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

Our Best. Nothing Less.

SUPPORT SERVICES NETWORK MEETING

Date: March 6th, 2018 at 9:30A.M.
Location: Ryan White Part A Program Office
115 S. Andrews Ave., A-337
Ft. Lauderdale, FL 33301

Facilitator: Clinical Quality Management Staff
quality@brhpc.org
(954) 561-9681 ext. 1250

AGENDA

I. **Welcome/Introductions**

II. **Icebreaker**

III. **Presentation: CQM Overview**

IV. **Part A Agency/Services Overview**

V. **Survey**

VI. **Questions/Suggestions**

VII. **Adjournment**

Next Meeting Date: June 5th, 2018

Governmental Garage Parking Validation: _____

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

SUPPORT SERVICES NETWORK
Tuesday, March 6th, 2018 at 9:30 A.M.
Ryan White Part A Program Office
115 S. Andrews Ave., Ft. Lauderdale 33301

MINUTES

PROVIDERS PRESENT
Barnes, B., Poverello
Yadoff, L., Coast to Coast Legal Aid
Schickowski, K., Legal Aid
SaintFleur, P., AHF
Labissiere, R., BCFHC
Romero, T., BCFHC
Whyte, K., Broward House
Pierre, I., BRHPC
Garcia, E., Care Resource
Muneton, Z., CDTC
Javier, J., Latinos Salud
Simpson, R., NBHD
Ferguson, E., NBHD
Pont, A, SBHD
Verger, G., SBHD

PROVIDERS ABSENT
None

PART A RECIPIENT STAFF
Fender, T.

CQM SUPPORT STAFF
Holloman, K.
Powers, C.
Akiti, D.

I. Welcome/Introductions
CQM staff welcomed everyone and individual introductions were made. The Quality Improvement Manager presented the new schedule for the year and explained the new structure of the Networks.

II. Icebreaker
The Network completed an icebreaker called "Connecting Stories." The goal of the icebreaker was to have the Providers learn more about each other and their similarities by telling short stories about themselves.

III. Presentation: CQM Overview & Part A Agency/Services Overview
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 difference between quality assurance and quality improvement, the CQM work plan, and the core medical and

support services. The Access to Care schedule is created by the Recipient staff and disseminated by the CQM staff to all providers. The presentation also reviewed the structure and logistics of the Network meetings. A provider asked if we can discuss the Broward Integrated Plan and where it fits in with the Network. Several agencies signed up for case studies for the rest of the year.

IV. Survey

Providers completed a survey about the topics they would like to see discussed at the meetings throughout the year.

V. Questions/Suggestions

Providers suggested changing the name of the "House Rules" to "Terms of Engagement" or "Meeting Requirements." A provider asked if CIED and BSS are under Non-Medical Case Management and the QI Manager explained that CIED and BSS are funded through Non-Medical Case Management since they are not specific services funded by HRSA. A provider asked if there is still training on the Ryan White Program and the difference between the service categories and Part A, B, C, and D. The QI Manager said that she will look into it. Another provider asked where Pharmacy falls under and staff explained that it falls under Medical and that the Pharmacists typically attend the Medical meetings. The provider then asked where the Nutrition Specialists fall under and staff will look into the service to see which service category they fall under.

VI. Adjournment

Meeting adjourned at 11:17 a.m.

Next Meeting Date: June 5th, 2018

BROWARD COUNTY CLINICAL QUALITY MANAGEMENT PROGRAM

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

GET CARE
BROWARD
TREAT HIV | BEAT HIV
BROWARD COUNTY
FLORIDA

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

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, QI Network Work Plans, 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, QI Networks, and stakeholders.

GET CARE
BROWARD
TREAT HIV | BEAT HIV
BROWARD COUNTY
FLORIDA

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

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

CQM PLAN: QUALITY ASSURANCE & QUALITY IMPROVEMENT

Quality **Assurance**

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

COMPLEMENTARY

Quality **Improvement**

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

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

CQM PLAN: PROCESSES AND ACTIVITIES

Broward EMA CQM Annual Work Plan 2017 (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
Goal 4: Communicate CQM data, evaluation, and improvement methods to the QMC, Networks, and stakeholders.													

