HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION
115 S Andrews Avenue, Room A360 • Fort Lauderdale, Florida 33301 • 954-357-8647 • FAX 954-357-8204

QUALITY NETWORK MEETING

Date: March 28th, 2018 – 9:30-11:30AM
Location: Ryan White Part A Program Office
115 S. Andrews Ave., GC-302
Ft. Lauderdale, FL 33301

Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1219

AGENDA

I. Call to Order

II. Welcome/Introductions
Icebreaker

III. Ryan White Part A Clinical Quality Management Overview and Network Meeting Expectations
Review of HRSA/HAB and Broward Part A CQM Program requirements and staff roles, CQM workplan, Network meeting layout and expectations

IV. Open Discussion

V. Adjournment

Next Meeting Date: June 27, 2018 @ 9:30AM

Governmental Garage Parking Validation: _____

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QUALITY NETWORK
Wednesday March 28th, 2018 at 9:30 A.M.
Ryan White Part A Program Office – GC-302
115 S. Andrews Ave., Ft. Lauderdale 33301

MINUTES

PROVIDERS PRESENT
Poverello- Brad Barnes
Legal Aid- Kara Schickowski
AHF- Amy Pinter
Broward House- Stephanie Miller
BRHPC- Vanessa Sooknanan
Care Resource- Nichole Roberts
Care Resource- Angelica Molina
Latinos Salud- Jose Javier
NBHD- Roxan Simpson
SBHD- Valery Moreno
SunServe- Gary Hensley
NSU- Jorge Golas
NSU- Katie Mooney
FLDOH- Jane Carter
FLDOH- Jose Fernandez

PROVIDERS ABSENT
BCFHC

PART A RECIPIENT STAFF
Walker, N.
Morris, R.
Jones, L.

CLINICAL QUALITY MANAGEMENT (CQM) SUPPORT STAFF
Holloman, K.
Powers, C.

I. Welcome/Introductions

CQM Staff welcomed everyone and individual introductions were made.

II. Icebreaker

Staff facilitated an icebreaker titled "Chain Stories" with meeting participants. Meeting participants divided themselves into four groups and began the icebreaker by sharing a fun fact about themselves with their group. The following participants picked one part of the story previously told and continued with a story sharing the same similar story piece. As they went through, the group formed a story chain and presented their connecting stories with the full group. Upon completing the icebreaker, participants agreed they feel more comfortable with their peers and in sharing in discussion with them in future Quality Network meetings.

III. Ryan White Part A Clinical Quality Management Overview and Network Meeting Expectations

CQM Staff gave a presentation of an overview of the CQM Program. The presentation went over the CQM Plan and program goals, the roles of the Quality Assurance and Quality Improvement teams, and the Quality Management Committee and Networks. The presentation went on to discuss the data responsibilities of Part A agencies, the CQM work plan, and the core medical and support services. Finally, the presentation discussed an overview of the structure of the Network meetings and participants agreed to arrive prepared to network meetings and engage in discussion in order to help improve the quality of Broward's Part A services.

IV. Open Discussion

An attendee mentioned issues aggregating data between RW, MMA, and private insurance clients to review data and implement QIPs. Recipient Staff suggested speaking with their superior to get a better understanding. Another attendee suggested merging the SDM Standards of Care to their EMR and also identifying RW clients within their EMR system. They also suggested pulling reports and data on ICD billing codes. Additionally, they noted their system is able to apply specific changes within the EMR based on departments.

V. Adjournment

The meeting was adjourned at 11:28am.

Next Meeting Date: June 27th, 2018 @ 9:30AM

BROWARD COUNTY CLINICAL QUALITY MANAGEMENT PROGRAM

Overview of the Ryan White HIV/AIDS Program Part A system and services

RYAN WHITE PART A CLINICAL QUALITY MANAGEMENT (CQM) PROGRAM

- Ryan White HIV/AIDS Program legislation requires all Ryan White Part A Recipients to establish Clinical Quality Management (CQM) programs to:
  - assess the extent to which HIV health services are consistent with the most recent **HHS Clinical Guidelines for the Treatment of HIV/AIDS and related opportunistic infections**, and
  - develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services.

