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 Retreat
Date/Time: Monday, July 18, 2016 at 12:30 - 2:30 p.m. **Location:** Governmental Center Annex, A337
Chair: Claudette Grant **Vice Chair:** Atensia Earp

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*
2. **APPROVALS**: 7/18/16 Agenda and 3/21/16 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   Reminder: Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
4. **UNFINISHED BUSINESS**
5. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #	*Action Items*
Item #1 QM Retreat Pre-Test (10 minutes)	**ACTION ITEM:** Assess knowledge of QM Committee before training
Item #2 QM Committee Overview (30 minutes)	**ACTION ITEM:** Provide an overview of the QM Program and Committee including Objectives, Committee structure, Committee Mission/Roles, and FY 16-17 Work Plan
Item #3 Review data measures (30 minutes)	**ACTION ITEM:** Review and discuss data measures and definitions.
Item #4 Group Activity (30 minutes)	**ACTION ITEM:** Break into groups and participate in a group activity to increase understanding of data trends.
Item #5 QM Retreat Post-Test (10 minutes)	**ACTION ITEM:** Assess knowledge of QM Committee after training

6. **GRANTEE REPORTS**
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS/TASKS FOR NEXT MEETING**
   a. Next Meeting Date: August 15, 2016
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 •

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Meeting Minutes

Committee: Quality Management Committee
Date/Time: Monday, March 21, 2016 12:30 p.m. **Location:** Governmental Center Annex, A337
Chair: Claudette Grant

Attendance						
#	**Members**	**Present**	**Absent**		**Guests**	**Grantee Staff**
1	Grant, C.	**X**			Garnica, J.	Degraffenreidt, S.
2	Katz, H. B.	**X**				Morris, R.
3	Huggins, L.	**X**				
4	Runkle, D.		**E**			
5	Earp, A.	**X**				
6	Soto, T.	**X**				**Support Staff**
7	De Hoyos, F.	**X**				Holloman, K.
8	Taveras, J.	**X**				Jackson, M.
	Quorum = 5	**7**				Newton, A.

1. CALL TO ORDER:

The Chair called the meeting to order at 12:43 p.m. and welcomed all present. The Chair and Clinical Quality Management (CQM) Support Staff welcomed guests. Attendees were notified of information regarding 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 3/21/16
Proposed by: Grant, C. **Seconded by:** All
Action: Passed Unanimously

Motion #2 To approve 2/21/16 meeting minutes
Proposed by: Earp, A. **Seconded by:** Soto, T**.**
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 18, 2016

4. UNFINISHED BUSINESS:

Goal/Work Plan Objective #	*Action Items*
Quarterly Data Review (WP 1.1)	This item was tabled until the updates are completed in Provide Enterprise.