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.

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

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.

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

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 Nlin LCSW	(954) 561-6900 Ext. 2657 rafis.nlin@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.

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

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

MEETING OVERVIEW: SERVICE CATEGORY NETWORK MEETING

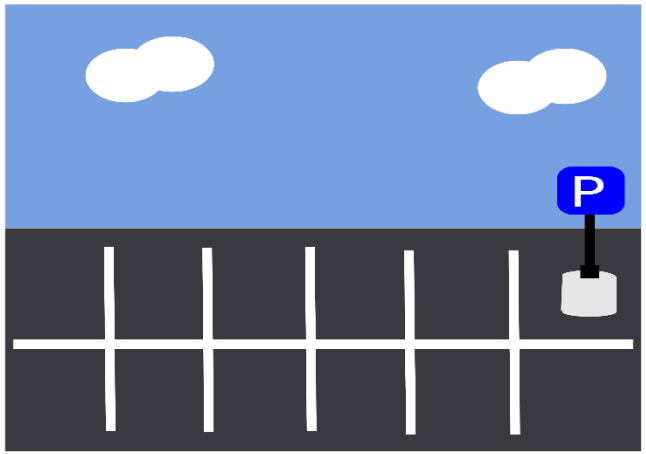
Network meetings are a vessel for improving Part A services by eliciting feedback from providers to better **understand** and **improve** the client experience.

- 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

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

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
    - Unfinished business to be followed up on at the next meeting
    - Noted in meeting minutes



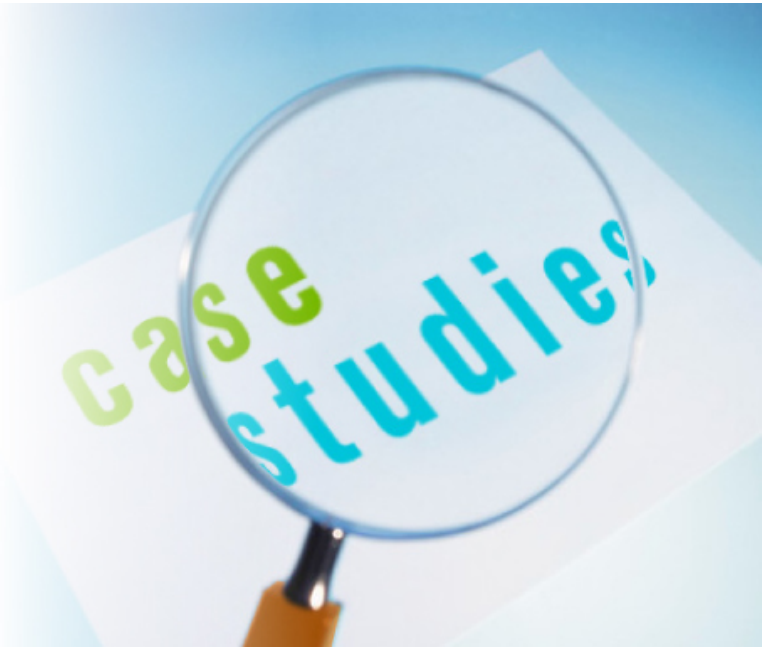
GET CARE
BROWARD
TREAT HIV | BEAT HIV
BROWARD COUNTY
FLORIDA

MEETING OVERVIEW: AGENDA ITEMS

- New Agenda Items
  - Evaluations
    - Completed at the end of every meeting
    - Short format
  - Topics of Interest (ex. Community resources, client communication/follow-up, etc.)
    - May include input from: Staff, Ryan White Providers, outside experts
    - Providers will complete the Topics of Interest survey form
  - Data Presentation
    - Abbreviated systemwide data presentation
      - Quarterly

