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

MEETING AGENDA

COMMITTEE: Quality Management Committee
Date/Time: Monday, April 20, 2015 at 12:30 p.m. **Location:** Governmental Center Annex, A335
Claudette Grant, **Chair**

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*
2. **APPROVALS:** 4/20/15 Agenda and 3/16/15 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
4. **UNFINISHED BUSINESS**
   a. *Data Update/Review*- ACTION ITEM: Receive an update on data findings regarding clients who have been out of care for over a year.
5. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Action Items*
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: PSRA Recommendation	ACTION ITEM: Determine next steps for the PSRA motion: *To recommend to the appropriate QI network to change the Broward OAMC Outcome #1.2 to <200 copies/mL, which is in line with the NQC measures.* **(HANDOUT A-1, A-2)**
Item #2: QM New Member/Refresher Training	ACTION ITEM: Provide training on purpose/goals of Quality Management Committee and its activities. **(HANDOUT B-1, B-2, B-3)**

6. **GRANTEE REPORTS**
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS/TASKS FOR NEXT MEETING**
   a. Next Meeting Date: May 18, 2015

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: Review service category-specific data (WP 4.1)	ACTION ITEM: Review and determine specific population trends, etc. for each service category.

9. **ANNOUNCEMENTS**
10. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE GUIDING IDEAS OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL
• Linkage to Care • Retention in Care • Viral Load Suppression •

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

Meeting Minutes

Committee: Quality Management Committee
Date/Time: Monday, March 16, 2015 12:30 p.m. **Location:** Governmental Center Annex, A335
Chair: Claudette Grant

Attendance						
#	**Members**	**Present**	**Absent**		**Guests**	**Grantee Staff**
1	Grant, C.	**X**			Thomas Schucker	Morris, R.
2	Katz, H. B.	**X**			Tomas Soto	Degraffenreidt, S.
3	Tavares, J.		**X**		Michele Jacobson	
4	Mitchell, T.		**X**		Lamont Lewis	**HIVPC Support Staff**
5	Earp, A.	**X**			Jennifer Rodriguez	Johnson, B.
6	Runkle, D.	**X**			Krystle Kirland-Mobley	McEachrane, T.
					Laura London-Weaver	Newton, A.
	Quorum = 4					

1. CALL TO ORDER:

The Chair called the meeting to order at 12:33 p.m. The Chair welcomed all present. The Chair and Clinical Quality Management (CQM) Support Staff welcomed guests and explained the purpose of the Quality Management (QM) Committee. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, grantee staff and support staff self-introductions were made. A moment of silence was observed.

2. APPROVALS:

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

Motion #2	To approve 2/23/15 meeting minutes		
Proposed by:	Katz, H.B.	**Seconded by:**	Runkle, D.
Action:	Passed Unanimously		

3. STANDARD COMMITTEE ITEMS

a. Request for Information/Directives
b. Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
c. Next Meeting Date: April 20, 2015

4. UNFINISHED BUSINESS:

CQM Staff provided an update on recruitment efforts for the QM Committee. The letter approved at the previous meeting was sent to providers. Staff received two responses from representatives at Broward Health and AIDS Healthcare Foundation. Staff provided an overview of the QM Committee to guests that are interested in joining. Staff explained that the QM Committee meets on the third Monday of each month. To become a member, interested parties must attend three meetings before being voted on the committee.

5. MEETING ACTIVITIES/NEW BUSINESS

Goal/Work Plan Objective #:	*Action Items*
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: Review Quarterly Data (WP 1.1)	The Committee requested data on zip codes of clients not retained in care at the previous meeting. CQM Staff provided a data presentation including zip codes of Part A clients not in care (Handout A-1). Staff explained that the gap measure from the In+Care Campaign was used to measure client retention in medical care. The Broward County Department of Health (DOH-BC) provided a prevalence map with zip codes of Broward County (Handout A-2). Staff explained that the zip codes with high prevalence on the map were similar to the top zip codes of Part A clients not in care. There were no significant differences with zip codes for clients retained in care compared to clients not retained in care. The top ten zip codes include 33311, 33313, 33334, 33304, 33312, 33309, 33020, 33060, and 33023. Staff reported the demographic breakdown of the top five zip codes including race, gender, and age. Staff explained that the retention report does not currently include information on country of origin. Staff will look into getting this information for future reporting. The current retention reports include information about clients who identify as Haitian. Staff reported the demographic and zip code data for Haitian clients. The Committee discussed the findings and what next steps should be taken based on the data. Members felt that the data showed the importance of focusing on women because of the large number of black females not retained in care. Members requested that the data be broken down by country of origin and ethnicity. Grantee staff noted that PE does collect data on this information, but it was not available in the retention report used for this presentation. The QM Committee can request this information moving forward. The Grantee explained that the committee needs to identify what information is needed for the committee to move forward with making a decision. The Committee discussed looking at the zip codes of each agency to identify any gaps in services within that zip code. Although Ryan White providers are located in areas of high prevalence, some clients may not feel comfortable accessing these services in their own neighborhoods due to stigma. Some clients feel more comfortable going to a neighborhood different from their own. The committee discussed the disparities for Haitian clients and what targeted interventions can be developed for that population. A guest noted that she works in Pompano Beach as

	a patient coordinator and reported that many Haitian-born clients have religious and cultural barriers. Older Haitian clients have trouble accepting that they have HIV. She also stated that outreach for Haitian clients is an important issue. The Chair stated that the Part A program does not currently fund outreach services, but that does not imply that outreach is not being done within Broward. Another guest stated that it is important to match clients with providers from the same culture. The Chair reminded members that Haitians only represent 13% of clients not retained in care and there is still a large percentage of clients from different backgrounds not being retained in care according to the In+Care Gap Measure definition. The committee discussed the significant percentage of females who are not retained in care and how to determine why women are falling out of care. Issues with women that might affect retention include Medicaid eligibility expiring and lack of attention for themselves. A guest noted that religion is an important factor for minority populations. The Grantee noted that the DOH-BC has been working with churches in Broward County to promote HIV awareness. A representative from the DOH-BC noted that there is a program targeting churches, called Faith Response to AIDS (FRTA). There is also a similar program for businesses in Broward called BRTA. The Chair noted that it is important to determine how many clients are truly out of care rather than transitioning to another payer source or rescheduled an appointment out of the time frame for the gap measure. If the clients who are out of care are identified, specific information can then be obtained about why they fell out of care. The committee discussed the role that providers have in targeting clients who are out of care. A guest noted that agencies are working to identify clients who are out of care and documenting what interventions are done to find them. Members were informed that there is a follow up protocol for case managers. The Grantee representative noted that agencies are responsible for developing follow-up protocols. The Committee was reminded that monitoring occurs every year, along with monthly provider calls to oversee what is being done for client retention. It was explained that each agency has representation on QI Networks for each service category as well. The QM Committee is able to send directives based on data to the networks. The Committee is also tasked with determining whether a data trend is a system-wide concern that should be addressed by the Priority-Setting and Resource Allocation (PSRA) and System of Care (SOC) committees. After discussing efforts in client retention, it was explained that linkage to care is facilitated by the DOH-BC, followed by Centralized Intake and Eligibility Determination (CIED).

