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

RETREAT AGENDA

COMMITTEE: Quality Management Committee
Date/Time: Monday, November 18, 2013 at 12:30 p.m. **Location:** Plantation Heritage Park
Chair, Claudette Grant

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

2. **APPROVALS:** 11/18/2013 Agenda and 8/19/2013 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: December 16, 2013

4. **UNFINISHED BUSINESS**

5. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Action Items*
Item #1 Quality Management Retreat Pre-Test	**ACTION ITEM:** Assess knowledge of QM Committee before training.
Item #2 Introduction	**ACTION ITEM:** Provide an overview of the training including: Objectives, Committee Mission/Roles and Collaborative Approach.
Item #3 Ice Breaker	**ACTION ITEM:** Break into groups and participate in an activity designed to outline the Plan-Do-Study-Act (PDSA) process.
Item #4 Review Data Measures and Definitions	**ACTION ITEM:** Review and discuss data measures and definitions to increase understanding of data elements to provide a foundation for understanding the Quality Management Committee.
Item #5 Group Activity-Scenario One	**ACTION ITEM:** Break into groups and participate in a group activity to increase understanding of data elements.
Item #6 Group Activity-Scenario Two	**ACTION ITEM:** Break into groups and participate in a group activity to increase understanding of data trends.
Item #7 Quality Management Retreat Post-Test	**ACTION ITEM:** Assess knowledge of QM Committee after training.

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)	
Item #3 Quarterly Data Review W.P. 1.1)	

9. **ANNOUNCEMENTS**

10. **ADJOURNMENT**

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

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

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Meeting Minutes

Committee: Quality Management Committee

Date/Time: Monday, August 19, 2013, 12:30 p.m. **Location:** Governmental Center Annex, A337

Chair: Claudette Grant

Attendance						
#	**Members**	**Present**	**Absent**		**Guests**	**Grantee Staff**
1	Grant, C.	**X**			Sullivan, G.	Swanson, M.
2	Katz, H. B.	**X**				Degraffenreidt, S.
3	Martin, M.		**X**			Jones, L.
4	Schweizer, M.	**X**				
5	Jefferson, M.	**X**				**HIVPC Support Staff**
6	Mitchell, T.	**X**				Eshel, A.
7	Majcher, B.	**X**				Solomon, R.
8	Gammell, B.	**X**				
9	Sabatino, D.		**X**			
	Quorum = 6					

1. CALL TO ORDER:

The Chair called the meeting to order at 12:38p.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:	Schweizer, M.	**Seconded by:**	Gammell, B.
Action:	Passed Unanimously		

Motion #2	To approve meeting minutes of 7/15/13		
Proposed by:	Katz, H.B.	**Seconded by:**	Majcher, B.
Action:	Passed Unanimously		

3. STANDARD COMMITTEE ITEMS

a. New Business:
The Committee discussed the meeting schedule for September and made the following motion:

Motion #3	To cancel the September Quality Management meeting		
Proposed by:	Katz, H.B.	**Seconded by:**	Schweizer, M.
Action:	Passed Unanimously		

b. Request for Information/Directives: None

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

d. Next Meeting Date: October 14, 2013 from 12:30pm-4:30pm; Staff to send cancellation notice for September QM Committee and meeting notice for QM training retreat.

4. UNFINISHED BUSINESS: None

5. MEETING ACTIVITIES / NEW BUSINESS

Accomplishments (Goal/Work Plan Objective #)

1. Review 3-Year Work Plan *(WP Item 2.2)*

The Committee tabled review of the 3-Year work plan pending Grantee approval.

2. Follow-Up on Viral Load Report Definition

The Committee heard clarification on the difference in denominators for the Viral Load Suppression measure in the HHS Indicators report and the Viral Load Analysis report in Provide Enterprise (PE). The Viral Load Analysis report in PE (73% suppressed) includes all individuals with at least one appointment billed to Part A. The HHS Indicators report (68% suppressed) includes individuals with at least one medical appointment billed to Part A. It was noted that all future data reports will include definitions, numerators and denominators, and exclusions. Staff informed the Committee that Groupware Technologies, Inc. (GTI). is working on the definition report for the HHS measures.

3. Development of Training for Quality Management Committee

The Committee discussed development of the Quality Management (QM) training for new and existing members to educate on the purpose and goals of the QM Committee and its activities. Members agreed to hold a half-day retreat instead of the regular October meeting. The Committee was asked to consider possible topics for the training. Members suggested the following topics: 3-Year work plan; Summary of service categories and related outcomes; Review and update Frequently Asked Questions; Relationship between QM Committee and the Quality Improvement (QI) Networks; HRSA expectations of QM; and Understanding data. The Committee agreed to email staff additional retreat ideas. It was suggested to save the template developed for the QM training to use for other committee trainings.

4. Approve Oral Health Care Service Delivery Model *(WP Item 2.4)*

The Committee was informed that the Oral Healthcare (OHC) QI Network reviewed their Service Delivery Model (SDM) at the last OHC Network meeting. The Grantee suggested adding recommendations from the OHC study before approving the SDM. The Committee tabled review of the OHC SDM until the recommendations have been added.

5. Approve MAI Medical Case Management SDM

The Committee tabled review of the Minority AIDS Initiative (MAI) Medical Case Management SDM.

6. Medical QI Network Update

The Committee heard a review of the Medical QI Network cervical screening Quality Improvement Project (QIP). The presentation included a review of Phases I and II of the QIP, including: Definition of the HAB performance measure for cervical screening and exclusions; Current Part A cervical screening standards; Cervical screening QIP initial steps; Preliminary cervical screening rates; HIVQual studies summarizing barriers and successful interventions; 2009 Broward women's focus group findings; PE/Electronic Medical Record (EMR) review findings; Proposed exclusions; Common barriers and improvement strategies; Factors influencing cervical cancer screening in HIV+ women; Blinded agency specific findings; and Next steps.

Each Agency compared the cervical screening rates in PE and the EMR to see internal rates; Agency rates were higher than the rates in PE due to data discrepancies. Agency data indicated that clients are compliant with medical care however they are not receiving Pap exams. It was noted that the cervical screening rates were compared to variables identified in a literature review as factors that influence cervical cancer screening in HIV+ women: Age; Race/Ethnicity; Tobacco use; Education; FPL; and Substance Abuse. Members discussed the cervical screening range for Agencies (11%-51%); current year-to-date cervical screening rate for this FY is 22%. There was discussion regarding specific barriers for cervical cancer screening: Women do

not want to hear anything else is wrong with their health; high no show Pap rate (36%-42% at some agencies); Not prepared for Pap exam at the time of medical visit; and Menstrual cycle. It was noted that the Medical QI Network agreed to the following next steps: 1) Agency to develop ways to improve data integrity 2) Create an Agency specific follow-up for cervical screening reminders 3) Identify education opportunities for providers and clients, and 4) Identify special populations for focus groups.

While hearing the review on the Medical Network cervical screening QIP, a member raised the concern that while cervical screenings are an annual requirement for women, anal Pap exams are not an annual requirement for men. The Chair explained that the Broward EMA follows the Department of Health and Human Services' guidelines and while anal Pap exams are recommended they are not mandatory. It was noted that the AIDS Education and Training Center (AETC) and Ryan White Part A physicians decided that annual rectal exams are sufficient. It was noted that anal Paps are conducted as needed based on the physician's discretion.

6. GRANTEE REPORTS

The Request for Proposal (RFP) is tentatively scheduled for release at the end of September. The EMA received the grant application last week, which is part of the reason September committee meetings are cancelled. There is a Case Management Training tomorrow (August 20, 2013) on the Affordable Care Act (ACA) with a panel discussion from different Grantees and Housing Opportunities for People with AIDS (HOPWA); second Case Management Training on August 29, 2013. The Part A Resource Fair is September 24, 2013 from 5:00pm-8:00pm at the African American Research Library; fair to include a presentation on the ACA. It was noted that the Part A Newsletter is complete and copies have been made for each Agency; for more copies contact Shaundelyn at the Grantee's Office. The next Newsletter will be a collaboration between Part A and Prevention.

7. PUBLIC COMMENT: None

8. AGENDA ITEMS / TASKS FOR NEXT MEETING:

Date: October 14, 2013 **Venue:** TBD

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.*
Quality Management Training Retreat	

a) ANNOUNCEMENTS

- Members welcomed Gary Sullivan to the Quality Management Committee as the Director of Contracts and Performance Management at Broward House. Mr. Sullivan expressed interested in joining the Committee. The following motion was made:

Motion #4	To appoint Gary Sullivan to the Quality Management Committee		
Proposed by:	Majcher, B.	**Seconded by:**	Jefferson, M.
Action:	Passed Unanimously		

b) ADJOURNMENT

Without objection the meeting was adjourned at 1:44 p.m.