5. MEETING ACTIVITIES/NEW BUSINESS

Goal/Work Plan Objective #:	*Action Items*

Explore the three target groups for the Needs Assessment Committee (WP 1.1)	The Chair reminded the Committee that they identified three target populations at a previous meeting, Non-Hispanic Black females 18-38, Non-Hispanic Black MSM 18-38, and Non-Hispanic Black heterosexual males 18-38. Today, the Committee will review data for non-Hispanic Black males 18-38. CQM staff presented the "Drilling Down Data: Heterosexual Black Males 18-38 years old" data presentation (on file). The data includes 152 non-Hispanic Black Heterosexual male clients (43 unsuppressed, 109 suppressed) 18-38 years olds for FY 14/15 with data on retention in care, core & support service utilization, medication adherence, co-morbidities, length of diagnosis, length of time in care, insurance status, and birth place/Country of origin. A Committee member asked staff why Hispanic Black males were not included in the presentation. CQM staff stated that all populations were reviewed during the initial data review conducted in Fall 2015, and Black Hispanic males were more likely to achieve viral load suppression compared to non-Hispanic Black males in the Part A system. For unsuppressed clients, 11.6% reported their country of origin as Jamaica. The majority of clients, both suppressed and unsuppressed, report their country of origin as the United States. Clients who were suppressed were more likely to have a college education. Clients who were suppressed were slightly more likely to be permanently housed. Clients who were unsuppressed were more likely to have an AIDS diagnosis (~12%), compared to 6% of clients who were suppressed. Clients who are unsuppressed are more likely to report no HIV therapy (37.2% report not being on therapy). The majority of suppressed patients (88%) report ART as their HIV therapy. Clients who are not virally suppressed are more likely to have been diagnosed less than 1 year ago (28%) compared to 14.7% of suppressed clients. Clients who are not suppressed are more likely to report Medicaid as their primary insurance type, and clients who are suppressed are more likely to report Ryan White as their primary insurance type. The unsuppressed black males are more likely to be new to care, and those who are suppressed are more likely to be in care for over one year. Unsuppressed clients, regardless of insurance type, are less likely to be retained in care (14%) compared to 61% of suppressed clients beings retained in care. Retention in medical care is slightly higher for Part A clients. However, only 39% of those not suppressed were retained in care compared to 78% of suppressed clients. Part A OAMC utilization was slightly higher for suppressed clients than unsuppressed clients (73.4% compared to 65.1%). Food services utilization was slightly higher for suppressed clients (24.4%) compared to unsuppressed clients (18.6%) who utilize food services. Oral health services utilization was also higher for suppressed clients (28.4%) than unsuppressed clients (9.3%). Mental health and substance abuse services are underutilized in the Part A system. Only 4.6% of suppressed clients utilize mental health services. Only 1.8% of suppressed clients utilize substance abuse services. Staff asked the Committee members if they had any questions or comments about the presentation. A Committee member had a comment about the literacy level data, and stated it was hard to find this information useful

	because it is self-reported. Perhaps a standardized test to determine the literacy level of a client would be more beneficial. The Committee member also asked if HIV stage is self-reported or based on labs. Staff stated that the HIV stage information is not based on labs, but on an assessment of the client and self-report. The Committee member stated that the HIV stage should be documented in eHARS and that information is easily accessible. The Grantee representative stated that the integrative workgroup is working on sharing data from eHARS to determine HIV stage, HIV therapy, where clients were tested, etc. A guest commended the Committee for using a data intensive approach. He stated that he has been to various Planning Council meetings in other EMAs, and they are not looking at data at this level. The guest was interested in knowing where patients are dropping off in regards to the HIV Care Continuum. The Grantee representative stated that the Ryan White Part A System in Broward has a System of Care Committee (SOC) and they work specifically on the HIV Care Continuum. She suggested he attend those meetings if interested. A committee member suggested integrating a mental health screening with centralized intake and eligibility determination (CIED) to determine any symptoms of mental health and/or substance abuse at certification. The information collected could flag potential clients with mental health issues, and a comparison could be made: how many clients need the service, how many clients are eligible, and how many eligible clients access that service. The Grantee representative stated that clients are aware of how to access mental health services and providers make referrals, but retaining clients in mental health is difficult. A committee member asked how many psychiatrists in Broward County accept Ryan White, because to his knowledge, there is only one, and in his experience, it is very difficult to get mental health services in Broward. The Grantee representative stated that there is an Access to Care Schedule that has all of the agencies in Broward County funded by Ryan White along with all of the services that they offer. The Committee member was also interested in knowing the cultural background of the mental health providers, because it is difficult for his clients to relate to providers of other races or cultures. The Grantee representative stated that their office requires that all Part A providers undergo cultural competency trainings. One member had a question about retention and mental health. The Committee member wanted to know if there is there any flexibility in regards to a client coming to one appointment versus a client that comes to five appointments. The Grantee representative stated that their office has data that tracks a client's length of treatment; however, there are not a specific number of time visits that clients must attend because it is individualized. The Grantee representatives stated that mental health providers set goals and care plans similar to case management clients. The Committee member was trying to determine if the number of visits for mental health services had something to do with retention in the service. The Grantee representative stated that there is not a definition of retention in mental health. A member stated that at his agency there is a lot of flexibility in terms of number of sessions. The agency tries to keep it aligned with 26 sessions within a calendar year, however if there is a need for extension that can be arranged.

