HUMAN SERVICES DEPARTMENT
COMMUNITY PARTNERSHIPS DIVISION / Health Care Services Section
115 S Andrews Avenue, Room A300 • Fort Lauderdale, Florida 33301
954-357-5390 • FAX 954-357-5897

Quality Network Meeting Agenda

Date: September 8th, 2021, at 9:00 – 10:15 a.m.
Location: WebEx Virtual Meeting Platform
Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1343

I. Call to Order
II. Welcome/Introductions
III. Quality Network Meeting Evaluation Results
IV. Step 3 Check-in (Checkpoints 3&4)
V. Checkpoint 5: PSDA Cycle Planning
VI. Announcements
VII. Adjournment

Next Meeting Date: October 20th, 2021

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 Minutes

Date: July 28th, 2021, 9:05 a.m. – 9:46 a.m.
Location: WebEx Virtual Meeting Platform
Facilitator: Clinical Quality Management Support Staff
quality@brhpc.org
(954) 561-9681 ext. 1343

Providers Present
AHF: Amy Pinter, Sandra Najuna
BCOM: Glynette Roberts
BRHPC: Natasha Markman
Broward Health: No representative present
Broward House: Gillian Cross Hogg
Care Resource: Ariel Williams
Community Rightful Center: Dr. Mary Hylor, Wislene Augustin, Roseline LouisXVI, Shella Volmar
Latinos Salud: No representative present
Legal Aid: Kara Schickowski
MHS: Alondra Machado
NSU: Kaitlin Mooney
Poverello: Santiago Barney

CQM & PCS Support Staff: Vanessa Oratien, Jaclyn Ramos

Part A Recipient Staff: Timothy Thompson, Neil Walker

I. Call to Order

The meeting was called to order at 9:05 a.m.

II. Welcome/Introductions

CQM Support Staff welcomed all attendees, made a statement of the meeting's goal, and made individual introductions.

III. Checkpoint 2 Check-in

CQM Support Staff provided a case study to reinforce the driver diagram and illustrate how the following checkpoints would be completed. The Network reviewed and completed a driver diagram based on the provided case study.

IV. QI Toolkit Step 3: Aim Statements; Strategies and Quality Indicators

After completing the driver diagram activity, the Quality Network utilized the case study to move into Checkpoint 3: developing an aim statement. Using what was discussed previously, a Network member developed an aim statement with a specific, clear aim that described the target population, desired improvement, and target timeframe. CQM Support Staff discussed the provided example and provided guidance on setting a strong aim statement. To further reinforce the aim statement exercise, attendees were polled and asked to find a complete aim statement. Network members' responses showed they recognized the complete aim statement.

Following the Checkpoint 3 exercise, the Quality Network used the case study and previously completed exercises to guide the Checkpoint 4 example: identifying drivers/contributing factors, selecting a change idea, and determining process and outcome measures. CQM Support Staff provided examples of what this process would look like and included guidance on quality measurement.

A quality measure is a tool to assess specific aspects of care and services that are linked to better health outcomes while being consistent with current professional knowledge and meeting client needs. Process measures evaluate the actions taken to produce the outcome and the procedures for achieving the best outcomes. Outcome measures are used to evaluate whether a goal has been met.

V. Announcements

Neither agencies nor the Recipient shared any announcements during the meeting. CQM Support Staff announced the Quality Network Evaluation Survey is now available. This survey can be completed in three minutes and is required. The data collected in the survey is used to inform future meeting discussion and training topics.

