013 Agenda and 7/15/2013 Meeting Minutes

3. **STANDARD COMMITTEE ITEMS**
   a. New Business
   b. Request for Information/Directives
   c. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
   d. Next Meeting Date: September 16, 2013

4. **UNFINISHED BUSINESS**

5. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Action Items*
Item #1 Review 3-Year Work Plan (WP Item 2.2)	**ACTION ITEM:** Review, update and approve 3-year work plan
Item #2 Follow-Up on Viral Load Report Definition	**ACTION ITEM:** Discuss viral load definition report in Provide Enterprise (PE) to clarify denominator for HHS indicator and viral load analysis reports
Item #3 Development of Training for Quality Management Committee	**ACTION ITEM:** Develop new member/refresher training on purpose/goals of Quality Management Committee and its activities
Item #4 Approve Oral Health Service Delivery Model (WP Item 2.4)	**ACTION ITEM:** Review and discuss recommended changes to the Oral Health QI Network Service Delivery Model
Item #5 Approve MAI Medical Case Management Service Delivery Model	**ACTION ITEM:** Review and discuss recommended changes to the MAI Medical Case Management Service Delivery Model
Item #6 Medical QI Network Update	**ACTION ITEM:** Update on Medical QI Network Cervical Screening Quality Improvement Project

6. **GRANTEE REPORTS**

7. **PUBLIC COMMENT**

8. **AGENDA ITEMS/TASKS FOR NEXT MEETING**

Agenda Items/Tasks for next Meeting (Work Plan Item/Goal#)	*Information requested (i.e. data, research, etc.)action to be taken, presentation, discussion, brainstorm etc.*
Item #1 Quarterly Network Update (W.P. 3.1)	
Item #2 Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care (W.P. 5.1)	

9. **ANNOUNCEMENTS**

10. **ADJOURNMENT**

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Meeting Minutes
Committee: Quality Management Committee
Date/Time: Monday, July 15, 2013, 12:30 p.m. **Location:** Governmental Center Annex, A335
Chair: Claudette Grant

Attendance						
#	**Members**	**Present**	**Absent**		**Guests**	**Grantee Staff**
1	Grant, C.	**X**			Downy, G.	Swanson, M.
2	Katz, H. B.	**X**			Sabatino, D.	Degraffenreidt, S.
3	Martin, M.	**X**			Finkelstein, J*	Strong, K.
4	Schweizer, M.	**X**				
5	Jefferson, M.	**X**				**HIVPC Support Staff**
6	Mitchell, T.	**X**				Eshel, A.
7	Ettinger, R.	**X**				Solomon, R
8	Majcher, B.	**X**				Crawford, T.
9	Gammell, B.	**X**				McEachrane, T.
	Quorum = 6	**9**			*attended via phone	

1. CALL TO ORDER:

The Chair called the meeting to order at 12:32p.m. The Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

Chairs, committee members, guests, grantee staff and support staff self-introductions were made. A moment of silence was observed.

2. APPROVALS:

Motion #1	To approve today's meeting agenda		
Proposed by:	Katz, H.B	**Seconded by:**	Schweizer, M.
Action:	Passed Unanimously		

Motion #2	To approve meeting minutes of 5/20/13		
Proposed by:	Katz, H.B.	**Seconded by:**	Schweizer, M.
Action:	Passed Unanimously		

3. STANDARD COMMITTEE ITEMS

a. New Business: None

b. Request for Information/Directives
The Committee requested the following: 1) Quarterly Data report template to include the definitions, numerators, denominators, and exclusions for each measure 2) The CY 12-13 Florida Health Department at Broward County surveillance report for the percentage of individuals newly diagnosed with HIV/AIDS, and 3) Clarification on the difference in denominators for the Viral Load Suppression measure in the HHS indicator report and the Viral Load Analysis report.

c. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date

d. Next Meeting Date: August 19, 2013

4. UNFINISHED BUSINESS: None

5. MEETING ACTIVITIES / NEW BUSINESS

Accomplishments (Goal/Work Plan Objective #)

1. Review Policies and Procedures *(WP Item 2.2)*

The Committee reviewed the Quality Management Committee (QMC) Policies and Procedures for possible revisions (*copy on file*). Members were informed that the Policies and Procedures were reviewed with the QMC Chair during review of the 3-year Quality Management Plan. Members were also informed that the draft 3-year Quality Management Plan will come to the Committee for review following Grantee approval. Staff noted that red text indicates changes made to the Policies and Procedures. The following motion was made:

Motion #3	To approve the Policies and Procedures as amended		
Proposed by:	Schweizer, M.	**Seconded by:**	Katz, H.B
Action:	Passed Unanimously		

2. Quarterly Network Update *(WP Item 3.1)*

The Committee heard an update on the Quality Improvement (QI) Network activities for the first Quarter of FY 13-14 (*copy on file*).

Oral Healthcare (OHC) Network: The Network approved outcome #2. Provide Enterprise (PE) to be programmed with all revised outcomes and indicators. It was noted that providers are continuing to use the current outcomes and indicators until PE is programmed.

Mental Health and Substance Abuse (MH/SA) Network: The Network is working on an *Assessing Depression* presentation for case managers. The presentation will be provided at the August Medical Case Management (MCM) QI Network meeting and a future case management training. The Network is also evaluating a depression screening tool for non-clinical providers. There was discussion on the content of the presentation and the reason the presentation focuses on depression; Members were reminded that the MH/SA Network conducted a client-level data analysis and identified depression as the most significant barrier to retention in medical care.

Medical Network: The Committee heard an overview of the Network's cervical screening Quality Improvement Project (QIP); The Network is running HAB Measures in PE and comparing cervical screening rates to those in each agency's Electronic Medical Record (EMR). The Network also made recommendations for additions and deletions to the formulary in preparation for the upcoming ad Hoc Local Pharmacy Advisory Committee (LPAC) meeting.

MCM Network: The Committee heard an update on the Network's QIP which is focused on improving retention in medical care. The Network is reviewing data to identify clients without a documented encounter in PE in the last 120 days. The MCM's will analyze the data to identify clients at risk of being lost to care, document reasons for no medical appointment, contact client/medical provider to schedule a medical appointment and make referrals to outreach or a retention program when applicable. Agencies to summarize and present findings to the Network. The Network will begin conducting case study reviews in August to share methodologies with other providers.

Combined Network: The Committee was informed that the Network is in the process of developing a health literacy QIP and establishing a timeline for implementation.

3. Review Performance Measures and Other Data Sources to Assess Linkage to Care *(WP Item 5.1)* and Quarterly Data Review*(WP Item 1.1)*

The Committee reviewed a summary of FY 12-13 HAB Performance Measures, In+Care Campaign Retention

Rates, HHS Indicators, and Part A/MAI client demographics.

