Broward Regional Health Planning Council, Inc.
200 Oakwood Lane, Suite 100
Hollywood, Florida 33020
T (954) 561.9681 F (954) 561.9685

Quality Management Committee
Meeting Agenda
January 7, 2013 at 12:30 P.M
Claudette Grant, Chair

1. **Call to Order**
2. **Welcome and Introductions**
3. **Moment of Silence**
4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
   B. Review Public Comment Requirements (Please Sign-in)
   C. Excused Absences
   D. Approval of Today's Agenda
   E. Approval of 10/15/12 Meeting Minutes
5. **Update on Outcome and Indicator Revisions**
   A. Summary Report to the HIVPC

ACTION ITEM: Discuss status of revisions to the pending Oral Health Care Outcome and Indicator and review the HIVPC response to the QMC-approved revisions forwarded for approval.

6. **Review of NQC Retention Rates Report and QI Network Update**

ACTION ITEM: Review annual summary of measures and discuss QI Network activities.

7. **Review Joint Planning Report**

ACTION ITEM: Review Community Viral Load data plan and discuss process of collaboration with other HIVPC Committees.

8. **Development of Annual QM Committee Work Plan**

ACTION ITEM: Review annual work plan and discuss development of FY13-14 plan.

9. **Unfinished Business**
   A. FAQ's for New Committee Members

ACTION ITEM: Review proposed orientation for new committee members.

10. **New Business**
11. **Grantee Reports**
    A. Part A Grantee Report
12. **Resources and Announcements**

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13. Public Comment

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

15. Request for Information/Directives

16. Agenda Items for Next Meeting

17. Next Meeting Date: TBD

18. Adjournment

Quality Management Committee
Monday, October 15, 2012 at 12:30 P.M.
Minutes

Attendance					
#	**Members**	**Present**	**Absent**	**Guests**	**Grantee Staff**
	Gammell, B. ,HIVPC Vice Chair	X		Bonnie Majcher	Degraffenreidt, S.
1	Grant, C., Vice Chair	X		Jamie Finkelstein*	Strong, K.
2	Johnson, K.		X	Brenda Colon	Jones, L.
3	Katz, H.B.	X		Rita Volpitta	
4	Martin, M.	X			**CQM Staff**
5	Mitchell, T.	X			Eshel, A.
6	Quintana-Jefferson, M.	X			Desa, G.
7	Rajner, M.		X		Crawford, T.
8	Schweizer, M.	X			Rosiere, M.
Quorum = 5		**6**	**2**		

*Attended via phone

1. **Call to Order**
   The meeting was chaired by the HIV Planning Council Vice-Chair with the assistance of the QM Committee Vice-Chair. The Chair called the meeting to order at 12:36 P.M.

2. **Welcome and Introductions**
   The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law. It was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. **Moment of Silence**
   A moment of silence was observed.

4. **Ground Rules and Approvals**
   A. Review Meeting Ground Rules and Statement of Sunshine
      The Chair reviewed Meeting Ground Rules and Statement of Sunshine.

   B. Review Public Comment Requirements (Please Sign-in)
      There was no Public Comment.

   C. Excused Absences
      There were no requests for excused absences.

   D. Approval of Today's Agenda
      The agenda was approved via consensus.

   E. Approval of 09/24/12 Meeting Minutes
      The minutes were approved via consensus.

5. Review Revisions to Outcomes and Indicators-Update

A. Outreach

The Committee reviewed the Outreach Outcomes and Indicators. Attendees voiced concern of whether having an appointment occur within two weeks of a client establishing eligibility was realistic. Members also voiced concern of whether targeting 25% of lost to care clients was too low, but it was concluded that there was no previous tracking so that was a good starting point.

The following is the revised Outreach outcome and indicators presented to the committee for approval:

Outreach	
Outcomes	**Revised Indicators**
Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	1.1 80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit ~~to~~ occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).
	1.2 25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit ~~to~~ occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).

After discussion, the Committee decided to accept Outreach indicators 1.1 and 1.2 as presented.

Motion 1	"To approve Outreach Indicator 1.1 as presented."
First	Claudette Grant
Second	H. Bradley Katz
Action	Passed Unanimously

Motion 2	"To approve Outreach Indicator 1.2 as presented."
First	Claudette Grant
Second	H. Bradley Katz
Action	4 approved, 1 opposition

B. Oral Health Care

Outcomes and Indicators for Oral Health will be discussed at the next Network meeting; an update will be provided at the next Committee meeting.

6. Update on 2012-2015 Comprehensive Plan Implications for QM Committee Work Plan

The Committee was presented with the 2012-2015 Comprehensive Plan. The purpose was to review the comprehensive plan in order to incorporate the National HIV/AIDS Strategy (NHAS) goals into the 2013-2015 work plans. It was noted that Chapter 4 of the comprehensive plan discusses monitoring and evaluation activities in detail and should be reviewed by members.

While reviewing the NHAS goals, the Committee expressed concern that there were some things that the QM committee could not capture and control. The Committee emphasized the need to acknowledge what pieces are missing as well as collaborate with other agencies.

There was also a recommendation made that the Committee review data on a regular basis (every three months) in order to monitor success towards achieving the NHAS goals.

7. Review Annual QM Work Plan

It was announced that the Annual QM Work Plan is included in the committee's agenda packet and is for informational purposes only.

8. Unfinished Business
None.

9. New Business
None reported.

10. Grantee Reports

A. Part A Grantee Report

The following announcements were made:

i. The National Quality Center (NQC) has extended the In+Care campaign to 2013, and the EMA will continue its participation.

ii. CQM Grantee and support staff will be traveling to a Central Florida Regional QI Group meeting facilitated by NQC on Thursday, October 25, 2012 to present on the EMA's participation in the campaign regarding programming, collection, and analysis.

11. Resources and Announcements

A. Review 2012 Client Survey Tool
The committee was presented with the draft survey and was instructed to review and direct questions, comments, or suggestions to staff by Tuesday, October 16, 2012 in order for additions to be incorporated and presented at the Executive Committee meeting on Thursday, October 18, 2012.

B. MCM Resource Fair
The MCM Resource Fair will be held on October 24, 2012 at Central Broward Regional Park. The session times are 11:00 a.m. to 1:00 p.m. or 1:00 p.m. to 3:00 p.m. This fair is mandatory for all medical case managers, HOPWA case managers and peers.

12. Public Comment
None.

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

14. Request for Information/Directives
There were no requests for information or directives.

15. Identify Agenda Items for Next Meeting

A. Review Annual QM Work Plan
B. Review NQC Retention Rates Report
C. Review Revisions to Outcomes and Indicators-Oral Health
D. Quarterly QI Network Update

16. Next Meeting Date: Monday, **December 17, 2012** at 12:30 p.m.
The cancellation of the November QM Meeting was proposed; a Coordination meeting will be held instead.

17. Adjournment
The meeting was adjourned at 2:34 P.M.

REVISION OF BROWARD COUNTY CLIENT-LEVEL OUTCOMES AND INDICATORS

Indicator: A measure used to determine, over time, an organization's or system's performance of a particular element of care. The indicator may measure function, process or outcome.

Outcome: Benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. Outcomes may be client-level or system-level.

Beginning in October 2011, the Quality Management Committee (QMC) initiated an in-depth review of the Broward County Client-Level Outcomes and Indicators. The outcomes and indicators are local performance measures developed to assess the quality of services in each service category. They are based on local standards as reflected in each service category's Service Delivery Model. The outcomes and indicators were developed by the Quality Improvement (QI) Networks in collaboration with the Grantee and QMC. They comprise one of several sets of performance measures used to assess the quality of services and their impact on clients' health outcomes. Other examples of performance measures used by the QM Program are the HIV/AIDS Bureau (HAB) Performance Measures and the National Quality Center (NQC) In+Care Campaign measures.

The purpose of the review was to determine whether the measures accurately reflect the quality of services provided and their impact on clients' health and retention in care. The first step was to determine which service category's outcomes and indicators should be revised. The QMC agreed to revise the following:

- Medical Case Managements
- Oral Health Care
- AIDS Pharmaceutical Assistance
- Mental Health
- Substance Abuse
- Legal Services
- Outreach
- Food Bank
- Central Intake Eligibility Determination

The QMC agreed that the Outpatient/Ambulatory Medical Care outcomes and indicators (*below*) did not require revision:

Outcome: Slow/prevent clients HIV disease progression

Indicators: 1.1 80% of clients with CD4 <500 are prescribed HAART

1.2 70% of clients on HAART for >6 months will have a viral load<400

The QMC developed recommendations for each QI Network to assist in the revision process. The QI Networks considered the recommendations, reviewed the outcomes and indicators used by other Eligible Metropolitan Areas (EMAs) as well as literature review summaries, and deliberated until consensus was reached. Once consensus was achieved, the Networks forwarded their recommendations to the QMC. In some cases, the QMC agreed with the Networks' recommendations and approved the revised outcomes and indicators while in other cases the QMC requested the Networks further revise the outcomes and indicators. The QMC regularly reported on its progress to the HIVPC. On December 22, 2011, the Mental Health, Substance Abuse, and Legal Services QMC-approved outcomes and indicators were included on the HIVPC's agenda as discussion items. The HIVPC requested that all outcomes and indicators be put on the agenda when completed with in-depth justification for the changes made.