	Members were reminded that providers are responsible for scheduling clients for Part A re-certification. **Action Items for Data:** • Clients who are not retained in care for at least a year broken down by subpopulations including ethnicity and country of origin • Include the sample size for data presentations

6. GRANTEE REPORTS

The Grantee showed the Committee the "Get Care Broward" media campaign with CBS 4. There is a dedicated phone number for the campaign: 954-357-9797.

7. PUBLIC COMMENT

None.

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: Review findings from Needs Assessment	**ACTION ITEM:** Identify at least 3 barriers to care, 3 areas for improvement in service delivery, and recommend at least 3 service category evaluations.
Item #2: Service Delivery Model Review	**ACTION ITEM:** Review and approve the Disease Case Management Service Delivery Model.
Item #3: QM New Member/Refresher Training	**ACTION ITEM:** Provide training on purpose/goals of Quality Management Committee and its activities.

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

The meeting was adjourned at 2:06 pm.

Quality Management Attendance CY: 2015

Count	Member	1/26/15	2/23/15	3/16/15
1	Grant, C. Chair	1	1	1
2	Mitchell, T.	A	A	E
3	Katz, H.B.	1	1	1
4	Tavares, J.	1	1	A
5	Earp, A.	Appointed 2.23.15		1
6	Runkle, D.	Appointed 2.23.15		1
	Quorum=4	4	3	4

PSRA Recommendation

PSRA Discussion

1. PSRA made the motion to recommend that the QM Committee direct the Medical Network to consider revising **Indicator 1.2** to reflect the HHS Treatment Guidelines and HAB/NQC In Care Measures which considers viral suppression <200 copies/mL

OUTPATIENT AMBULATORY MEDICAL CARE (OAMC)		
1. Slow/prevent clients' HIV disease progression	**1.1 80% OF CLIENTS WITH CD4 ≤ 500 ARE PRESCRIBED ART.** **1.2 70% OF CLIENTS ON ART FOR > 6 MONTHS WILL HAVE A VIRAL LOAD < 400.**	1.1 **91.1%** 1.2 **90.9%**

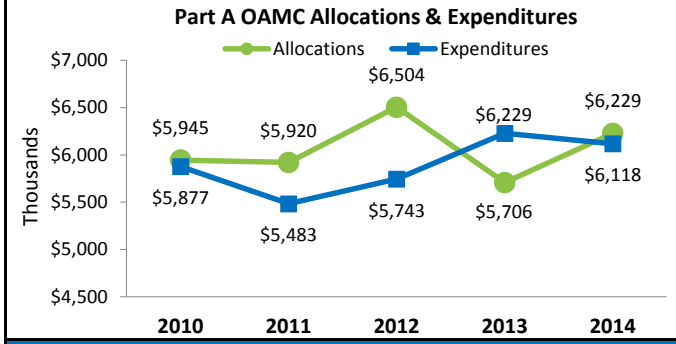
Recommendations

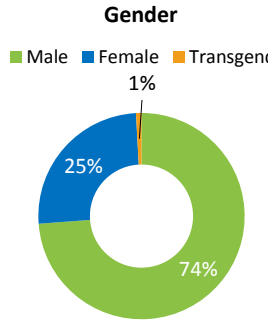
1. Send recommendation to Medical Network to review outcomes and provide reasoning for why it should/should not be changed.
2. Review service category-specific data based off the PSRA scorecards and provide overviews of the clients accessing those services along with recommendations

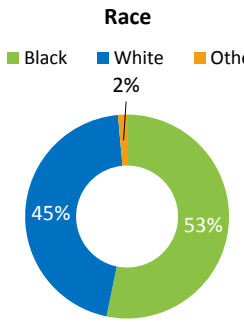
FY 2014-2015 Scorecard: Outpatient Ambulatory Medical Care

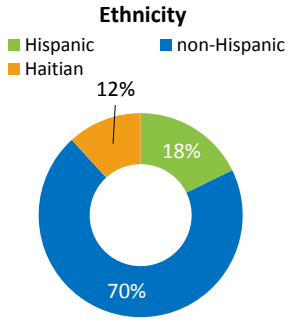
ELIGIBILITY: </= 400% FPL

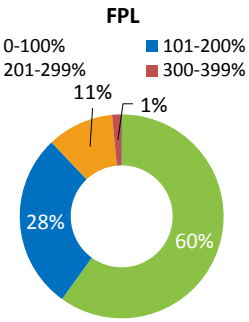
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2014	$6,228,636	$264,596	**$6,493,232**	$6,118,160	$264,586	**$6,382,746**	-1.46%	**$16,012,762**	**39.9%**	**1**
2013	$5,706,496	$100,000	$5,806,496	$6,228,552	$248,874	$6,477,426	10.86%	$15,366,650	42.2%	1
2012	$6,504,282	$100,000	$6,604,282	$5,743,196	$99,936	$5,843,132	4.7%	$15,423,413	37.9%	1
2011	$5,920,360	$234,473	$6,154,833	$5,482,813	$99,993	$5,582,806	-9.1%	$15,006,261	37.2%	1
2010	$5,944,675	$120,035	$6,064,710	$5,876,974	$263,344	$6,140,318	N/A	$15,395,252	39.9%	1











FY 14-15 OAMC Utilization & Demographics

Year	Total Clients	% change	# New	% New
2014	4,102	**7.61%**	1,025	**25.0%**
2013	3,790		997	26.3%

Ryan White Part A & MAI Providers		
Type	Part A	MAI
Number	5	1

FPL*	#	%
0-100%	2,459	59.9%
101-200%	1,148	28.0%
201-299%	433	10.6%
300-399%	58	1.4%
400% & over	4	0.1%

Insurance	#	%
Private	414	10.1%
Medicare	73	1.8%
Medicaid	287	7.0%
Other Public	15	0.4%
None	3,312	80.7%

* FPL is current for the end of the FY

Demographics, cont.