MEETING OVERVIEW: CASE STUDIES

- Case Studies: Method of **obtaining feedback** on barriers to client care, resource sharing, and improving communication among providers
  - Two assigned agency presentations per meeting
  - Assigned Agency Representatives will complete the Case Study worksheet with all relevant information to share with the network
    - Completed worksheets shall be e-mailed to Staff for inclusion in the meeting packets **two weeks** prior to the assigned meeting date



GET CARE
BROWARD
TREAT HIV | BEAT HIV
BROWARD COUNTY
FLORIDA

HOUSE RULES

- **Providers/Attendees as meeting stakeholders**
- **Improve attendee performance & working relationships**

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

GET CARE BROWARD TREAT HIV | BEAT HIV BROWARD COUNTY FLORIDA

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

GET CARE
BROWARD
TREAT HIV | BEAT HIV
BROWARD COUNTY
FLORIDA

Clinical Quality Management Plan

Fort Lauderdale/Broward County Part A Eligible Metropolitan Area FY 2017-2019

Revised
March 2018

HIVPC Approved 03/23/2017

CONTENTS

I. INTRODUCTION

The United States Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act in 1990 and has since been amended and reauthorized in 1996, 2000, 2006 and 2009. The Ryan White HIV/AIDS Program is operated by the U.S. Department of Health and Human Services (HHS) and the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). Ryan White HIV/AIDS Program legislation requires all Ryan White Part A Recipients to establish Clinical Quality Management (CQM) programs to: (1) 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 (2) 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 necessary components of a comprehensive CQM program. The three necessary components are infrastructure, performance measurement, and quality improvement.

To be effective, a CQM program requires:

- Specific aims based in health outcomes;
- Support by identified leadership;
- Accountability for CQM activities;
- Dedicated resources; and
- Use of data and measurable outcomes to determine progress and make improvements to achieve the aims cited above.

The Ryan White HIV/AIDS Program focuses on ensuring access to high quality Outpatient/Ambulatory Medical Care (OAMC), medications, and other core health care services for persons living with HIV/AIDS. To ensure that resources are available to undertake CQM, the Ryan White HIV/AIDS Program also provides Minority AIDS Initiative (MAI) funding under Part A to Eligible Metropolitan Areas (EMAs) for CQM initiatives. CQM data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the EMA planning process and ongoing assessment of progress toward achieving program goals and objectives.

History of CQM program:

The Fort Lauderdale/Broward County EMA established a systemwide quality assurance and continuous quality improvement program in 1997. Standards of care, service delivery protocols, client level outcomes and indicators for each service category, as well as uniform data collection instruments were adopted in 2000. An Assessment Committee was created in 2003 which evolved into a CQI Committee in 2005. In 2008, the Quality Management Committee (QMC) was formed as a part of the Broward HIV Health Services Planning Council (HIVPC) to increase HIVPC and consumer involvement in the CQM program. Service Provider Networks transitioned to Quality Improvement (QI) Networks in 2007 to develop and execute quality improvement projects (QIPs). The CQM program was nationally recognized for performance measurement by the National Quality Center (NQC) in 2012 for its use of an integrated data software system, Provide Enterprise. Data gathered through the CQM program is used as part of the planning process and ongoing assessment of progress toward achieving program goals and objectives through an inclusive structure that integrates consumer and provider input.