HIVPC DISCUSSION ITEMS

To approve mental health outcomes and indicators 1-Improvement in client's symptoms associated with primary mental health diagnosis. 1.1-85% of clients achieve Plan of Care goals by designated target date. 2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. 2.1-85% of clients are retained in Outpatient/Ambulatory Medical Care.
Passed unanimously
To approve substance abuse outcomes and indicators 1-Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis. 1.1-85% of clients achieve Plan of Care goals by designated target date. 2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. 2.1-85% of clients are retained in Outpatient/ Ambulatory Medical Care. **Remove**: Decreased substance use. 60% of all clients will achieve at least 30 days clean/sober at time of discharge (data collection only).
Passed (3 opposition)
HIVPC Comment: Recommend to add back the removed outcome 'Decreased Substance Use'
To approve legal services outcomes and indicators 1-Increased access to benefits for which the client is eligible. 1.1-80% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability. 1.2-60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.
Passed (1 opposition)
HIVPC Comment: Consider increasing the percentage on Indicator 1.1
To approve medical case management outcomes and indicators 1-Increased access, retention and adherence to Outpatient/Ambulatory Medical Care 1.1-80% of clients achieve POC goals related to Outpatient/Ambulatory Medical Care services by designated target dates 1.2 ~~2.2~~ 80% of clients are retained in Outpatient/Ambulatory Medical Care **Remove:** Improved ability to independently navigate and access needed services Initial: 100% of new clients receive information regarding available services and corresponding eligibility criteria Intermediate: 80% of clients achieve initial POC goals by designated target date
Passed (3 oppositions)
HIVPC Comment: Review annually; consider changing Indicator 1.1 to reflect all core services
To approve AIDS pharmaceutical assistance outcomes and indicators 1-Improve access to medication. 1.1- Attempts will be made to contact 100% of clients who do not pick up medications within 7 to 14 days of filling the prescription ~~will be contacted.~~ 2-Clients provided an opportunity to improve medication adherence. 2.1-100% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence)
Passed (2 oppositions)
To approve outreach outcomes and indicators 1-Facilitate client access to outpatient/ambulatory medical care and/or medical case management 1.1-80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder). 1.2-25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or

medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).
Passed (1 opposition)
To approve food bank outcomes and indicators 1-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care 1.1-85% of clients are retained in Outpatient/Ambulatory Medical Care. 1.2-100% of those clients not retained in Outpatient/Ambulatory Medical Care will be referred to the appropriate provider (i.e., medical case management, physician, Treatment Adherence Program, etc.). **Remove**: Improve client's knowledge of food handling. Initial: 100% of clients will receive food handling information as indicated by clients' signature.
Passed unanimously
To approve CIED outcomes and indicators 1-Provide rapid engagement of clients into care. 1.1-95% of clients eligible for Part A who have not had an OAMC visit within the last 6 months at the time of recertification shall have an OAMC or Medical Case Management appointment scheduled within 1 business day. 2-Provide access to benefits for which client is eligible. 2.1-95% of clients who meet eligibility criteria for 3rd party benefits will receive assistance in completing applications for those benefits. **Remove:** Clients will have their HIV/AIDS related needs met. 95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment. 95% of clients receiving referrals will have a disposition follow up within 14 business days.
Passed unanimously

MENTAL HEALTH OUTCOMES AND INDICATORS

Original Outcomes	Original Indicators	Justification	Revised Outcomes	Revised Indicators
Improvement in client's symptoms associated with primary diagnosis.	60% of clients showed improvement in related clinical scale over baseline (quarterly until discharge or at the end of one year).	**Limitation:** Reflects only clients who have had a related clinical scale done. **Recommendation:** Approximately 5% of clients are administered clinical scales. Indicators should be based on every client's improvement not only those who had a clinical scale.	**1-Improvement in client's symptoms associated with primary mental health diagnosis.**	**1.1-85% of clients achieve Plan of Care goals by designated target date.**
Increased retention and adherence to Outpatient/ Ambulatory Medical Care for clients who have not been in care or have been out of care for a period of 6 months or more.	Initial: 85% of clients referred to Outpatient/Ambulatory Medical Care kept their initial appointment. Long-Term: 85% of clients remain enrolled in Outpatient/Ambulatory Medical Care at time of discharge.	**Limitation:** Unnecessary distinction between initial and long-term indicators. **Recommendation:** Remove initial indicator and develop outcome that more accurately reflects improvement in retention beyond the initial appointment.	**2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care.** *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	**2.1-85% of clients are retained in Outpatient/Ambulatory Medical Care.**

SUBSTANCE ABUSE OUTCOMES AND INDICATORS

Original Outcomes	Original Indicators	Justification	Revised Outcomes	Revised Indicators
Improvement in client's symptoms associated with co-occurring diagnosis.	60% of clients showed improvement in related clinical scale (if applicable) over baseline.	**Limitation:** Reflects only clients who have had a clinical scale done. **Recommendation:** Indicators should be based on every client's improvement not only those who had a clinical scale done. Substance Abuse Outcomes and Indicators should mirror the Mental Health Outcomes and Indicators. Treatment plans for substance abuse will be based on a substance abuse diagnosis and co-occurring mental health diagnosis for the majority of clients. Action plans will be customized to clients' needs.	**1-Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.**	**1.1-85% of clients achieve Plan of Care goals by designated target date.**
Increased Access, Retention and Adherence to Outpatient/Ambulatory Medical Care.	Initial: 60% of clients referred to Outpatient/Ambulatory Medical Care that kept their initial appointment. Intermediate: 85% of clients remain enrolled in Outpatient/ Ambulatory Medical Care at time of discharge.	**Limitation:** Unnecessary distinction between initial and long-term indicators. **Recommendation:** Develop outcome that more accurately reflects improvement in retention beyond the initial appointment.	**2-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care.** *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	**2.1-85% of clients are retained in Outpatient/ Ambulatory Medical Care.**
Decreased substance use.	60% of all clients will achieve at least 30 days clean/sober at time of discharge (data collection only).	**Limitation:** Depends on accurate data entry. **Recommendation:** Remove - The indicator does not consider lapses and relapses.	**Outcome Removed**	**Indicator Removed**

LEGAL SERVICES OUTCOMES AND INDICATORS

Original Outcomes	Indicators	Justification	Revised Outcomes	Revised Indicators
Increased access to benefits for which the client is eligible.	70% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability. 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.	**Limitation:** None noted **Recommendation:** Indicator 1.1 increased based on Legal Services' history of surpassing the original benchmark. Indicator 1.2 remains the same with the justification that if the case is lost at the hearing level (measured in indicator 1.1), it is very unlikely it will be reversed (as measured in indicator 1.2). Consider at a later date an indicator that better reflects the services provided (e.g., permanency planning).	**1-Increased access to benefits for which the client is eligible**.	**1.1-80% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability.** **1.2-60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.**

AIDS PHARMACEUTICAL ASSISTANCE OUTCOMES AND INDICATORS

Original Outcomes	Indicators	Justification	Revised Outcomes	Revised Indicators
Clients provided an opportunity to improve medication adherence.	**1.1** 100% of clients accepts or rejects counseling as indicated by Patient's signature.	**Limitation:** Data not entered in PE. Signature does not indicate the content of adherence needs of the client. Adherence to ARV's is not measured through Part A pharmacy services since clients generally receive ARV's from other sources **Recommendation:** Develop outcome that more accurately reflects improvement in adherence. Must be programmed in PE.	**1-Improve access to medication.**	**1.1-100% of clients who do not pick up medications within 7 to 14 days of filling the prescription will be contacted.** *(Clients can call in a prescription up to 7 days early. The maximum window between filling and picking up a medication will not exceed 14 days as each pharmacy will conduct a review of the Return to Stock list once a week).*
Improve access to medication.	**1.2** 80% of new prescriptions filled and available within 24 hours or refills filled and available within 48 hours.	**Limitation:** Data not entered in PE. Access to ARV's is not measured through Part A pharmacy services since clients generally receive ARV's through ADAP. **Recommendation:** Develop outcome that more accurately reflects improvement in adherence and retention. Must be programmed in PE.	**2-Clients provided an opportunity to improve medication adherence.**	**2.1-100% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence)** *(Identifying clients who have difficulty with adherence and referring to appropriate provider for intervention with a goal of improving adherence).*