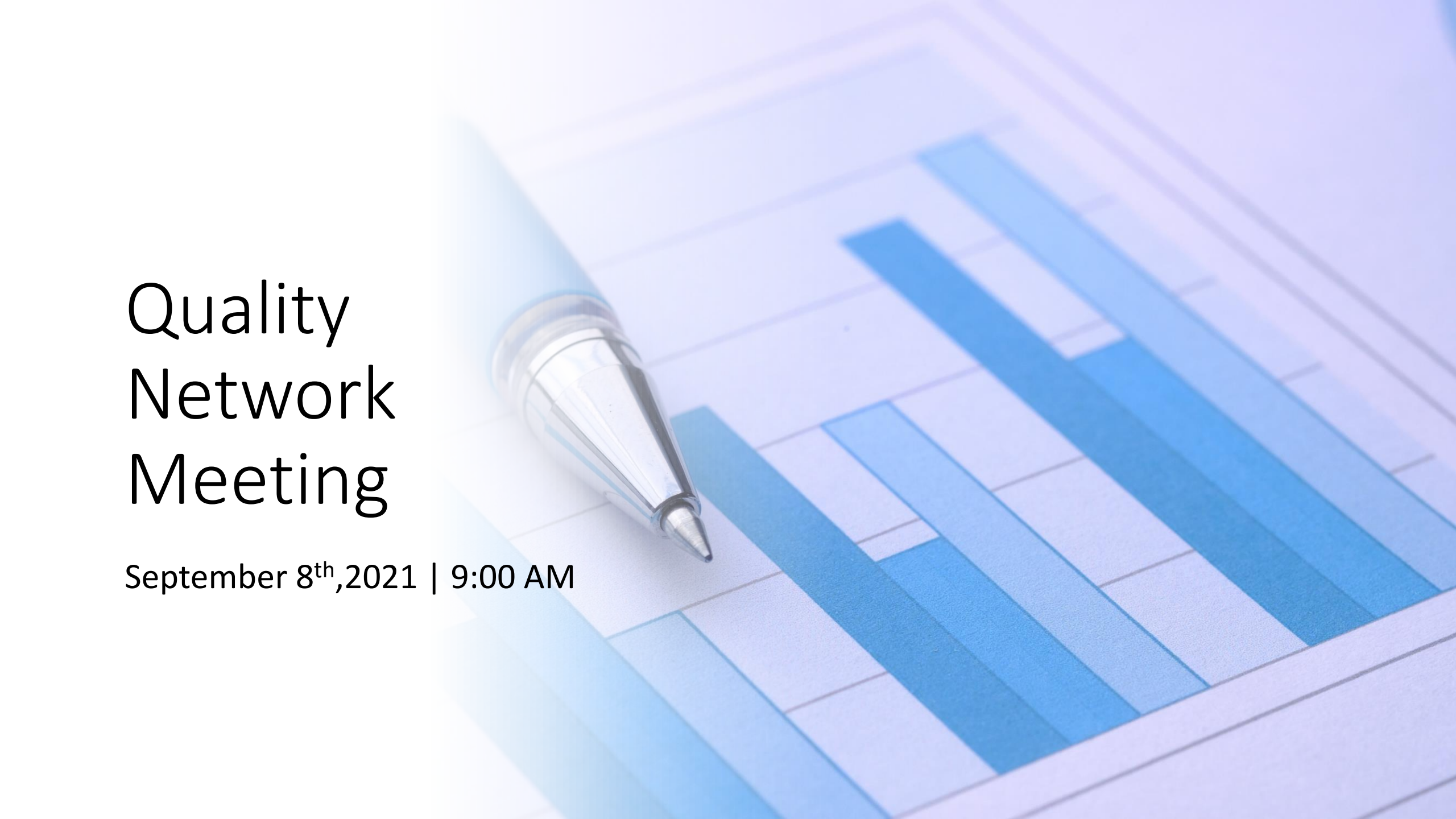
VI. Adjournment

The meeting was adjourned at 9:46 a.m.

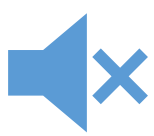
Next Meeting Date: September 8th, 2021, at 9:00 a.m.

Quality Network Meeting

September 8th,2021 | 9:00 AM



Housekeeping Rules



Mute Microphone

Participants will be automatically muted to limit background noise

Identify Yourself

State your name and agency when speaking

Use the Chat Box

Type in the chat box to identify yourself and agency, ask questions, and request additional clarification

Raise Your Hand

The “raise hand” option will notify the presenter of any questions that may arise