HAB Measures: The Committee discussed the Oral Health Care HAB measure and reviewed the measure's definition for clarification. The Grantee informed the Committee of projected changes HRSA is making to the HAB Performance Measures; Staff to send the HAB webinar presentation and handouts to the Committee for review. A member inquired how the EMA gauges improvement. It was noted that the EMA reviews local trends over time and uses studies and comparisons to other EMA's to assess and measure improvement.

In+Care Campaign: Staff explained the In+Care Campaign graph. Members were informed that the denominator is based on In+Care Campaign requirements. Staff to revise scale and include the rates moving forward.

HHS Indicators: The Committee discussed the HHS Indicator *HIV Positivity* and expressed concern over reported percentage. Staff to contact GTI for clarification on how the data is captured. Members were reminded that part of the Committee's responsibility is to assist with data discrepancies and identifying areas of concern. A guest inquired about the percentage of clients newly diagnosed with AIDS. Members discussed the difference between long time survivors (*elite controllers* or *long-term non-progressors*) and those who have been living with the HIV/AIDS for a long period of time.

Viral Load: The Committee reviewed Viral Load analysis by category (*copy on file*). The report provides demographic data (such as gender, race, ethnicity, age, education level, housing status, sexual orientation, HIV disease stage, etc.) by viral load category: *Undetectable VL: Viral Load is < / = 50; Suppressed Detectable VL: Viral Load >50 and < / =200; Not Suppressed VL: Viral Load >200 and < 100,000; High VL: Viral Load is > / = 100,00.* Members inquired about the way PE is pulling data for suppressed and undetectable Viral Loads; Staff to check with GTI and clarify to the Committee. One Member expressed concern that the county is paying special attention to MSM populations while heterosexual rates are increasing; Staff informed the Committee that the Joint Planning Committee has named both Black heterosexuals (men and women) and MSMs as special populations requiring increased attention.

6. GRANTEE REPORTS

The EMA had a HRSA site visit June 17-20, 2013; the EMA received positive feedback, indicating that the EMA is a "national model" and should market achievements more effectively. HRSA suggested that the EMA link with a university to educate other EMAs. It was noted that HAB Measures are being streamlined to reduce duplications in reporting; Committee should anticipate work in the future to incorporate HAB Measure changes.

7. 7. PUBLIC COMMENT: None

8. AGENDA ITEMS / TASKS FOR NEXT MEETING:

Date: August 19, 2013 **Venue:** Governmental Center Annex, A335

Agenda Items/Tasks for next Meeting (Work Plan Item/Goal#)	*Information requested (i.e. data, research, etc.)action to be taken, presentation, discussion, brainstorm etc.*
Review 3-year Quality Management Plan	
Follow-up on Data Review	

a) ANNOUNCEMENTS

- The University of New Mexico is hiring a Clinical Quality Management (CQM) Manger; Individuals to contact Jamie Finkelstein if interested.
- The attendance policy has been updated to include jury duty and court subpoena to the list of acceptable excused absences. Members reminded that a warning is given for 2 consecutive absences and 3 total absences within a calendar year, and an automatic dismissal occurs following 3 consecutive absences or 4 total absences within a calendar year.

- Donna Sabatino, Broward County Prevention Planning Council Community Co-Chair, expressed her desire to join the QM Committee. Ms. Sabatino discussed her experience and noted she hopes to share the community's input with the Committee. The following motion was made:

Motion #4	To nominate Donna Sabatino to the Quality Management Committee		
Proposed by:	Martin, M.	**Seconded by:**	Katz, H.B.
Justification	Broward County Prevention Planning Council Community Co-Chair; she can bring good insight from the community		
Action:	Passed Unanimously		

b) ADJOURNMENT

Without objection the meeting was adjourned at 2:01 p.m.

Quality Management Attendance CY: 2013

Count	Member	1/7/13	3/18/13	4/15/13	5/20/13	7/15/13
1	Grant, C.	√	√	√	√	√
2	Katz, H.B.	√	√	√	√	√
3	Martin, M.	A	A	√	√	√
4	Schweizer, M.	√	A	A	√	√
5	Jefferson, M.	√	√	A	A	√
6	Mitchell, T.	E	A	√	√	√
7	Ettinger, R.	Appointed 3/28/13		√	A	√
8	Majcher, B.	Appointed 3/28/13		√	√	√
9	Gammell, B.	Appointed 6/27/13				√
Quorum=6		YES	NO	YES	YES	YES

Quality Management Committee
Cervical Screening QIP Update
Phases I and II

Cervical Cancer Screening HAB Performance Measure

Percentage of women with HIV infection who have a Pap screening in the measurement year

- Numerator: *Number of HIV-infected female clients who had Pap screen results documented in the measurement year*
- Denominator: *Number of HIV-infected female clients who:*
  - *Were ≥18 years old in the measurement year or reported having a history of sexual activity, and*
  - *Had a medical visit with a provider with prescribing privileges at least once in the measurement year*
- Patient Exclusions:
  - Patients who were < 18 years old and denied history of sexual activity
  - Patients who have had a hysterectomy for non-dysplasia/non-malignant indications

Part A Medical Standards

(Revised January 2013)

Immunizations/Treatments	
18. Consenting female clients are given PAP test, at least annually.	18.1. 100% of charts of female clients show a PAP test and pelvic exam offered annually.
	18.2 90% of charts of female clients for which a PAP test and pelvic exam were appropriate are successfully completed.
	18.3. 100% of charts of female clients with abnormal PAP tests or with lesions present show referral to a gynecologist and the outcome will be documented.