MEDICAL CASE MANAGEMENT OUTCOMES AND INDICATORS

Original Outcomes	Indicators	Justification	Revised Outcomes	Revised Indicators
Improved ability to independently navigate and access needed services	Initial: 100% of new clients receive information regarding available services and corresponding eligibility criteria Intermediate: 80% of clients achieve initial POC goals by designated target date	**Limitation:** Mainly a CIED function. Measures initial POC goals only **Recommendation:** Remove - Outcome more reflective of CIED function.	**Removed**	**Removed**
Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care	80% of clients self-report adherence with their prescribed medication regimen (data collection only) Initial: 80% of new clients have outpatient medical visit scheduled to occur within 2 weeks of intake Intermediate: 80% of clients remain enrolled in OAMC at time of discharge or episodic status	**Limitation:** Self-reported information. Mainly a CIED function **Recommendation:** Develop indicator that measures overall retention in care and does not rely on self-reported information.	**1-Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care** *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.*	**1.1-80% of clients achieve POC goals related to Outpatient/ Ambulatory Medical Care services by designated target dates** **2.2 80% of clients are retained in Outpatient/ Ambulatory Medical Care**

OUTREACH OUTCOMES AND INDICATORS

Original Outcomes	Indicators	Justification	Revised Outcomes	Revised Indicators
Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	1.1 80% of new or lost to care clients will have an outpatient/ambulatory medical care or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).	**Limitation:** Outcome does not distinguish between new and lost to care clients. **Recommendation:** Consider creating separate indicators for new clients and returning clients.	**1-Facilitate client access to outpatient/ambulatory medical care and/or medical case management**	**1.1-80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).** **1.2-25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).**

FOOD BANK OUTCOMES AND INDICATORS

Original Outcomes	Indicators	Justification	Revised Outcomes	Revised Indicators
Improve and/or maintain a client's adherence to medication when food is required.	80% of clients report an improved ability to take medications when food is required.	**Limitation:** Part A Food Bank services are too limited in scope to measure impact on adherence **Recommendation:** Develop outcomes that reflect Food Bank's impact on client health outcomes	**1-Increase and/or maintain retention in Outpatient/Ambulatory Medical Care** *Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period*	**1.1-85% of clients are retained in Outpatient/Ambulatory Medical Care.** **1.2-100% of those clients not retained in Outpatient/Ambulatory Medical Care will be referred to the appropriate provider (i.e., medical case management, physician, Treatment Adherence Program, etc.).**
Improve client's knowledge of food handling.	Initial: 100% of clients will receive food handling information as indicated by clients' signature.	**Limitation:** Contractually required **Recommendation:** Remove	**Removed**	**Removed**

CIED OUTCOMES AND INDICATORS

Original Outcomes	Original Indicators	Justification	Revised Outcomes	Revised Indicators
Provide rapid engagement of clients into care.	95% of clients requiring Ambulatory Outpatient Medical Care or Medical Case Management services shall have an appointment scheduled within 1 business day.	**Limitation:** Not specific. **Recommendation:** Clarify CIED responsibility for linkage to care.	**1-Provide rapid engagement of clients into care.**	**1.1-95% of clients eligible for Part A who have not had an OAMC visit within the last 6 months at the time of recertification shall have an OAMC or Medical Case Management appointment scheduled within 1 business day.**
Provide access to benefits for which client is eligible.	95% of clients eligible for 3rd party benefits will receive assistance in completing applications for those benefits.	**Limitation:** CIED is not the only entity screening for eligible for 3rd party benefits. **Recommendation:** Indicator to measure CIED's assistance, not actual receipt of benefits.	**2-Provide access to benefits for which client is eligible.**	**2.1-95% of clients who meet eligibility criteria for 3rd party benefits will receive assistance in completing applications for those benefits.**
Clients will have their HIV/AIDS related needs met.	95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment. 95% of clients receiving referrals will have a disposition follow up within 14 business days.	**Limitation:** Ability to document outside of Ryan White services in PE **Recommendation:** Remove	**Removed**	**Removed**

In+Care Campaign Retention Measures

Gap Measure
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year.
Medical Visit Frequency
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.
Patients Newly Enrolled in Medical Care
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year.
Viral Load Suppression
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year.

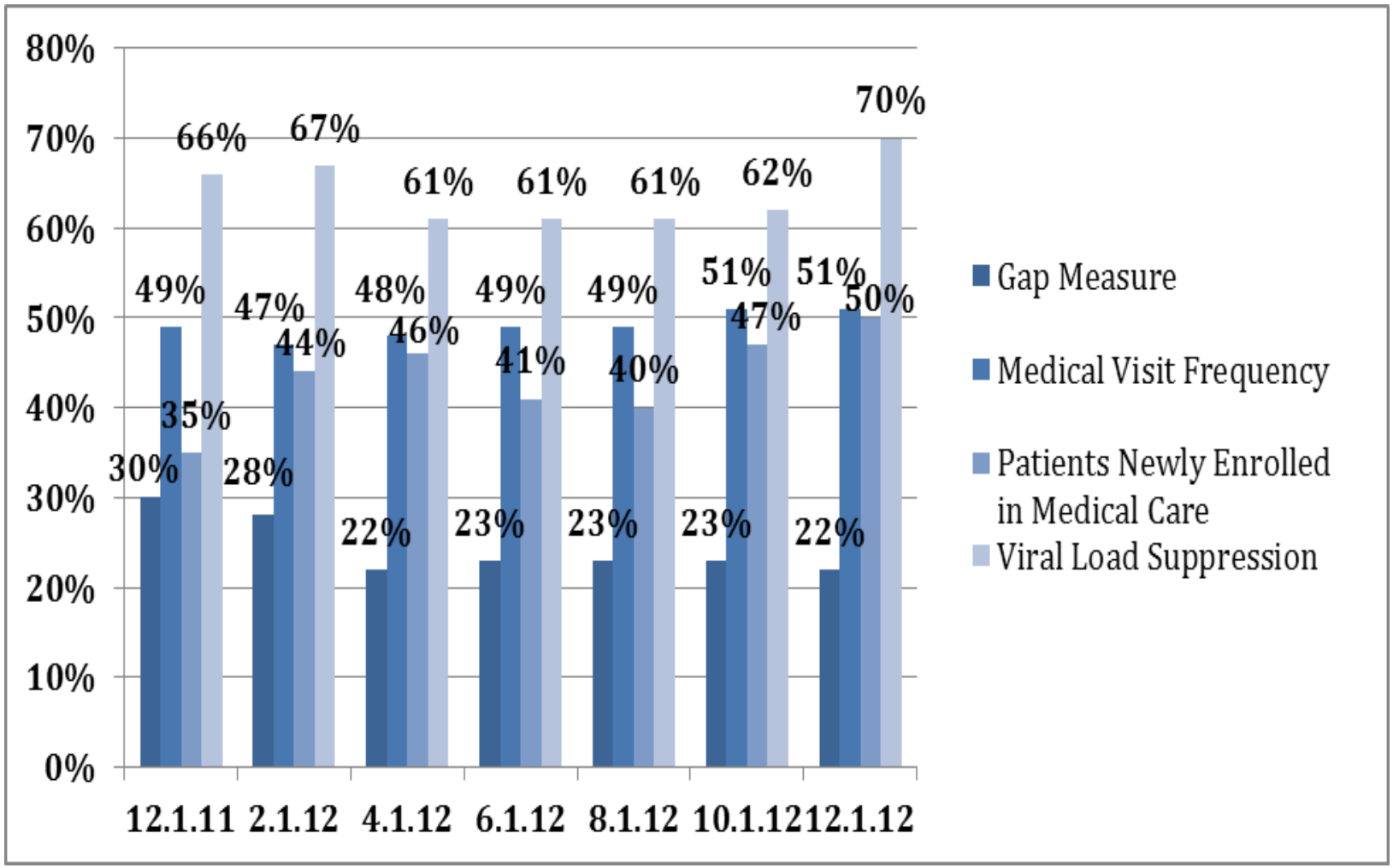
Data Submission Dates

Submission Due Date	Measurement Year*	24 Month Measurement Period**
12/01/2011	10/01/2010 - 09/30/2011	10/01/2009 - 09/30/2011
02/01/2012	12/01/2010 - 11/30/2011	12/01/2009 - 11/30/2011
04/02/2012	02/01/2011 - 01/31/2012	02/01/2010 - 01/31/2012
06/01/2012	04/01/2011 - 03/31/2012	04/01/2010 - 03/31/2012
08/01/2012	06/01/2011 - 05/31/2012	06/01/2010 - 05/31/2012
10/01/2012	08/01/2011 - 07/31/2012	08/01/2010 - 07/31/2012
12/03/2012	10/01/2011 - 09/30/2012	10/01/2010 - 09/30/2012