Gender	#	%
Male	3,028	73.8%
Female	1,039	25.3%
Transgender	35	0.9%
Race	**#**	**%**
Black	2,184	53.2%
White	1,859	45.3%
Other	59	1.4%
Ethnicity	**#**	**%**
Hispanic	826	20.1%
non-Hispanic	3,276	79.9%
Haitian	549	13.4%

FY 14-15 Top 10 Procedures

Top 10 Procedures		Top 10 Expenditures	
Procedure	% of Procedure	Procedure	% of Expenditures
1. HIV-1 DNA Detection	15.80%	1. HIV-1 DNA Detection	30.42%
2. Office/Outpatient Visit	15.20%	2. Est. Patient Office/Outpatient Visit	29.64%
3. Comprehensive Metabolic Panel	13.80%	4. TB Test Cell Immun Measure	5.69%
4. Complete CBC with Diff WBC	10.10%	5. Genotype DNA HIV Reverse T	5.54%
5. Lipid Panel	10.00%	6. Comprehensive Metabolic Panel	3.58%
6. Blood Serology Qualitative	9.30%	7. Chylamydia Trach DNA AMP Prob	3.06%
7. Flowcytometry/TC Add-on	8.90%	8. Flowcytometry/ Tc 1 Marker	2.88%
8. T Cell Absolute Count	6.90%	9. Destruction Anal Lesions	2.75%
9. Chylamydia Trach DNA AMP Prob	5.40%	9. Phenosensegt/Genosure	2.60%
10. N. Gonorrhoeae DNA AMO Prob	5.00%	10. N.Gonorrhoeae Dna Amp Prob	2.35%

Average Cost Per Client

$ 1,418.76

Total Nutrition Services Expenditure

$ 112,219.22

Fort Lauderdale/Broward EMA Medical Outcome	2012		2013		2014	
Outcome: Slow/prevent HIV disease progression.	Num/Denom	%	Num/Denom	%	Num/Denom	%
1.1 80% of clients with a CD4 <500 are on HAART.	1,660/1938	85.7%	1,700/1,913	88.9%	3,320/3,644	91.1%
1.2 70% of clients on HAART >6 months have a VL <400.	2,748/3,264	84.2%	3,266/3,546	92.1%	6,980/7,674	91.0%

FY 2014-2015 Scorecard: Outpatient Ambulatory Medical Care ELIGIBILITY: </= 400% FPL

HAB HRSA HIV Performance Measures

Measures	2013 (n/d)	Achieved	2014 (n/d)	Achieved	Screenings	2013 (n/d)	Achieved	2014 (n/d)	Achieved
CD4 Count	2,772/3,529	78.5%	2,731/3604	75.8%	Chlamydia	530/790	67.1%	745/962	77.4%
HAART	284/293	96.9%	312/321	97.2%	Gonorrhea	467/790	59.1%	622/962	64.7%
Medical Visits	2,882/3,529	81.7%	2,834/3,604	78.6%	Syphilis	3,194/4,118	77.6%	3,463/4,295	80.6%
Oral Exam	1,948/4,118	47.3%	1,842/4,295	42.9%	Cervical Cancer	468/1,115	42.0%	428/1,097	39.0%
Lipid Screening	2,873/3,609	79.6%	3,226/3,837	84.1%	Hepatitis B	3,644/4,118	88.5%	3,680/4,295	85.7%
TB Screening	3,149/4,109	76.6%	3,185/4,287	74.3%	Hepatitis C	3,315/4,118	80.5%	3,385/4,295	78.8%

National Quality Center (NQC) inCARE Retention Measures for Part A/MAI Medical Patients	2013		2014		Participant National Avg	Comments
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement yr / Patients with >/= 1 medical visit in 1st 6 months of measurement yr	64 / 708	9.0%	605 / 2,101	28.8%	14.8%	Strive for low%. Worse than avg.
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in each 6 month period of 24 months / Patients with >/=1 medical visit in 1st 6 months of 24 months	520 / 586	88.7%	1,024 / 2,962	34.6%	64.1%	Strive for high%. Worse than avg.
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement yr / Patients newly enrolled w/ provider & >/=1 visit in 1st 4 mos. of yr	20 / 54	37.0%	80 / 212	37.7%	56.9%	Strive for high%. Worse than avg.
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	697 / 782	89.1%	2,236 / 2,634	84.9%	80.0%	Strive for high%. Better than avg.

FY 14-15 Percent of Clients NOT Virally Suppressed (≥ 200 copies/mL) by Subpopulation

All Clients	#	%	Race/Ethnicity	#	%	Risk Factor	#	%
	596	14.6%	Black non-Hispanic Male	225	17.5%	MSM	276	13.9%
Gender	#	%	Black non-Hispanic Female	136	16.6%	Black MSM	115	21.5%
Male	419	13.9%	**Total Black non-Hispanic**	**361**	**17.20%**	White MSM	157	11.1%
Female	167	16.2%	White non-Hispanic Male	134	13.7%	Hispanic MSM	46	8.2s%
Transgender*	10	28.6%	White non-Hispanic Female	17	18.5%		#	%
Age	#	%	**Total White non-Hispanic**	**151**	**14.10%**	Heterosexual	280	14.6%
18-28	110	28.5%	Hispanic Male	57	8.1%	Black Hetero	237	15.2%
29-38	153	20.5%	Hispanic Female	13	13.1%	White Hetero	42	12.1%
39-48	148	13.6%	**Total Hispanic**	**70**	**8.7%**	Hispanic Hetero	21	9.5%
49-58	148	10.5%	Haitian	10	28.6%		#	%
59+	37	8.4%	Non-Haitain	586	14.5%	Hemophilia*	1	16.7%
Living Arrangements	#	%	**Educational Level**	#	%	IDU*	7	11.1%
Permanent	390	13.2%	<8th Grade	35	13.5%	MSM/IDU*	3	15.8%
Non-Permanent	203	18.6%	8-12th Grade	393	16.2%	Perinatal*	21	44.7%
Institution*	3	14.3%	College	168	12.0%	Transfusion*	2	20.0%

*Small population group (N<75 in program year)

Quality Management Committee

Presentation Overview

- PROGRAM OVERVIEW
- STAFF ROLES AND RESPONSIBILITIES
- QUALITY MANAGEMENT COMMITTEE AND QUALITY IMPROVEMENT NETWORK ACTIVITIES
- CONSUMER PARTICIPATION
- DATA COLLECTION