- HAB has identified three necessary components of a comprehensive CQM program.
  1. Infrastructure
  2. Performance measurement, and
  3. Quality improvement
  - Broward **Eligible Metropolitan Area (EMA)** CQM Program expectations are written in the CQM Plan

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RYAN WHITE PART A
CLINICAL QUALITY MANAGEMENT (CQM) PLAN

Fort Lauderdale/Broward County EMA

The **mission** of the CQM program in the Fort Lauderdale/Broward County EMA is to ensure equitable access to a seamless system of high-quality comprehensive HIV services that improve health outcomes and eliminate health disparities for people living with HIV/AIDS in Broward County.

CQM PLAN: PROGRAM GOALS

1. Use client-level demographic, clinical, and utilization data to identify disparities in care and areas of improvement.
2. Evaluate the CQM program, including the CQM Plan and service categories.
3. Implement continuous quality improvement to ensure core and support services are linked to increase access to care, retention in care, and viral load suppression.
4. Communicate CQM data, evaluation, and improvement methods to the QMC, Networks, and stakeholders.

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CQM PLAN: TEAM ROLES

Quality Assurance Team (Recipient Staff)

- Oversight of Implementation of CQM Plan and QI initiatives
- Monitor and analyze client- and system-level data
- Conduct monitoring activities

Quality Improvement Team (BRHPC Staff)

- Assist with implementation of CQM Plan
- Implement & plan QI initiatives for all Part A service providers (systemwide or service category-specific)
- Review client- and system-level data
- Planning and facilitation of QMC and Networks

Quality Management Committee

- Made up of HIV Planning Council members, consumers, and HIV service providers
- Ensure completion of the CQM Work Plan
- Review client and system level data
- Coordinate Networks activities

Networks (Agency Representatives)

- Made of up subrecipients from each service category
- Meet to discuss service delivery challenges and solutions
- Develop and implement QIPs
    1. Support Services (Non-MCM, CIED, Food, Legal)
    2. Oral Health
    3. Medical/DCM
    4. Behavioral Health
    5. Quality

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CQM PLAN: QUALITY ASSURANCE & QUALITY IMPROVEMENT

Quality **Assurance** ⟷ COMPLEMENTARY ⟷ Quality **Improvement**

- An effort to find and overcome problems with quality
- Measures compliance against certain necessary standards
- Focused on the outcome
- Based on standards

- A proactive approach to improve processes and systems
- Continual improvement
- Processes, not people, are the focus of improvement
- Based on facts, data, and specifications

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CQM PLAN: PROCESSES AND ACTIVITIES

Broward EMA CQM Annual Work Plan FY 2018 (March 1, 2018-Febuary 28, 2019)													
Goals and Objectives	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Responsible**
Goal 1: Use client-level demographic, clinical, and utilization data to identify disparities in care and areas of improvement.													
1. Select performance measures and annual goals.		X											CQM Staff, QMC
2. Review and analyze performance measures including HAB measures and locally adopted outcomes and indicators.		X			X			X			X		CQM Staff, QMC, Quality Network
3. Analyze client utilization data to identify and address disparities and gaps among stages of the HIV Care Continuum.			X			X			X			X	CQM Staff, QMC, Quality Network
4. Make recommendations to Committees and Networks to address disparities in care and areas of improvement.													QMC
Goal 2: Evaluate the CQM program, including the CQM Plan and service categories.													
1. Conduct evaluation of performance measures including HAB measures, client utilization data, and locally adopted outcomes and indicators annually to the QMC and Networks.												X	CQM Staff
2. Perform annual monitoring of subrecipients and review agency-specific quality plans to ensure compliance with directives established in contract with Recipient.					X								Recipient CQM Staff
3. Identify accomplishments and challenges by reviewing progress in completing the CQM Annual Work Plan.						X						X	CQM Staff, QMC, Networks
4. Provide a quarterly Network update to the QMC and identify areas for improvement and potential QIPs.	X			X			X			X			HIVPC CQM Staff
Goal 3: Implement continuous quality improvement to ensure core and support services are linked to increased access to care, retention in care, and viral load suppression.													
1. Review SDMs annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.										X			QMC, Networks
2. Organize/conduct quarterly trainings for subrecipients, the QMC, and the HIVPC to expand knowledge and skills on QI Processes.		X			X			X			X		All CQM Staff
3. Provide and facilitate systemwide and individual TA to subrecipients monthly.	X	X	X	X	X	X	X	X	X	X	X	X	Recipient CQM Staff
4. Conduct annual review of findings from needs assessment, client survey, service category assessments, and client-level data to identify potential QIPs.							X						Networks
5. Networks implement and evaluate two QIPs in the fiscal year.						X						X	Networks

CQM Annual Work Plan: Timeline of objectives to accomplish the CQM goals.