	One member asked if there was a relationship between mental health, substance abuse, and viral load suppression. Another stated that there is a documented evidence in the literature of the relationship, but with the Part A data will not reflect that relationship. The Committee members agreed that if better data were collected in terms of mental health issues at the initial CIED intake, the correlation between mental health, substance abuse, and viral load suppression would be stronger. A member stated that research has shown that mental health and substance abuse diagnoses have worse treatment outcomes whether it be due to medication adherence or retention in care. The guest stated that until clients are retained in primary HIV care they would not attend mental health services. The Grantee representative informed the Committee that many mental health providers are moving toward trauma informed care, and treating the trauma first before dealing with HIV. A Committee member was interested in knowing if clients are more likely to be virally suppressed the longer they are diagnose or if there is a point when medication fatigue occurs. She stated that there may be a learning curve that once a client is retained in care for so many years they are more likely to be virally suppressed, so the focus may need to be directed to clients who are recently diagnosed. A member stated that he noticed in the data presentation that there is a high number of clients with non-permanent housing due to the housing issue in Broward. The member stated that he believes non-permanent housing is just as important as mental health and substance abuse, because without a stable housing, clients cannot take their medications properly. The Committee wants to know what can be done to improve the housing problem in Broward County. The Grantee representative stated that the Ryan White system is integrated with HOPWA, and there is data sharing between the two programs. HOPWA recently hired a quality management employee, and she has been invited to attend the QMC meetings in the future. Staff informed the Committee that findings and recommendations from the data analysis will be sent to PSRA and the Needs Assessment consultant.
Case Management QI Network Update (WP 3.1)	CQM Staff informed the Committee that each of the service categories in the Part A system have a Quality Improvement (QI) Network that meets regularly. Within the Network meetings, they plan Quality Improvement Projects (QIP) and review data. The Case Management (CM) QI Network worked on a project to identify barriers to care for black females. Staff presented the findings from the Barriers to Care Quality Improvement Project that the CM QI Network has been working on for several months, which included 60 unsuppressed Black females that utilized Part A case management services. Staff informed the Committee that the CM Network reviewed FY 14-15 viral load suppression data for case management clients. The CM Network identified that Black females had low rates of viral load suppression and wanted to identify the barriers to care and viral suppression for them. The Network used a modified version of the Barriers to Care scale to collect data for unsuppressed Black females. The top barriers to care reported were lack of personal finances, mental health issues, lack of transportation, and lack of affordable housing. Staff

	informed the Committee that case managers reported that patients view taking medications as an option not a necessity, and living with family members is also a barrier to staying adherent to medication. In this small project, almost 50% of clients had mental health issues, but only 1-2% of black females utilize mental health services. One member reminded the Committee of the importance of focusing on females because females are the center of their families, and when women are healthy and strong, the whole family is strong.
Review accomplishments and challenges. (WP 2.3)	Staff presented the accomplishments and challenges for QMC in FY 2015. The committee accomplished a significant review of data on populations with low rates of viral suppression. The limitations of the qualitative data present a challenge to determining why certain populations are not achieving viral suppression. Staff thanked the members for their dedication to the committee this past year.
Review and update Work Plan and Policies & Procedures (WP 2.4)	This item will be discussed during the retreat next month.

6. GRANTEE REPORTS

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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.*
QM Committee Retreat	**ACTION ITEM:** Review QM objectives, QM Committee mission/roles, PDSA process, and data measures.

9. ANNOUNCEMENTS

None.

10. ADJOURNMENT

The meeting was adjourned at 2:10 pm.

ASSESSMENT OF QUALITY MANAGEMENT KNOWLEDGE

Name: _____ PRE TEST

1. The responsibilities of the QM committee include (*circle all that apply*):
    a) Collaborate with the Grantee Staff to develop/revise committee policies and procedures consistent with other HIVPC committees
    b) Participate in developing the annual work plan to achieve the three-year QM plan
    c) Provide direct services to consumers
    d) Identify, prioritize, and implement quality improvement projects (QIPs)

2. QM Committee members are expected to:
    a) Comply with the HIVPC attendance policy
    b) Be respectful
    c) Provide input
    d) All of the above