Phase I

Cervical Screening QIP Development

- Initial Steps (2011)
  - Cervical screening rates in PE for the last three years
  - Findings from the 2009 Client Needs Assessment and Women's Focus Group
  - Reviewed barriers and improvement strategies in other areas
- Proposed data elements for collection to help identify trends among clients who do not get annual screenings
- Compared Client Level Data Side by Side in EMR and PE
- Reviewed cervical screening CPT codes in PE
- Discussed exclusions

Cervical Screening Rates 2009-2011

FY 3/1/2009 – 2/28/2010

- 122/1,106 = 11%

FY 3/1/2010 – 2/28/2011

- 228/1,086 = 21%

3/1/2011 – 10/25/2011

- 139/854 = 16%

HIVQUAL Studies

- Cervical cancer is the 3rd most common type of cancer among women in the general population
- Among women living with HIV the risk of developing cervical cancer is 2-3 fold
- HIV+ women are less likely to receive routine Pap tests compared to their negative counterparts
- HIV+ women with invasive cervical cancer are more likely to present at more advanced stages of disease and metastasize to unusual locations
- The HIVQUAL group used the HRSA/HAB performance measure: Percentage of women with HIV infection who have a Pap screening in the measurement year
- Baseline Pap Rates: 17%-71%
  - Each team set an appropriate improvement goal based on their baseline rate
- Follow-Up Pap Rates: 60.5%-84.9%

Source: Mississippi HIVQUAL-US Regional Group – Shared Efforts: Improving Rates for Pap Tests Performed in Mississippi 2010

HIVQUAL Studies

- Project stages
  - Brainstorm barriers preventing female patients from completing the recommended annual Pap test
    - Screening refusals, no-shows, lack of reminders for both providers and patients when a Pap is due, follow-up on results done off site or by referral
  - Implementation of various dynamic interventions
    - Revised Pap test policy, enhanced patient education and test scheduling, improved accuracy of data entry, highlighted 'Pap Me' note on front of encounter form, daily reviews of next day's appointments in need of a Pap test
  - Quarterly meetings to report on results
    - Rates increased at all facilities (*A. 17%-80%; B. 71%-84.9%; C. 50%-67%; D. 48%-60.5%*).
  - Plan to sustain improvements
    - Standardize successful interventions at each clinic
      - Personalized reminder cards, track pending results from tests done off site

Source: Mississippi HIVQUAL-US Regional Group – Shared Efforts: Improving Rates for Pap Tests Performed in Mississippi

HIVQUAL Studies

Client Barriers

- Two underlying themes emerged:
  - "I **don't** get a Pap because I don't want to hear that anything else is wrong with me. I have enough to worry about"
  - "I **get** my Pap because my doctor is nice. I can talk to her, she respects me, I like her"

Barriers for Providers

- Staff Education: Physicians don't always have a comfort level with sexual health issues
- Normalize Paps as a routine part of HIV care
- Staff member performing Paps, should be visible, familiar, approachable, and respectful
- Need "buy in" by the medical staff AND the consumer

Source: New Jersey Ryan White Part D Statewide Network (NQC)

2009 Broward Focus Group Findings

- Women's Focus Group Question:
  - Women living with HIV need to get gynecological services, like Pap and other tests, to prevent cancers and other conditions.
    - What information has your HIV doctor given you about gynecological conditions among women living with HIV?
    - In what ways could your HIV doctor improve your gynecological services?

- Participants of the women's group reached consensus that *women's health services were not accessible in several HIV clinics*.

- They reported that while they were aware that they should get routine Pap smears and pelvic exams, for example, they were referred to a gynecologist for their tests. They *questioned why a separate medical visit at another site was necessary to get basic women's care*.

- The women's group was quite articulate about *the need to integrate better routine women's health service in HIV clinics, and for HIV clinicians to feel comfortable conducting those procedures*.

NQC Call to Action

- Find out YOUR program's Pap data
  - What does it say about your program?
  - Does it accurately reflect how well your program cares for women?
  - Are you proud of your data? Would you share it widely?
    - If the answers are "yes", teach others and share your good work.
    - If the answers are "no", how will you determine if it is the quality of the ***data*** or the ***care*** or the ***system*** that needs improvement?
- Who will you engage to help figure this out?
- How would you move from data to action and improvement?
- What is your first test of change to seek improvement?

Questions for Review

- How many Part A female clients did your clinic have in the last 12 months?
- Are cervical screenings provided at your clinic or are clients referred to another site?
- How many Part A female clients had cervical screening appointments scheduled?
- How many clients who missed their original appointment rescheduled for another date? Did they provide a reason for the missed appointment? Did they attend the rescheduled appointment?
- Should any of the clients been excluded as a result of moving, incarceration, a change in insurance status, or any other reason?
- Can you identify any trends among those who did not receive a cervical screening? (e.g., demographics, disease status, etc.)
- Has your clinic implemented strategies to improve cervical screening rates? Describe those strategies.