Quality Management Program

Purpose

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

Mission

Ensure high quality services are provided to HIV+ Broward residents that meet or exceed HAB's clinical and other performance measures, through an inclusive structure that integrates consumer and provider input

History of Broward County EMA QM Program

The Fort Lauderdale/Broward County EMA established a system-wide quality assurance and Continuous Quality Improvement (CQI) program in FY 1997

Standards of care, service delivery protocols, client level outcomes, and indicators for every service category, as well as uniform data collection instruments, were adopted in FY 2000

- **QM Committee Evolution:**

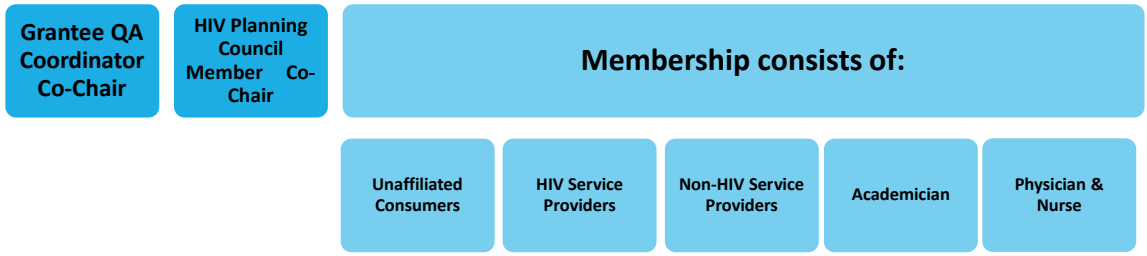
  (2003) Assessment Committee

  (2005) CQI Committee

  (2008) QM Committee

History of Broward County EMA QM Program

The QM Committee formed as a part of the Broward HIV Health Services Planning Council (HIVPC) to increase HIVPC and Consumer Involvement in the Broward EMA QM Program



Quality Improvement Networks

Service Provider Networks Transitioned to Quality Improvement Networks to Develop and Execute Quality Improvement Projects

Outpatient/Ambulatory Medical Care (5 providers)

Oral Health (2 providers)

Medical Case Management (6 providers)

Mental Health (3 providers)

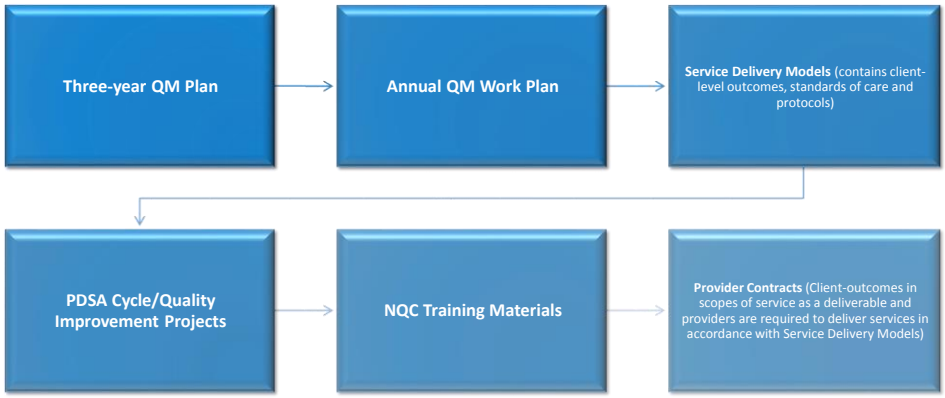
Substance Abuse (2 providers)

Centralized Intake and Eligibility (1 provider)

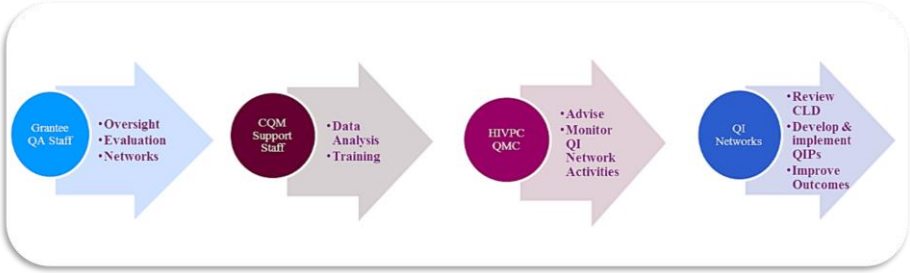
Food Services (1 provider)

Pharmacy (2 providers)

Tools Used



Quality Management Program Structure



GOALS OF THE QM STRUCTURE

- Ensure delivery of highest quality services possible
- Increase consumer participating in QM Initiatives
- Increase HIV Planning Council participation in QM Initiatives
- Make QM and QI processes and activities transparent
- Develop client-level outcomes (QM Committee)
- Develop realistic, observable and measurable outcome indicators (QI Networks)
- Provide QI training to providers, QM Committee members, consumers, and staff

Monitoring Service Delivery and Improving Client Health Outcomes

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
- Conduct 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
- Gather and analyze client-level and system-level data and performance outcomes and indicators
- Facilitate trainings
- Provide technical assistance through methods of analysis which include:
  - Literature reviews
  - 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

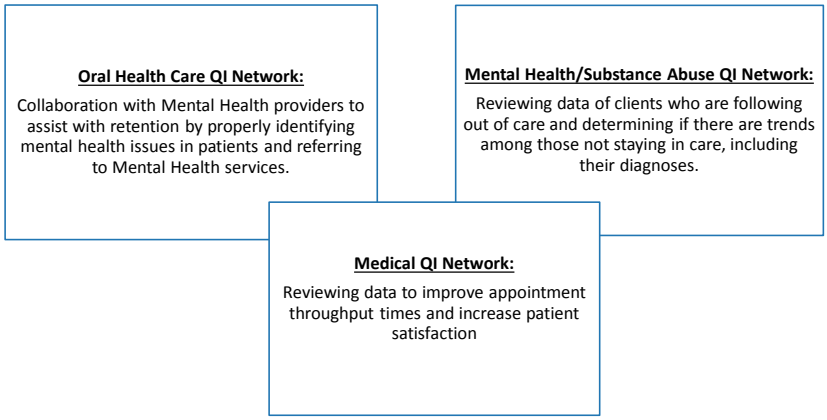
HIVPC QM Committee

- Comprised of consumers, client service professionals, HIV and non-HIV providers
- Develop/revise committee policies and procedures consistent with other HIVPC committees
- Participate in developing the annual work plan to achieve the three-year QM Plan
- Review progress of client, provider, and system-level quality outcomes, including HAB, HHS, and NQC performance measures
- Ensure standards of care are achieving desired client, provider, and system-level outcomes and indicators
- Review Service-specific delivery models for approval
- Identify, prioritize, and monitor Quality Improvement Projects 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 Transportation)
- Review client and agency-level outcome data and design standards of care and performance measures and indicators
- Address emerging barriers impeding access to and retention in services
- Develop performance improvement strategies and testing the processes selected for improvement (QIPs)
- Update Service Delivery Models

QI Network QIP Examples



Identifying and Addressing Disparities in Care

- Special Populations
- Directives from HIVPC (QM Committee, NAE, SOC, PSRA)
- Focus Groups
- Viral Load Report
- Developing client profiles through 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) provides viral load analysis reports, service utilizations, etc.