3. QI Networks are comprised of subgrantees representing all locally funded Ryan White Part A service categories.
    - True_____ False_____

4. Client-level data components are not necessary for CQM data analysis reviews.
    - True_____ False_____

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

6. As a recipient of federal funding, In+Care Campaign reports are required by the U.S. Department of Health & Human Services.
    a) True_____ False_____

7. There are six standing committees under the HIV Planning Council.
    a) True_____ False_____

8. A consumer is considered virally suppressed if their viral load measures:
    a) </=100,000
    b) >200 and <100,000
    c) >500
    d) >50 and </=200

9. Provider Enterprise (PE) reports include:
    a) Eligibility information
    b) Bus passes
    c) Viral load analysis
    d) All of the above

10. Match the word with the best description
    - Gap measure
    - Viral Load report
    - Service delivery models
    - HAB Measures
    - QI Networks

    A. Measures recommended by HRSA for monitoring core measures, case management measures, and oral health measures.
    B. A service category specific, set of protocols, definitions, standards and indicators to guide the delivery of services.
    C. Percentage of patients who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year.
    D. Report that includes demographic information such as gender, race, ethnicity, age, etc.
    E. Service category 'subcommittees' that are made up of providers and consumers and charged with identifying and addressing service category barriers to care by developing and implementing QIP's. Activities are overseen by the Grantee and the QM Committee.

FY 2016-17 Quality Management Committee Work Plan

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

GOAL: Monitor, evaluate, and ensure the quality and appropiateness of HIV care and services meets or exceeds HAB's expectations and performance measures.

Objective 1: Select Data For Review & Analyze Performance Measures

Activities	Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
1.1 Select annual measures and data for tracking and evaluation.	Staff, QMC	Identify measures for review	Select data for review including HAB Performance Measures, Broward Client Level Outcomes and Indicators, NQC In+Care Measures, NHAS Indicators.		X										
1.2 Review and analyze annual measures and data quarterly. Send recommended areas for exploration to NAE, SOC, PSRA, and QI Networks.	QMC	Identify trends and areas for improvement for exploration related to linkage to care, retention in care, or viral load suppression	Review data including HAB Performance Measures, Broward Client Level Outcomes and Indicators, NQC In+Care Measures, NHAS Indicators.			X			X			X			X
1.3 Provide data and information to the PSRA Committee to assist in the PSRA process.	Staff/QMC	Improved PSRA process	Submit data summary reports as needed and annual service category scorecards to PSRA.					X							

Objective 2: Conduct Annual Evaluation of QM Program, Work Plans, and Processes

Activities	Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2.1 Review and approve Service Delivery Models and Broward Client-level Outcomes as needed.	QMC	Updated service delivery models	Review and approve revisions to Service Delivery Models and Broward Outcomes as submitted by QI Networks. Submit recommendations to HIVPC.										X		
2.2 Conduct annual evaluation to assess QMC and recommend improvements.	Staff/QMC	Improved Process	Identify QMC accomplishments and challenges. Identify areas for improvement for the upcoming year.	X											
2.3 Review and update QMC Work Plan and Policies & Procedures.	Staff/QMC	Updated planning documents	Review and update QMC Work Plan and Policies and Procedures. Submit recommendations to HIVPC.	X											
2.4 Review and update 3 year CQM Plan.	Staff/QMC	Approve and update 3 Year CQM Plan	Review and update 3 year CQM Plan. Submit recommendations to HIVPC.				X						X		

Objective 3: Monitor QI Network Activities & Provide Directives and Guidance in QIP Development

Activities	Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
3.1 Conduct quarterly Network update.	Staff/QMC	Identify trends and areas for improvement	Identify areas for improvement and recommend potential QIPs.	X			X			X			X		

Objective 4: Review & Analyze Findings from Needs Assessment, Service Category Studies, & Record Reviews

Activities	Responsible Party	Outcomes	Action Items/Data Prep	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
4.1 Review and analyze service category assessments and studies.	QMC	Identify barriers to care and areas for improvement in service delivery	Identify service delivery deficiencies and assess whether QIPS are necessary based on findings.				X								
4.2 Evaluate and assess data and results from needs assessment including focus groups and surveys.	QMC	Identify barriers to care and areas for improvement in service delivery	Identify service delivery deficiencies and assess whether QIPS are necessary based on findings.						X						