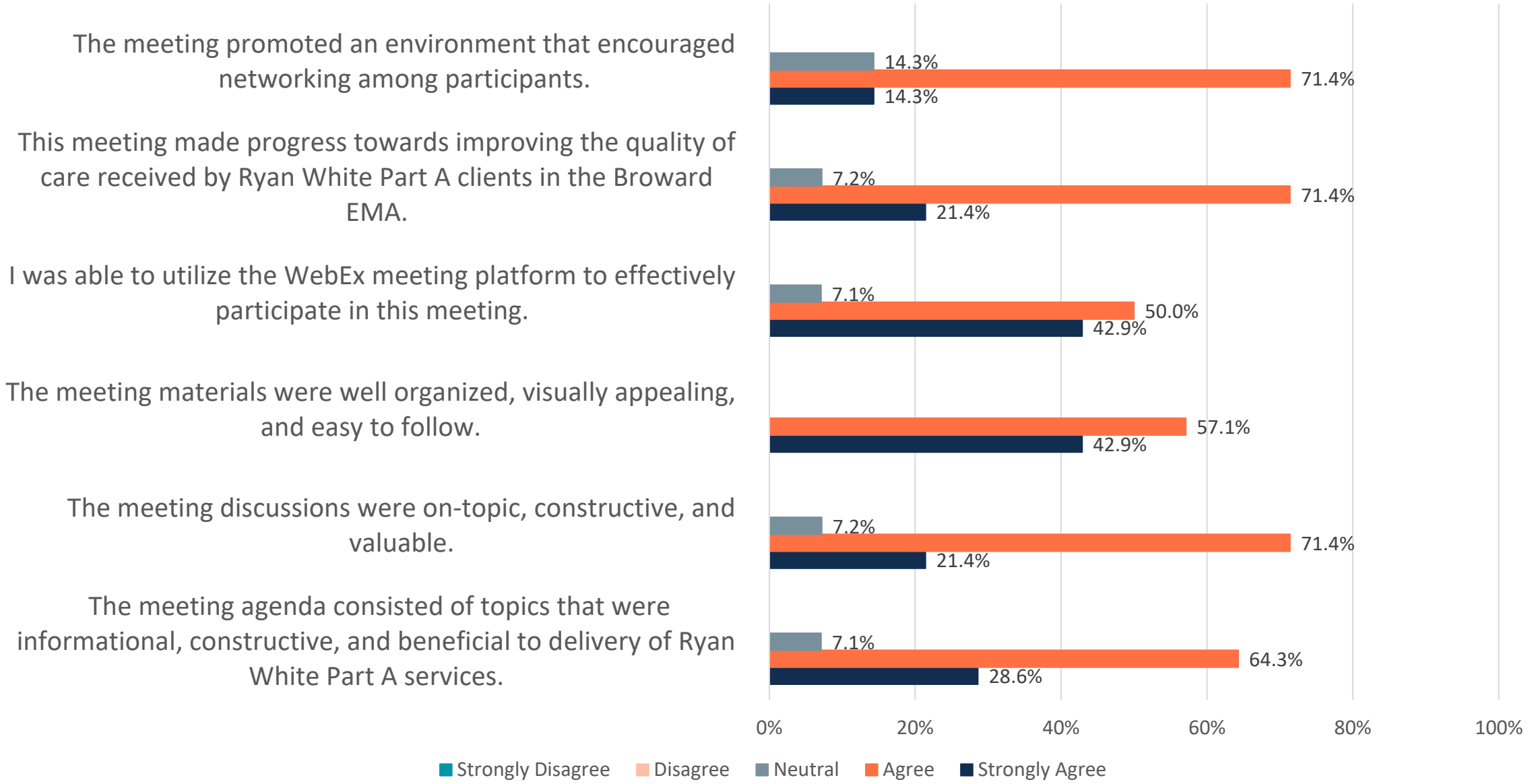
Ask Questions

Please save questions until the end of each slide

Welcome & Introductions

Quality
Network
Meeting
Evaluation
Results

Quality Network FY2021-2022 Q2 Meeting Evaluation



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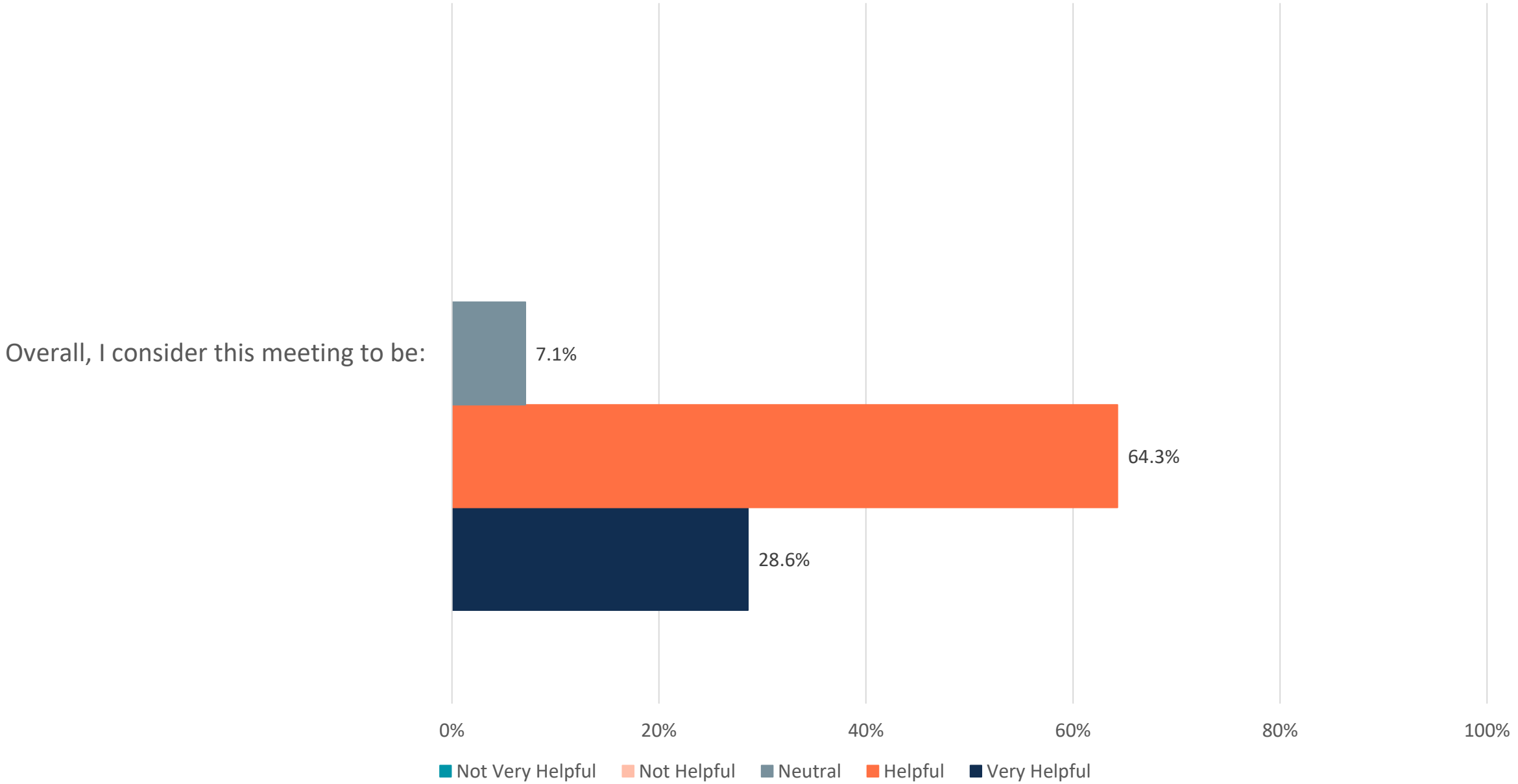
Quality Network FY2021-2022 Q2 Meeting Evaluation



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Please list a minimum of two discussion or training topics (and provide relevant context) for future network meetings:

- “I appreciate the preparation of data and relevant topics provided. The network meeting offers a great opportunity to see Quality Assurance through a new lens and to collaborate with peers on the accomplishments that have been made as a result.”
- “Retention in care during Delta wave, vaccine hesitancy.”
- “Referral training for case managers (Oral Health referrals) Motivational Training.”
- “More Training for Frontline staff *Billing Discussion/EH”
- “-Client retention. -Possible client food assistance increase beyond 2 units per month.”
- “Mental Health Housing”

Please list a minimum of two discussion or training topics (and provide relevant context) for future network meetings:

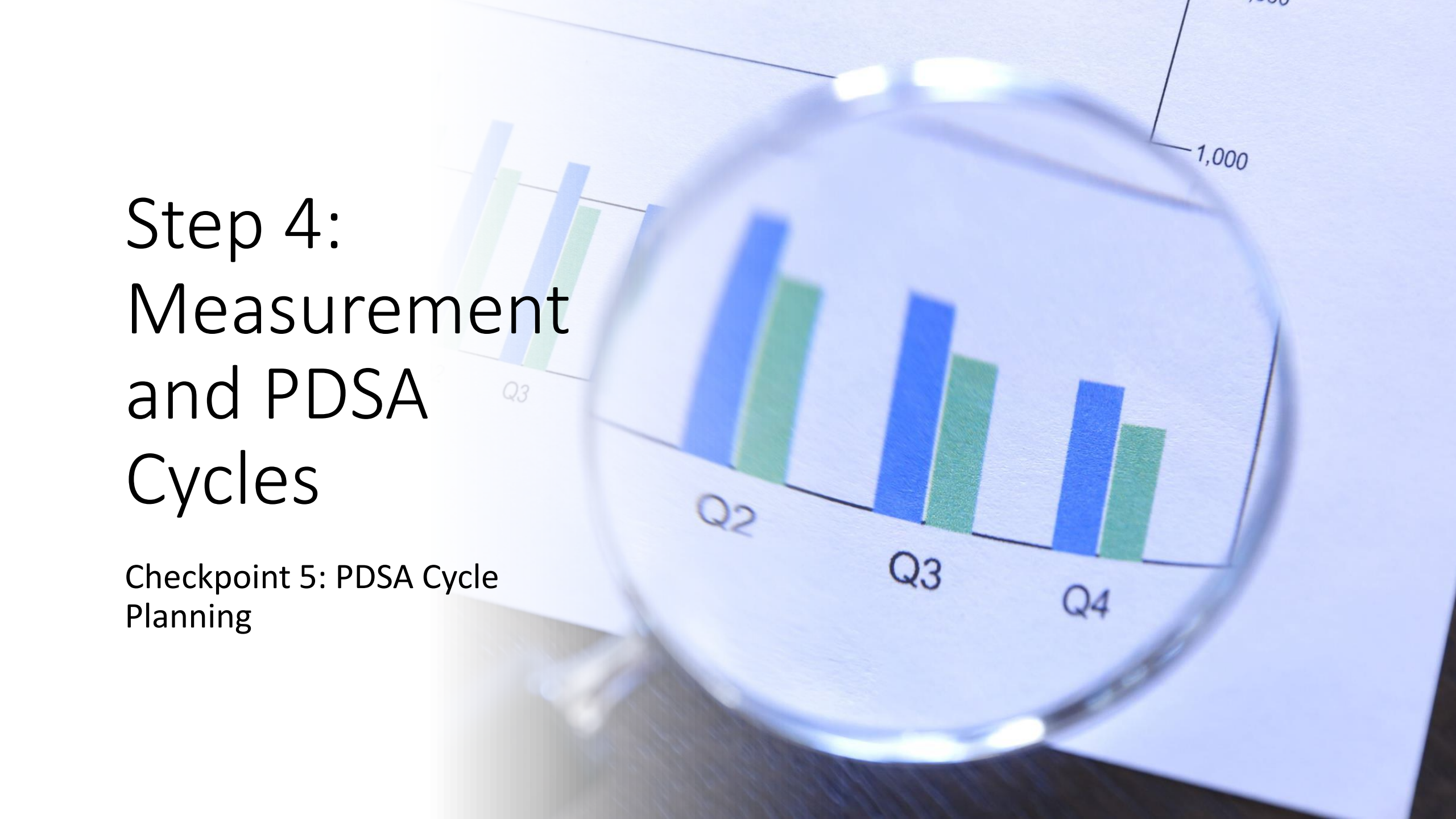
- “How data is captured and utilized for reporting (What period of time is utilized? Data changes frequently through progress notes, updates and uploads within the Provide Enterprise system and affects the outcome of measures and data being reviewed, and percentages calculated.) *Is there an opportunity to review data prior to and at the time of discussion?”
- “Best practices to document small changes made to improve service delivery and track effectiveness.”
- “Sharing best practices among participants.”
- “Tracking Data in Quality Improvement and Reporting Quality Improvement Data.”
- “I would like to discuss about Mental Illness and Housing Issues.”