Quality Management Attendance CY: 2013

Count	Member	1/7/13	3/18/13	4/15/13	5/20/13	7/15/13	8/19/13
1	Grant, C.	√	√	√	√	√	√
2	Katz, H.B.	√	√	√	√	√	√
3	Martin, M.	A	A	√	√	√	E
4	Schweizer, M.	√	A	A	√	√	√
5	Jefferson, M.	√	√	A	A	√	√
6	Mitchell, T.	E	A	√	√	√	√
7	Ettinger, R.	Appointed 3/28/13		√	A	√	Resigned
8	Majcher, B.	Appointed 3/28/13		√	√	√	√
9	Gammell, B.	Appointed 6/27/13				√	√
10	Sabatino, D.	Appointed 7/16/13					A
Quorum=6		YES	NO	YES	YES	YES	YES

ASSESSMENT OF QUALITY MANAGEMENT KNOWLEDGE

Name: _____ **PRE TEST**

1. The responsibilities of the QM committee include (*circle all that apply*):

    a) Analyze data- summarize data and identify where improvements are needed
    b) Review annual service delivery models
    c) Monitor QI network activities, and provide direction to the QI networks regarding QIP development
    d) Meet quarterly to have a party

2. The Ryan White program legislation includes a requirement for each Part to have a clinical quality management program
    - True_____ False_____

3. The QM plan is a written document that outlines the Ryan White Part A program wide quality plan, and includes a quality statement and goals and objectives. Broward County has developed a 10 year QM plan.
    - True_____ False_____

4. The PDSA Cycle is a "trial and learning method" to test changes on a small scale before system wide implementation
    - True_____ False_____

5. Match the word with the best description
    - Indicator
    - Outcome
    - Service delivery models
    - HAB Measures
    - QI Networks

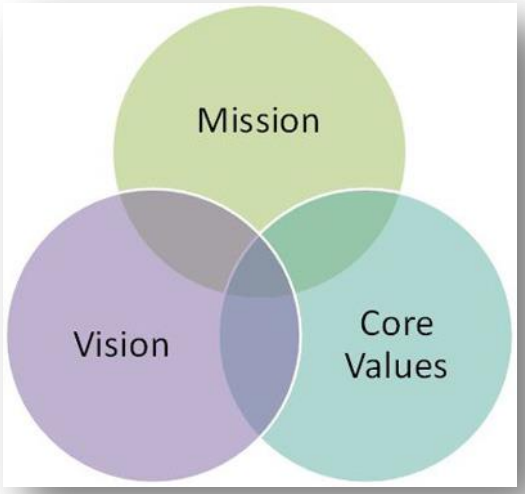
    A. Measures recommended by HRSA for monitoring core, clinical, oral health care, medical case management, ADAP, and System level performance
    B. A service category specific, set of protocols, definitions, standards and indicators to guide the delivery of services.
    C. Benefits or other results for clients that may occur during or after their participation in a program. Outcomes may be system level or client level Slow/prevent client HIV disease progression (for clients on HAART with a viral load of >400)
    D. Method used to determine, over time, an organization or systems performance of an element of care. Indicators may measure function, process, or outcome (e.g., 80% of clients with CD4<500 are prescribed HAART)
    E. A QI Network is a service category 'subcommittee' that is made up of providers and consumers and is charged with identifying and addressing service category barriers to care by developing and implementing QIP's. Network activities are overseen by the Grantee and the QM Committee.

QM Retreat
November 18, 2013

Pre-Test

Mission Statement

The purpose of the QM Program is to monitor, evaluate, and systematically and continuously improve the quality and appropriateness of HIV care and services provided to consumers.

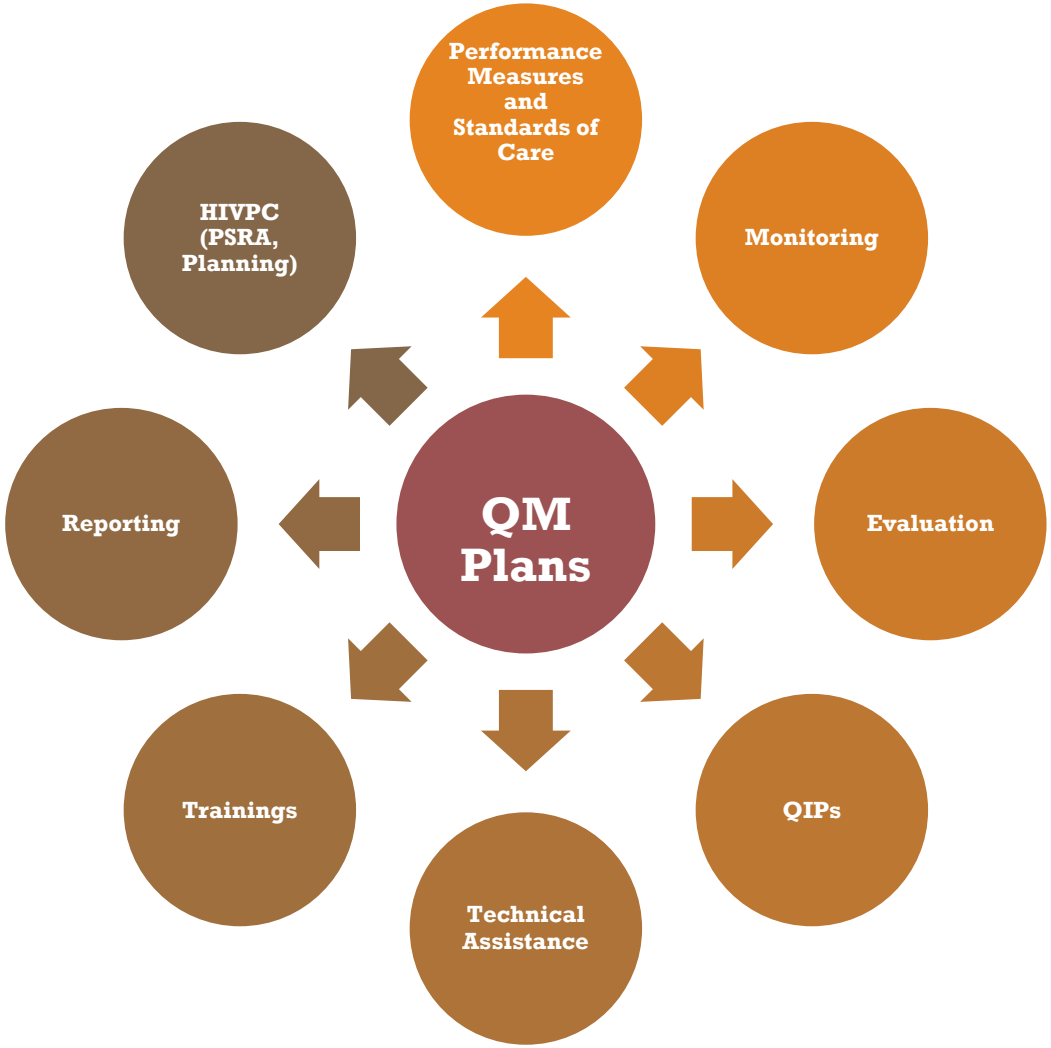


Our mission is to ensure access to and retention in high quality HIV core and support services for Part A and MAI eligible Broward County residents living with HIV.

Retreat Objectives

- Refresher for long standing members; introduction to the QM Program and Committee for new members
- Learn about performance measures and reporting requirements
- Think about new ways to review and utilize data
- Learn to develop directives to the QI Networks
- Plan for collaboration across committees

Monitoring Service Delivery and Improving Client Health Outcomes



CQM Program Team

QA Coordinator

Health Care QA Specialist

Subcontracted QI/TA Manager

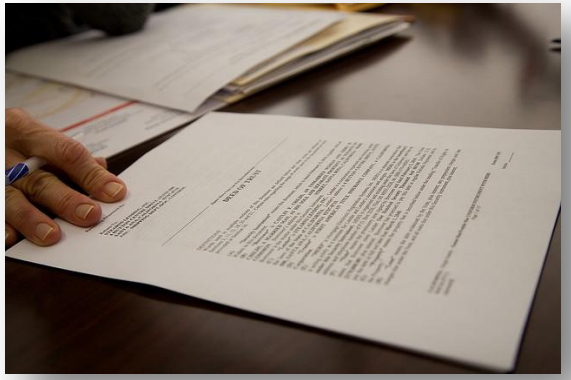
Health Care QA Specialist

Subcontracted QI Coordinator

CQM Program Structure

Grantee QA Staff Roles

- Maintain oversight of EMA system-wide Part A QI initiatives
- Develop and evaluate progress toward successful implementation of the three-year QM Plan and Annual QM work plans
- Facilitate integration of and interaction among Part A Consumers, HIVPC QM Committee and QI Networks
- Establish standards of care
- Gather and analyze client-level and system-level data and performance outcomes and indicators
- Provide Technical Assistance
- Annual on-site monitoring evaluation visits