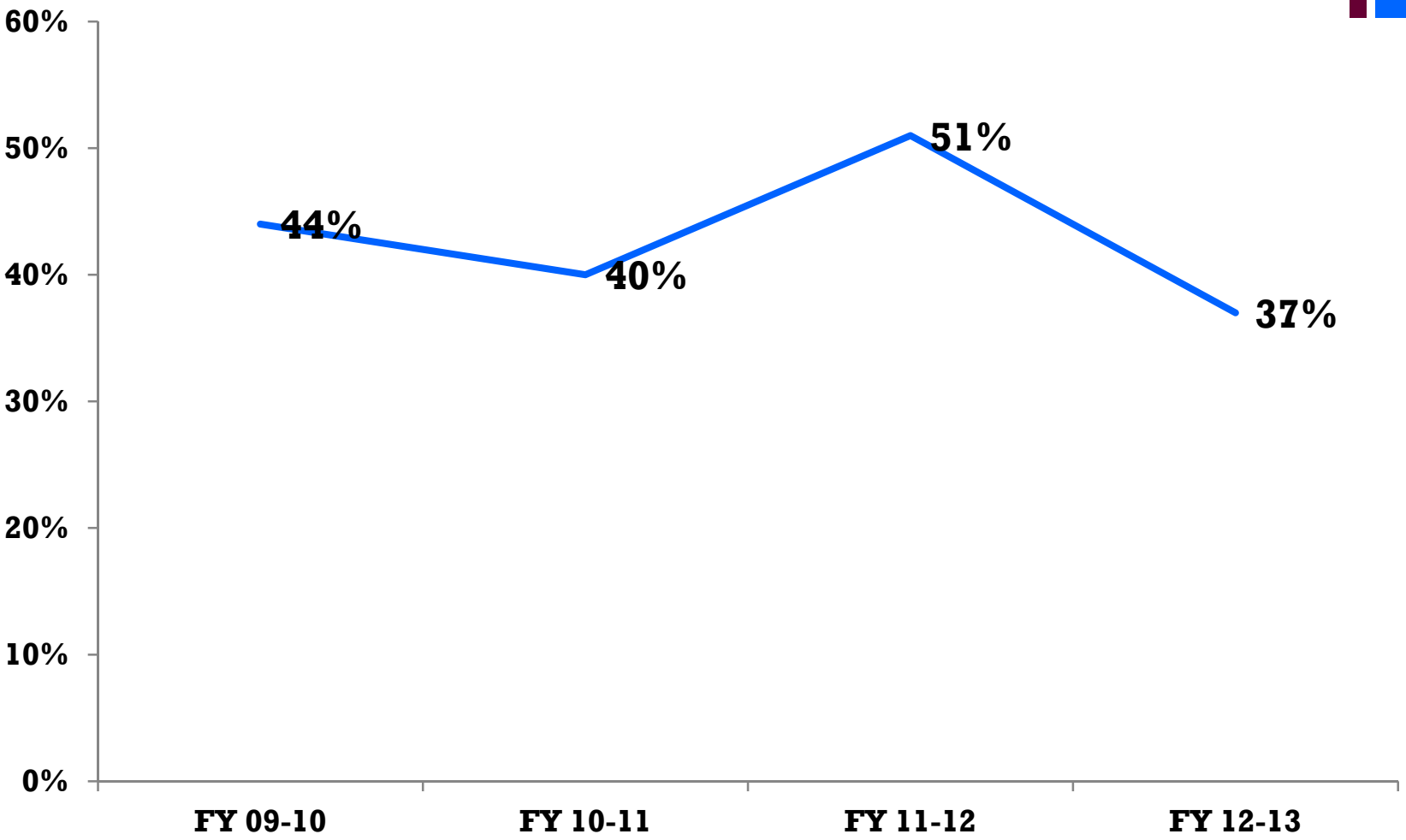
PE/EMR Data Review Findings

- Clients Who Should Have Been Excluded
  - Left state (case not closed)
  - New clients
  - Medicaid/Medicare/Health Insurance coverage
- Documentation
  - Pap in the EMR but no Pap in PE
  - Chlamydia screening documented but not Pap
- No Shows
- Eligibility Expired
- Date of Last Screening
  - Several screenings documented in the EMR in either 2009 or 2010
  - Very few with more than one Pap in the EMR

Update of CPT Codes in PE

- 88141
- 88142
- 88143
- 88147
- 88148
- 88150
- 88152
- 88153
- 88154
- 88155
- 88160
- 88161
- 88162
- 88164
- 88165
- 88166
- 88167
- 88174
- 88175

Cervical Screening Rates 2009-2013



Benchmarks

- 71% (HIVQUAL 2005)
- 90% (Institute for Healthcare Improvement)
- Other Funding Sources

HEDIS® Health Plan Performance Rates

Table 1. HEDIS CCS Measure Performance—Commercial Plans

Year	Average	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2011	75.9	70.2	72.9	76.1	78.7	81.5
2010	76.1	70.2	73.4	76.6	79.3	81.6
2009*	77.9	70.0	74.3	78.1	82.3	85.6

*Hybrid data collection was removed in 2010; results cannot be trended to prior years' results.

Table 2. HEDIS CCS Measure Performance—Medicaid Plans

Year	Average	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2011	67.2	53.0	64.0	69.7	74.2	78.7
2010	65.8	50.5	61.0	67.8	72.9	78.9
2009	66.0	52.1	60.9	67.6	73.2	79.5

Proposed Exclusions

- Clients who have had a Hysterectomy
- Age: >65
  - <18 (already programmed)
- Medicaid/Medicare/Private Insurance
- Patients documented to be deceased at any time in the measurement year
- Patients who were incarcerated for greater than 90 days of the measurement year
- Patients who relocated out of the service area or transferred medical care at any time in the measurement year

Cervical Cancer Screening Guidelines for Average-Risk Women [1]

	American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP), and American Society for Clinical Pathology (ASCP) [2] 2012	U.S. Preventive Services Task Force (USPSTF) [3] 2012	American College of Obstetricians and Gynecologists (ACOG) [4] 2012
When to start screening [5]	Age 21. Women aged <21 years should not be screened regardless of the age of sexual initiation or other risk factors. *(Strong recommendation)*	Age 21. *(A recommendation)* Recommend against screening women aged <21 years. *(D recommendation)*	Age 21 regardless of the age of onset of sexual activity. Women aged <21 years should not be screened regardless of age at sexual initiation and other behavior-related risk factors. *(Level A evidence)*
Statement about annual screening	Women of any age should not be screened annually by any screening method. *(Strong recommendation)*	Individuals and clinicians can use the annual Pap test screening visit as an opportunity to discuss other health problems and preventive measures. Individuals, clinicians, and health systems should seek effective ways to facilitate the receipt of recommended preventive services at intervals that are beneficial to the patient. Efforts also should be made to ensure that individuals are able to seek care for additional health concerns as they present.	In women aged 30–65 years, annual cervical cancer screening should not be performed. *(Level A evidence)* Patients should be counseled that annual well-woman visits are recommended even if cervical cancer screening is not performed at each visit.
Screening method and intervals [6]			
Cytology (conventional or liquid based) — 21-29 years of age	Every 3 years. [7] *(Strong recommendation)*	Every 3 years. *(A recommendation)*	Every 3 years. *(Level A evidence)*
Cytology (conventional or liquid based) — 30-65 years of age	Every 3 years. [7] *(Strong recommendation)*	Every 3 years. *(A recommendation)*	Every 3 years. *(Level A evidence)*
HPV co-test (cytology + HPV test administered together) — 21-29 years of age	HPV co-testing should not be used for women aged <30 years.	Recommend against HPV co-testing women aged <30 years. (D recommendation)	HPV co-testing [8] should not be performed in women aged < 30 years. *(Level A evidence)*
HPV co-test (cytology + HPV test administered together) — 30-65 years of age	Every 5 years *(Strong recommendation)* ; this is the preferred method *(Weak recommendation)* .	For women who want to extend their screening interval, HPV co-testing every 5 years is an option. (A recommendation)	Every 5 years; this is the preferred method. *(Level A evidence)*
Primary HPV testing [9]	For women aged 30-65 years, screening by HPV testing alone is not recommended in most clinical settings. *(Weak recommendation)* [10]	Recommend against screening for cervical cancer with HPV testing (alone or in combination with cytology) in women aged <30 years. *(D recommendation)*	Not addressed.
When to stop screening	Aged >65 years with adequate screening history. [11,12]	Aged >65 years with adequate screening history. *(D recommendation)* [11]	Aged >65 years with adequate screening history [11, 13] *(Level A evidence)*
Screening post-hysterectomy	Women who have had a total hysterectomy (removal of the uterus and cervix) should stop screening. [14] Women who have had a supra-cervical hysterectomy (cervix intact) should continue screening according to guidelines. *(Strong recommendation)*	Recommend against screening in women who have had a hysterectomy (removal of the cervix). [13] *(D recommendation)*	Women who have had a hysterectomy (removal of the cervix) should stop screening and not restart for any reason. [13] *(Level A evidence)* [15]
The need for a bimanual pelvic exam	Not addressed in 2012 guidelines but was addressed in 2002 ACS guidelines. [16]	Addressed in USPSTF ovarian cancer screening recommendations (draft). [17]	Addressed in 2012 well-woman visit recommendations. [18] **Aged <21 years**, no evidence supports the routine internal examination of the healthy, asymptomatic patient. An "external-only" genital examination is acceptable. **Aged ≥21 years**, no evidence supports or refutes the annual pelvic examination or speculum and bimanual examination. The decision whether or not to perform a complete pelvic examination should be a shared decision after a discussion between the patient and her health care provider. Annual examination of the external genitalia should continue. [19]
Screening among those immunized against HPV 16/18	Women at any age with a history of HPV vaccination should be screened according to the age specific recommendations for the general population.	The possibility that vaccination might reduce the need for screening with cytology alone or in combination with HPV testing is not established. Given these uncertainties, women who have been vaccinated should continue to be screened.	Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated. *(Level C evidence)*