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).*

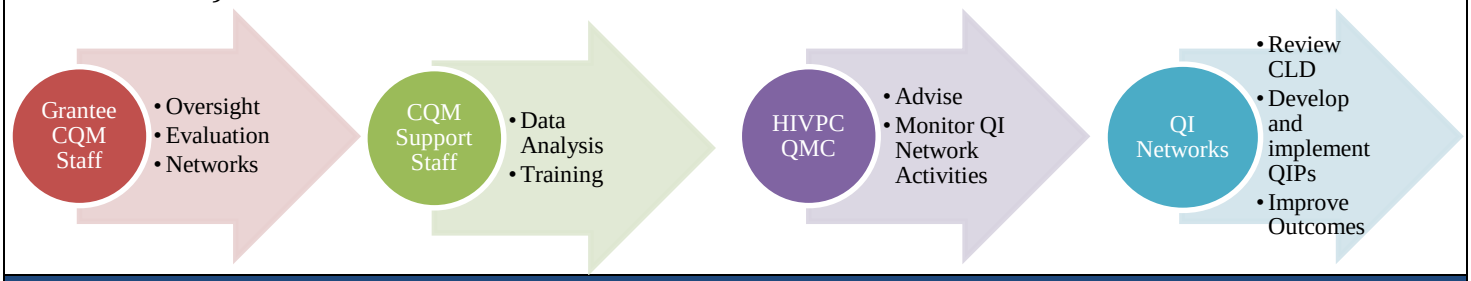
What is the Purpose of the QM Committee?

- 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
- PE – Provide Enterprise
- 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.

Provide Enterprise (PE)

The Part A data system used to capture client, agency, and system-level information for monitoring and billing purposes.

The CQM program extracts data from PE to assess level of care, performance measures, and health outcomes.

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.

QUALITY MANAGEMENT COMMITTEE
Policies and Procedures

Purpose

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

Policy

The Quality Management (QM) Committee shall ensure that 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.

Annual Work Plan Goals

- Develop 3-Year QM Plan
- Review & Analyze Annual Measures and Chart Review Data
- Review & Assess Client-Level Data
- Provide Quality Assurance and Quality Improvement Training to All Stakeholders
- Review and Implement QM Committee Policies and Procedures
- Approve Service Delivery Model Modifications
- Evaluate Client Survey from Needs Assessment
- Apply QM methods to identify areas of improvement and modify processes to support EIIHA Strategy
- Conduct Annual QM Plan Evaluation
- Participate in the development of the Clinical Quality Management section of the Ryan White Grant Application

Procedures

QM Committee functions as a committee of the Broward County EMA HIV Planning Council. The QM Committee is chaired by a HIV Planning Council Member.

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 data sources.

The QM Committee maintains oversight of Standards of Care within Service Delivery Models including:

a. Application of Best Practice Models
b. Review of Standards of Care
c. Recommend changes to Standards of Care to:
    i. Conform to best practice models
    ii. Support achievement of client and system outcomes
    iii. Respond to emerging client needs
d. Direct QI Networks to make specific service protocol modifications to support recommended changes to standards of care

i. Approve the need for program and/or population evaluation studies
ii. Develop and/or approve the Scopes of Service for program and/or population evaluation studies
iii. Identify and recommend opportunities to improve Client satisfaction