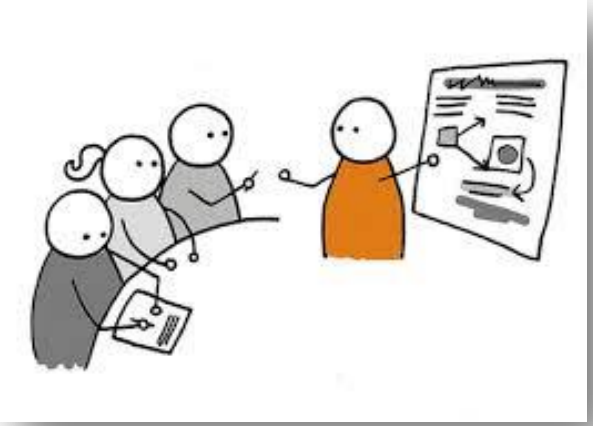


CQM Support Staff

- Develop tools for quality and performance data collection
- Provide accurate, reliable, and timely data for decision- making support
- Conduct annual system- wide consumer satisfaction surveys, focus groups, and in depth quantitative service assessments
- Facilitate trainings
- Employ methods of analysis to include:
  - Literature review
  - Develop hypotheses or evaluative questions
  - Design evaluative assessments
  - Collect and analyze data relevant to achievement of client, provider, and system-level outcomes, HAB measures, and Fort Lauderdale/Broward EMA standards

HIVPC QM Committee

- Provide management of the CQM Program comprised of consumers, client service professionals, HIV and non-HIV providers
- Develop committee policies and procedures that are consistent with other HIVPC committees
- Participate in the development of client-level and system-level outcomes and indicators
- Assess standards of care
  - Identify, prioritize, and monitor QIPs and other Network activities



QI Networks

- QI Networks are comprised of subgrantees representing all locally funded Ryan White Part A service categories
  - OAMC
  - MCM
  - Oral Health
  - Mental Health & Substance Abuse
  - Combined Network (Pharmacy, Food Bank, Legal, CIED, as well as representatives from HOPWA and Part B funded Transportation services)
- Design standards of care and performance measures and indicators
- Address emerging barriers impeding access to and retention in services
- Developing performance improvement strategies, and testing the processes selected for improvement
- Responsible for designing and implementing QIPs

Consumer Participation

- Informs the entire CQM Program regarding the HIV service delivery system and aspects of service delivery that impede access to, retention in, and adherence to care
- Consumers comprise over 50% of QM Committee and participate in QI Networks
- Focus groups
- Client satisfaction surveys

Data Collection and Reporting

- Integrated Data Software System
  - Provide Enterprise (PE)
- Contractually Required Data Elements
  - Client-level data components necessary for CQM data analysis reviews
  - RSR required data elements
- Quality Measures
  - HAB Measures
  - EMA-specific Client-Level Outcomes and Indicators
  - In+Care Campaign Measures
  - NHAS Measures
  - Viral Load Analysis Report

Program Accomplishments

- Revision of Broward County Client Level Outcomes and Indicators
- QI Network Restructuring
  - Collaborative Meetings
- QI Network annual work plans that align with QM annual work plan, EMA 3-year CQM plan, 2012-2015 Comprehensive Plan, and NHAS Goals
- Increased Provider accountability of client health outcomes
- Data Driven / Collaborative Structure among the CQM program
- Planning Council Peer retention model pilot
- Other Initiatives:
  - In+Care Campaign
  - Operation H.O.P.E.F.U.L
  - Health Literacy
- Formulary revisions

QI Network Activities

- Mental Health/Substance Abuse QI Network:
  - Network is developing a training to educate providers on the signs of depression and the referral process
- Oral Health Care QI Network:
  - Oral Health Care and Medical Case Management collaboration to assist with retention activities pertaining to Oral Health Care
  - Oral Health Care Study
- Medical Case Management QI Network:
  - QIP in progress focusing on retention through client-level-data analysis of the In+Care Campaign Gap Measure
- Outpatient/Ambulatory Medical QI Network:
  - QIP in progress to improve cervical screening rates
  - Regularly provides recommendations to LPAC on additions/deletions to the Part A Formulary
- Combined QI Network:
- QIP focusing on the role of support services in ensuring retention
- Health Literacy

Identifying and Addressing Disparities in Care

- Special Populations
- Directives from HIVPC (QM Committee, Joint Planning, PSRA)
- Focus Groups
- VL Report
- Developing client profiles through QIPs

Ice Breaker


break

QM Committee Retreat

Reporting

Reporting

- Health Resources & Services Administration (HRSA)
  - HIV/AIDS Bureau (HAB) measures
  - Health & Human Services (HHS)outcomes
- PE (Provide Enterprise) Reports
  - Viral Load reports
- Voluntary Reports
  - In+Care Campaign
- Local Reports
  - Broward Outcomes

HRSA Reporting

- As a recipient of federal funding, some HRSA reports are required by the U.S. Department of Health & Human Services
- Our office is the gatekeeper of those reports and we submit them as required by HHS
- Although you do not directly submit information for those reports to our office, the service you provide resulting in outcomes, indicators and percentages, are important factors that ultimately go into reports submitted to HRSA
- Two reports in particular: HAB measures and HHS outcomes are programmed into PE to capture data

HAB Performance Measures

- HAB performance measures used by our office help us in monitoring the quality care provided by our provides
- The 3 primary performance measure categories we use for our EMA are Core Clinical Measures, Medical Case Management Measures and Oral Health Measures
  - These measures are used at either the provider or system level
- These measures are being revamped, so we are currently updating in PE
- The current performance measure portfolio consists of 56 measures. The revised structure consists of 44 measures
- All of the measures are located in the Service Delivery Models (SDMs) which outline the standards of care for each service

Outcomes Report
6/01/2013 - 8/31/2013
For Agency(s): Sally Sue Hospital
Run Date: 10/7/2013

HAB Clinical Performance Measures - Group 1

Measure	*Numerator*	*Denominator*	*Percentage*	
ARV Therapy for Pregnant Women	0	0	0%	
CD4 T-Cell Count		0	0	0%
HAART	0	0	0%	
Medical Visits	0	0	0%	
PCP Prophylaxis	0	0	0%	
Medical Case Management Care Plans	11	396	3%	
Medical Case Management Medical Visits	396	396	100%	

HAB Clinical Performance Measures - Group 2

Measure	*Numerator*	*Denominator*	*Percentage*	
Adherence Assessment and Counseling	0	0	0%	
Cervical Cancer Screening	66	403	16%	
Hepatitis B Vaccination	0	0	0%	
Hepatitis C Screening	506	1,018	50%	
HIV Risk Counseling	97	1,018	10%	
Lipid Screening	609	878	69%	
Oral Exam	260	1,018	26%	
Syphilis Screening		412	1,018	40%
TB Screening	842	1,012	83%	

HAB Clinical Performance Measures - Group 3

Measure	*Numerator*	*Denominator*	*Percentage*	
Chlamydia Screening	12	51	24%	
Gonorrhea Screening	12	51	24%	
Hepatitis B Screening	845	1,018	83%	
Influenza Vaccination	224	1,018	22%	
MAC Prophylaxis		0	0	0%
Pneumococcal Vaccination	2	7	29%	
Toxoplasma Screening	74	985	8%	

Sample PE Reports

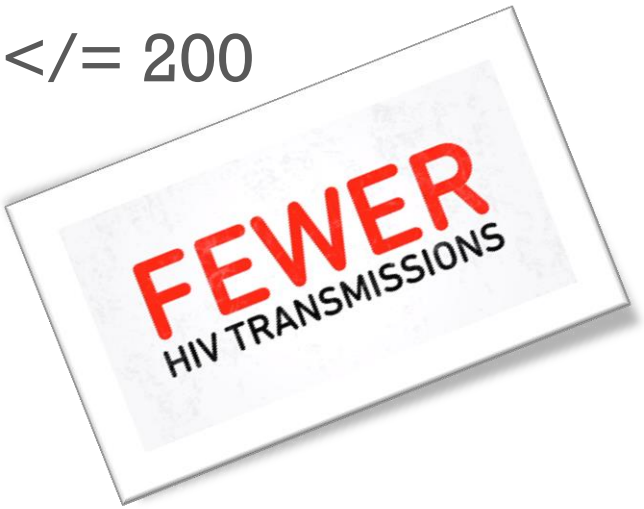
- Activity Summary
- Bus Passes
- Client Cost Summary
- Client List
- Eligibility Information
- Service Utilization
- Viral Load Analysis

Viral Load Report

- Demographic information:
  - Gender, Race, Ethnicity
  - Transgender
  - Haitian
  - Age Categories
  - Sexual Orientation
  - Living
  - Literacy
  - Education Level
  - HIV Risk
  - HIV Stage
  - HIV Therapy

Viral load categories

- High VL </= 100,000
- Not Suppressed >200 and < 100,000
- Suppressed Detectable >50 and </= 200
- Undetectable </= 50