- All objectives are assigned to Recipient CQM Staff, HIVPC CQM Staff, the QMC, and/or the Quality Networks.

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BROWARD'S PART A SERVICES

- Available services

PART A SERVICES: CORE MEDICAL

- **Integrated Primary Care & Behavioral Health (OAMC):** Diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting.
- **Oral Health Care:** Services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.
- **Mental Health:** The provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services by psychiatrists, psychologists, and licensed clinical social workers.
- **Substance Abuse:** The provision of outpatient services for the treatment of drug or alcohol use disorders.
- **Disease (Medical) Case Management:** The provision of a range of client-centered activities, including all types of case management encounters, focused on improving health outcomes in support of the HIV care continuum.
- **Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HICP):** Provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

PART A SERVICES: SUPPORT

- **Emergency Financial Assistance:** Provides limited one-time or short-term payments (direct payment to an agency or through a voucher program) to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication.
- **Food Bank:** The provision of actual food items, hot meals, or a voucher program to purchase food.
- **Legal Services:** Provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease.
- **Non-Medical Case Management:** Provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services.
  - **Centralized Intake & Eligibility Determination (CIED):** A single entry point for eligible Broward County residents to determine eligibility and access to Ryan White Part A services and/or other benefits provided by third party payers including private, federal, state and local funding programs.
  - **Benefits Support Services (BSS):** delivers information to clients about their health insurance coverage such as how they can navigate and utilize insurance effectively to achieve better health outcomes.

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PART A SERVICES: RESOURCES

Access to Care Schedule

- Comprehensive list of all Broward Part A service providers **exclusive to service providers**
  - Created by the Recipient
  - Disseminated by Staff to all Providers
- Contact information
  - Phone
  - E-mail
  - Address
  - Hours of Operation

Ryan White Part A Program Office
Access To Care Schedule
February 2018

Provider Name	Services Categories	Office Locations	Contact Name	Contact Information	Fax Number	Preferred Contact Method	Treatment Languages Available	Client Wait Time	Additional Notes
AIDS Health Care Foundation	Medical	NPH	George Butchko	(954) 772-2411 Ext. 3617	(954) 761-2231			1st Clinical Encounter 45 minutes minimum intake appt with goal of being seen within 3 days of contact	
	Medical	AHF Ft. Lauderdale Downtown	Dan Sheridan	(954) 767-0887					
	Medical	OPK	Barbara Santamaria	(954) 561-6900					
	Medical		Patrick Nuss	(954) 767-0887 Ext. 2558				16 to 30 min appt and seen the same day or next day. Triaged by Nurse and sees the medical provider as applicable.	Emergency (Non ER Contact)
	Dental	700 SE 3rd Ave Ste. 206	Dr. Deborah Davis	(954) 761-2230 deborah.davis@aidshealth.org		Email	English, Spanish	1-2 Months for an Initial; Same day for an Emergency	M-F 8:00AM-5:00PM; Leave a Voice Message.
	Integrated Behavioral Health	701 SE 3rd Ave 4th Floor	Dr. Robert Wilson	(954) 522-3152 (Office) (954) 423-9439 (Cell) drwilson@aidshealth.org		Phone/Email			Tues. Fri- 8AM-12PM
	Integrated Behavioral Health	702 SE 3rd Ave Ste. 301 Floor	Damon Jones	(954) 767-0887 Ext. 2251 damon.jones@aidshealth.org		Phone/Email			M,T,TH,F-8AM-5PM W- 11AM-7PM
	Integrated Behavioral Health	6405 N. Federal Highway Ste 205	Christopher "David" Shelton LMHC	(954) 767-2411 Ext. 3625 Davidshelton@aidshealth.org		Phone/Email			M,T,TH,F-8AM-5PM W- 11AM-7PM
	Integrated Behavioral Health	1164 E. Oakland Park Blvd. 3rd Floor	Rafis Nin LCSW	(954) 561-6900 Ext. 2657 rafis.nin@aidshealth.org		Phone/Email			M-F 8am-5pm
	Disease Case Management	NPH	Usyani Machado	(954) 540-3435					
	Disease Case Management	AHF Ft. Lauderdale Downtown	Carlos Pina	(954) 767-0887					
	Case Management	AHF Ft. Lauderdale Downtown	Richard Ortiz	(954) 767-0887 richard.ortiz@aidshealth.org					
	Case Management	1164 E. Oakland Park Blvd. 3rd Floor	**Patrick Saint Fleur**	(954) 488-0441 patrick.saintfleur@aidshealth.org		Phone/Email			
	Disease Case Management	1164 E. Oakland Park Blvd. 3rd Floor	Paulo dos Santos	(954) 561-6900					M-F
	Case Management	NPH	Greg Beltran Karen Haughey	(954) 772-3638 (727) 409-0759				Existing clients seen on same day/New clients within 1 week	
Broward Addiction Recovery Center	Substance Abuse	900 NW 31st Ave., Suite 2000 Fort Lauderdale, FL 33311	Polly Cacurak	**(954) 357-5093 pcacurak@broward.org**	(954) 564-5058			Detoxification Provided 24 Hours/7 Days a week	Admissions: M,T,Th,F: 7-5/ W: 7-7 Detox Unit: M,W,Th,F: 7-5/ T: 7-7