GROUP 2 – DATASET 2: MEDICAL VIRAL LOAD ANALYSIS

FY 15-16 Medical Viral Load Analysis							
	Not Suppressed		**Suppressed**		**Unknown**		**Total**
TOTAL	**651**	**17%**	**3,083**	**82%**	**29**	**1%**	**3,763**
Female	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black	153	20.3%	591	78.5%	9	1.2%	753
White*	18	21.4%	66	78.6%	0	0.0%	84
Hispanic	23	19.7%	94	80.3%	0	0.0%	117
Other*	0	0.0%	5	100.0%	0	0.0%	5
Female Total	**194**	**20.2%**	**756**	**78.8%**	**9**	**0.9%**	**959**
Male	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black	231	19.7%	934	79.6%	9	0.8%	1,174
White	137	15.9%	718	83.5%	5	0.6%	860
Hispanic	73	10.4%	623	88.7%	6	0.9%	702
Other*	4	13.3%	26	86.7%	0	0.0%	30
Male Total	**445**	**16.1%**	**2,301**	**83.2%**	**20**	**0.7%**	**2,766**
Transgender	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black*	8	34.8%	15	65.2%	0	0.0%	23
White*	2	33.3%	4	66.7%	0	0.0%	6
Hispanic*	2	28.6%	5	71.4%	0	0.0%	7
Other*	0	0.0%	2	100.0%	0	0.0%	2
Transgender Total*	**12**	**31.6%**	**26**	**68.4%**	**0**	**0.0%**	**38**
Age Categories	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
18-28	99	27.3%	259	71.5%	4	1.1%	362
29-38	173	21.9%	609	77.0%	9	1.1%	791
39-48	180	17.9%	815	81.1%	10	1.0%	1,005
49-58	160	13.1%	1,052	86.4%	6	0.5%	1,218
59 years of age or older	39	10.1%	348	89.9%	0	0.0%	387
Sexual Orientation	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Bisexual	41	17.6%	187	80.3%	5	2.1%	233
Heterosexual	332	18.4%	1,455	80.7%	16	0.9%	1,803
Homosexual	266	15.7%	1,419	83.8%	8	0.5%	1,693
Lesbian*	4	33.3%	8	66.7%	0	0.0%	12
Unknown*	8	36.4%	14	63.6%	0	0.0%	22
Living Arrangement	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Institution*	3	15.0%	17	85.0%	0	0.0%	20
Non-permanently housed	243	21.8%	861	77.3%	10	0.9%	1,114
Permanently housed	385	15.1%	2,147	84.2%	19	0.7%	2,551
Unknown/unreported	20	25.6%	58	74.4%	0	0.0%	78
Literacy	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Level 0 - Illiterate*	3	15.8%	15	78.9%	1	5.3%	19
Level 1 - 4th Grade or below*	9	18.4%	40	81.6%	0	0.0%	49
Level 2 - 5th to 8th Grade	32	13.6%	203	86.4%	0	0.0%	235
Level 3 - 9th to 12th Grade	299	17.5%	1,392	81.6%	14	0.8%	1,705
Level 4 - Above 12th Grade	308	17.5%	1,433	81.7%	14	0.8%	1,755

GROUP 2 – DATASET 2: MEDICAL VIRAL LOAD ANALYSIS

Education Level	Not Suppressed		Suppressed		Unknown		Total
8th Grade or Less	36	15.2%	200	84.4%	1	0.4%	237
Between 8th-12th Grade	402	18.2%	1,790	81.0%	17	0.8%	2,209
College	213	16.2%	1,093	83.0%	11	0.8%	1,317
HIV Risk Factor	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Hetero	300	17.8%	1,371	81.4%	14	0.8%	1,685
Black Hetero	260	19.2%	1,082	79.9%	12	0.9%	1,354
White Hetero	41	12.7%	281	87.0%	1	0.3%	323
Hispanic Hetero	28	13.2%	183	86.3%	1	0.5%	212
MSM	302	16.1%	1,562	83.2%	13	0.7%	1,877
Black MSM	114	21.0%	424	78.2%	4	0.7%	542
White MSM	188	14.3%	1,118	85.0%	9	0.7%	1,315
Hispanic MSM	64	11.1%	507	88.2%	4	0.7%	575
Hemophilia*	0	0.0%	4	100.0%	0	0.0%	4
IDU*	9	16.7%	45	83.3%	0	0.0%	54
Mother*	16	43.2%	19	51.4%	2	5.4%	37
MSM/IDU*	6	23.1%	20	76.9%	0	0.0%	26
Transfusion*	0	0.0%	13	100.0%	0	0.0%	13
Unknown/unreported*	13	26.5%	36	73.5%	0	0.0%	49
HIV Stage	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
AIDS	60	21.4%	219	78.2%	1	0.4%	280
AIDS Status Unknown	151	16.7%	743	82.3%	9	1.0%	903
HIV Positive Not AIDS	440	17.1%	2,121	82.2%	19	0.7%	2,580
HIV Therapy	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Dual	11	9.5%	104	89.7%	1	0.9%	116
HAART	444	13.9%	2,724	85.4%	22	0.7%	3,190
None	186	49.3%	186	49.3%	5	1.3%	377
Single*	7	9.9%	63	88.7%	1	1.4%	71
Unknown*	3	33.3%	6	66.7%	0	0.0%	9