Viral Load Report

	High VL		Not Suppressed		Suppressed		Undetectable		Total
TOTAL	**227**	**4%**	**1,210**	**22%**	**698**	**13%**	**3,279**	**61%**	**5,419**
Female	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Female Total	**62**	**4%**	**430**	**27%**	**178**	**11%**	**918**	**58%**	**1,588**
Black	53	85%	372	87%	141	79%	725	79%	81%
White	9	15%	54	13%	33	19%	188	20%	18%
Non-Hispanic	59	95%	398	93%	160	90%	825	90%	91%
Hispanic	3	5%	32	7%	18	10%	93	10%	9%
Male	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Male Total	**163**	**4%**	**770**	**20%**	**517**	**14%**	**2,343**	**62%**	**3,798**
Black	87	53%	409	53%	209	40%	966	41%	44%
White	75	46%	350	45%	305	59%	1,353	58%	55%
Other	1	1%	11	1%	3	1%	24	1%	1%
Non-Hispanic	143	88%	643	84%	420	81%	1,850	79%	80%
Hispanic	20	12%	127	16%	97	19%	493	21%	19%
Transgender	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Transgender Total	**1**	**3%**	**10**	**33%**	**3**	**10%**	**16**	**53%**	**30**
Black	1	100%	5	50%	3	100%	9	56%	60%
White	0	0%	5	50%	0	0%	6	38%	37%
Non-Hispanic	1	100%	6	60%	3	100%	14	0%	80%
Hispanic	0	0%	4	40%	0	0%	2	13%	20%
Age	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
18-24	24	11%	156	13%	36	5%	149	5%	7%
29-38	47	21%	257	21%	110	16%	410	13%	15%
39-48	84	37%	389	32%	204	29%	974	30%	30%
49-58	66	29%	314	26%	266	38%	1,283	39%	36%
>/=59	6	3%	94	8%	82	12%	463	14%	12%
Sexual Orientation	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Bisexual	11	5%	69	6%	38	5%	148	5%	5%
Heterosexual	126	56%	729	60%	355	51%	1,776	54%	55%
Homosexual (MSM/WSW)	89	39%	403	33%	301	43%	1,328	41%	39%
Risk	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Hemophila	1	0%	2	0%	3	0%	12	0%	0%
Hetero	114	50%	677	56%	331	47%	1,680	51%	52%
IDU	3	1%	24	2%	14	2%	71	2%	2%
Mother	3	1%	26	2%	7	1%	17	1%	1%
MSM	101	44%	454	38%	330	47%	1,454	44%	43%
MSM/IDU	0	0%	10	1%	6	1%	12	0%	1%
HIV Therapy	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
HAART	158	70%	800	66%	614	88%	2,926	90%	83%
Dual	5	2%	34	3%	17	2%	114	3%	3%
Single	2	1%	11	1%	6	1%	37	1%	1%
None	60	26%	341	28%	57	8%	174	5%	12%
Education Level	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
8th Grade or Less	19	8%	92	8%	42	6%	228	7%	7%
Between 8th-12th Grade	145	64%	787	65%	435	62%	1,996	61%	62%
College	63	28%	327	27%	221	32%	1,052	32%	31%
Living Arrangement	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Institution	3	1%	23	2%	3	0%	17	1%	1%
Non-permanent	75	33%	348	29%	151	22%	625	19%	22%
Permanent Housing	149	66%	830	69%	543	78%	2,631	80%	77%
HIV Stage	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
AIDS	36	16%	134	11%	84	12%	370	11%	12%
HIV Indeterminate	1	0%	1	0%	1	0%	0	0%	0%
HIV/AIDS Status Unkown	45	20%	311	26%	174	25%	791	24%	24%
HIV Not AIDS	145	64%	762	63%	439	63%	2,117	65%	64%

Undetecetable 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 > / = 100,000

In+Care Campaign

- National Quality Center (NQC) teamed up with HRSA on a national retention campaign, the In+Care Campaign. The goal of this campaign is to bring patients back to care and keep others from falling out of care. It is a voluntary quality improvement effort focused on retention
- The campaign aims to ensure efforts are aligned with the NHAS to improve access to, and retention in, quality care that will help lower individual and community viral loads
- The ultimate goal is not just to measure outcomes, but to improve lives of the people we serve

In+Care Campaign

- Our EMA elected to participate in the In+Care campaign in October 2011 - it began as a one year project, but has been extended due to the overwhelming response from the community
  - It aligns with the EMA's vision for delivery of high quality care
  - Network activities are guided by the goal of timely engagement, linkage, retention and coordination of car
    - Data driven, collaborative structure
- In+Care retention measures are programmed into PE
  - System-wide aggregate data
  - Provider specific data
  - Client-level data

In+Care Campaign

Retention Measure 1: Gap Measure

Numerator: Number of patients who had no medical visits in the last 180 days of the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges [1] in the first 6 months of the measurement year

Numerator	Denominator	Percentage
652	3696	18%

Retention Measure 2: Medical Visit Frequency

Numerator: Number of patients with a least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period compared to the last medical visit in the subsequent 6-month period

Denominator: Number of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges [1] in the first 6 months of the 24-month measurement period

Numerator	Denominator	Percentage
1,871	3,372	55%

Retention Measure 3: Patients Newly Enrolled in Medical Care

Numerator: Number of patients who had at least one medical visit in each 4-month period of the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled [2] with a medicial provider AND had at least one medical visit with a provider with prescribing privileges in the first 4 months of the measurement year

Numerator	Denominator	Percentage
250	479	52%

Retention Measure 4: Viral Load Suppression

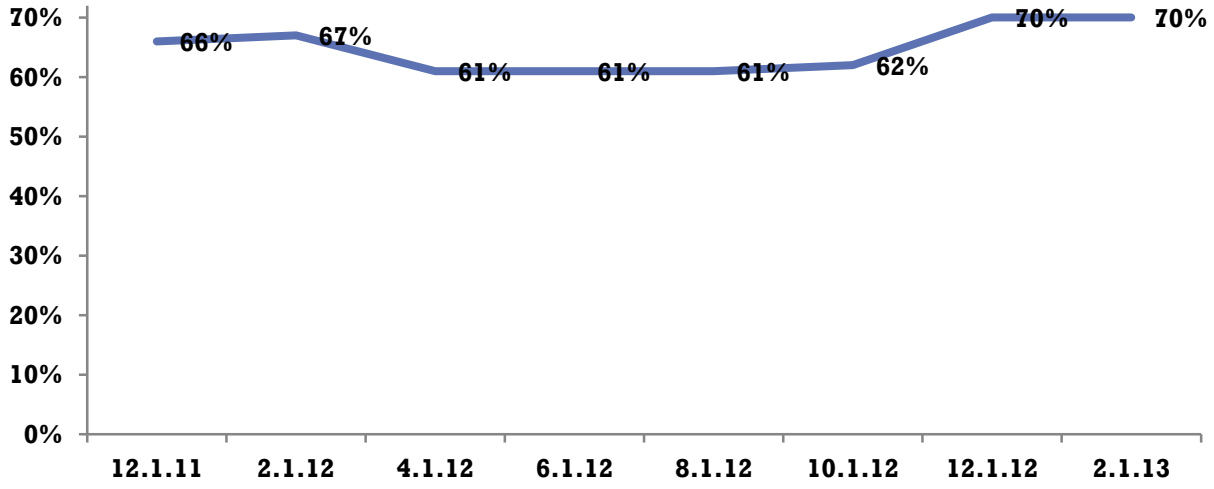
Numerator: Number of patients with a viral load less than 200 copies/ mL [2] at last viral load test during the measurement year [3]

Denominator: Number of patients, regardless of age, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges [1] in the measurement year

Numerator	Denominator	Percentage
3,168	4,828	66%

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
02/01/2013	12/01/2011 - 11/30/2012	12/01/2010 – 11/30/2012
04/01/2013	02/01/2012 – 01/31/2013	02/01/2011 – 01/31/2013
06/03/2013	04/01/2012 – 03/31/2013	04/01/2011 – 03/31/2013
08/01/2013	06/01/2012 – 05/31/2013	06/01/2011 – 05/31/2013
10/01/2013	08/01/2012 – 07/31/2013	08/01/2011 – 07/31/2013
12/02/2013	10/01/2012 – 09/30/2013	10/01/2011 – 09/30/2013

In+Care Measure#4: Viral Load Suppression



Broward County Ryan White Part A Program Staff

Ft. Lauderdale, FL

AIDS Healthcare Foundation

Ft. Lauderdale, FL

Memorial Healthcare System

Ft. Lauderdale, FL

Broward Community & Family Health Centers

Ft. Lauderdale, FL

Broward Health

Ft. Lauderdale, FL

Minority Development & Empowerment, Inc.

Broward House

Broward Regional Health Planning Council

Ft. Lauderdale, FL

Care Resource, Inc.

Ft. Lauderdale, FL

Local Outcomes Report

Outpatient/Ambulatory Medical Care

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

Denominator: Clients that received ambulatory medical care during the reporting period, and had a most recent CD4 count less than (<) 500 prior to the end of the reporting period.

Numerator: Clients in the denominator who were on HAART according to their most recent HIV History record prior to the end of the reporting period.