Step 3 Check-in

Checkpoints 3 and 4

Step 4: Measurement and PDSA Cycles

Checkpoint 5: PDSA Cycle Planning



QI TOOLKIT

FY2021-2022

RESOURCE GUIDE FOR BROWARD COUNTY RYAN WHITE PART A QUALITY NETWORK PROVIDERS

GET CARE BROWARD TREAT HIV | BEAT HIV RYAN WHITE | PART A

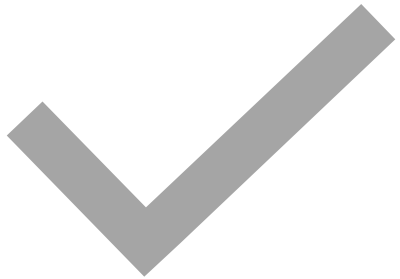
TABLE OF CONTENTS

Checkpoints

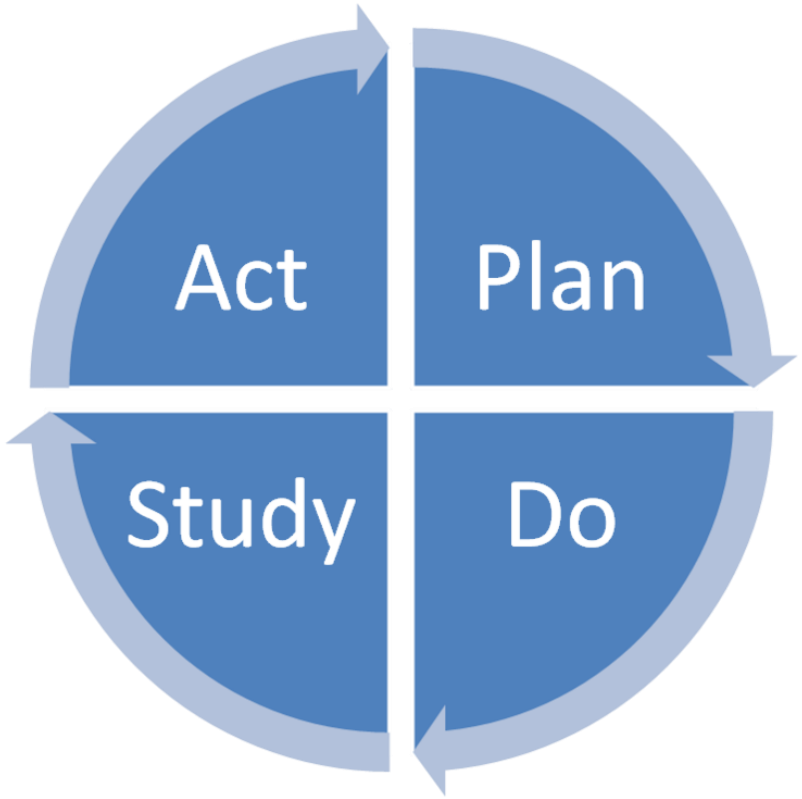
- ☐ Checkpoint 1: Identify Focus Areas for Quality Improvement Projects (Step 1)
- ☐ Checkpoint 2: Driver Diagram (Step 2)
- ☐ Checkpoint 3: AIM Statement (Step 3)
- ☐ Checkpoint 4: Drivers/ Contributing Factors (Step 3)
- ☐ Checkpoint 5: PDSA Cycle Planning Form (Step 4)
- ☐ Checkpoint 6: Preliminary Data Review (Step 5)
- ☐ Checkpoint 7: Writing the QI Summary Report (Step 6)
- ☐ Checkpoint 8: QIP Poster (Step 7)

Learning Objectives

Discuss PDSA cycles



Design PDSA cycles to implement in the QIP



What is the PDSA Cycle?