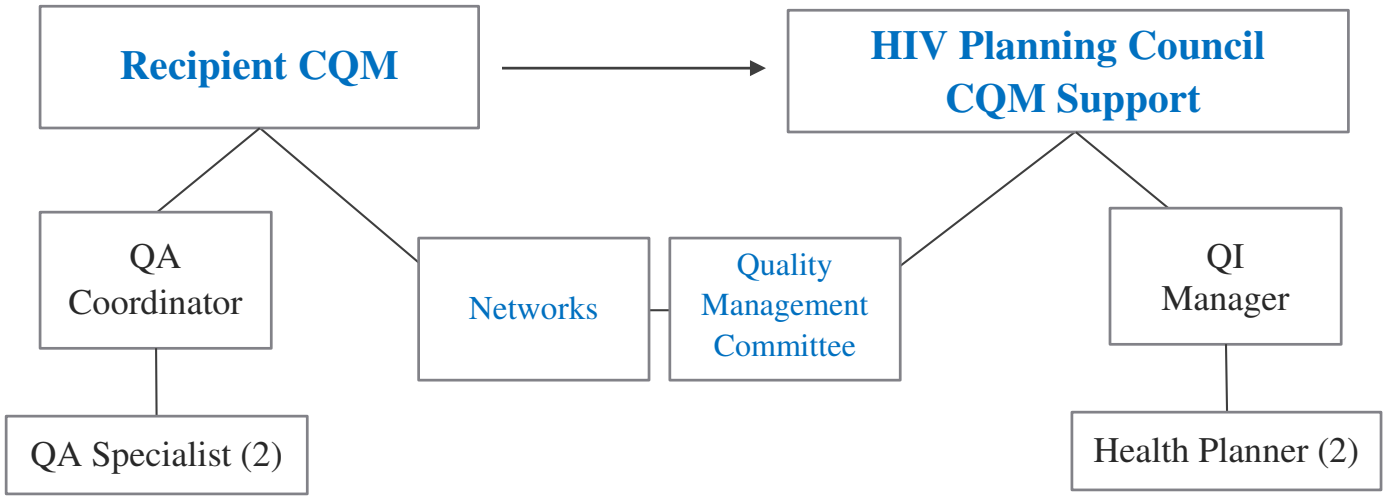
Quality Statement:

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.

The *purpose* of the CQM program in the Fort Lauderdale/Broward County EMA is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV services provided to people living with HIV/AIDS in Broward County. This will be accomplished by:

- Assessing the extent to which HIV services are consistent with the most recent HHS Clinical Guidelines for the Treatment of HIV/AIDS and related opportunistic infections;
- Developing strategies for ensuring that such services are consistent with the guidelines for improvement in the access to, and quality of HIV services;
- Monitoring the quality of HIV services through application of the HIV Care Continuum, HAB performance measures, HHS indicators, and Broward EMA local outcomes and indicators;
- Implementing continuous quality improvement strategies to ensure core and support services promote retention in care, adherence to medical treatment, and viral suppression;
- Applying client-level demographic, clinical, and utilization data to identify areas of improvement in clinical processes and outcomes; and
- Developing action-oriented QIPs to improve care and support strategies.

II. CQM INFRASTRUCTURE



The Recipient is ultimately responsible for all quality related activities that fulfill the legislative requirements for the CQM program in the Broward EMA. There are four interconnected bodies that oversee the Broward EMA CQM program: Recipient CQM staff, HIV Planning Council (HIVPC) CQM Support staff, HIVPC Quality Management Committee (QMC), and the Networks.

Quality Management Committee:
The HIVPC has established a standing Quality Management Committee. The Committee is comprised of HIVPC members, consumers, client service professionals, and HIV and non-HIV providers. The Chair and Vice-Chair of the Committee is appointed at will by the HIVPC Chair and is responsible for convening the meetings and coordinating the work of the Committee in collaborating with the Part A office. The Committee advises the Recipient on clinical performance issues to be addressed in the CQM Plan and Annual Work Plans, provides feedback on periodic quality assessments, guides design of systemwide QIPs, and coordinates Networks' activities. CQM staff are assigned to coordinate the work of the Committee with HRSA's requirements and to assist in data evaluation.