Not Suppressed VL: Viral Load is > 200

Suppressed VL: Viral Load ≤ 200

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

GROUP 1 – DATASET 1: SYSTEMWIDE VIRAL LOAD ANALYSIS

FY 15-16 System-wide Viral Load Analysis

	Not Suppressed		Suppressed		Unknown		Total
TOTAL	**1,181**	**16%**	**6,130**	**83%**	**87**	**1%**	**7,398**
Female	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black	328	20.0%	1,292	78.6%	23	1.4%	1,643
White	40	19.0%	169	80.1%	2	0.9%	211
Hispanic	34	17.5%	156	80.4%	4	2.1%	194
Other*	1	10.0%	9	90.0%	0	0.0%	10
Female Total	**403**	**19.6%**	**1,626**	**79.0%**	**29**	**1.4%**	**2,058**
Male	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black	421	19.5%	1,717	79.5%	22	1.0%	2,160
White	227	11.5%	1,727	87.5%	20	1.0%	1,974
Hispanic	108	9.9%	969	88.7%	16	1.5%	1,093
Other*	6	10.0%	54	90.0%	0	0.0%	60
Male Total	**762**	**14.4%**	**4,467**	**84.5%**	**58**	**1.1%**	**5,287**
Transgender	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black*	12	34.3%	23	65.7%	0	0.0%	35
White*	2	25.0%	6	75.0%	0	0.0%	8
Hispanic*	2	25.0%	6	75.0%	0	0.0%	8
Other*	0	0.0%	2	100.0%	0	0.0%	2
Transgender Total*	**16**	**30.2%**	**37**	**69.8%**	**0**	**0.0%**	**53**
Age Categories	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
18-28	152	30.3%	343	68.3%	7	1.4%	502
29-38	269	23.5%	863	75.2%	15	1.3%	1,147
39-48	295	17.6%	1,363	81.3%	18	1.1%	1,676
49-58	344	12.8%	2,313	85.9%	35	1.3%	2,692
59 years of age or older	121	8.8%	1,248	90.4%	12	0.9%	1,381
Sexual Orientation	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Bisexual	71	18.0%	317	80.5%	6	1.5%	394
Heterosexual	673	18.1%	2,989	80.5%	49	1.3%	3,711
Homosexual	416	12.9%	2,774	86.1%	31	1.0%	3,221
Lesbian*	5	22.7%	16	72.7%	1	4.5%	22
Unknown*	16	32.0%	34	68.0%	0	0.0%	50
Living Arrangement	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Institution*	9	17.3%	43	82.7%	0	0.0%	52
Non-permanently housed	392	22.8%	1,305	76.0%	20	1.2%	1,717
Permanently housed	747	13.7%	4,655	85.1%	66	1.2%	5,468
Unknown/unreported	33	20.5%	127	78.9%	1	0.6%	161
Literacy	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Level 0 - Illiterate*	4	14.3%	22	78.6%	2	7.1%	28
Level 1 - 4th Grade or below	17	20.7%	65	79.3%	0	0.0%	82
Level 2 - 5th to 8th Grade	78	16.4%	398	83.4%	1	0.2%	477
Level 3 - 9th to 12th Grade	585	17.5%	2,716	81.2%	44	1.3%	3,345
Level 4 - Above 12th Grade	497	14.4%	2,924	84.5%	40	1.2%	3,461