Numerator	Denominator	Percentage
72	75	96%

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

Denominator: Clients that received ambulatory medical care during the reporting period, and was on HAART for more than six (6) months as of the end of the reporting period.

Numerator: Clients in the denominator whose most recent Viral Load test result prior to the end of the reporting period was less than (<) 400.

Numerator	Denominator	Percentage
120	155	77%

Medical Case Management

Indicator 1.1: 100% of clients receive information regarding available services and corresponding eligibility criteria.

Denominator: Clients that were new to medical case management services during the reporting period, according to their most recent Action Plan prior to the end of the reporting period.

Numerator: Clients in the denominator who received information regarding available services and corresponding eligibility criteria.

Numerator	Denominator	Percentage
11	11	100%

Indicator 1.2: 80% of new clients achieve initial POC goals by designated target dates.

Denominator: Clients that received medical case management service(s) during the reporting period, and had at least one (1) Action Plan Goal closed during the reporting period.

Numerator: Clients in the denominator whose closed Action Plan Goal was successful, and was completed by the target date.

Numerator	Denominator	Percentage
8	9	88%

Quarterly Reporting

- These reports are submitted to our office quarterly from each agency providing services
- The outcomes and indicators in these reports are provided to HRSA to get an overall picture of where we are as an EMA
- Monthly provider calls

Group Activity - Part 1

- What story is the data telling you? What stands out?
- What other information would be helpful to understand this data and support what you are seeing?
- How can we use the data to assess successful health outcomes?
- How do you give directives to Networks? What questions would you send to the Network for analyses?


break

Group Activity - Part 2

- What are the next steps after Network identified trends?
- Other data sets would you want to see if this is really a problem holistically? Trend overall or just within specific Network?
- If overall trend, what information would you send to HIVPC to inform on service/measure as a whole?

Post-Test

1. The responsibilities of the QM committee include (Circle all that apply):

A. Analyze data- summarize data and identify where improvements are needed

B. Review annual service delivery models

C. Monitor QI network activities, and provide direction to the QI networks regarding QIP development

D. Meet quarterly to have a party

2. The Ryan White program legislation includes a requirement for each Part to have a clinical quality management program

- **True: X**

- 3. The QM plan is a written document that outlines the Ryan White Part A program wide quality plan, and includes a quality statement and goals and objectives. Broward County has developed a 10 year QM plan.
  - **False: X**
    - Broward County has a 3 year QM plan, and an annual work plan to provide a guide to meet the 3 year plan

4. The PDSA Cycle is a "trial and learning method" to test changes on a small scale before system wide implementation

- **True X**

5. Match column A with the best description from column B

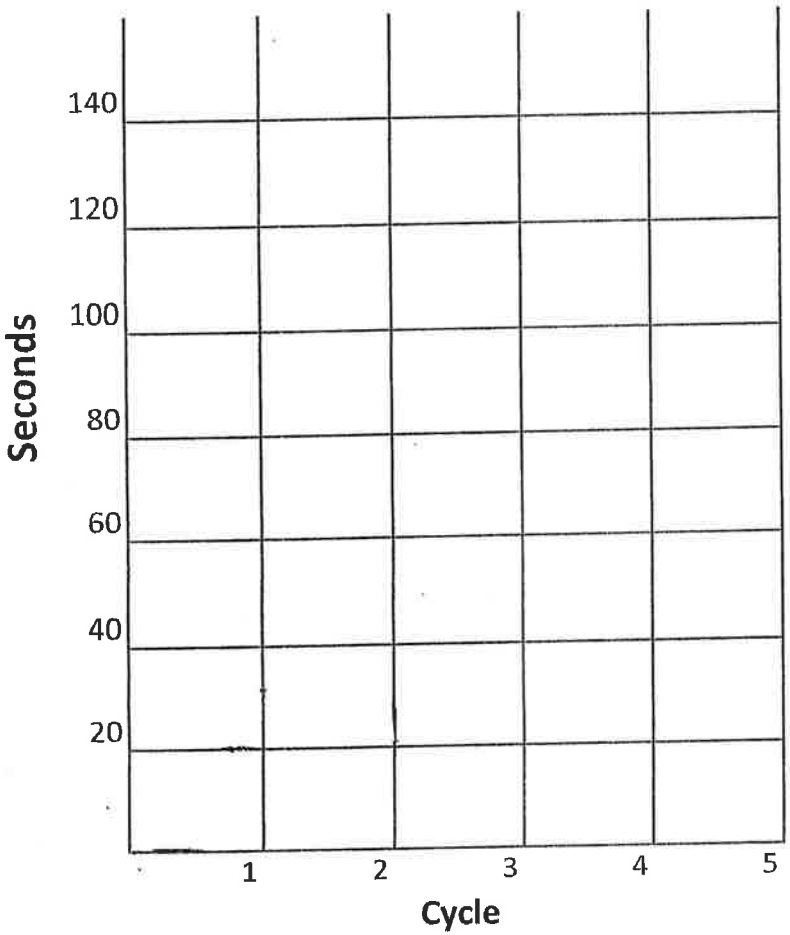
- Indicator **D**
- Outcome **C**
- Service delivery models **B**
- HAB Measures **A**
- QI Networks **E**


Any questions?

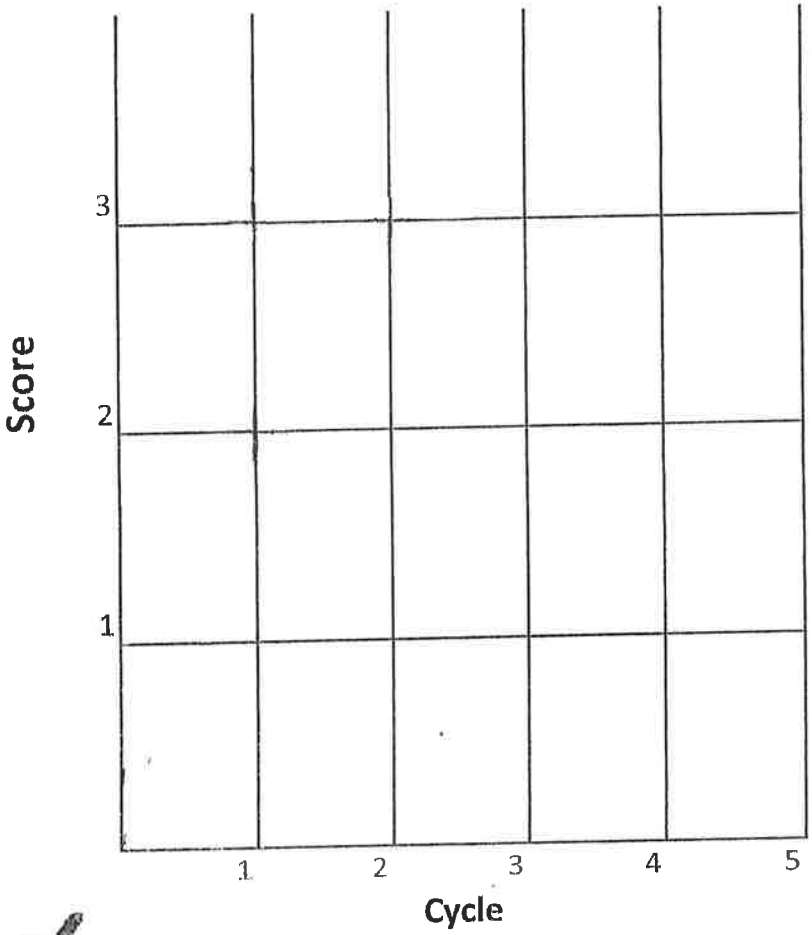
PDSA Cycle
Time Accuracy Graphs

Team Name _____

Time



Accuracy



3 – All pieces on Sam & positioned correctly
2 – All pieces on Sam, but one or more is out of place
1 – One or more pieces are not on Sam.

GROUP ACTIVITY – PART 1

GROUP 1 – VIRAL LOAD ANALYSIS

- The Viral Load reports are based on 4 categories:
  - **Undetectable VL:** Viral Load < / = 50
  - **Suppressed Detectable VL:** Viral Load >50 and < / =200
  - **Not Suppressed VL:** Viral Load >200 and < 100,000
  - **High VL:** Viral Load is > / = 100,000
- What story is the data telling you? What stands out?
  - Race/Ethnicity/Gender
  - Education and literacy
  - HIV Stage
- What other information would be helpful to understand this data and support what you are seeing?
- How can we use the data to assess successful health outcomes?
- How do you give directives to Networks? What questions would you send to the Network for analyses?