Networks:
The QMC oversees Networks that have been established by the Recipient. The Service Category Networks are comprised of subrecipients representing all locally funded Ryan White Part A service categories and serve as a forum to discuss and address matters within each service category. The Quality Network is comprised of Quality contacts and Managers for all Part A agencies. The Networks meet quarterly to discuss service delivery barriers and challenges and develop the means to resolve them. CQM staff collaborate with the Networks to develop and implement quality improvement projects to improve system processes and health outcomes among Part A clients in Broward County.

Roles and Responsibilities:

A. *Recipient CQM Staff –*

- Maintain oversight of EMA systemwide Part A QI initiatives and related activities.
- Facilitate integration and interaction among Part A QMC, Networks, and consumers.
- Develop, review, and evaluate progress toward successful implementation of the CQM Plan and Annual Work Plans.
- Ensure all provided services are consistent with the most recent HHS guidelines.
- Collaborate with HIVPC CQM support staff to routinely extract Management Information System (MIS) data to assess level of care, performance measures, and health outcomes.
- Collect, monitor, and analyze client- and system-level data and performance measures.
- Develop Service Delivery Models (SDMs), standards of care, and performance indicators for each service category.
- Conduct annual on-site monitoring evaluation visits and monthly subrecipient calls. Provide and facilitate technical assistance (TA).

B. *HIVPC CQM Support Staff –*

- Research national guidelines and best practice models to ensure quality activities follow national standards.
- Facilitate the development, review, and updating of the CQM Plan, CQM Annual Work Plan, and SDMs.
- Collaborate with Recipient CQM staff to routinely extract MIS data to assess level of care, performance measures, and health outcomes.
- Collect, monitor, and analyze client- and system-level data and performance measures.
- Report data findings to the QMC and Quality Network to assess systemwide data and achievement of health outcomes.
- Assist with the planning and facilitation of the Networks.
- Assist with the development, implementation, and tracking of QIPs to address identified deficiencies.
- Plan and facilitate QI trainings to the QMC and Networks.

C. HIVPC QMC –

- Develop Committee policies and procedures that are consistent with other HIVPC Committees.
- Review CQM data to evaluate progress in achieving CQM goals.
- Participate in the development and evaluation of Broward outcomes and indicators.
- Assist with the development and implementation of the CQM Plan, CQM Annual Work Plan, and SDMs.
- Review and update SDMs to ensure services are provided in accordance with national guidelines and best practice models.

- Identify, monitor, and advise QIPs for the Networks.

D. *Networks* –
- Service Category Networks
  - Design standards of care and performance indicators for each service category.
  - Address emerging barriers impeding access to and retention in services.
  - Review and update SDMs to ensure services are provided in accordance with national standards and best practice models.
- Quality Network
  - Design standards of care and performance indicators for each service category.
  - Develop quality improvement strategies and test processes selected for quality improvement.
  - Assist CQM staff with the development and implementation of QIPs to improve service delivery and health outcomes.
  - Review service category and agency specific performance measures using client- and system-level data.
  - Review and update SDMs to ensure services are provided in accordance with national standards and best practice models.

Involvement of Stakeholders:
Consumers—Ryan White consumers are ultimately impacted by the quality of Part A and MAI funded services. For this reason, the consumer voice is vital in the development and planning of CQM program activities. Consumers play a critical role in informing the CQM program about the HIV Care Continuum and barriers that impede access, retention, and adherence to care. Consumers complete the feedback loop through focus groups, client satisfaction surveys, key informant interviews, and consumer participation at QMC and Network meetings. Consumers comprise over 50% of QMC membership and actively participate in Networks.

Subrecipients—The Broward EMA works closely with Ryan White Part A subrecipients located in the area. The Recipient has laid out very specific standards and guidelines for contracted agencies to ensure the highest quality of HIV health care is provided to consumers. The Service Category Networks are comprised of subrecipients representing all Part A and MAI funded service categories. The Quality Network members include leaders of subrecipient organizations charged with communicating and implementing QIPs.