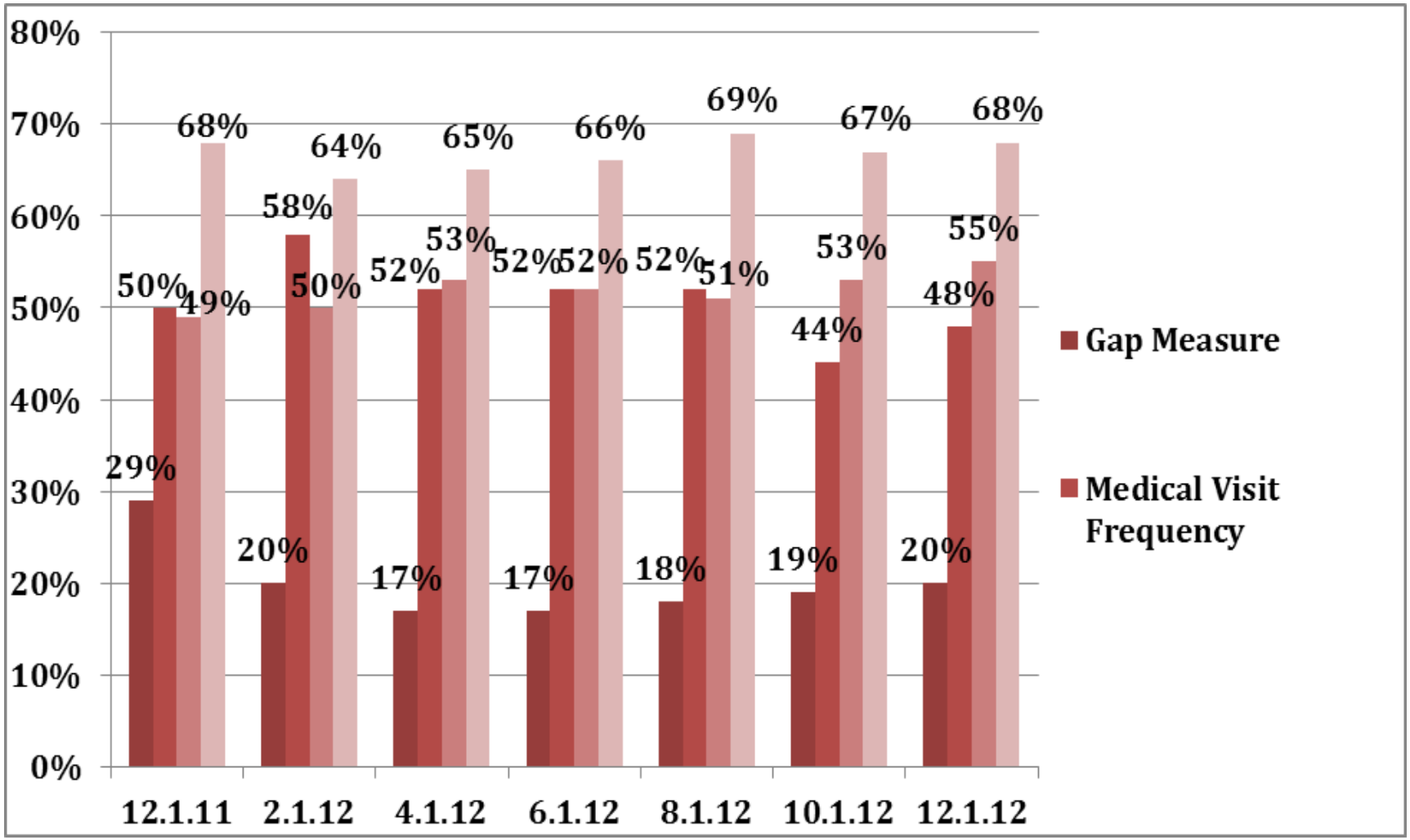
*applies to the following measures: Gap Measure, Patients Newly Enrolled in Medical Care, and Viral Load Suppression