Contractually Required Data Elements

- Client-level data components necessary for CQM data analysis reviews
- RSR required data elements

Quality Measures

- HAB
- HHS
- EMA-specific Client-Level Outcomes and Indicators
- In+Care Retention

Program Activities

- Revision of Broward County Client Level Outcomes and Indicators
- 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 within the CQM program
- Other Initiatives:
  - In+Care Campaign
  - Formulary revisions

Major Accomplishment

The EMA received the NQC's 2012 Award for Performance Measurement

The award honors grantees that have significantly strengthened their ability to measure the quality of HIV care and services. The EMA was recognized for its capacity to use an integrated software system to collect data on over 7,000 Part A clients annually, ongoing data-driven QI activities, and refining CQM infrastructure that enhances system wide performance.

Quality management seeks to enhance the quality of HIV care provided and increase access to services. They do so by measuring how health and social services meet established professional standards and user expectations.

HRSA's HIV/AIDS Bureau's (HAB's) quality of care initiatives

Questions?

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).*

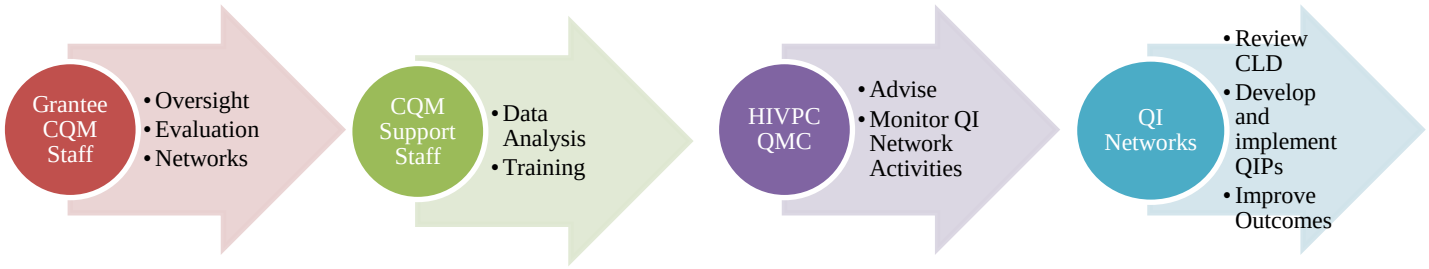
What is the Purpose of the QM Committee?

- 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.

Fort Lauderdale/Broward County Part A Eligible Metropolitan Area (EMA) Three-Year Clinical Quality Management (CQM) Plan FY 2014-2016

Background

The United States Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990, amended in 1996, 2000, 2006 and reauthorized as the Ryan White HIV/AIDS Extension Act of 2009. The HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) operates the Ryan White HIV/AIDS Program. The Ryan White HIV/AIDS Extension Act focuses on ensuring access to high quality Outpatient/Ambulatory Medical Care (OAMC), medications, and other core health care services for persons living with HIV. The Ryan White HIV/AIDS Extension Act requires that Part A grantees develop and implement CQM programs to assess and improve the quality of core and support services. To ensure that resources are available to undertake CQM, the Ryan White HIV/AIDS Extension Act provides funding for Part A and Minority AIDS Initiative (MAI) for Eligible Metropolitan Area (EMA) CQM initiatives. CQM data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the EMA/TGA planning process and ongoing assessment of progress toward achieving program goals and objectives. It should also be used by the grantee to examine and refine services based on outcomes.

HAB has established minimum expectations of Part A grantees regarding CQM:

- Establish and implement a CQM plan
- Establish processes for ensuring that primary medical care services are provided in accordance with the US Department of Health and Human Services (DHHS) treatment guidelines and standards of care
- Incorporate quality-related expectations into requests for proposals (RFP) and EMA/TGA contracts

The HAB HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents are offered as a set of indicators for use in monitoring the quality of care provided. The measures may be modified by Part A grantees to meet specific needs of the EMA/TGA. Grantees may select measures that are most important to their programs and the populations they serve, as they relate to their overall goals for improving clinical health outcomes.

Part A and MAI CQM funds are used to improve services for individuals living with HIV/AIDS and CQM activities will include:

- Assess the extent to which HIV clinical services provided to patients under the grant are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV/AIDS and recommendations of the Centers for Disease Control and Prevention (CDC)[1].

[1] Center for Disease Control and Prevention. Recommendations and Guidelines. http://www.cdc.gov/hiv/resources/guidelines/index.htm (Last visit date: March 2011)

- Evaluate the quality of core and support services through the application of HAB performance measures[2], quality benchmarks, and collection and analysis of client, provider, and system-level data.
- As applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

Quality Statement

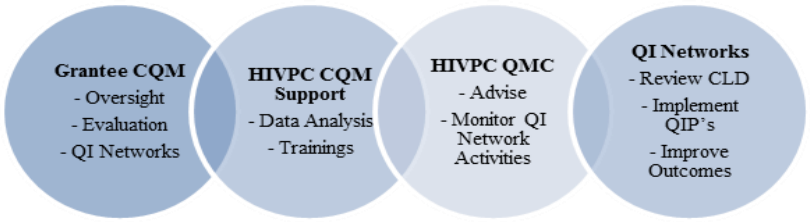
The purpose of the CQM Program for Ryan White Part A and MAI funded services in the Fort Lauderdale/Broward County EMA is to monitor, evaluate, and systematically and continuously improve the quality and appropriateness of HIV care and services provided to consumers.

Our mission is to ensure high quality services are provided to Part A and MAI eligible Broward County residents living with HIV that meet or exceed HAB's clinical and other performance measures, through an inclusive structure that integrates consumer and provider input.