Guidelines (HIV+ Women)

- Several studies have documented an increased prevalence of SIL in HIV-infected women
- The following recommendations for Pap test screening among HIV-infected women are consistent with most of the guidelines published by the U.S. Department of Health and Human Services (HHS) and are based partially on the opinions of professionals knowledgeable about the care and management of cervical cancer and HIV infection in women
- HIV-positive women should be provided cervical cytology screening twice (every 6 months) within the first year after initial HIV diagnosis and, if both tests are normal, annual screening can be resumed thereafter
- HIV-positive women with ASC-H, LSIL, or HSIL on cytologic screening should undergo colposcopic evaluation
- Recommendations for management of HIV-positive women with ASC-US vary:
  - HHS recommends a more conservative management approach (i.e., immediate colposcopy)
  - ASCCP recommends that these women be managed like HIV-negative women with ASC-US (i.e., tested for HR HPV DNA)

Source: CDC

Exclusion Guidelines (HIV+ Women)

- Women who have had a total hysterectomy do not require a routine Pap test unless the hysterectomy was performed because of cervical cancer or its precursor lesions
- As recommended by ACOG, for women with hysterectomy resulting from CIN 2 or higher, cervical or vaginal cuff screening can be discontinued once 3 normal Pap tests have been documented
  - In these situations, women should be advised to continue follow-up with the physician(s) who provided health care at the time of the hysterectomy, if possible
- In women whose cervix remains intact after a hysterectomy, regularly scheduled Pap tests should be performed as indicated

Source: CDC

Common Barriers and Improvement Strategies

Barriers

- Restrictive time slots
- Limited access to transportation
- Access to proper equipment
- Patient refusal (Menstrual period, 'I don't want one', too long with legs in the air, unpleasant, need more education on importance of exam)
- Designating a women's health clinic with a female NP
- Consumer access to information

Improvement Strategies

- Staff trained on importance of pelvic exam and Pap test
- Phone Reminder
- Consumer newsletter article highlighting the importance of GYN care
- Weekly 'women's clinic' with female providers, meals, support groups
- Process examination and root cause analysis (flow diagrams, fishbone diagrams)
- Improved documentation of cervical screenings done elsewhere
- Attaching results of screening to charts
- Increasing the number of referrals
- Follow-up calls for no-shows
- Ordering different size specula
- Daily review of clients in need of screening
- Inserting education messages into reminders and follow-up calls

Source:
HIVQUAL-US Regional Group Spotlight: Involving Consumers Meaningfully in Quality Improvement in the West
HIVQUAL-US Eastern Pennsylvania Regional Group: Cervical Cancer Screening: Improving Rates and Subsequent Treatment Through Quality Improvement

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
■ Consumer Access	■ Create a resource list of patient education materials ■ Offer patient education materials in different locations throughout the clinic setting ■ Offer information using a variety of mechanisms such as brochures, newsletters, or community-based forums
■ Accessibility	■ Integrate GYN care and cervical cancer screening into regular clinic visits for one stop care ■ Offer Pap Festivals ■ Set up Pap smear only appointments ■ Create walk-in hours for Pap smears ■ Increase number of providers qualified and trained to conduct Pap smears onsite

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
■ Missed appointments	■ Implement an intensive tracking system ■ Make reminder calls to the patient ■ Have bilingual staff available to assist in scheduling appointments ■ Schedule appointments for cervical cancer screening when the patient is also at the clinic for primary care ■ Utilize outreach and case management ■ Train all front desk staff on the importance of cervical cancer screening
■ Lack of trained and culturally competent providers	■ Train providers on how to do a Pap ■ Train providers on issues that may impact a woman's decision to complete cervical cancer screening ■ Train providers on how to use equipment such as a colposcope ■ Train providers on how to assess the health literacy level of their patients ■ Train providers to listen to patients ■ Providers should approach patients in a non-judgmental, compassionate, and sensitive manner

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
■ Documentation	■ Create and implement tracking and patient information forms ■ If using EMRs, establish a system where Pap smear results are easy to obtain ■ Create a locked database that tracks appointment status, completion of Pap smears, and reasons for not completing a Pap smear
■ Equipment	■ Create a mobile Pap cart that has all of the necessary supplies and can be wheeled from one exam room to another ■ Utilize a checklist for material needed to conduct a Pap smear to ensure that materials and equipment are collected and available ■ Place a picture of a completely equipped room and prep tray in the exam room to serve as a visual cue for ensuring all materials are available ■ Equip all rooms with stirrups

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
Childcare	Offer childcare services onsite Create a child-friendly play space Utilize volunteers or interns to assist with childcare
Transportation	Provide public transportation vouchers Utilize transportation services available at your healthcare setting Coordinate appointments to minimize number of trips required
Exam rooms	Provide a space that is large enough to accommodate women with children, including a privacy curtain Equip all rooms with stirrups

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
■ Fear factor (Provider)	■ Provide training on topics relevant to cervical cancer screening and providing quality care to women living with HIV ■ Utilize models so providers can gain experience completing an exam
■ Fear factor (Consumer)	■ Provide patient education materials that address cervical cancer screening terminology and information about female reproductive anatomy ■ Begin educating girls and women early about the benefits of GYN care and Pap smears. ■ Providers should engage in trust building exercises with their patients (eg.,provider should describe what will occur at the appointment and provide information about when a patient should return for follow-up care) ■ Providers should be aware of their patients' possible family history of reproductive cancer ■ Nurses and support staff can prepare the patient by reminding them that they are scheduled for a Pap smear, particularly if it is during a regular exam

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Common Barriers and Improvement Strategies