** applies to the Medical Visit Frequency measure

Broward County Rates

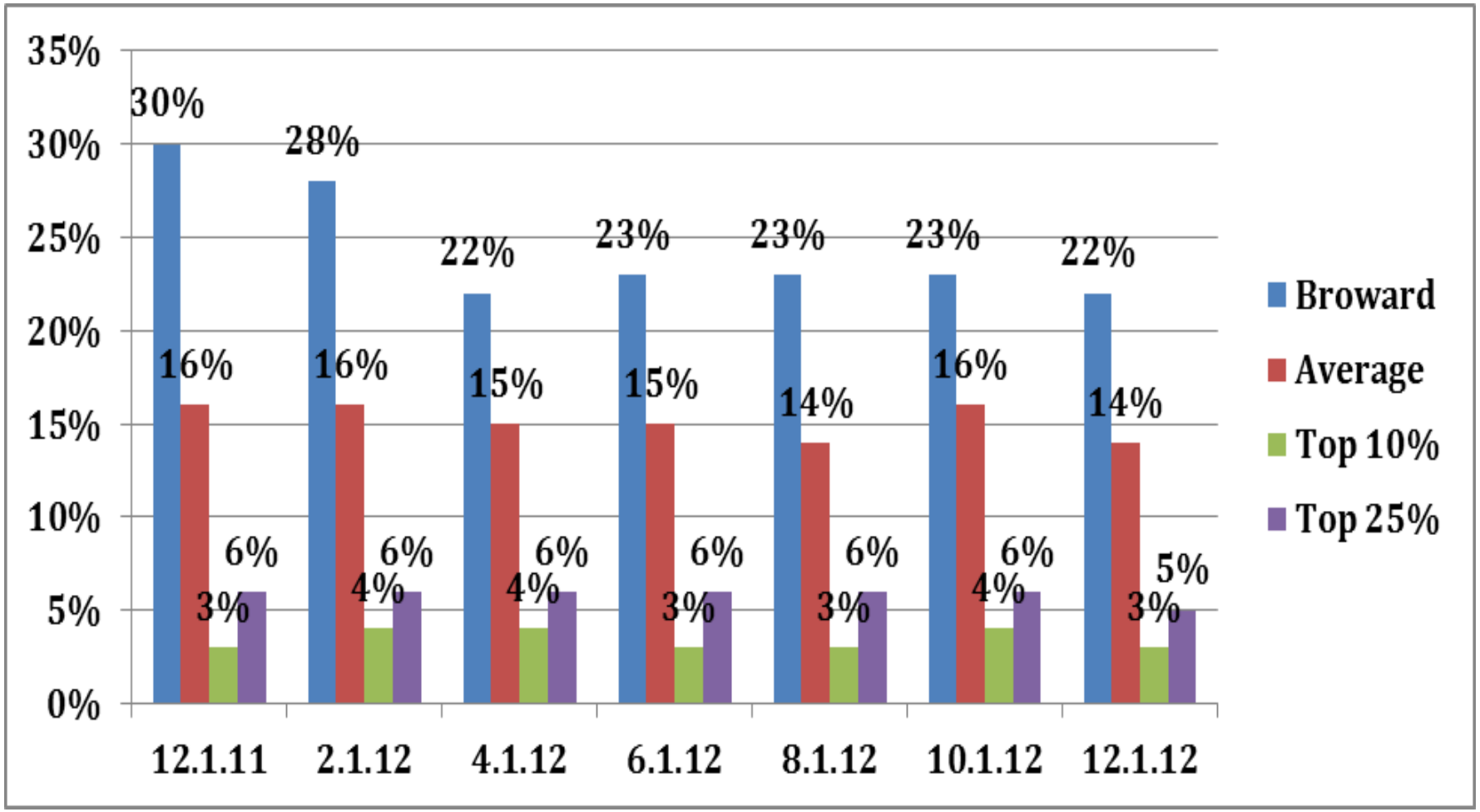


National Part A Data Group Rates



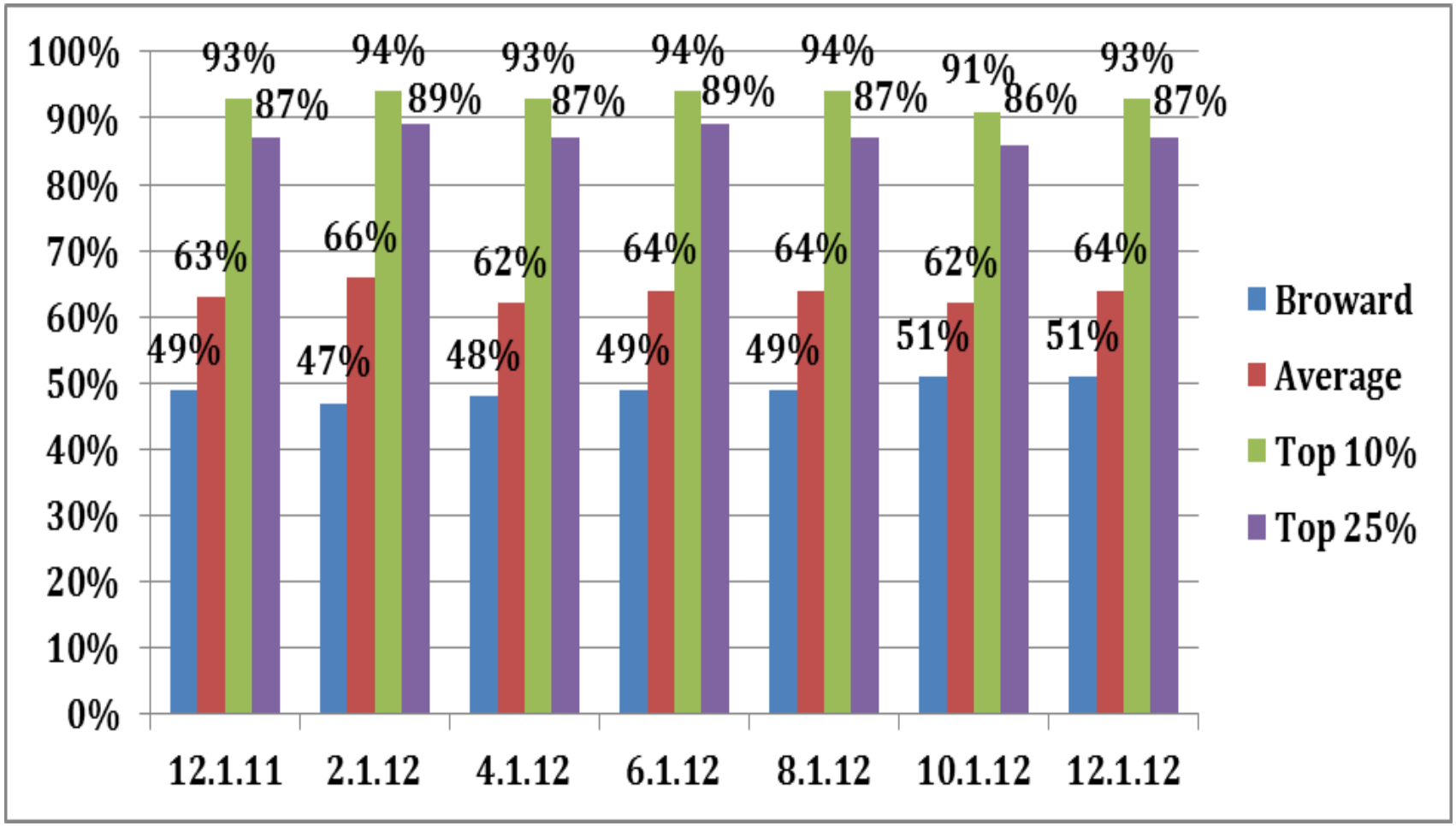
Part A Benchmark Report

GAP MEASURE



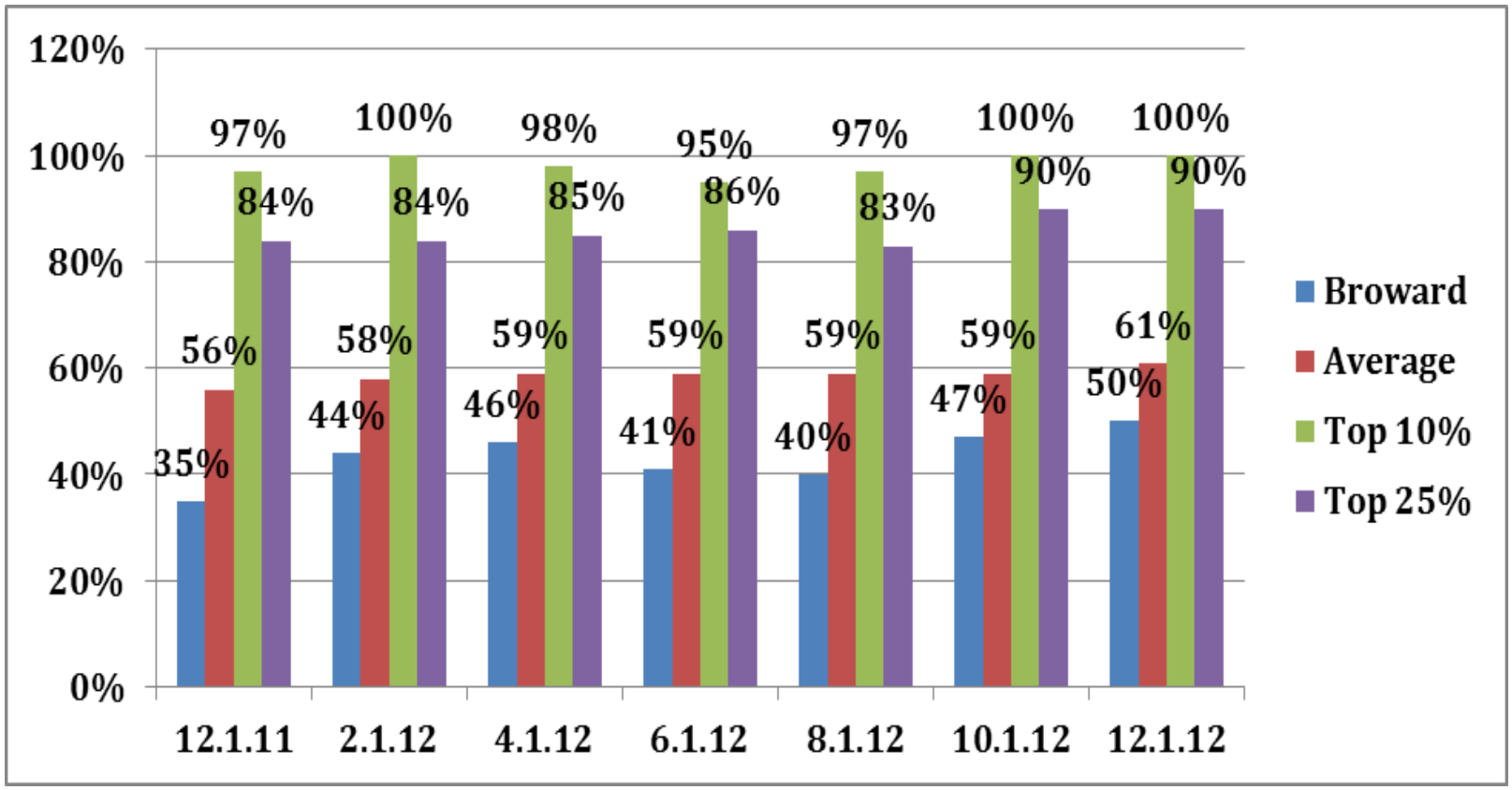
Part A Benchmark Report

MEDICAL VISIT FREQUENCY



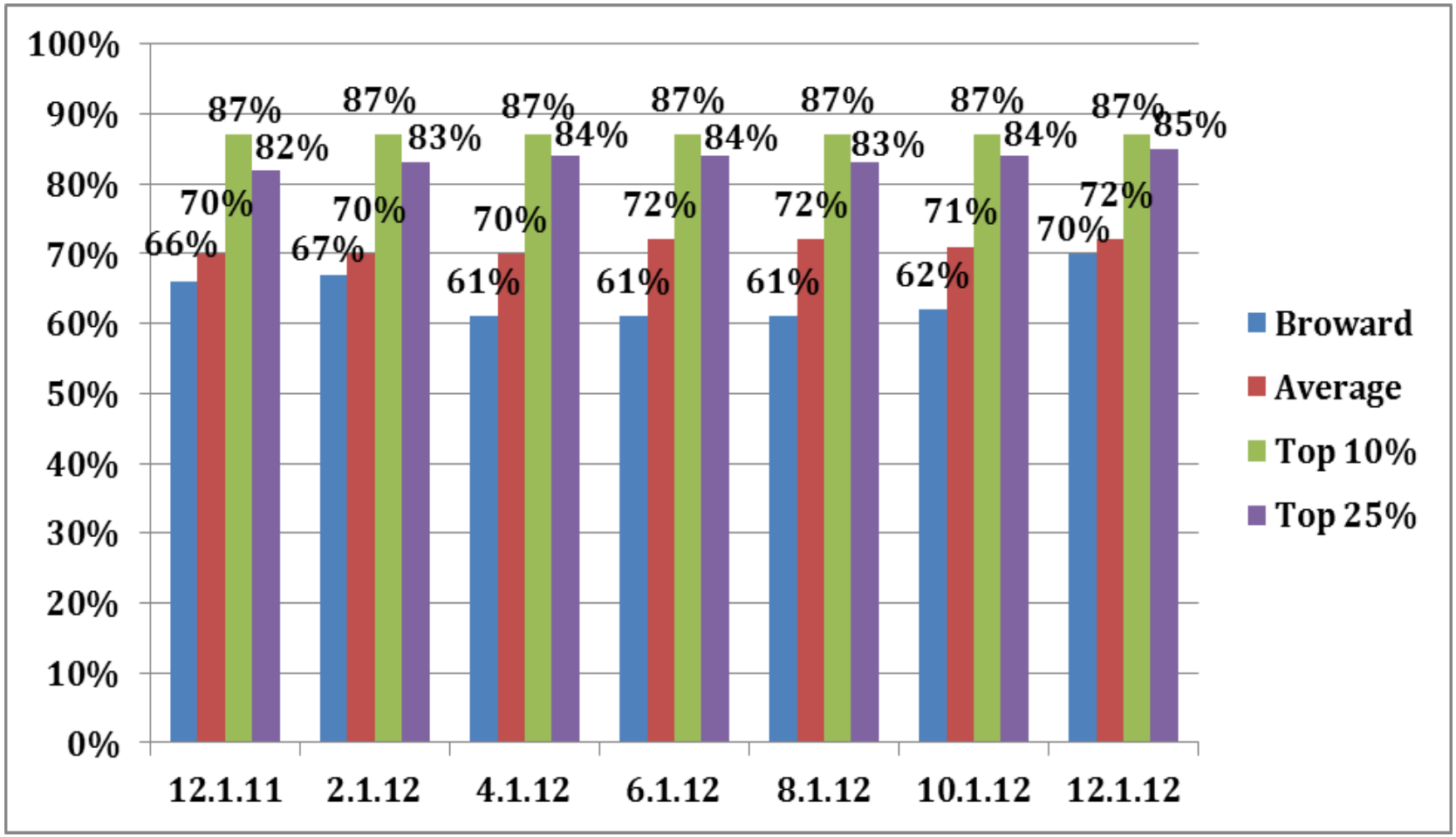
Part A Benchmark Report

PATIENTS NEWLY ENROLLED IN MEDICAL CARE



Part A Benchmark Report

VIRAL LOAD SUPPRESSION



QUARTERLY QUALITY IMPROVEMENT (QI) NETWORK UPDATE

Oral Health Care Network

- Members discussed revisions to the outcomes and indicators.
- The revised outcomes and indicators were sent to the QM Committee for approval; consensus was not reached on outcome and indicator #2.
- **Nest steps:**
  - Agree on suitable revisions to outcome and indicator #2.
  - Review SDM.
  - Oral Health retention data will be utilized to discuss improving Oral Health Care clients' retention.

Mental Health/Substance Abuse Network

- Major themes impeding retention were identified: severe depression, chronic and persistent mental illness, homelessness, cultural barriers, etc. Depression was noted to be the greatest indicator of non-retention.
- The network discussed the possibility of implementing an "*Additional Support Needed*" flag in PE to reflect clients who have the aforementioned barriers to care. The network will develop a presentation to explain these barriers and signs/symptoms to all providers.
- The Network began developing language for the "alert" to be placed in PE with respect to these barriers without disclosing/violating client privacy.
- **Next Steps:**
  - The Network discussed providing two trainings, one for the medical Network and one for an All Networks meeting on identifying and addressing mental health barriers to retention.
  - Review SDM.

Outpatient Ambulatory Medical Care Network

- Operation H.O.P.E.F.U.L: Members provided input regarding the use of the cards. Most providers noted the cards were useful but time consuming in the context of a 15 minute medical appointment. MCM's, and other non-clinical staff, have been using the cards primarily. Discussion took place regarding ways to track observations about the usage of the cards as well as associated outcomes.
- The Network reviewed FY11-12 drug utilization and provided recommendations to LPAC on additions/deletions to the Part A Formulary. The formulary changes were approved by the HIVPC (*copy on file*).
- **Next Steps:**
  - Develop QIPs to improve cervical screenings, retention in medical care, and Viral Load suppression.
  - Provide summary of non-HIV related specialty referrals.
  - Network restructuring.
  - Review SDM.

Medical Case Management Network

- Operation HOPEFUL: The Network provided feedback on Operation HOPEFUL. A summary was provided to AETC.
- QIP Development: The Network received agency specific client level data for the Gap Measure for the time period of 04/01/2011 - 03/31/2012. Each provider was asked to document the following in a spreadsheet: Last Attended OAMC Appointment, Reasons for Missed Appointment, Next Scheduled OAMC Appointment, Date and Result of Last CD4 Test, Date and Result of Last VL, Data Source (e.g., PE, EMR, client self-report).
- MCM Training and Resource Fair took place during September and October, 2012.
- **Next Steps:**
  - Review SDM.
  - Invite outreach provider to meeting.

Combined Network

- No meetings were held.

All Network