The CQM program has five objectives:

1. Assess the extent to which Outpatient/Ambulatory Medical Care is consistent with the most recent PHS guidelines for the treatment of HIV and related Opportunistic Infections.
2. Develop strategies for improving quality through the application of HAB performance measures and best practices identified by the National Quality Center (NQC).
3. Implement continuous quality improvement to ensure core and support services are strongly linked to promote engagement and retention in care and adherence to medical treatment.
4. Apply client-level demographic, clinical, and utilization data to identify areas of improvement in clinical processes and outcomes.
5. Apply action-oriented Quality Improvement Projects (QIPs) to test and adopt new or improved care and support strategies.

CQM Infrastructure



The CQM program is committed to improving the quality of services provided to HIV+ Broward residents by ensuring that an action-oriented CQM infrastructure is carefully aligned with HAB and the Grantee's goals for Quality Improvement (QI). There are four interconnected bodies that oversee the CQM program: Grantee CQM staff, Broward

[2] HIV/AIDS Bureau. The HIV/AIDS Program Home: HAB Performance Measures. http://hab.hrsa.gov/special/habmeasures.htm (Last visit date: March 2011)

County HIV Health Services Planning Council (HIVPC) CQM support staff, HIVPC Quality Management Committee (QM Committee), and QI Networks made up of providers, consumers and other stakeholders.

The Grantee CQM staff has primary responsibility for developing, overseeing, and jointly evaluating progress made in completing the CQM three-year and annual work plans with HIVPC and community stakeholders. The Grantee CQM staff also facilitates integration of and interaction among QI Networks and evaluates progress toward successful implementation of the CQM program.

The CQM support staff assists the Grantee CQM staff to achieve CQM responsibilities. The support staff convenes the QM Committee and QI Networks and ensures progress is made achieving program objectives; supports the QM Committee and QI Networks by providing data for decision making; conducts annual system wide consumer satisfaction surveys, focus groups, and in depth quantitative service assessments; and organizes training for the QM Committee, QI Networks, and consumers.

Together, the Grantee CQM and support staff work in collaboration to extract Management Information System (MIS) data monthly and quarterly to assess level of care, performance measures, and health outcomes. As a part of the CQM reporting, monitoring, and improvement processes, results from MIS data extracts are then shared with the QM Committee and QI Networks to assess overall system-wide data achievement of clinical outcomes.

The QM Committee collaborates with the Grantee CQM staff in developing quality policies and procedures; participates in developing the EMA three-year CQM plan and annual work plans; participates in the development of client-level and system-level outcomes and indicators; assists the Grantee CQM staff to assess standards of care outlined in current service delivery models to ensure achievement of desired client and system-level performance measures and outcomes; review CQM data to evaluate progress in achieving CQM program goals and objectives; and monitors and advises on potential QIPs for QI Networks. The QM Committee is comprised of consumers, client service professionals, and HIV and non-HIV providers.

For service category specific data, the QM Committee then collaborates with the QI Networks. Under the direction of the Grantee CQM staff, the QI Networks are comprised of subgrantees representing all locally funded Ryan White Part A service categories. QI Networks design standards of care and performance indicators; identify, test, and implement QIPs to improve quality or related processes; address emerging barriers impeding access to and retention in services; and review and update service delivery models to ensure services are provided in accordance with PHS treatment guidelines, HAB measures, and locally adopted standards of care. QI Networks also allow for discussion of MIS-related matters.

Currently there are five QI Networks: Outpatient/Ambulatory Medical Care, Medical Case Management, Mental Health/Substance Abuse, Oral Health Care, and the Combined Network which includes representatives of the following: Centralized Intake and Eligibility Determination, Food Bank, Pharmacy, and Legal Services as well as representatives from Housing Opportunities for People with AIDS (HOPWA) and Part B funded Transportation services. This forum creates an opportunity to discuss specific data requests and reports as well as general questions or concerns related to the MIS system.

It is the consumer who is ultimately impacted by the quality of Part A and MAI funded services. Consumers complete the feedback loop through focus groups, client satisfaction surveys, key informant interviews, and client participation at QI Networks and QM Committee. Consumer input informs the entire CQM Program's stakeholders regarding the HIV service delivery system.

Quality Implementation Plan

The QM Committee, in conjunction with the Grantee CQM Staff, provides the daily management and implementation of the CQM Program, achievement of the EMA three year CQM Plan and Annual Work Plans, and overseeing the QIPs. The CQM support staff will collect and analyze performance data, and create reports summarizing findings and recommendations to help inform the CQM program, the Grantee's implementation of the EMA three-year CQM plan, the QM Committee, and the QI Networks.

The collaboration of subgrantees in implementing the EMA three-year CQM Plan is sought in several ways. Evaluation of subgrantee technical assistance (TA) and capacity building needs through annual provider surveys. Subgrantees also maintain and implement individual agency specific C QM plans and QIPs within their internal CQI processes.

Subgrantees also participate in the QI Networks, implement their own CQM programs and plans, and assess consumer satisfaction through surveys and feedback from the HIV Planning Council. Participation in the QI Networks allows subgrantees to conduct QIPs and to provide input and feedback relative to service delivery standards. As areas of improvement in performance and outcome are identified, QI Network members also develop possible solutions, test improved processes through use of the PDSA cycles, and implement system-wide their solutions.

QI training is conducted throughout the three-year planning period for all QM Committee members, QI Network members, and consumers. Resources to achieve this CQM Plan include: Grantee leadership, HIVPC leadership, QM Committee and QI Network members, and subgrantees to strive to deliver the highest quality services possible. Other resources include HAB CQM funds, experts and well trained staff, space to meet, timely and accurate databases, and consumers' firsthand experience with the Part A and MAI funded service delivery system.

Various methods will be used to solicit feedback from consumers relative to service delivery effectiveness and efficiency. Among these methods are consumer focus groups, consumer surveys, key informant interviews, and participation of consumers in the CQM Committee and QI Networks.

Performance Measurement

The CQM Grantee and support staff, QM Committee, and QI Networks will establish annual work plans and benchmark to assess progress made toward achievement of the EMA three-year CQM Plan. Data from provider quarterly outcome reports, annual Grantee program evaluations, chart reviews, and the MIS client-level data will be used in the quarterly progress review.