Coordination with other funders of HIV Prevention, Care and Treatment—Collaboration between funders of HIV Prevention, Care, and Treatment documents the EMA's commitment to community viral suppression and the establishment of seamless linkage and retention in care to improve health outcomes within Broward's Continuum. Recipient CQM staff collaborate with Part C and D recipients and the HOPWA administrator to provide quarterly trainings to MCMs, peer educators, supervisors, CIED workers, and housing case managers. The Part C Grantee currently serves as the Chair of the QMC and is responsible for coordinating the work of the Committee in collaboration with CQM staff. The HIV Prevention Monitoring and Evaluation Consulting Manager actively participates as a member of the QMC and plays an active role in the CQM process and providing updates on prevention activities. Through participation in Part A CQM process, other recipients review Part A performance and outcome measures, unmet need data, and annual needs assessment data to inform efforts to improve service delivery and addressing barriers to care across funders.

III. CQM Goals

Process for Developing CQM Goals:

Quality goals are endpoints or conditions toward which the CQM program will direct its efforts and resources during quality improvement work. CQM staff work with the QMC to develop CQM goals to guarantee they are understood and embraced at the system level. The goals are aligned with HRSA standards and the HIV Care Continuum. Progress toward achieving these goals is monitored by the QMC using the CQM Annual Work Plan (*Appendix B*).

CQM Annual Work Plan:

- The CQM Plan includes an Annual Work Plan that is reviewed and updated monthly at QMC meetings.
- The Annual Work Plan is a timeline that specifies objectives and strategies to accomplish CQM goals.
- The Annual Work Plan is attached as *Appendix B*.

CQM Goals:

Goal 1: Use client-level demographic, clinical, and utilization data to identify disparities in care and areas of improvement.

Objectives:

1. Select performance measures and annual goals.
2. Review and analyze performance measures including HAB measures and locally adopted outcomes and indicators.
3. Analyze client utilization data to identify and address disparities and gaps along stages of the HIV Care Continuum.
4. Make recommendations to Committees and Networks to address disparities in care and areas of improvement.

Goal 2: Evaluate the CQM program, including the CQM Plan, Network Work Plans, and service categories.

Objectives:

1. Conduct evaluation of performance measures including HAB measures, client utilization data, and locally adopted outcomes and indicators annually to the QMC and Networks.
2. Perform annual monitoring of subrecipients and review agency-specific quality plans to ensure compliance with directives established in contract with Recipient.
3. Identify accomplishments and challenges by reviewing progress in completing the CQM Annual Work Plan.
4. Provide a quarterly Network update to the QMC and identify areas for improvement and potential QIPs.

Goal 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.

Objectives:

1. Review Service Delivery Models annually to ensure standards of care and protocols are consistent with HHS guidelines and best practice models.
2. Organize/conduct quarterly trainings for subrecipients, the QMC, and the HIVPC to expand knowledge and skills on QI processes.
3. Provide and facilitate systemwide and individual TA to subrecipients monthly.
4. Conduct annual review of findings from needs assessment, client survey, service category assessments, and client-level data to identify potential QIPs.
5. Quality Network implement and evaluate two QIPs in the fiscal year.

Goal 4: Communicate CQM data, evaluation, and improvement methods to the QMC, Networks, and stakeholders.

Objectives:

1. Conduct biannual evaluations of data review and presentation methods to ensure all data is effectively communicated.
2. Disseminate data dashboards quarterly and publish annual quality report.
3. Provide quarterly CQM program updates to the HIVPC.
4. Disseminate CQM program information quarterly to community stakeholders through media campaigns and social media outlets.
5. Conduct annual QMC retreat.
6. Hold annual "All Networks Retreat" among the Networks and celebrate accomplishments.