GROUP 1 – DATASET 1: SYSTEMWIDE VIRAL LOAD ANALYSIS

Education Level	Not Suppressed		Suppressed		Unknown		Total
8th Grade or Less	82	18.2%	366	81.2%	3	0.7%	451
Between 8th-12th Grade	757	17.4%	3,534	81.4%	50	1.2%	4,341
College	342	13.1%	2,228	85.6%	34	1.3%	2,604
HIV Risk Factor	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Hetero	613	18.0%	2,760	80.9%	40	1.2%	3,413
Black Hetero	532	19.3%	2,200	79.6%	31	1.1%	2,763
White Hetero	77	12.1%	549	86.5%	9	1.4%	635
Hispanic Hetero	42	11.7%	310	86.4%	7	1.9%	359
MSM	474	13.4%	3,024	85.6%	36	1.0%	3,534
Black MSM	175	19.7%	706	79.6%	6	0.7%	887
White MSM	296	11.4%	2,263	87.4%	29	1.1%	2,588
Hispanic MSM	92	10.6%	763	88.1%	11	1.3%	866
Hemophilia*	2	13.3%	13	86.7%	0	0.0%	15
IDU	21	14.3%	122	83.0%	4	2.7%	147
Mother*	27	37.5%	42	58.3%	3	4.2%	72
MSM/IDU*	10	20.8%	38	79.2%	0	0.0%	48
Transfusion*	2	5.6%	31	86.1%	3	8.3%	36
Unknown/unreported	25	24.0%	78	75.0%	1	1.0%	104
HIV Stage	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
AIDS	148	16.6%	732	82.2%	10	1.1%	890
AIDS Status Unknown	284	17.3%	1,332	81.4%	21	1.3%	1,637
HIV Positive Not AIDS	749	15.4%	4,066	83.5%	56	1.1%	4,871
HIV Therapy	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Dual	26	10.6%	218	88.6%	2	0.8%	246
HAART	854	13.3%	5,512	85.6%	70	1.1%	6,436
None	276	49.3%	272	48.6%	12	2.1%	560
Single	15	12.1%	107	86.3%	2	1.6%	124
Unknown*	12	35.3%	21	61.8%	1	2.9%	34

Not Suppressed VL: Viral Load is > 200

Suppressed VL: Viral Load ≤ 200

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

ASSESSMENT OF QUALITY MANAGEMENT KNOWLEDGE

Name: _____ POST TEST

1. The responsibilities of the QM committee include (*circle all that apply*):
    a) Collaborate with the Grantee Staff to develop/revise committee policies and procedures consistent with other HIVPC committees
    b) Participate in developing the annual work plan to achieve the three-year QM plan
    c) Provide direct services to consumers
    d) Identify, prioritize, and implement quality improvement projects (QIPs)

2. QM Committee members are expected to:
    a) Comply with the HIVPC attendance policy
    b) Be respectful
    c) Provide input
    d) All of the above

3. QI Networks are comprised of subgrantees representing all locally funded Ryan White Part A service categories.
    - True_____ False_____

4. Client-level data components are not necessary for CQM data analysis reviews.
    - True_____ False_____

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

6. As a recipient of federal funding, In+Care Campaign reports are required by the U.S. Department of Health & Human Services.
    a) True_____ False_____

7. There are six standing committees under the HIV Planning Council.
    a) True_____ False_____

8. A consumer is considered virally suppressed if their viral load measures:
    a) </=100,000
    b) >200 and <100,000
    c) >500
    d) >50 and </=200

9. Provider Enterprise (PE) reports include:
    a) Eligibility information
    b) Bus passes
    c) Viral load analysis
    d) All of the above

10. Match the word with the best description
    - Gap measure
    - Viral Load report
    - Service delivery models
    - HAB Measures
    - QI Networks

    A. Measures recommended by HRSA for monitoring core measures, case management measures, and oral health measures.
    B. A service category specific, set of protocols, definitions, standards and indicators to guide the delivery of services.
    C. Percentage of patients who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year.
    D. Report that includes demographic information such as gender, race, ethnicity, age, etc.
    E. Service category 'subcommittees' that are made up of providers and consumers and charged with identifying and addressing service category barriers to care by developing and implementing QIP's. Activities are overseen by the Grantee and the QM Committee.