GROUP 1 - DATASET 1: MCM VIRAL LOAD ANALYSIS

Part A MCM Viral Load Analysis - 03/01/12 - 02/28/13 (n= 3,132)									
	High VL		Not Suppressed		Suppressed		Undetectable		Total
TOTAL	**127**	**4%**	**685**	**22%**	**433**	**14%**	**1,883**	**60%**	**3,132**
Female	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Female Total	**30**	**4%**	**197**	**24%**	**101**	**13%**	**478**	**59%**	**806**
Black	26	4%	169	26%	81	12%	375	58%	651
White	4	3%	27	18%	18	12%	101	67%	150
Other	0	0%	1	20%	2	40%	2	40%	5
Non-Hispanic	29	4%	182	25%	89	12%	428	59%	728
Hispanic	1	1%	15	19%	12	15%	50	64%	78
Male	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Male Total	**97**	**4%**	**479**	**21%**	**329**	**14%**	**1,396**	**61%**	**2,305**
Black	53	5%	263	24%	150	14%	609	57%	1077
White	43	4%	210	17%	177	15%	775	64%	1207
Other	1	5%	6	29%	2	10%	12	57%	21
Non-Hispanic	82	4%	390	21%	271	15%	1,108	60%	1,855
Hispanic	15	3%	89	20%	58	13%	288	64%	450
Transgender Male to Female	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Transgender Male to Female Total	**0**	**0%**	**9**	**43%**	**3**	**14%**	**9**	**43%**	**21**
Black	0	0%	5	38%	3	23%	5	38%	13
White	0	0%	4	50%	0	0%	4	50%	8
Non-Hispanic	0	0%	6	38%	3	19%	7	44%	16
Hispanic	0	0%	3	60%	0	0%	2	40%	5
Age	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
18-24	8	5%	65	38%	19	11%	80	47%	172
29-38	30	6%	133	29%	61	13%	242	52%	466
39-48	45	5%	244	25%	121	13%	552	57%	962
49-58	41	4%	187	16%	166	14%	756	66%	1,152
>/=59	3	1%	56	15%	66	17%	253	67%	380
Education Level	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
8th Grade or Less	10	4%	57	25%	28	12%	130	57%	227
Between 8th-12th Grade	80	4%	447	23%	267	14%	1,139	59%	1,933
College	37	4%	180	19%	138	14%	614	63%	971
HIV Stage	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
AIDS	18	5%	71	21%	47	14%	199	59%	336
HIV Indeterminate	1	100%	0	0%	0	0%	0	0%	1
HIV/AIDS Status Unknown	25	3%	173	23%	108	14%	456	60%	765
HIV Positive Not AIDS	83	4%	441	22%	278	14%	1,228	60%	2,030

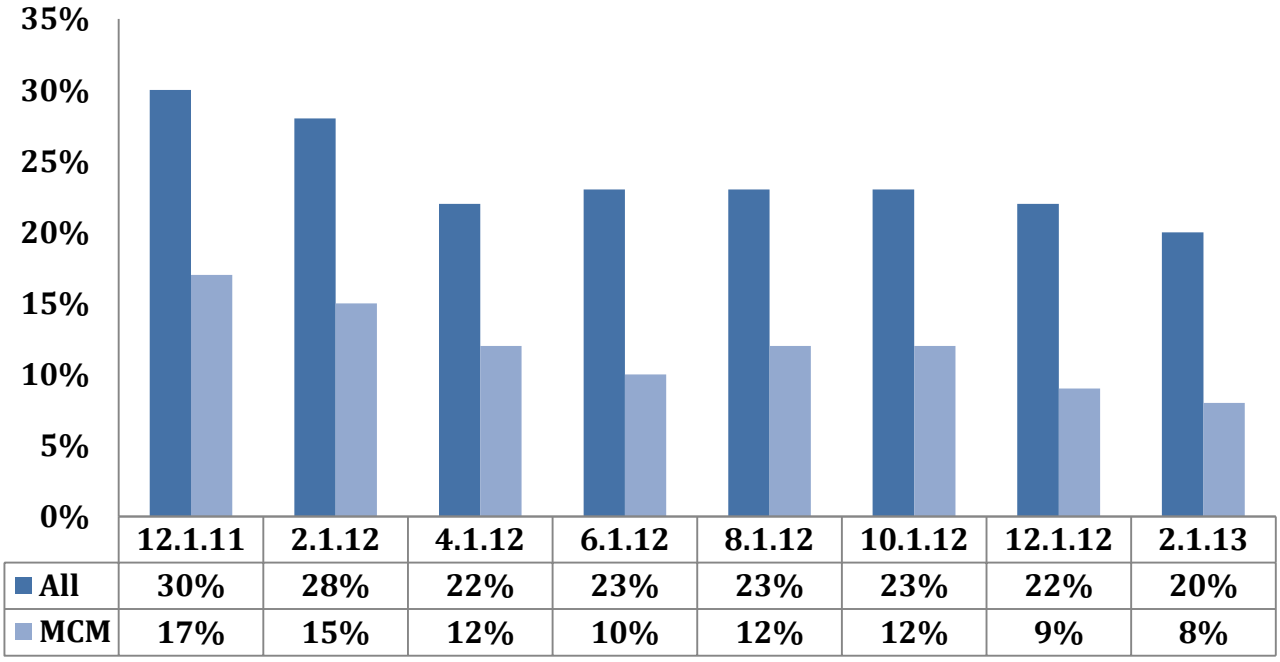
GROUP 1 - DATASET 2: SYSTEM-WIDE VIRAL LOAD ANALYSIS

Part A Viral Load Analysis - 03/01/12 - 02/28/13 (n= 5,419)									
	High VL		Not Suppressed		Suppressed		Undetectable		Total
TOTAL	**227**	**4%**	**1,210**	**22%**	**698**	**13%**	**3,279**	**61%**	**5,419**
Female	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Female Total	**62**	**4%**	**430**	**27%**	**178**	**11%**	**918**	**58%**	**1,588**
Black	53	85%	372	87%	141	79%	725	79%	81%
White	9	15%	54	13%	33	19%	188	20%	18%
Non-Hispanic	59	95%	398	93%	160	90%	825	90%	91%
Hispanic	3	5%	32	7%	18	10%	93	10%	9%
Male	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Male Total	**163**	**4%**	**770**	**20%**	**517**	**14%**	**2,343**	**62%**	**3,798**
Black	87	53%	409	53%	209	40%	966	41%	44%
White	75	46%	350	45%	305	59%	1,353	58%	55%
Other	1	1%	11	1%	3	1%	24	1%	1%
Non-Hispanic	143	88%	643	84%	420	81%	1,850	79%	80%
Hispanic	20	12%	127	16%	97	19%	493	21%	19%
Transgender	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
Transgender Total	**1**	**3%**	**10**	**33%**	**3**	**10%**	**16**	**53%**	**30**
Black	1	100%	5	50%	3	100%	9	56%	60%
White	0	0%	5	50%	0	0%	6	38%	37%
Non-Hispanic	1	100%	6	60%	3	100%	14	0%	80%
Hispanic	0	0%	4	40%	0	0%	2	13%	20%
Age	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
18-24	24	11%	156	13%	36	5%	149	5%	7%
29-38	47	21%	257	21%	110	16%	410	13%	15%
39-48	84	37%	389	32%	204	29%	974	30%	30%
49-58	66	29%	314	26%	266	38%	1,283	39%	36%
>/=59	6	3%	94	8%	82	12%	463	14%	12%
MSM/IDU	0	0%	10	1%	6	1%	12	0%	1%
Education Level	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
8th Grade or Less	19	8%	92	8%	42	6%	228	7%	7%
Between 8th-12th Grade	145	64%	787	65%	435	62%	1,996	61%	62%
College	63	28%	327	27%	221	32%	1,052	32%	31%
HIV Stage	**High VL**		**Not Suppressed**		**Suppressed**		**Undetectable**		**Total**
AIDS	36	16%	134	11%	84	12%	370	11%	12%
HIV Indeterminate	1	0%	1	0%	1	0%	0	0%	0%
HIV/AIDS Status Unknown	45	20%	311	26%	174	25%	791	24%	24%
HIV Not AIDS	145	64%	762	63%	439	63%	2,117	65%	64%

GROUP 2 – MCM IN+CARE GAP MEASURE ANALYSIS

- What story is the data telling you? What stands out?
- What other information would be helpful to understand this data and support what you are seeing?
- How can we use the data to assess successful health outcomes?
- How do you give directives to Networks? What questions would you send to the Network for analyses?