FOR PROVIDER USE ONLY
The following table is information supplied by each provider on a monthly basis. Be sure to inform clients of providers that have the shortest wait time for an appointment so that they can make an informed decision.

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NETWORK MEETING OVERVIEW

MEETING OVERVIEW: NETWORK MEETINGS

Quality Network

From all 13 Part A Agencies:

- Quality Managers
- Designated Quality Contacts

Service Category Networks

Support Services, Non-MCM, CIED, Food, Legal

- Oral Health
- Medical/DCM
- Behavioral Health

QUALITY NETWORK MEETING OVERVIEW

Network meetings are a vessel for improving Part A services by eliciting feedback from providers to better **understand** and **improve** the client experience.

- Outcome
  - Turning network meeting time into sustained results
    - Streamlined processes
    - Improved communication between and among service providers
      - All parties as stakeholders
    - Improved **client health outcomes**
    - Improved performance measures
- Organization
  - Optimization of meetings to benefit all system members: providers, staff, and clients
    - Logistics
    - Agenda/Meeting Prep

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MEETING OVERVIEW: LOGISTICS

- Meeting Minutes
  - Last meeting minutes will be provided **two days** prior to the meeting date
  - Meeting minutes will be disseminated to attendees within **three days** of the meeting occurrence
- Meeting Notice/Reminder
  - Staff will e-mail all necessary parties the Meeting Notice **two weeks** prior to the meeting date and the Meeting Reminder **two days** prior
    - Agenda and meeting materials
- Parking Lot
  - Method of tracking emerging topics to return to as a group in upcoming meetings
  - Action items for next meeting

All Network meeting packets and CQM program resources can be found on our website!
http://www.brhpc.org/programs/hiv-planning-council/

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MEETING OVERVIEW: AGENDA ITEMS

Agenda Items

- **Data Presentation**
  - Quarterly Scorecard – System-wide and by agency
  - The Network will review system-wide data in quarterly meeting
  - Staff will send each Quality Manager (QM) data for their agency prior to meeting
- **Quality Improvement Projects**
  - Each QM will be required to submit one Plan, Do, Study, Act (PDSA) Cycle each quarter
  - Network will discuss QIPs
- **Training Component**
  - Curriculum developed using survey results
- **Evaluations**
  - Completed at the end of every meeting
  - Short format

DATA PRESENTATION

Data scorecard will include the following measures:

- Viral Load Analysis
- Care Continuum
- Broward Outcomes and Indicators
- HRSA's HIV/AIDS Bureau (HAB) Performance Measures

DATA

Viral Load Analysis:

Breakdown of clients achieving/not achieving viral load suppression by subpopulations. Report is reviewed quarterly. Subpopulations include:

- Gender
- Race/ethnicity
- Age
- Sexual orientation
- Living arrangement
- Literacy level
- Education level
- HIV risk factor
- HIV stage
- HIV therapy