Barriers	Improvement Strategies
■ Referral Process	■ Offer all services in one location ■ Assign each patient to a staff member or provider who will monitor the referral process ■ Create a calendar for patients with a schedule of all medical appointments ■ Build a relationship with the program you are referring a patient to by identifying one or two contact people in that program so you can give your patient their name specifically

Source: Overcoming System Barriers to Cervical Cancer Screening For HIV-Infected Women In A Clinical Setting, 2007

Next Steps

- Review Client-Level Data per Agency for FY 12-13
  - Review cervical screening data in EMR for Part A Clients (FY 12/13)
  - Review cervical screening data in PE for the same time frame
  - Compare HAB and EMR data; provide rates
  - Answer basic questions: Do rates reflect care provided? If not, reasons for rates?
    - Network to report findings within 4 weeks
- Develop strategy to improve data integrity
- Determine current method for cervical screening reminders and follow-up
- Define exclusions to be programmed in PE
- Review agency findings and client demographics to determine appropriate populations for future Focus Groups

Phase II

Factors Influencing Cervical Cancer Screening in HIV+ Women

- Systematic review of peer-reviewed journal articles
- Age, race/ethnicity, tobacco use, weight, education, economic issues, and risk behaviors such as substance abuse are factors that affect all women
  - Viral Load and CD4 count affect HIV+ women
- Literature Review:
  - HPV: Women with HIV are more likely to be infected with multiple types of HPV, less likely to have the virus cleared by their immune system, and more likely to develop cancer
  - Cervical Cancers: Persistent infections with high-risk HPV types can progress to cervical cancer. Risk factors, along with HPV, include tobacco use, compromised immune system, giving birth to 3 or more children, and being on oral contraception for more than 5 years

Source: Factors Influencing Cervical Cancer Screening in Women Infected with HIV: A Review of the Literature, 2013

Factors Influencing Cervical Cancer Screening in HIV+ Women

- Cervical Cancer in HIV+ women:
  - Considered an AIDS-defining illness
  - Risk is greater than in HIV- women
  - HAART has not decreased the incidence of cervical cancer
  - Women with an HIV/HPV co-infection and CD4<200 have a risk of poorer outcomes
  - Women with a CD4<50 are at higher risk of the cancer returning after treatment

- Screening Guidelines: Routine screenings and follow-up treatment reduce mortality in all women.
  - Women with HIV should be screened twice in the first year after diagnosis and annually thereafter
  - Recommended that HIV+ women receive two screenings, 6 months apart, after changing sexual partners, and annually thereafter if normal
  - Discontinue after age 65 with 3 or more negative tests in a row and in women without a history of abnormal tests in the last 10 years
  - Sexually active women over 65 with multiple partners should continue to be screened
  - Clinicians should continue to conduct risk assessments after discontinuing screening

Source: Factors Influencing Cervical Cancer Screening in Women Infected with HIV: A Review of the Literature, 2013

Factors Influencing Cervical Cancer Screening in HIV+ Women

- **Age:** Older women less likely to adhere
- **Race/Ethnicity:** No consistent association for women with HIV.
  - Among HIV- women, African American women were more likely to adhere
- **Tobacco Use:** Current or past smoking in HIV+ women associated with decreased likelihood of being screened
- **Weight:** Both obesity and underweight may be associated with poor adherence to cervical screening
  - Overweight women have a greater risk for developing cervical cancer

Source: Factors Influencing Cervical Cancer Screening in Women Infected with HIV: A Review of the Literature, 2013

Factors Influencing Cervical Cancer Screening in HIV+ Women

- **Education:** Having less than a high school education was generally associated with poor cervical screening adherence
- **Economic Issues:** Economic difficulties and lack of insurance are generally associated with a reluctance to seek preventive care
- **Risky Behaviors:** Former and current drug use associated with poor Pap test adherence
- **HIV Viral Load:** Women with low VL are usually more adherent to guidelines. A VL greater than 10,000 copies was associated with no Pap testing during an 18-month period
- **CD4 Count:** Women with a low CD4 count (<200) were associated with no Pap or poor Pap test adherence

Source: Factors Influencing Cervical Cancer Screening in Women Infected with HIV: A Review of the Literature, 2013

Factors Influencing Cervical Cancer Screening in HIV+ Women

Recommended Next Steps:

- Reduce barriers to cervical screenings
- Consider qualitative studies that assess barriers per population of interest
- Patient education
- Encourage, increase knowledge, reduce barriers

Instructions for Agency Data Review

- Review Client-Level Data per Agency (FY 12-13)
  - Review cervical screening data in EMR for Part A Clients (FY 12/13)
  - Review cervical screening data in PE for the same time frame
  - Compare HAB and EMR data; provide rates
  - Answer basic questions:
    - Do rates reflect care provided?
    - If not, reasons for rates?
  - Report findings

PE Cervical Screening Rates per Agency FY 12-13

Agency A	Agency B	Agency C	Agency D	Agency E
36%	43%	51%	11%	48%

Agency A

- Data from PE:
  - Percentage of Clients with documented screening: 36%
  - Percentage of Clients with no documented screening: 64%
- Data from EMR:
  - 7/1/12–12/31/12=101 screenings done
  - 7/1/12–6/30/13=187 screenings done
  - 1/1/13–6/30/13=280 screenings done

Agency B

PE Report	EMR comparison to those with no Pap in PE
N=98	N=56
56 No Pap in PE	Never Seen: 4% Not in EMR: 2% Due: 34%
42 Pap in PE	Pap documented in EMR: 59%

Agency B

- Agency findings:
  - Internal rate: 86% in EMR
  - Screenings were done within the CY but not FY
- Reasons for no documented screening:
  - Missed appointments
  - Failure to schedule appointment for cervical screening
- Follow-up plan to ensure screenings will be done:
  - Clients due will be contacted and scheduled to see the provider
  - Incentives will be provided for those who kept their scheduled appointment
  - Agency recruiting for a Clinical Coordinator whose role will be to monitor outcome measures and ensure compliance

Agency B	Received Pap	No Pap
HIV Status		
HIV+	93%	91%
AIDS	7%	9%
Race		
Black	74%	73%
White	24%	23%
N. Hawaiian/Pac Islander	1%	----
Asian	----	4%
Ethnicity		
Hispanic	14%	9%
Non-Hispanic	86%	91%
FPL		
0%-50%	43%	45%
50%-100%	22%	27%
100%-150%	16%	5%
150%-200%	8%	5%
200%-250%	5%	18%
350%-400%	5%	----