The quality of services provided, provider performance, and clinical outcomes are assessed through service delivery standards and HAB and EMA-specific performance measures Conceptually, achievement of client, provider, and system-level outcomes and performance indicators are viewed as a result of how well the quality of service delivery standards are carried out in this EMA. Further, HAB performance and outcome measures are used to assess the quality of care provided across the EMA. As HAB updates it quality measures, the EMA will adopt those measures by reference in the Three-Year CQM Plan. The CQM support staff is responsible for the primary daily responsibility for data collection and analysis. The QM Committee will develop and implement mechanisms for sharing findings with QI networks, subgrantees, front-line providers, consumers, HIVPC, other HAB grantees operating in the EMA, and other stakeholders.

Capacity Development

Annual provider assessments will be conducted to assess the capacity and training needs of subgrantees and direct service staff. Critical to capacity development is initial and ongoing training for all stakeholders. CQM Grantee and support staff, QM Committee, and AIDS Education and Training Center (AETC) staff will conduct periodic training. Curriculum will be adopted from the National Quality Center (NQC) and AETC to impart new knowledge and skills to QM Committee and QI Network members. Frontline direct services and administrative staff will be encouraged to participate in training to expand their capacity to design and implement their own CQM programs and undertake QIPs.

Central to this process is the ability of the CQM Grantee and support staff to work in a supportive and facilitative method with the QM Committee, QI Networks, and individual subgrantees to facilitate QIPs and the receipt of technical assistance. Grantee QA staff and CQM support staff will arrange for CQM capacity development to address subgrantees' needs.

Evaluation

The Grantee CQM staff will facilitate the QM Committee and QI Networks to identify QIP critical to the achievement of performance measures and client, provider, and system level outcomes and performance measures. Annually, the QM Committee will use the NQC Part A CQM Program Assessment Tool to evaluate subgrantees' CQM programs and plans. On a quarterly basis, the CQM Committee and QI Networks will review all service category client, provider, and system-level outcomes and performance measures to assess incremental improvement and achievement of benchmarks. Additionally, support staff will provide data relative to the achievement of quality outcomes and performance measures.

Fundamental to evaluation of the CQM Plan is the solicitation of consumer input via focus groups, key informant interviews, satisfaction surveys, and participation in the CQM Committee and QI Network chairs. The Grantee CQM staff will solicit input from the CQM Committee and QI Networks regarding topics to be covered in client focus groups and satisfaction surveys. Subgrantees will also be required to design their own CQM evaluation processes, including consumer satisfaction assessments. Grantee CQM staff will provide capacity development and TA to assist providers in these activities.

Process to Review and Update CQM Annually

The Grantee CQM staff will ensure that active QIP updates will be a standing item on monthly CQM Committee agendas. CQM support staff will facilitate this process by collecting and analyzing clinical quality measure data, then report findings and progress to the CQM Committee. While QIPs are underway, the respective QI Network will also meet monthly to review progress and make modifications as necessary.

The Grantee CQM staff will ensure that subgrantee Quarterly Outcome reports are aggregated and findings are reported to both the CQM Committee and the respective QI Network. Additionally, a formal review of the CQM Plan, on a quarterly basis will become a standing item on the CQM Committee agenda. This process will help facilitate the identification of future QIPs toward the accomplishment of the annual CQM Plan. As the Grantee CQM staff has collected and analyzed Clinical Quality Performance Measures, they will report findings and recommendations to the CQM Committee and respective QI Networks.

Process to Update Annual CQM Work Plans

The Grantee CQM staff will prepare an Annual CQM Work Plans for review and comment by CQM Committee and QI Network members. The Work Plan will summarize service category-specific quality assessments, analytic reports, QIPs, training, CQM evaluation activities, TA, and other activities to be undertaken in the year. An annual CQM schedule will be included in the plan, as well as stakeholders responsible for implementation of the Work Plan's activities. Grantee CQM staff will facilitate implementation of the annual planning process by collecting and analyzing quality data, and reporting findings to the CQM Committee and QI Networks. While QIPs are underway, the respective QI Network will meet monthly to review progress and make modifications as necessary.

At least annually, just prior to the development of the next year's CQM Plan, the CQM Committee and QI Chairs will review progress made on the current year's annual CQM Work Plan and the EMA Three-Year Plan.

Communication

The Grantee CQM and support staff, and other relevant program staff will meet on a monthly basis to discuss and review progress made on the CQM Plan and QIPs. This meeting will also include a review of other relevant materials such as best practice models, literature reviews, review of ancillary reports and data, other EMA efforts, and additional material that may potentially enhance this EMA's CQM Plan.

At least two months prior to the expiration of the CQM Plan, the Grantee CQM and support staff will draft the next three-year CQM Plan and disseminate it among the HIVPC, QM Committee, QI Networks, Grantee program staff, and consumers. Advertisement of this presentation will be through fliers in subgrantees' facilities, community stakeholder organizations and email listings maintained by the CQM support staff. Through this activity, it is anticipated that all stakeholders and consumers will be informed of scheduled reviews and of the need for their input and feedback for the three-year CQM plan. Consumer input informs the entire CQM Program's stakeholders regarding the HIV service delivery system.

Appendix

Attachment 1 – CQM Work Plan

Work Plan Activity	Outcome	2014	2015	2016
1.1. Quarterly Data Reviews a) NQC In+Care Campaign Measures b) NHAS Indicators c) HAB Performance Measures d) Broward Client Level Outcomes and Indicators	• Review And Select Annual Data Measures • Identify Areas For Improvement • Provide Directives To The QI Networks			
Work Plan Activity	**Outcome**			
2.1. Review Policies And Procedures (P&P) 2.2. Review, Update & Approve 3-Year Work Plan 2.3. Review, Update And Approve Annual QM Work Plan 2.4. Review Service Delivery Models Submitted By QI Networks 2.5. Review Accomplishments And Challenges	• Updated P&P As Needed • Updated 3-Year And Annual Work Plans That Include Short-Term And Long-Term Strategies To Achieve QM Objectives • Service Delivery Models Reflect Most Current National Guidelines And Best Practices • Annual Work Plan Addresses Challenges Identified In The Previous FY			
Work Plan Activity	**Outcome**			
3.1. Quarterly Network Update	1. Identify Areas For Improvement 2. Provide Guidance And Directives To Improve Network Activities and QIPs			
Work Plan Activity	**Outcome**			
4.1. Review Findings From: a) Needs Assessment b) Client Survey c) Service Category Assessment/Studies d) Record Reviews e) Identify Service Category For Annual Evaluation	• Identify Barriers To Care • Identify Areas For Improvement In Service Delivery • Recommend Service Category Evaluation			
Work Plan Activity	**Outcome**			
5.1. Review Performance Measures And Other Data Sources To Assess Successful Linkage To Care	• Linkage To Care And Retention Deficiencies Addressed			