- A presentation was provided on: 1) the National HIV/AIDS Strategy (NHAS) and the 2012-2015 Broward County Comprehensive Plan, 2) annual summary report of the In+Care Campaign, and 3) revisions made to Broward County outcomes and indicators.
- National HIV/AIDS Strategy (NHAS) and 2012-2015 Broward County Comprehensive Plan:
  - The 2012-2015 Plan uses as its foundation the NHAS goals: (1) Reduce the Number of People who Become Infected with HIV, (2) Increase Access to Care and Improve Health Outcomes for PLWHA, and (3) Reduce HIV-

Related Health Disparities. Additionally, the fourth goal, collaboration across agencies and funding streams to maximize resources and avoid duplication of services, is discussed throughout the plan. The Network agreed that a local baseline measure must be established in order to monitor success towards achieving these goals. The need to identify new and innovative methods while continuing to value old successful practices was emphasized.
    - A video developed by AIDSVu followed the discussion. The video provided a brief summary of the NHAS goals and the importance of understanding the local characteristics of the epidemic.
    - The Network discussed the treatment cascade and noted that the Unmet Need for Broward County is approximately 4,000 individuals.
    - It was noted that progress towards achieving the NHAS goals occurs at the Network level; HIVPC committees are incorporating the NHAS goals into their annual work plans and monthly agendas. Staff noted that the last year has been spent on data reviews to improve data integrity; with better data integrity, it will be easier to move forward with implementation of QI projects.
- NQC In+Care Campaign and Annual Summary:
    - The In+Care measures were discussed. Improvement was noted in three of the four measures. It was noted that the campaign has been extended for another year.
    - The Grantee noted that there is a prospective initiative to start a quality group in Miami, West Palm and Broward to discuss the Campaign amongst the EMA's.
- Revision of Broward County Client Level Outcomes and Indicators:
    - The QMC made recommendations to all Networks (except Medical) to assist with the revision process. Each Network reviewed its outcomes and indicators and brought revisions to the QMC for approval. Nearly all revisions have been approved by the QMC and will be brought to the HIVPC for approval.
- The EMA received the NQC's 2012 Award for Performance Measurement.

Joint Planning Council – November 5, 2012

Part A Co-Chair: Carl Roberson, Part B Co-Chair: Kim Saiswick

The Part B Chair welcomed the new Part A Chair. The Committee reviewed the 2012 Client Survey it had developed and that was approved by the Executive Committee. Also, Joint Planning members discussed seven data measures the federal Health and Human Services recommends be collected, and agreed to request that all the Ryan White Grantees supply the data. Their reports would be due by March or April, in time for the funding allocations process. The Part B Chair asked that an item be added to the agenda of the next Joint Executive Committee meeting to discuss requiring annual viral load results from all clients of Part A services, to help develop a Community Viral Load measure. Also, the Committee endorsed the Chairs suggestions on actions the Committee can take to advance the goals of the National HIV/AIDS Strategy, and added no additional actions. *Agenda items for the next meeting*: Update on Client Survey; report on prevention and routine testing. *Next Meeting Date*: Monday, December 10, 2012.