Agency B	Received Pap	No Pap
Age Category		
19-25	5%	5%
26-30	4%	----
31-35	9%	5%
36-40	12%	18%
41-45	20%	27%
46-50	23%	27%
51-55	14%	9%
56+	16%	9%
Risk		
Mother	3%	----
Heterosexual	91%	91%
IDU	1%	----
Unknown	4%	9%
Sex Worker (Past)	9%	9%
IDU (Past)	8%	0%
Education Level		
8th or less	3%	9%
8th to 12th	72%	55%
College	26%	36%
Was Smoker	27%	41%
Tobacco Counseling	0%	0%

Chart Review Findings – Agency B

- N=5
  - Most recent VL: 60%<48
  - Most recent CD4: 0%<200
  - Disease Status: HIV+ (Not AIDS)
  - Race/Ethnicity: 60% Black/African American, Non-Hispanic
  - Average Age: 48
  - Current/Past Tobacco Use: 20%
  - Education: 60% 8th-12th Grade; 40% College
  - Insurance: 80% No insurance
  - Employment: 60% Unemployed
  - Risky Behavior: IDU, Past incarceration
  - Co-morbidities: Hypertension, Asthma, Bi-polar, PTSD, Schizophrenia

Agency C

PE Report	EMR comparison to those with no Pap in PE
N=94	N=37 (agency compared 55 charts including other URNs)
46 no Pap in PE	No Pap in EMR: 27% (Note: *Pap completed in 2011*) Pap completed outside of FY12-13: 16%
47 Pap in PE	Pap documented in EMR: 38%

Agency C	Received Pap	No Pap
HIV Status		
HIV+	96%	97%
AIDS	4%	3%
Race		
Black	80%	73%
White	20%	27%
Ethnicity		
Hispanic	11%	8%
Non-Hispanic	89%	92%
FPL		
0%-50%	39%	46%
50%-100%	18%	24%
100%-150%	21%	16%
150%-200%	11%	14%
200%-250%	9%	----
350%-400%	2%	----

Agency C	Received Pap	No Pap
Age Category		
19-25	2%	11%
26-30	4%	5%
31-35	9%	5%
36-40	16%	11%
41-45	7%	19%
46-50	23%	22%
51-55	27%	16%
56+	13%	11%
Risk		
Hemophilia	2%	----
Heterosexual	96%	95%
IDU	2%	----
Sex Worker (Past)	4%	8%
IDU (Past)	2%	5%
Education Level		
8th or less	30%	11%
8th to 12th	63	78%
College	7%	11%

Chart Review Findings – Agency C

- N=10
  - Most recent VL: 60%<48
  - Most recent CD4: 10%<200
  - Disease Status: 10% AIDS Diagnosis
  - Race/Ethnicity: 70% Black/African American, Non-Hispanic
    Average Age: 44
  - Current/Past Tobacco Use: 30%
  - Education: 30% 8th Grade or less; 50% 8th-12th Grade; 20% College
  - Insurance: 90% No insurance
  - Employment: 40% Unemployed
  - Risky Behavior: Incarcerated, Substance abuse, Past Commercial sex worker
  - Co-morbidities: Hypertension, Depression, High cholesterol, Asthma

Agency D

PE Report	EMR comparison to those with no Pap in PE
N=126	N=7 (*sample review*)
112 No Pap in PE	No Pap in EMR: 57% (Reasons: non-compliance with care, atrophy/client refusal)
14 Pap in PE	Pap documented in EMR: 43%

Agency D	Received Pap	No Pap
HIV Status		
HIV+	94%	75%
AIDS	6%	25%
Race		
Black	65%	75%
White	29%	25%
Asian	6%	----
Ethnicity		
Hispanic	24%	----
Non-Hispanic	76%	100%
FPL		
0%-50%	35%	75%
50%-100%	12%	25%
100%-150%	6%	----
150%-200%	24%	----
200%-250%	12%	----
350%-400%	12%	----

Agency D	Received Pap	No Pap
Age Category		
19-25	----	----
26-30	18%	----
31-35	12%	----
36-40	29%	----
41-45	6%	25%
46-50	29%	----
51-55	----	25%
56+	6%	50%
Risk		
Hemophilia	----	----
Heterosexual	100%	75%
IDU	----	----
Sex Worker (Past)	0%	0%
IDU (Past)	0%	0%
Education Level		
8th or less	----	25%
8th to 12th	47%	50%
College	53%	25%
Was Smoker	18%	25%
Tobacco Counseling	0%	0%

Chart Review Findings – Agency D

- N=10
  - Most recent VL: 30%<48
  - Most recent CD4: 20%<200
  - Disease Status: 20% AIDS diagnosis
  - Average Age: 47
  - Race/Ethnicity: 60% Black/African American, Non-Hispanic
  - Current/Past Tobacco Use: 30%
  - Education: 70% 8th-12th Grade; 30% College
  - Insurance: 80% No insurance
  - Employment: 80% Unemployed
  - Risky Behavior: Substance abuse, Past incarceration
  - Co-morbidities: Diabetes, Cardiac, Cholesterol, Adrenal gland disease, Asthma, Hep C, Anxiety, Depression, Pain

Agency E

PE Report	EMR comparison to those with no Pap in PE
N=159	N=78
78 No Pap in PE	No Pap in EMR: 79%
81 Pap in PE	Pap documented in EMR: 22%

- Of the 61 patients who did not receive a screening, 44 patients should have been excluded due to the following reasons: Cancer, Expired RW certification, Hysterectomy, Lost to Care, Medicaid, Moved, Non-Compliant, New & Scheduled Clients, Pregnancy, Virgin, Non-Ryan White patient

Agency E	Received Pap	No Pap
HIV Status		
HIV+	87%	89%
AIDS	13%	11%
Race		
Black	79%	64%
White	21%	34%
N. Hawaiian/Pac Islander		2%
Ethnicity		
Hispanic	14%	17%
Non-Hispanic	86%	83%
FPL		
0%-50%	42%	59%
50%-100%	17%	13%
100%-150%	22%	14%
150%-200%	8%	6%
200%-250%	5%	3%
350%-400%	4%	----

Agency E	Received Pap	No Pap
Age Category		
19-25	3%	6%
26-30	1%	6%
31-35	7%	8%
36-40	15%	19%
41-45	18%	19%
46-50	22%	9%
51-55	11%	11%
56+	23%	22%
Risk		
Hemophilia	1%	----
Heterosexual	92%	91%
Mother	1%	----
Transfusion	2%	3%
Unknown	3%	3%
IDU	----	3%
Sex Worker (Past)	2%	5%
IDU (Past)	1%	3%
Education Level		
8th or less	9%	8%
8th to 12th	72%	70%
College	20%	22%
Was Smoker	24%	25%
Tobacco Counseling	4%	3%