FY 16-17 Systemwide Viral Load Analysis							
	Not Suppressed		**Suppressed**		**Unknown**		**Total**
TOTAL	**1,204**	**15.6%**	**6,499**	**84.1%**	**22**	**0%**	**7,725**
Female	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black Female	337	19.3%	1,393	80.0%	12	0.7%	1,742
White Female	33	15.1%	184	84.0%	2	0.9%	219
Hispanic Female	34	16.3%	173	83.2%	1	0.5%	208
Other Female*	0	0.0%	8	100.0%	0	0.0%	8
*American Indian Non-Hispanic Female**	*0*	*0.0%*	*1*	*100.0%*	*0*	*0.0%*	*1*
*Asian Non-Hispanic Female**	*0*	*0.0%*	*6*	*100.0%*	*0*	*0.0%*	*6*
*Native Hawaiian Non-Hispanic Female**	*0*	*0.0%*	*1*	*100.0%*	*0*	*0.0%*	*1*
Female Total	**404**	**18.6%**	**1,758**	**80.8%**	**15**	**0.7%**	**2,177**
Male	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black Male	398	18.2%	1,789	81.7%	4	0.2%	2,191
White Male	252	12.5%	1,763	87.5%	1	0.0%	2,016
Hispanic Male	136	11.1%	1,090	88.8%	2	0.2%	1,228
Other Male*	4	7.4%	50	92.6%	0	0.0%	54
*American Indian Non-Hispanic Male**	*3*	*27.3%*	*8*	*72.7%*	*0*	*0.0%*	*11*
*Asian Non-Hispanic Male**	*1*	*2.6%*	*38*	*97.4%*	*0*	*0.0%*	*39*
*Pacific Islander Non-Hispanic Male**	*0*	*0.0%*	*4*	*100.0%*	*0*	*0.0%*	*4*
Male Total	**790**	**14.4%**	**4,692**	**85.5%**	**7**	**0.1%**	**5,489**
Transgender	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Black Transgender*	7	18.9%	30	81.1%	0	0.0%	37
White Transgender*	1	11.1%	8	88.9%	0	0.0%	9
Hispanic Transgender*	2	18.2%	9	81.8%	0	0.0%	11
Other Transgender*	0	0.0%	2	100.0%	0	0.0%	2
*Asian Non-Hispanic Transgender**	0	0.0%	2	100.0%	0	0.0%	2
Transgender Total*	**10**	**16.9%**	**49**	**83.1%**	**0**	**0.0%**	**59**
Age Categories	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
18-28	168	32.7%	343	66.9%	2	0.4%	513
29-38	282	22.7%	956	76.8%	6	0.5%	1,244
39-48	276	16.4%	1,399	83.1%	9	0.5%	1,684
49-58	352	13.0%	2,354	86.9%	4	0.1%	2,710
59 years of age or older	139	8.7%	1,457	91.2%	1	0.1%	1,597
Sexual Orientation	**Not Suppressed**		**Suppressed**		**Unknown**		**Total**
Bisexual	71	16.7%	353	83.3%	0	0.0%	424
Heterosexual	646	16.9%	3,158	82.6%	17	0.4%	3,821
Homosexual	461	13.5%	2,940	86.3%	5	0.1%	3,406
Lesbian*	5	26.3%	14	73.7%	0	0.0%	19
Unknown*	34	43.6%	44	56.4%	0	0.0%	78

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DATA

1. • **Total HIV+ Clients**: Clients who are HIV+ and received at least one service from the selected service category(s) in the reporting period.
2. • **Ever in Care:** HIV+ clients who ever had medical care* documented.
3. • **In Care:** HIV+ clients who had medical care within reporting period.
4. • **Retained in Care:** HIV+ clients who had two or more medical care services at least three months apart in the reporting period.
5. • **On ARV:** HIV+ clients who have a documented ARV Therapy at any time during the reporting period within HIV History records.
6. • **Virally Suppressed:** HIV+ clients with most recent viral load as of end of the reporting period less than 200 copies/mL.

Part A HIV Care Continuum:

Used to better identify gap in HIV services.

Care Continuum data is reviewed bi-annually and can be broken down by service category and subpopulations.