Quality Management Committee Work Plan for FY 12/13

1. Develop 3-Year QM Plan				Accountability: Grantee Staff, CQM Support Staff, QMC
Objectives	Outcome	Start	Due	Status
1a. Review and make recommendations for changes to 3 Year QM Plan	3 Year QM Plan Review Completed	2/13	12/13	FY11-13 3-Year Plan in effect
1b. Update 3 Year QM Plan & Annual QM Work Plan	Update 3 Year QM Plan	2/13	12/13	FY11-13 3 Year Plan in effect
1c. Approve updated 3 Year QM Plan	Approve 3 Year QM Plan	2/13	12/13	FY 11-13 3-Year Plan in effect
2. Review and Analyze Annual Measures, Chart Review Data, and QI Network Activities				
Objectives	Outcome	Start	Due	Status
Select annual measures and data for tracking and evaluation	Identification of areas for improvement	3/212	12/12	HAB Core Clinical Performance Measures, Client Level Outcomes, NQC In+Care Measures, NHAS Indicators
Review and analyze annual measures and data	Identification of areas for improvement	QTR	10/12	HAB Core Clinical Performance Measures, Client Level Outcomes, NQC In+Care Measures , NHAS Indicators
Review and analyze core category assessment chart review results	Identification of areas for improvement	11/11	10/12	**PENDING: Core** Category is Oral Health. Draft report submitted 07/12; final report pending.
Identify service delivery deficiency based on data	Identification of areas for improvement	3/12	2/13	OAMC QIP in the Plan stage: **COMPLETED** Review of PE and EMR cervical screening data for data integrity **IN DEVELOPMENT** Improvement in Cervical Screening Rates QIP
Review QI Network Activities	Identification of areas for improvement	10/12	QTR	Summary provided quarterly
Complete revisions to Broward Client Level Outcomes and Indicators	Client Level Outcomes and Indicators appropriate to each service category and include OAMC client retention measure	10/11	2/13	1. Final revisions to be presented to QMC on 09/12 2. PE programming completed 02/13
3. Review and Implement QM Committee Policies and Procedures				**Accountability**: QMC, CQM Support Staff
Objectives	Outcome	Start	Due	Status
3a. Review, update, and approve policies and procedures to conform to updated QMC purpose and mission	Updated QMC policies and procedures	12/12	2/13	Review annually at end of FY or sooner if needed
4. Approve Service Delivery Model Modifications				**Accountability**: QMC, QI Networks, Grantee Staff, CQM Support Staff, HIVPC
Objectives	Outcomes	Start	Due	Status
4a. Review and approve modified service delivery models submitted by QI Networks	Updated Service Delivery Models annually	10/12	2/12	1. Networks to review and revise as needed the following SDM's: OAMC; MCM; OHC; MH; SA; APA; Outreach 2. Network to develop Food Bank SDM
5. Recommendations from Needs Assessment Analysis				**Accountability:** QMC, QI Networks, CQM Support Staff, Grantee staff
Objectives	Outcomes	Start	Due	Status
Evaluate and assess annual survey results	Data analysis to identify service delivery deficiency determine QIP and inform PSRA	2/12	/13	Survey tool is being developed

Quality Management Committee Work Plan for FY 12/13

6. Identify Areas of Improvement and Modify Processes to Support Linkage and Retention Accountability: QMC, QI Networks, CQM Support Staff, Grantee Staff				
Objectives	Outcomes	Start	Due	Status
NQC Measure 1: Reduce the percentage of patients who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year	Gap Measure Reduced to 15%*	10/11	10/13	-Quarterly report to QMC on the Gap Measure -QIP's to improve retention are in the Plan stage for -MCM; MH/SA; and Combined Networks MH/SA: Development of PE trigger for additional support to assist clients who are depressed remain in care; Development of a presentation for all Networks on identifying signs of mental illness MCM: Gap Measure data analysis Combined: Identify ways for support services to impact OAMC retention
NQC Measure 2: % of patients who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Medical Visit Frequency Increased to 63%*	10/11	10/13	**PENDING** Quarterly report to QMC on medical visit frequency Planning in progress to identify ways to improve medical visit frequency
NQC Measure 3: % of patients newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in measurement year	Patients Newly Enrolled in Medical Care Increased to 60%*	10/11	10/13	**PENDING** Quarterly report to QMC on newly enrolled patients rates Planning in progress to identify barriers to enrolling new patients
NQC Measure 4: Percentage of patients with a viral load less than 200 copies/mL at last viral load test during the measurement year	Viral Load Suppression Increased to 72%*	10/11	10/13	**PENDING** Quarterly report to QMC on VL suppression rates Planning in progress to identify barriers to VL suppression
Incorporate the Partners In+Care Campaign into linkage and retention efforts	Peer focused interventions to improve retention	5/12	TBD	09/12: Provide recommendations to QMC on how to incorporate Partners In+Care in Network activities
7. Conduct Annual QM Plan Evaluation				**Accountability**: QMC
Objectives	**Outcomes**	**Start**	**Due**	**Status**
Describe Committee annual accomplishments and challenges	Submit to Grantee for inclusion in RW Progress Report	1/13	2/13	To be completed by FY end

***Percentages reflect the average among Part A participants of the In+Care Campaign as of the latest submission date (08/01/12)**

BROWARD COUNTY HIV PLANNING COUNCIL

QUALITY MANAGEMENT COMMITTEE

Quality Management Program's Mission

Ensure Access to and Retention in High Quality HIV Core and Support Services

For Part A and MAI Eligible Broward County Residents Living with HIV

Celebrating 30 Years of Excellence

BRHPC

HEALTH & HUMAN SERVICE INNOVATIONS

Broward Regional Health Planning Council • www.BRHPC.org

QUALITY MANAGEMENT COMMITTEE FREQUENTLY ASKED QUESTIONS

What is Quality?

The Health Resources and Services Administration (HRSA) HIV AIDS Bureau (HAB) working definition of quality is "the degree to which a health or social service meets or exceeds established professional standards and user expectations." *(HAB Manual)*

What is Quality Management (QM)?

QM encompasses continuous quality improvement activities (ongoing monitoring, evaluation, and improvement processes) and the management of systems that foster such activities: communication, education, and commitment of resources. *(HAB Manual)*

What is a QM Program?

- A QM program is rooted in a systematic process with identified leadership, accountability, and dedicated resources and uses data and measurable outcomes to determine progress towards relevant, evidence-based benchmarks.
- QM programs also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and should be adaptive to change.
- The process is continuous and should fit within the framework of other programmatic quality assurance and quality improvement activities.
- Data collected as part of this process should be fed back into the QM process to assure that goals are accomplished and improved outcomes are realized. *(HAB Manual)*

What is the Purpose of the Ryan White QM Program?

The overall purpose of a Ryan White QM program is to ensure that:

- Services adhere to Public Health Service (PHS) guidelines and established clinical practice
- Program improvement includes supportive services linked to access and adherence to medical care
- Demographic, clinical and utilization data are used to evaluate and address characteristics of the local epidemic *(HAB Manual)*
- The purpose of the Ryan White Part A QM Program 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 MAI funded services in Broward County. *(2009-2011 Three-Year QM Work Plan).*

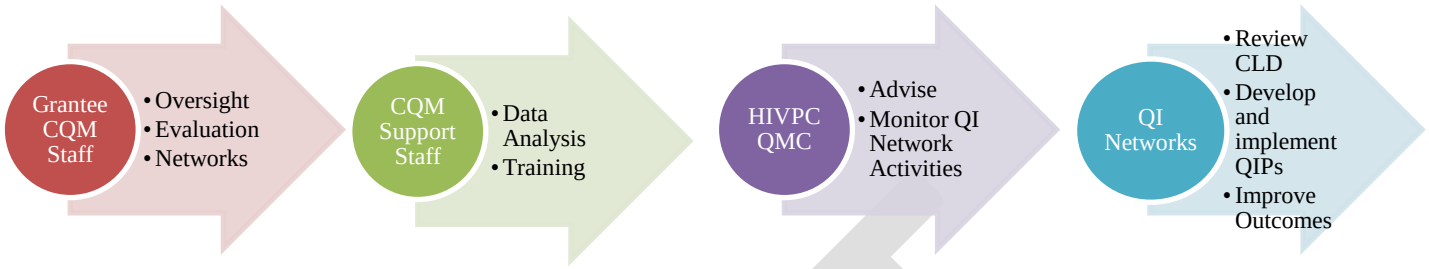
What is the Purpose of the QM Committee?

- The QM Committee is part of the HIV Planning Council (HIVPC). HIVPC directs and coordinates effective response to the HIV epidemic in Broward County in order to ensure quality, comprehensive care and to positively impact the health of people with HIV at all stages of illness.
- The QM Committee is tasked with ensuring the highest quality HIV medical care and support services are provided to eligible Broward County residents living with HIV/AIDS by developing client and system based outcomes and indicators, providing oversight of standards of care within the service delivery models, developing scopes of service for program evaluation studies, evaluating client satisfaction and identifying client and staff education and training needs. *(HIVPC Policies and Procedures)*

What are the QM Committee's Roles and Responsibilities?

- Meet on a monthly basis
- Collaborate with Grantee staff to develop/revise committee policies and procedures consistent with other HIVPC committees
- Collaborate with the Grantee to design and implement the three-year QM plan
- Participate in developing the annual work plan to achieve the three-year QM Plan
- Develop client, provider, and system-level quality and outcome indicators, and review HAB and other outcomes and indicators for adoption by the Grantee

- Collaborate with the Grantee, CQM support staff, and QI Networks to ensure standards of care, delineated in current service delivery models, are achieving desired client, provider, and system-level outcomes and indicators
- Review draft standards of care for approval
- Identify, prioritize, and implement quality improvement projects (QIPs) *(HIVPC Policies and Procedures)*



What is a QM Plan?

- A written document that outlines the program-wide HIV quality program. The QM Plan should be the vehicle for examining how well an agency or system is doing in executing the program's priorities and strategies. *(NQC)*
- Broward County has developed both a three-year QM Plan and an Annual Work Plan to facilitate the goals of the latter

What are Quality Improvement Networks?