Chart Review Findings – Agency E

- N=10
  - Most recent VL: 70%<48
  - Most recent CD4: 10%<200
  - Disease Status: 10% AIDS Diagnosis
  - Race/Ethnicity: 70% Black/African American, Non-Hispanic
  - Average Age: 37
  - Current/Past Tobacco Use: 40%
  - Education: 100% 8th-12th Grade
  - Insurance: 70% No insurance
  - Employment: 80% Unemployed
  - Risky Behavior: Substance abuse, Past Commercial Sex Worker, Past incarceration
  - Co-morbidities: Depression, Asthma, Hypertension, Diabetes, Breast cancer, Bi-polar

Cervical Cancer Screening HAB Performance Measure

Percentage of women with HIV infection who have a Pap screening in the measurement year

- Numerator: Number of HIV-infected female clients who had Pap screen results documented in the measurement year
- Denominator: Number of HIV-infected female clients who:
  - Were ≥18 years old in the measurement year or reported having a history of sexual activity, and
  - Had a medical visit with a provider with prescribing privileges at least once in the measurement year
- Patient Exclusions:
  - Patients who were < 18 years old and denied history of sexual activity
  - Patients who have had a hysterectomy for non-dysplasia/non-malignant indications

NEW Draft Cervical Cancer Screening HAB Performance Measures

Performance Measure:	**Cervical Cancer Screening (*follow Medicaid plan measure definition*)**
National Quality Forum #:	32
Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer (*follow Medicaid plan measure definition*)	
Numerator:	One or more Pap test during the measurement year
Denominator:	Women 24-64 years of age during measurement year
Patient Exclusions:	1. Women who had a hysterectomy with no residual cervix
Use in Other Federal Program:	CMS/ONC EHR Incentive Program (meaningful Use – MU); Physician Quality Reporting System (PQRS); Patient Centered Medical Home (PCMH); Accountable Care Organization (ACO); and Medicaid-Eligible Adult Core Set http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

Next Steps

- Develop strategy to improve data integrity
- Determine current method for cervical screening reminders and follow-up
- Finalize exclusions in PE
  - Clients who have had a Hysterectomy
  - Age: >65
    - <18 (already programmed)
  - Medicaid/Medicare/Private Insurance
  - Patients documented to be deceased at any time in the measurement year
  - Patients who were incarcerated for greater than 90 days of the measurement year
  - Patients who relocated out of the service area or transferred medical care at any time in the measurement year
- Determine need for Special Populations focus groups
- Identify educational opportunities for providers and clients

OBJECTIVE 1. REVIEW PERFORMANCE MEASURES AND SELECT ANNUAL DATA FOR REVIEW				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
1.1 Quarterly Data Reviews a) NQC In+Care Campaign Measures b) NHAS Indicators c) HAB Performance Measures d) Broward Client Level Outcomes and Indicators	• Review And Select Annual Data Measures • Identify Areas For Improvement • Provide Directives To The QI Networks	5/13 7/13 10/13 1/14	7/13 10/13 1/14 3/14	• Data reviews to begin in May as some March WP items were tabled for April
OBJECTIVE 2: CONDUCT ANNUAL EVALUATION OF QM PROGRAM, WORK PLANS, AND PROCESSES				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
2.1 Review Policies And Procedures(P&P) 2.2 Review, Update & Approve 3 -Year Work Plan 2.3 Review, Update And Approve Annual QM Work Plan 2.4 Review Service Delivery Models Submitted By QI Networks 2.5 Review Accomplishments And Challenges	• Updated P&P As Needed • Updated 3-Year And Annual Work Plans That Include Short-Term And Long-Term Strategies To Achieve QM Objectives • Service Delivery Models Reflect Most Current National Guidelines And Best Practices • Annual Work Plan Addresses Challenges Identified In The Previous FY	4/13 4/13 3/13 3/13 3/13	5/13 5/13 4/13 3/13 3/13	• **Completed** • **Completed:** MCM, Medical, Pharmacy, Outreach, Mental Health, and Substance Abuse; Pending: OHC and MAI MCM • **Completed**
OBJECTIVE 3: MONITOR QI NETWORK ACTIVITIES AND PROVIDE DIRECTIVES AND GUIDANCE IN QIP DEVELOPMENT				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
3.1 Quarterly Network Update	1. Identify Areas For Improvement 2. Provide Guidance And Directives To Improve Network Activities and QIPs	12/12 3/13 6/13 9/13	3/13 6/13 9/13 12/13	• **Completed**
OBJECTIVE 4: REVIEW AND ANALYZE FINDINGS FROM NEEDS ASSESSMENT, CLIENT SURVY, SERVICE CATEGORY STUDIES, AND RECORD REVIEWS				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
4.1 Review Findings From: a) Needs Assessment b) Client Survey c) Service Category Assessment/Studies d) Record Reviews e) Identify Service Category For Annual Evaluation	• Identify Barriers To Care • Identify Areas For Improvement In Service Delivery • Recommend Service Category Evaluation	5/13	6/13	
OBJECTIVE 5: ASSESS LINKAGE TO CARE AND RETENTION PROCESSES				
Work Plan Activity	**Outcome**	**Start**	**Due**	**Progress**
5.1 Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	• Linkage To Care And Retention Deficiencies Addressed	3/13 6/13 9/13 12/13	6/13 9/13 12/13 2/14	

Updated 4.15.13

2013-14 WORK PLAN CALENDAR FOR QM COMMITTEE

	March	April	May	June	July	August
QM	❖ Review Accomplishments And Challenges ❖ Quarterly Network Update ❖ Review Annual Summary of In+Care Data ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Review Policies and Procedures (P&P) ❖ Review, Update And Approve 3-Year WP ❖ Review, Update And Approve Annual QM WP (Tabled from March) ❖ Review Service Delivery Models Submitted By QI Networks (Tabled from March)	❖ Review Findings from Needs Assessment and Client Survey ❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators) (Tabled from April)	❖ Quarterly Network Update ❖ Review Findings (as available) From: ❖ Service Category Assessment/Studies ❖ Record Reviews ❖ Identify Service Category For Annual Evaluation ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators) ❖ Quarterly network update	❖ MH Record Reviews ❖ Review, Update and Approve 3-Year WP

	September	October	November	December	January	February
QM	❖ Quarterly Network Update ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators)	❖ HHS, HAB, Broward Outcomes and Indicators	❖ Quarterly Network Update ❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	❖ Quarterly Data Review (NQC, NHAS, HAB Performance Measures, and Broward Client Level Outcomes and Indicators)	❖ Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care ❖ Conduct Annual Evaluation of QM Program, Work Plans, and Processes

Updated 4.15.13