GROUP 2 - DATASET 1: MCM GAP MEASURE VS. SYSTEM-WIDE



	12.1.11	2.1.12	4.1.12	6.1.12	8.1.12	10.1.12	12.1.12	2.1.13
All	30%	28%	22%	23%	23%	23%	22%	20%
MCM	17%	15%	12%	10%	12%	12%	9%	8%

- **Definition:** 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 180 days of the measurement year
  - **Numerator:** Number of patients who had no medical visits in the last 180 days of the measurement year
  - **Denominator:** Number 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 the first 6 months of the measurement year

GROUP 2 - DATASET 2: MEDICAL CASE MANAGEMENT GAP MEASURE ANALYSIS

- MCM providers analyzed their agencies' client level data looking at reasons for missed appointments, next scheduled appointments, and dates and results of most recent CD4 and Viral Load tests

Reasons for Missed Appointments
Too Busy with Work
Case Closed (Client Transferred)
Private Insurance/ Medicaid
Unable to Contact Client
Incarcerated
Unaware of Appt.
Appt. Was Attended
Receives Care through Another RW Provider
Fallen Out of Care
Failed to Recertify for RW
SA Treatment

GROUP 2 - DATASET 3: MEDICAL CASE MANAGEMENT GAP MEASURE ANALYSIS

Last CD4 and Viral Load Results		
	Viral Load Result	**CD4 Result**
Agency A	58% - detectable	33% - CD4<200
Agency B	21% - detectable	16% - CD4<200
Agency C	47% - detectable	20% - CD4<200
Agency D	100% - detectable	33% - CD4<200
Agency E	90% - detectable	40% - CD4<200

GROUP ACTIVITY – PART 2

- What are the next steps after Network identified trends?
- Other data sets would you want to see if this is really a problem holistically? Trend overall or just within specific Network?
- If overall trend, what information would you send to HIVPC to inform on service/measure as a whole?

ASSESSMENT OF QUALITY MANAGEMENT KNOWLEDGE

POST TEST

1. The responsibilities of the QM committee include (*circle all that apply*):

    a) Analyze data- summarize data and identify where improvements are needed
    b) Review annual service delivery models
    c) Monitor QI network activities, and provide direction to the QI networks regarding QIP development
    d) Meet quarterly to have a party

2. The Ryan White program legislation includes a requirement for each Part to have a clinical quality management program
    - True_____ False_____

3. The QM plan is a written document that outlines the Ryan White Part A program wide quality plan, and includes a quality statement and goals and objectives. Broward County has developed a 10 year QM plan.
    - True_____ False_____

4. The PDSA Cycle is a "trial and learning method" to test changes on a small scale before system wide implementation
    - True_____ False_____

5. Match the word with the best description
    - Indicator
    - Outcome
    - Service delivery models
    - HAB Measures
    - QI Networks

    A. Measures recommended by HRSA for monitoring core, clinical, oral health care, medical case management, ADAP, and System level performance
    B. A service category specific, set of protocols, definitions, standards and indicators to guide the delivery of services.
    C. Benefits or other results for clients that may occur during or after their participation in a program. Outcomes may be system level or client level Slow/prevent client HIV disease progression (for clients on HAART with a viral load of >400)
    D. Method used to determine, over time, an organization or systems performance of an element of care. Indicators may measure function, process, or outcome (e.g., 80% of clients with CD4<500 are prescribed HAART)
    E. A QI Network is a service category 'subcommittee' that is made up of providers and consumers and is charged with identifying and addressing service category barriers to care by developing and implementing QIP's. Network activities are overseen by the Grantee and the QM Committee.

HIV/AIDS Bureau's Performance Measure Portfolio

November 6, 2013

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
Clinical Unit

INTRODUCTIONS

- Marlene Matosky and Tracy Matthews

- Webinar participants: Enter your name, grantee organization, location, and Ryan White HIV/AIDS Program Part in the chat room

- Summarize factors and principles for revisions to the HIV/AIDS Bureau performance measure portfolio
- Review changes to the HIV/AIDS Bureau performance measure portfolio
- Outline the next steps

Ryan White HIV/AIDS Treatment Extension Act of 2009

All Ryan White HIV/AIDS Program grantees are required "to establish **clinical quality management programs** to:

Measure

- Assess the extent to which HIV health services are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections

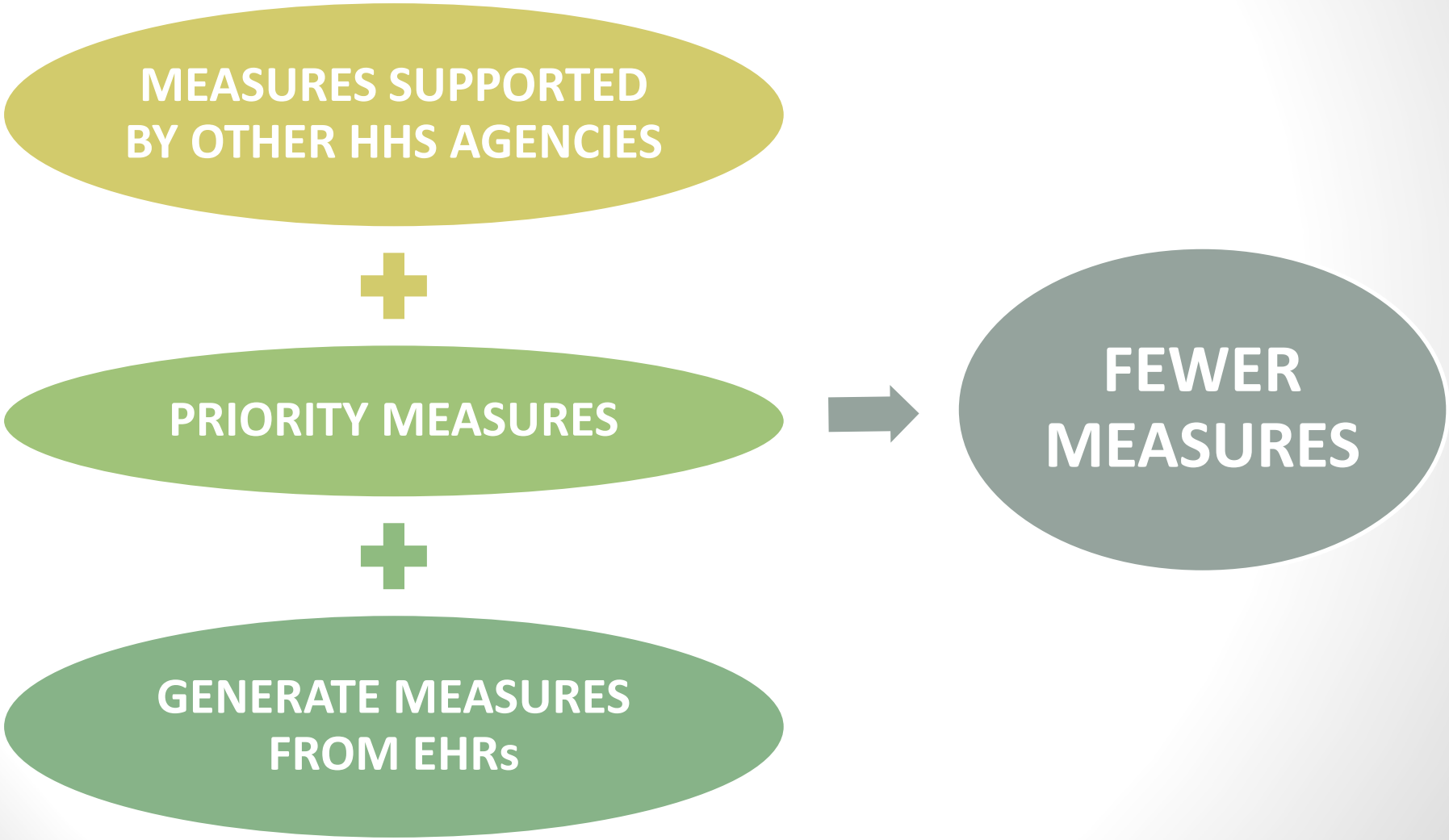
Improvement

- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services"