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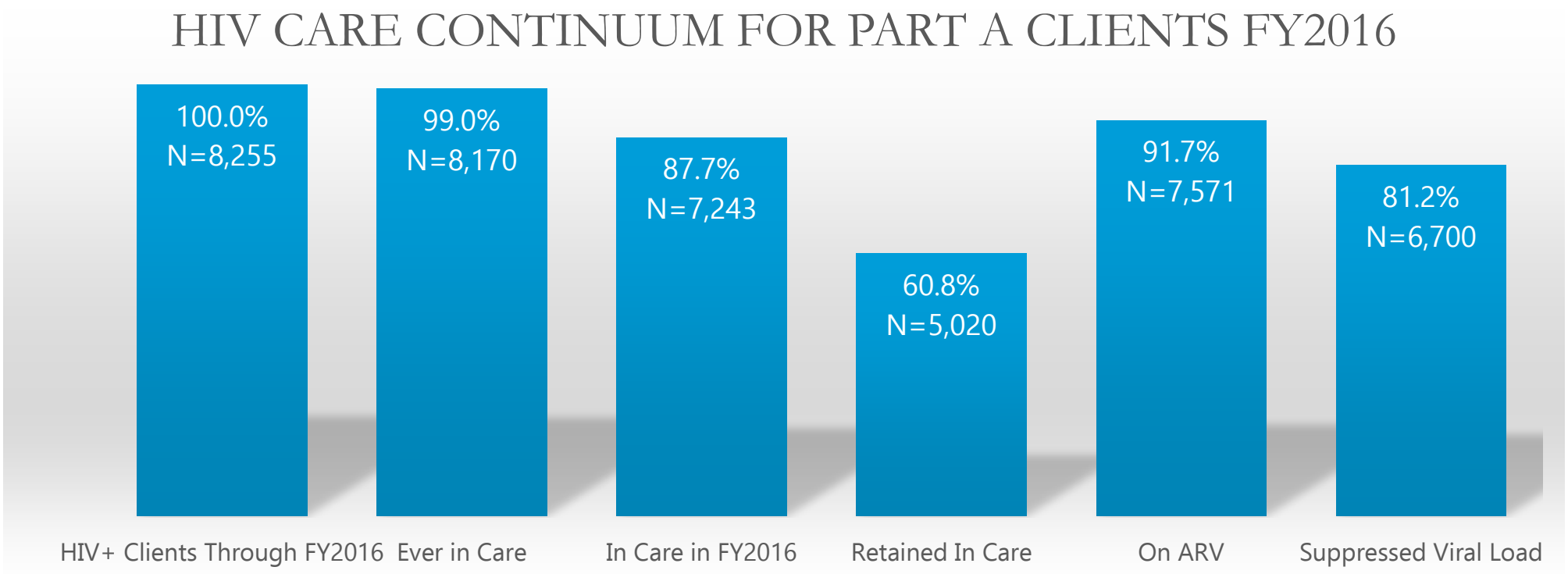
DATA



Data collection limitations may impact the following measures:

[1]Retained in care – Challenges collecting/updating medical care information for clients who visit a doctor outside of the Ryan White Part A system, move, or pass away during the reporting period.

[2]On ARV – Measures clients who self-reported being prescribed ARV Therapy at **any time** during the reporting period. Therefore, measure does not exclude clients who may have experienced an interruption in ARV Therapy during the reporting period.

DATA

Broward Outcomes & Indicators:

Measures established by the Broward EMA to assess the performance of each funded service category. Report is reviewed quarterly.