- QI Networks exist for each Part A and MAI funded service category.
- Network members include representatives from each subgrantee funded for that service category.
- QI Networks include Outpatient Ambulatory Medical Care (OAMC), oral health care, mental health/substance abuse, medical case management, and Combined (Legal Services, Food Bank, Outreach, and Pharmacy along with Transportation and HOPWA representatives). *(2009-2011 Three Year QM Work Plan)*

What are the QI Networks' Roles and Responsibilities?

- Meet at least quarterly
- Identify service delivery barriers and challenges at the service category level and develop the means to resolve them
- Collaborate to develop and test QIPs to improve processes and increase performance rates in an effort to achieve specified standards' benchmarks
- Implement QIP positive test changes across all subgrantees in the respective QI Network

What are Indicators and Outcomes?

- *Indicator*: A measure used to determine, over time, an organization's or system's performance of a particular element of care. The indicator may measure function, process or outcome.
- *Outcome*: Benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. Outcomes may be client-level or system-level. *(NQC)*
- Policy and funding decisions at the Federal level are increasingly being determined by outcomes.

What Makes a Good Indicator?

- *Relevance*: Does the indicator affect a lot of people or programs? Does the indicator have a great impact on the programs or clients in the EMA, State, Network or clinic?
- *Measurability*: Can the indicator realistically and efficiently be measured given finite resources?
- *Accuracy*: Is the indicator based on accepted guidelines or developed through formal group-decision making methods?
- *Improvability*: Can the performance rate associated with the indicator realistically be improved given the limitations of your services and population?

Tips for Defining Indicators

- Base the indicator on guidelines and standards of care when possible
- Include staff and consumers when developing an indicator to create ownership
- Be clear in terms of client/program characteristics (gender, age, condition, provider type, etc.)
- Set specific time-frames in indicator definitions

(NQC)

What is Outcomes Evaluation?

- Outcomes evaluation looks at the effectiveness of a service or program in achieving its intended results. It can help Ryan White Programs determine if they are making a difference in the lives of people living with HIV/AIDS (PLWHA).
- Documentation of outcomes can be used in multiple ways, including:
  - Ensuring and improving service quality
  - Helping guide program planning
  - Setting priorities and allocating resources
  - Securing funding from public and private resources

(HAB Ryan White HIV/AIDS Program Part A Manual)

How Does the Committee Address Emerging Issues?

The QM Committee reviews emerging issues and provides recommendations for action to the QI Networks or the HIVPC and/or its Committees.

How Does the Work of The Committee Affect Clients?

The QM Committee's activities are geared towards ensuring quality of care. The QM Committee ensures the support of themes addressed by the QM program, namely:

- Improved access to and retention in care and adherence for HIV-positive individuals aware of their status
- Quality of services and related outcomes
- Linkage of social support services to medical services

(HAB Ryan White HIV/AIDS Program Part A Manual)

How Does the Committee Assess Quality?

Standards or targets can be used to determine whether a program's implementation and/or outcomes are successful. Below are examples of criteria that can be used to evaluate service delivery processes and/or outcomes:

- *Benchmarks (also called Best Practices).* Benchmarks provide performance data that are used for comparisons. A program may compare its performance with that of a recognized high-quality provider that offers similar services or with leading performance standards for the health (or social services) profession. Some organizations use their own data as a baseline benchmark against which to compare future performance.
- *Clinical Practice Guidelines.* Such guidelines provide statements by recognized authorities on the "most appropriate" treatments for specific diagnoses or conditions. Clinical practice guidelines are developed to promote effective patterns of practice and to reduce inappropriate and unnecessary care.
- *Critical Pathways.* These "pathways" are statements of the specific steps and procedures that should be followed when diagnosing, treating, and managing specific medical problems. The intent is to ensure that only the indicated steps are taken and that these steps are taken in the correct sequence. Because resources vary from one health facility to another, critical pathways are usually developed locally.
- *Standards of Care.* Standards of care are principles and practices for the delivery of health and social services that are accepted by recognized authorities and used widely. Standards of care are based on specific research (when available) and the collective opinion of experts.

What is The Role of a Committee Member?

- QM Committee functions as a committee of the Broward County EMA HIV Planning Council. The QM Committee is co-chaired/facilitated by a representative of the HIV Planning Council and an ex-officio co-chair of the Grantee's office, and, as such the ex-officio co-chair does not have voting privileges.
- Membership of the committee should ideally consist of consumers, client service professionals, and HIV and non-HIV providers. Committee membership must be broadly reflective of the epidemic. To assist and inform the QM Committee's work, the Service Provider Networks are invited and encouraged to provide input into the development of client and system based outcomes and associated indicators as indicated in the QM Committee Policy section.
- Program data and research are provided by Council and Clinical Quality Assurance staff, drawing from a wide range of data sources.
- Members are expected to:
    - Comply with the HIVPC attendance policy
    - Be respectful
    - Provide input
- Consumers are encouraged to be involved in every level of the decision-making and planning process. Through participation in and/or membership on HIVPC committees, consumers may: identify aspects of service delivery models that impede access to, retention in, and adherence to care; provide input regarding the efficacy and efficiency of services; recruit other consumers' input; provide input through focus groups, key informant interviews, consumer satisfaction surveys.

DEFINITION OF TERMS AND ACRONYMS

Common Acronyms and Definitions

- AETC - AIDS Education and Training Center
- CDC - Centers for Disease Control and Prevention
- CLD – Client Level Data
- CQI - Clinical Quality Improvement/Continuous Quality Improvement
- CQM - Clinical Quality Management
- DHHS - US Department of Health and Human Services
- EMA - Eligible Metropolitan Area
- HAB - HIV/AIDS Bureau
- HRSA - Health Resources and Services Administration
- MAI - Minority AIDS Initiative
- NQC - National Quality Center
- PDSA - Plan-Do-Study-Act
- QA - Quality Assurance
- QI - Quality Improvement
- QIP – Quality Improvement Project
- QM - Quality Management
- SDM - Service Delivery Model
- TA - Technical Assistance

Common Terms and Definitions (in Alphabetical Order)

Chronic Care Model

A tool to improve the care of individuals with chronic illness, including HIV/AIDS, which focuses on six essential elements: Self Management and Adherence, Decision Support, Clinical Information System, Delivery System Design, Organization of Health Care, and community. The model was originally developed

by Ed Wagner, MD, MPH. (*HAB, http://hab.hrsa.gov*)

Continuous Quality Improvement (CQI)

Generally used to describe ongoing monitoring, evaluation, and improvement processes. It is a client-driven philosophy and process that focuses on preventing problems and maximizing quality of care. The key components of CQI are: Clients and other customers are first priority; quality is achieved through people working in teams; all work is part of a process, and processes are integrated into systems; decisions are based upon objective, measured data; quality requires continuous improvement.

Continuum of Care

A system of connected services designed to match an individual's needs with the appropriate level and type of medical, psychological, health or social service within an organization or across multiple organizations. Assuring quality of care across the continuum can be especially challenging.

HAB HIV/AIDS Performance Measures

HAB Performance Measures are a set of recommended indicators for monitoring the quality of care provided.

Indicator

A measure used to determine over time, an organization's performance of a particular element of care. The indicator may measure a particular function, process or outcome. An indicator can measure Accessibility Efficiency Appropriateness Patient satisfaction Continuity Safety of the environment Effectiveness Timeliness of care Efficacy Demographic characteristics.

Outcomes

Benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. Outcomes can be client-level or system-level.

PDSA (Plan-Do-Study-Act)

A widely used framework for testing change on a small scale.

Performance

The way in which an individual, a group, or an organization carries out or accomplishes its important functions and processes.

Performance Measure

A quantitative tool that provides an indication of an organization's performance in relation to a specified process or outcome.

Process

A sequence of tasks to get to an outcome. It is a goal directed interrelated series of actions, events, mechanisms, or steps.

Quality Assurance (QA)

A broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards. Quality assurance focuses on individuals.

Quality Improvement (QI)

A set of activities aimed at improving performance and an approach to the continuous study and improvement of the processes of providing services to meet the needs of the individual and others. This term generally refers to the overriding concepts of continuous quality improvement and total QM. Focuses on processes and systems.

Root Cause Analysis

The process of developing permanent solutions to problems by first identifying all of the contributing and underlying causes of a problem.

System

A group of related processes.

Team

A small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable. Project teams are

just one element of a quality effort, though an extremely important one. Teams should include a team leader or project sponsor to lead the initiative.

Total Quality Management (TQM)

A somewhat larger concept, encompassing continuous quality improvement activities and the management of systems that foster such activities: communication, education, and commitment of resources.

Workplan

Describes the steps in the implementation of an annual plan with a detailed description of responsibilities, timetables, and milestones.