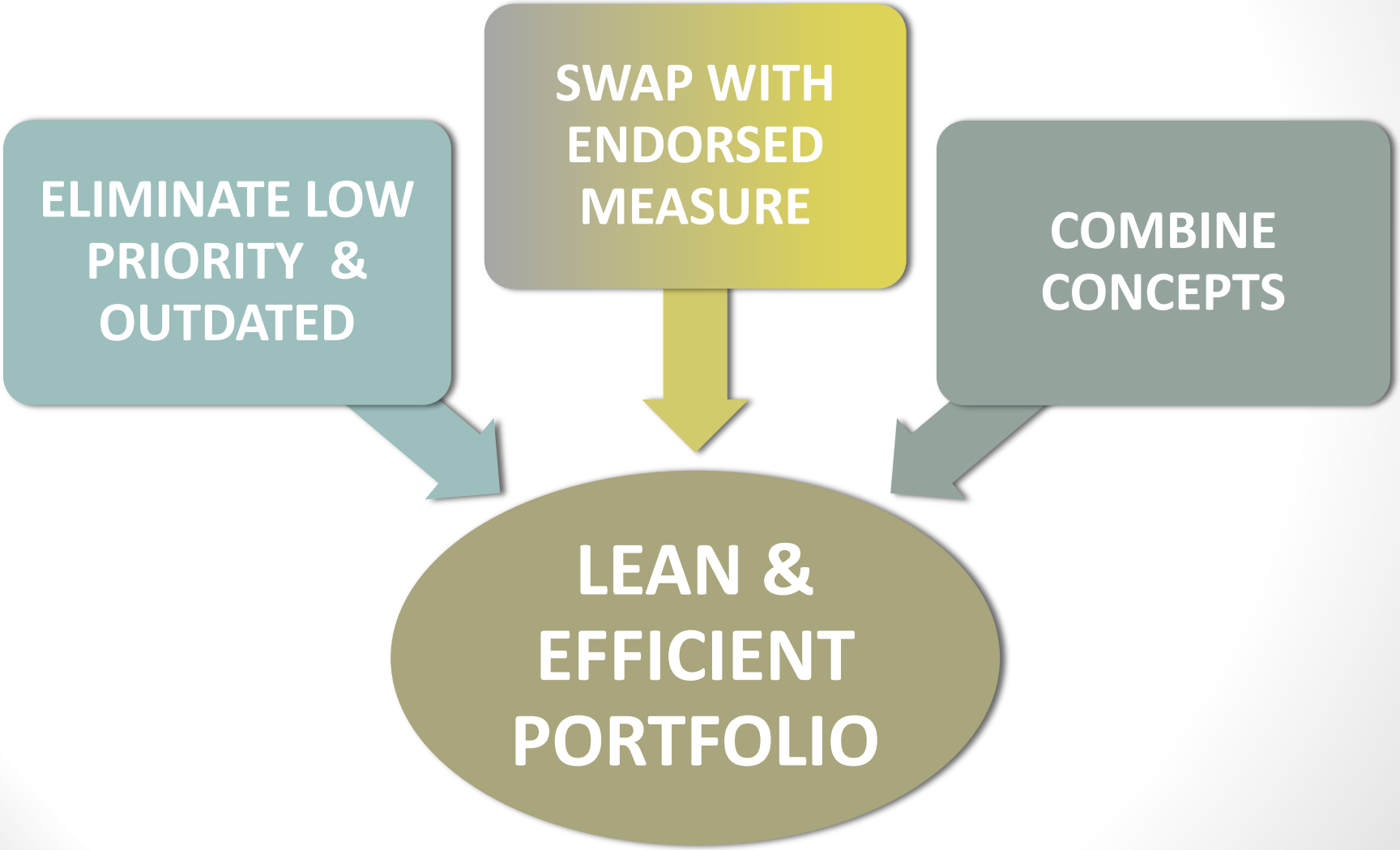
WHAT DO WE **WANT TO ACHIEVE?**

1. Emphasize Priorities
2. Alignment with Other Federal Stakeholders
3. Parsimony

MEASURE REFORM
GUIDING PRINCIPLES



RESULTS OF REFORMS



TIMELINE

May 2013

Presentation to HIV/AIDS Bureau Staff

June 2013

Presentation to Stakeholders

July - September 2013

Collect & Analyze Feedback

November 2013

Post Final Portfolio

CURRENT PERFORMANCE MEASURE
PORTFOLIO STRUCTURE

http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Old: 56 Measures

- Clinical Groups 1, 2, & 3
- Pediatric
- Medical Case Management
- ADAP
- Oral Health
- Systems

New: 46 Measures

- Core
- Clinical
- Medical Case Management
- ADAP
- Oral Health
- Systems
- Archived

CHANGES

- Core – promote use by all grantees
- All ages measures
- Swapped for measures in other Federal program with same concept
- HIV/AIDS Bureau did not develop all of the measures in the portfolio
- Archived measures

CORE

1. Viral Load Suppression
2. Prescribed Antiretroviral Therapy
3. Medical Visits Frequency
4. Gap in Medical Visits
5. PCP Prophylaxis

CLINICAL – ALL AGES

1. CD4 Count
2. HIV Drug Resistance Testing Before Initiation of Therapy
3. Influenza Vaccination
4. Lipids Screening
5. TB Screening
6. Viral Load Monitoring

CLINICAL – ADOLESCENT/ADULT

1. Cervical Cancer Screening
2. Chlamydia Screening
3. Gonorrhea Screening
4. Hepatitis B Screening
5. Hepatitis B Vaccination
6. Hepatitis C Screening
7. HIV Risk Counseling
8. Oral Exam
9. Pneumococcal Vaccination
10. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
11. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
12. Substance Use Screening
13. Syphilis Screening

CHILDREN

HIV-Infected Children:

1. MMR Vaccination

HIV-Exposed Children:

1. Diagnostic Testing to Exclude HIV Infection in Exposed Infants
2. Neonatal Zidovudine Prophylaxis
3. PCP Prophylaxis for HIV-Exposed Infants

ORAL HEALTH

1. Dental and Medical History
2. Dental Treatment Plan
3. Oral Health Education
4. Periodontal Screening or Examination
5. Phase I Treatment Plan Completion

MEDICAL CASE MANAGEMENT

1. Care Plan
2. Gap in Medical Visits
3. Medical Visit Frequency

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

1. Application Determination
2. Eligibility Recertification
3. Formulary
4. Inappropriate Antiretroviral Regimen

SYSTEM LEVEL

1. HIV Positivity
2. HIV Test Results for PLWHA
3. Housing Status
4. Late HIV Diagnosis
5. Linkage to HIV Medical Care
6. Waiting Time for Initial Access to Outpatient/ Ambulatory Medical Care

ARCHIVED

Adolescent/Adult:

1. ARV Therapy for Pregnant Women
2. CD4 T-Cell Count
3. HAART
4. Medical Visits
5. PCP Prophylaxis
6. Adherence Assessment & Counseling
7. TB Screening
8. Hepatitis/HIV Alcohol Counseling
9. Influenza Vaccination
10. MAC Prophylaxis
11. Mental Health Screening
12. Tobacco Screening
13. Toxoplasma Screening

All Ages:

1. Viral Load Monitoring
2. Viral Load Suppression on ART

Medical Case Management (MCM):

1. Medical Visits

Pediatrics:

1. Adherence Assessment and Counseling
2. ARV Therapy
3. CD4 Value
4. Developmental Surveillance
5. Health Care Transition Planning for HIV-infected Youth
6. HIV Drug Resistance Testing Before Initiation of Therapy
7. Lipid Screening
8. Medical Visit
9. PCP Prophylaxis for HIV-Infected Children
10. Planning for Disclosure of HIV Status to Child
11. TB Screening

System:

1. Disease Status at Time of Entry Into Care
2. Quality Management Program

KEY POINTS

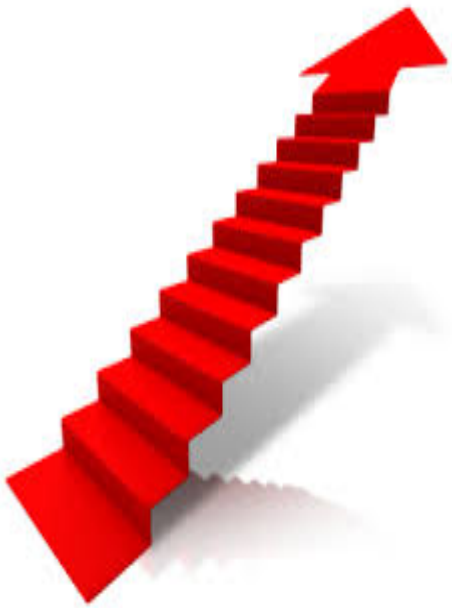
Recommend, at a minimum, to incorporate the Core measures into quality management programs

Choose measures appropriate for your program based on services funded

Consider stratifying measures to look at disparities (e.g., gender, race/ethnicity, age, risk, insurance status, etc.)

Archived measures does not preclude use when meaningful for your program

NEXT STEPS



- ⇨ Review HIV/AIDS Bureau performance measure webpage
  - ⇨ Measure detail sheets
  - ⇨ Frequently asked questions (FAQs)
- ⇨ Identify changes to own measure portfolio
- ⇨ Send questions to HIVmeasures@hrsa.gov or call Marlene Matosky (301-443-0798)

http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

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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).*

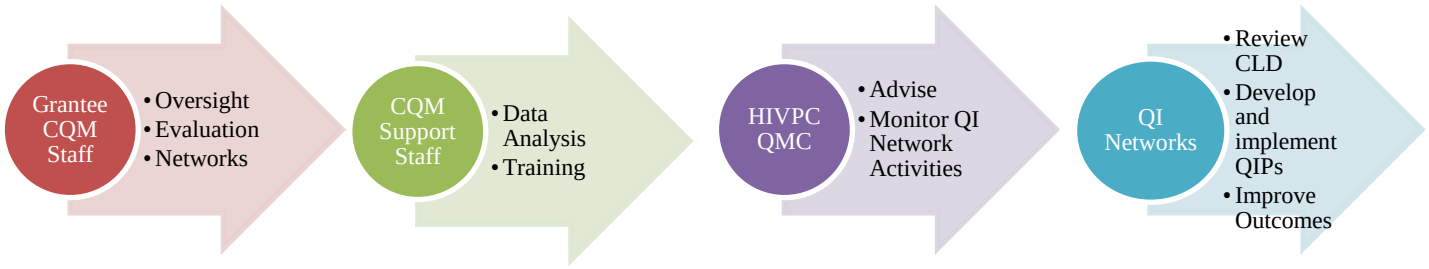
What is the Purpose of the QM Committee?

- 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.