Rapid test of improvement

Allows for a structured approach to rapid testing of the idea of a small scale

Continuous; the trend should be uphill if the approach is correct

Plan

Clarify your objective

Make a prediction

What is to be done (Who, What, Where, When, How)

Do

Carry out the plan

Document your observations (Expected/Unexpected)

Begin analysis

Study

Look at the test

Complete the analysis of data

Compare it to your theory and predictions

Summarize what you have learned

Act

Adjustments

- Changes to previous test?
- What adjustments?
- Expand last cycle?

New Cycles

- What are you planning?
- What are you going to test?

Case Study: Our Community Health Center

Our Community Health Center is a non-profit agency in Broward County that serves people with HIV. This agency offers disease case management and non-medical case management services. *Our Community Health Center* services a total of 150 clients, however 50% of clients are not retained in care. After drilling-down data, the quality management team identifies the affected population: clients aged 18-28 years. After developing an aim statement and identifying main drivers, *Our Community Health Center* is ready to conduct a Plan-Do-Study-Act (PDSA) Cycle.

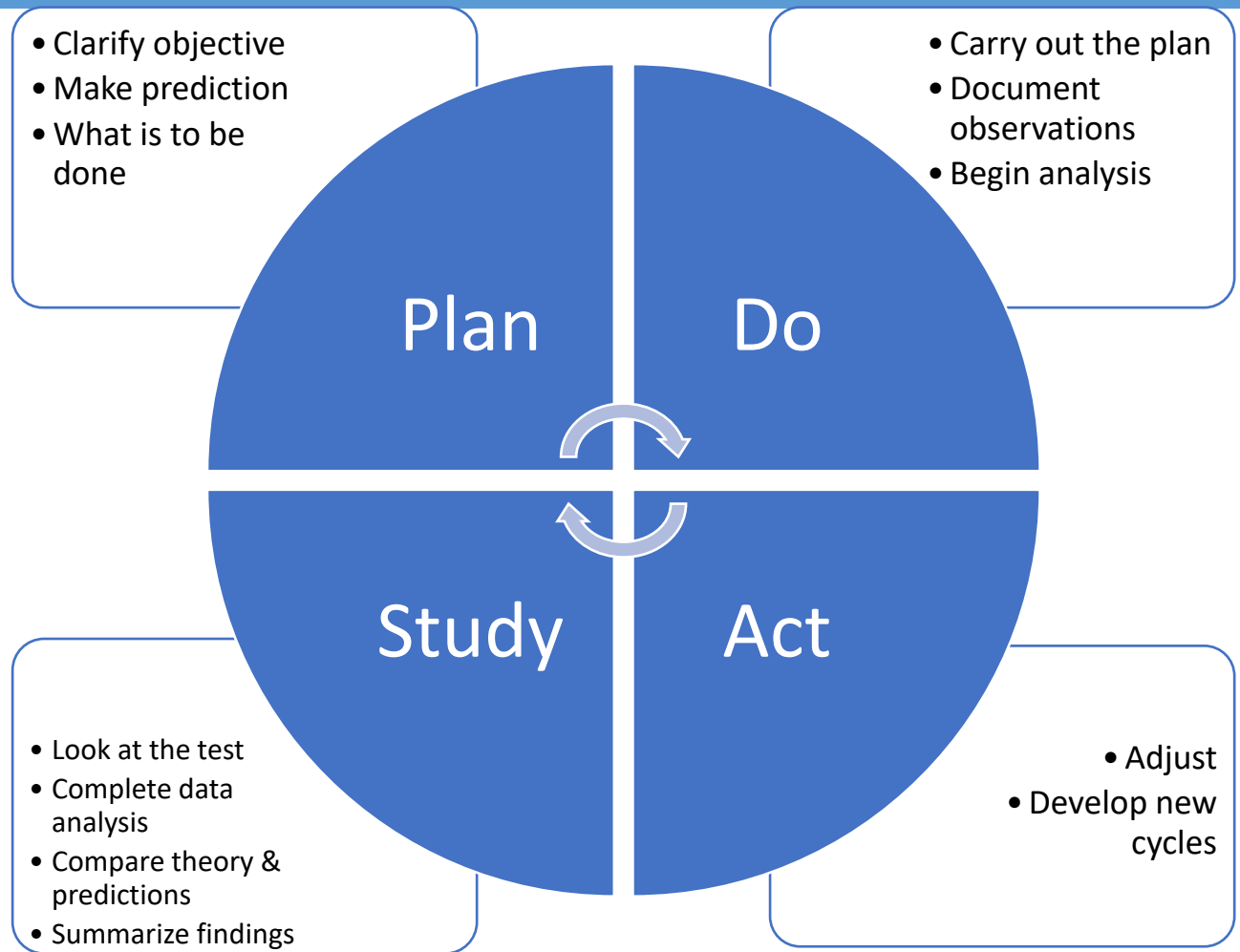
Aim Statement Development

To increase/decrease	Retention in care	**(process/outcome)**
from	50%	**(baseline%, rate, #, etc.)**
to	65%	**(goal/target%, rate, #, etc.)**
by	February 28, 2022	**(date)**
in	Adults aged 18-28 years	**(group, population)**
Full Aim Statement: To increase retention in care from 50% to 65% by February 28, 2022, in adults aged18-28 years.		

Main Driver/Factor Identification

Driver/Contributing Factors: List the main drivers/factors that contribute to the outcome you want to change.	**Change Idea:** What do you plan to do to address the driver/contributing factor?	**Process Measure:** How can you measure that your change idea is taking place?	**Outcome Measure(s):** How can you measure if your change idea worked?
Difficult ART Regimen	Recommend Cabenuva	Client completes watching a 3- minute video on Cabenuva, followed by a 12-minute MI session with a trained staff member discussing engagement in care and viral suppression/U=U	(1) Client attends psycho-education session (2) Client provides a rating of 7 or above on a 10-point rating scale indicating their intention to attend a 15-minute follow-up appointment (virtual or in-person) (3) Client attends follow-up session