Outcomes and Indicators	FY 2015-2016		FY 2016 - 2017	
MAI Medical Case Management	Num/Denom	%	Num/Denom	%
Outcome 1: Increased access, retention, and adherence to Primary Medical Care.				
Indicator 1.1: 100% of clients will achieve session objectives by designated target dates.	48/48	100%	69/69	100%
Indicator 1.2: 100% of clients were linked to Primary Medical Care within five sessions.	48/48	100%	69/69	100%
Case Management (Non-Medical)				
Outcome 1: Increased access, retention, and adherence to Primary Medical Care.				
Indicator 1.1: 80% of clients achieve POC goals related to Primary Medical Care services by designated target dates.	2,249/2,535	88.72%	1,897/2,168	87.46%
Indicator 1.2: 80% of clients are retained in Primary Medical Care.	2,200/2,558	86.00%	1,899/2,181	87.07%
Oral Health				
Outcome 1: Reduction in number of teeth with untreated caries (tooth decay).				
Indicator 1.1: 75% of caries identified in the Phase 1 (Disease Control) treatment plan will be treated within 6 months.	685/691	99.13%	695/702	99.00%
Outcome 2: Improved periodontal health.				
Indicator 2.1: 80% of clients will have a 50% reduction in the number of bleeding sites at the completion of Phase I (Disease Control) Plan.	530/540	98.15%	738/748	98.66%
Mental Health				
Outcome 1: Improvement in client's symptoms associated with primary mental health diagnosis.				
Indicator 1.1: 85% of clients achieve POC goals by designated target date.	141/182	77.47%	18/25	72.00%
Outcome 2: Increased access, retention, and adherence to Primary Medical Care.				
Indicator 2.1: 85% of clients are retained in Primary Medical Care.	299/332	90.06%	127/129	98.45%
Substance Abuse				
Outcome 1: Improvement in client's symptoms associated with primary mental health diagnosis.				
Indicator 1.1: 85% of clients achieve POC goals by designated target date.	50/67	74.63%	6/12	50.00%
Outcome 2: Increased access, retention, and adherence to Primary Medical Care.				
Indicator 2.1: 85% of clients are retained in Primary Medical Care.	83/94	88.30%	31/32	96.88%
Pharmacy				
Outcome 1: Improve access to medication.				
Indicator 1.1: Attempts will be made to contact 100% of clients who do not pick up medications within 7 to 14 days of filling the prescription.	554/554	100%	710/710	100%
Outcome 2: Clients provided an opportunity to improve medication adherence.				
Indicator 2.1: 100% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, clinical pharmacist, prescribing physicians, treatment adherence).	294/295	99.66%	352/362	97.24%
Integrated Primary Care & Behavioral Health				
Outcome 1: Slow/prevent clients' HIV disease progression				
Indicator 1.1: 95% of clients are prescribed ART.	1,589/1,703	93.31%	1,545/1,698	90.99%
Indicator 1.2: 80% of clients on ART for > 6 months will have a viral load < 200 copies/mL.	2,984/3,439	86.77%	2,834/3,293	86.06%

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DATA

HAB Performance Measures:

All HAB recommended *core*, *all ages*, *adolescent/adult*, *MCM*, and *Oral Health* performance measures are reported in PE.

Measures	FY 17 Q4	
ADOLESCENT/ADULT	***Num/Den***	***%***
Cervical Cancer Screening	495/1304	38.0%
Chlamydia Screening	1398/1711	82.0%
Gonorrhea Screening	1201/1711	70.0%
Hep B Screening	3699/3958	93.0%
Hep B Vaccination	1401/3579	39.0%
Hep C Screening	4567/5199	88.0%
HIV Risk Counseling	767/5199	15.0%
Oral Exam	0/5199	0.0%
Pneumococcal Vaccination	2486/4445	56.0%
Depression Screening	0/5206	0.0%
Tobacco Cessation Counseling	676/22795	3.0%
Substance Abuse Screening	625/1620	39.0%
Syphilis Screening	4696/5194	90.0%
MCM		
MCM Care Plans	1179/3199	37.0%
Gaps in HIV Medical Visits	657/1450	45.0%
HIV Medical Visit Frequency	0/1450	0.0%
ORAL HEALTH		

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MEETING OVERVIEW: AGENDA ITEMS

QIP: Series of activities directed towards the specific goal of improving a system, process, or outcome.

- Plan, Do, Study, Act (PDSA) Cycle is a tool used to accomplish the goal of a QIP
- QM's will complete one PDSA Cycle each quarter with all relevant information to share with the Network
  - Completed worksheets shall be e-mailed to Staff for inclusion in the meeting packets **one week** prior to the assigned meeting date

Training Components: Curriculum designed based on QI Assessment completed by QM's.

- Staff will present on various topics including QM/QI principles and methods, service delivery in our system, performance measurement, etc.
- The Network will discuss service delivery successes and barriers driven by Quarterly Reports, requested topics of discussion, or QIP overviews