Attachment 2 – Performance Measurement

HAB Performance Measures[3]: Revised in November 2013 by HRSA

Core Measures

- **HIV Viral Load Suppression** - Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year
- **Prescription of HIV Antiretroviral Therapy** - Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year
- **HIV Medical Visit Frequency** - Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits
- **Gaps in Medical Visits** - Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year
- **PCP Prophylaxis** - Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis

All Ages Measures

- **CD4 Cell Count** - Percentage of patients aged six months and older with a diagnosis of HIV/AIDS, with at least two CD4 cell counts or percentages performed during the measurement year at least 3 months apart
- **HIV Drug Resistance Testing Before Initiation of Therapy** - Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year
- **Influenza Immunization** - Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
- **Lipid Screening** - Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and who had a fasting lipid panel during the measurement year
- **TB Screening** - Percentage of patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection
- **Viral Load Monitoring** - Percentage of patients, regardless of age, with a diagnosis of HIV with a viral load test performed at least every six months during the measurement year

Adolescent/Adult Measures

- **Cervical Cancer Screening** - Percentage of female patients with a diagnosis of HIV who have a Pap screening in the measurement year

[3] HIV/AIDS Bureau. The HIV/AIDS Program Home: HAB Performance Measures. http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html (Last visit date: December 2014)

- **Chlamydia Screening** – Percentage of patients with a diagnosis of HIV at risk for sexually transmitted infections (STI) who had a test for chlamydia within the measurement year
- **Gonorrhea Screening** - Percentage of patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year
- **Hepatitis B Screening** - Percentage of patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity
- **Hepatitis B Vaccination** - Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B
- **Hepatitis C Screening** - Percentage of patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV
- **HIV Risk Counseling** - Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year
- **Oral Exam** - Percent of patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year
- **Pneumococcal Vaccination** - Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine
- **Preventive Care and Screening**: **Screening for Clinical Depression and Follow-up Plan** - Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
- **Preventative Care and Screening**: **Tobacco Use: Screening and Cessation Intervention** - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
- **Substance Use Screening** - Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year
- **Syphilis Screening** - Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year

Medical Case Management Measures

- **Care Plan -** Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year
- **Gaps in HIV Medical Visits** - Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record)
- **Medical Visit Frequency -** Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits

Oral Health Measures

- **Dental and Medical History -** Percentage of HIV-infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year
- **Dental Treatment Plan** - Percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year
- **Oral Health Education** - Percentage of HIV-infected oral health patients who received oral health education at least once in the measurement year
- **Periodontal Screening or Examination** - Percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year
- **Phase 1 Treatment Plan Completion** - Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months

System-Level Measures

- **Waiting Time for Initial Access to Outpatient/Ambulatory Medical Care** - Percent of Ryan White Program-funded outpatient/ambulatory care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care
- **HIV Test Results for PLWHA** - Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year
- **HIV Positivity** - Percentage of HIV positive tests in the measurement year
- **Late HIV Diagnosis** - Percentage of patients with a diagnosis of Stage 3 HIV (AIDS) within 3 months of diagnosis of HIV
- **Linkage to HIV Medical Care** - Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis
- **Housing Status** - Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis

Client Level and System Level Outcomes and Indicators (REVISED 2013):

Outpatient/Ambulatory Medical Care (No Changes Made)

- Outcome: Slow/prevent clients HIV disease progression.
  - 1.1 - 80% of clients with CD4 <350 are prescribed HAART**.**
  - 1.2 - 70% of clients on HAART for >6 months will have a viral load<400**.**

AIDS Pharmaceutical Assistance (local)

- Outcome 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).

- Outcome 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 for follow up (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).

Oral HealthCare

- Outcome 1: Reduction in number of teeth with-untreated caries (tooth decay).
  - 1.1 - 75% of caries identified in the Phase I (Disease Control) treatment plan will be treated within 6 months.

- Outcome 2: Improved Periodontal Health.
  - 2.1 - 80% of clients will have a 50% reduction in the number of bleeding sites at the completion of the Phase I (Disease Control) Plan.

Medical Case Management

- Outcome: 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.
  - 1.2 - 80% of clients are retained in Outpatient/ Ambulatory Medical Care.

Mental Health Services

- Outcome 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.

- Outcome 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 Services Outpatient

- Outcome 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.

- Outcome 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.

Outreach Services

- Outcome: 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

- Outcome: 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.).

Legal Services

- Outcome: 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.

CIED

- Outcome 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.

- Outcome 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.

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

BRHPC
HEALTH & HUMAN SERVICE INNOVATIONS

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. *(2012-2015 Three-Year QM Work Plan).*

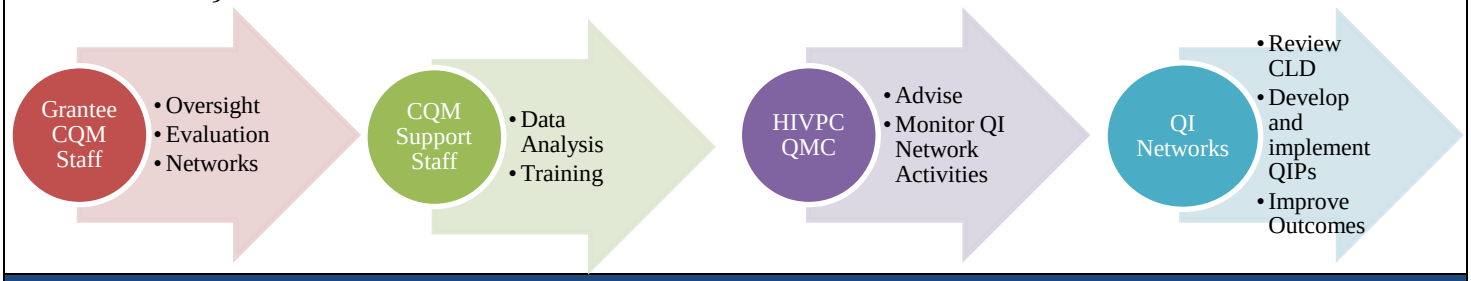
What is the Purpose of the QM Committee?

- 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, and Pharmacy along with Transportation and HOPWA representatives). *(2012-2015 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
- 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
- EIIHA – Early Identification of Individuals with HIV/AIDS
- 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.