Lack of Support	Peer Counseling	Client is introduced to a peer advocate and completes three 30-minute sessions over the course of six weeks focused on HIV self-management and wellbeing.	Attendance at three 30-minute peer sessions over a six-week period.
Depression/Anxiety	Screening for depression and anxiety	Client completes the PHQ9 and if score is 10 or above the client is referred for MH Assessment; clients scoring 5-9 on the PHQ9 receive one 30-minute session with a peer or community health worker to co-develop a 6-week plan of care to support emotional fitness; 30-minute follow-up appointment to include administration of the PHQ9 and client self-assessment of application of emotional fitness plan of care.	(1) Completion of PHQ9 (2) Referral for MH Assessment for PHQ scores 10 or above. (3) Completion of session and development of plan of care to support emotional fitness for clients scoring 5-9 on PHQ9. (4) Repeat PHQ9 screening for clients with emotional fitness plan of care.
Crisis of HIV Diagnosis	SBIRT (screening, brief intervention and referral to treatment) curriculum applied for population of youth at risk for developing substance use disorders	Client agrees to participate in SBIRT and attends 3 sessions over the course of 8 weeks.	(1) SBIRT outcomes (2) Client show rate for three scheduled SBIRT appointments over 8-week time period.

PDSA Cycle


• Clarify objective
• Make prediction
• What is to be done
• Carry out the plan
• Document observations
• Begin analysis
Plan
Do
Study
Act
• Look at the test
• Complete data analysis
• Compare theory & predictions
• Summarize findings
• Adjust
• Develop new cycles

PDSA Cycle: Plan

In the month of October 2021, *Our Community Health Center* anticipates caring for 25 clients in the identified age group. *Our Community Health Center* wants to develop its plan so it can begin its PDSA cycle then.

Necessary Elements of a Plan

- Objective
- Prediction
- Steps
- Necessary Tasks

PDSA Cycle: Plan

Plan: Incorporate peer advocates into client care.

- Objective: Determine a way to increase client retention in care by providing support.
- Prediction: Incorporating peer advocacy into client care will add time to client visits but will also improve retention.
- Steps: Introduce clients to a peer advocate. Client and peer advocate complete three 30-minute sessions over the course of six weeks focused on HIV self-management and wellbeing.
- Necessary Tasks:

1. Identify peer advocates
2. Develop a plan for the sessions
3. Develop client & advocate meeting timelines

Step 4 Next Steps

Checkpoint 5 due date:

November 17th,2021

Technical Assistance:

As needed

Announcements

Next Meeting Date:

October 20th, 2021