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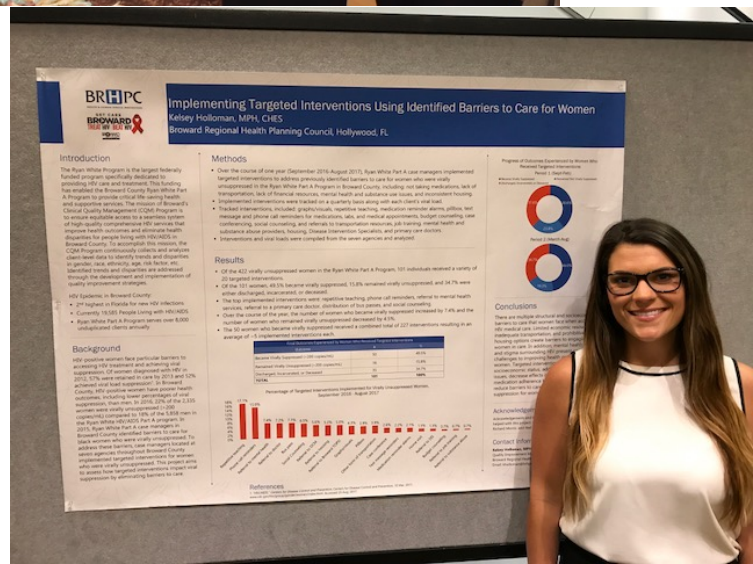
PAST QIPS

- **Drilling Down Data: Impact of Service Utilization on black heterosexual females, black MSM, and black heterosexual males**
  - *This project examined the correlation of viral load suppression and service utilization through data analysis. The goal was to identify particular medical and support services that may benefit our target populations.*
- **Identifying Barriers to Care and Viral Load Suppression for Black Females**
  - *This project assessed the extent to which a given medical or social service barrier makes it difficult for black women to obtain medical care and achieve viral suppression.*
  - *Ryan White Part A case managers identified barriers to care through patient interviews, multidisciplinary case staffing, and chart reviews.*
- **Implementing Targeted Interventions Using Identified Barriers to Care for Women**
  - *Ryan White Part A case managers implemented targeted interventions to address barriers to care for women who were not virally suppressed.*



RULES OF ENGAGEMENT

In the interest of helping clients achieve the best possible health outcomes and **quality** of life, as a group, we agree:

- To arrive prepared to meetings, including but not limited to: confirming meeting attendance, being familiar with agenda topics, completing any previously assigned tasks, etc.
- To openly communicate & participate fully
- All meeting parties/attendees are equal
- To acknowledge individual responsibility in group outcomes
- Network meetings are a safe place to consult with colleagues and peers to find workable solutions to identified issues

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FEEDBACK
QUESTIONS
SUGGESTIONS
RECOMMENDATIONS

Meeting Facilitators: CQM Staff

Contact Information: Business cards for Staff located at the sign-in table

E-mail: quality@brhpc.org

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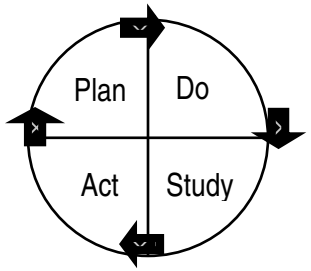

PDSA WORKSHEET

Team: Case Management QI Network	Date: 7/5/16	Completion Date:
Aim: What is the objective/purpose of the test? Increase the percentage of case management clients with viral load suppression (<200 copies/mL) to 89% by March 2017		

PLAN:

Briefly describe the test:

Interventions targeted to specific needs of female case management clients

How will you know that the change is an improvement?

% of clients with targeted interventions

% of clients with decreasing viral loads

% of clients with suppressed viral loads

What additional information will we need to take action?

Current female case management clients with viral loads > 200 copies/mL

- Viral Load Analysis Report in PE – FY 2016 YTD

What do you predict will happen?

Overall viral suppression for Case Management will increase by targeting female clients with unsuppressed viral loads and implementing interventions based on their specific needs

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1. Create excel spreadsheet for documentation purposes	CQM Staff	June 2016	
2. Create list of current female clients with viral loads > 200 copies/mL at each agency	Case Managers	July 2016	Agencies
3. Implement targeted interventions based on specific needs of clients with unsuppressed viral loads and document on spreadsheet	Case Managers	Ongoing	Agencies
5. Monitor viral loads quarterly for each client and document on spreadsheet	Case Managers	Quarterly	Agencies
5. Report findings/results to CM QI Network.	CM QI Network representative	Monthly Network meetings	

Plan for collection of data:

Interventions and viral loads documented on excel spreadsheet

DO: Test the changes.

Was the cycle carried out as planned? ☐ Yes ☐ No

Record data and observations.

What did you observe that was not part of our plan?

STUDY:

Did the results match your predictions? ☐ Yes ☐ No

Compare the result of your test to your previous performance:

What did you learn?

ACT: What are we going to do now? Decide to Adopt, Adapt, or Abandon.

☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one