IV. PERFORMANCE MEASUREMENT

Selection of Performance Measures:

To assess the quality of care provided across the Broward EMA, the QMC has approved performance measures including outcomes along the HIV Care Continuum, a variety of HAB performance measures, and locally adopted outcomes and indicators (*Appendix A*). The QMC utilizes the HIV Care Continuum to inform the development of CQM program performance measures and CQM goals and objectives outlined in the CQM Plan. The Continuum model allows processes to achieve high quality, accessible, and affordable services to all HIV+ Broward residents. Also, starting in 2017, the Broward EMA will be implementing an Integrated Prevention and Care Plan. The goal of the integrated plan is to streamline HIV prevention and care planning in a manner that will enhance prevention efforts for the highest risk populations. The integration of planning activities aid in accomplishing CQM goals and improving outcomes along the Continuum.

The CQM Plan puts high focus on accomplishing the NHAS goal to increase access to care and improve health outcomes. To accomplish this goal, which is also prioritized in the Integrated Plan, the CQM program assists in a strategy to increase retention in care and viral load suppression through coordinated and integrated activities between and among prevention, care, and treatment providers. CQM staff efforts to implement this strategy include the analysis of client utilization data to (1) identify areas of improvement in the coordination and integration of activities, and (2) conduct utilization focused evaluation to identify and address disparities and gaps along the stages of the HIV Care Continuum.

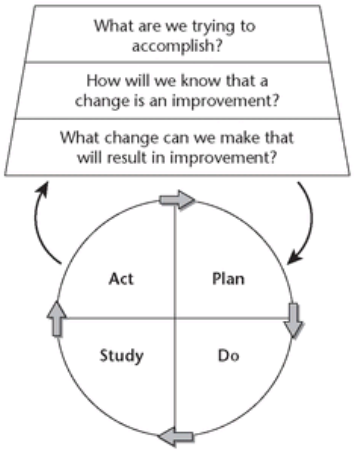
Data Collection:

The CQM program is responsible for the regular collection, analysis, and reporting of CQM data. To generate outcome reports, the Broward EMA funds a management information system, Provide Enterprise (PE), by Groupware Technologies, Inc. PE collects client data on sociodemographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. Subrecipients are contractually required to enter client data into PE allowing CQM staff to extract data to assess level of care, performance measures, and health outcomes.

Data Analysis and Reporting:

CQM staff perform routine analyses of all CQM performance measures (*Appendix A*). CQM staff uses PE to generate quarterly performance analysis reports using client- and system-level data. CQM program performance measures are analyzed for trends and disparities in gender, race, ethnicity, age, risk factor, education, etc. The performance measures are also compared to national benchmarks. The quality of services provided, provider performance, and health outcomes are assessed through service delivery standards and various HAB and EMA-specific performance measures. CQM staff develops and implements mechanisms for sharing findings with the QMC, Networks, subrecipients, front-line providers, consumers, HIVPC, Broward County community, and other stakeholders.

V. QUALITY IMPROVEMENT



QI Approach:
The CQM program uses the Model for Improvement as a framework to guide QI efforts. The model applies: (1) three fundamental questions to set the aim, establish measures, and select changes and (2) the Plan-Do-Study-Act (PDSA) cycle to test small-scale. The three questions ensure that the aim is clear, measures are in place, and the focus is on making change. The PDSA cycle is used by CQM staff and Networks as a tool to guide QIPs.

Process to Determine QIP Priorities:
CQM staff uses a data-driven process for identifying priorities and designing and implementing QIPs to improve systemwide and agency-specific performance measures. All priorities are set within the context of the Part A mission to ensure access, retention, and adherence to care. QIPs are designed through analysis of PE data, consumer surveys, focus groups, and service assessments. Analytic results guide the design and implementation of systemwide changes, and are an essential part of QMC and Quality Network meetings. The CQM Annual Work Plan includes scheduled data and progress reviews. The Networks and CQM staff identify processes needing improvement, as well as data needed to design and implement interventions and monitor their impact.

Process to Monitor and Support Subrecipients Engagement in QIPs:
Quality-related requirements are incorporated in all Part A Request For Proposals (RFPs), subrecipient contracts, quarterly outcome reports, and contract monitoring polices designed to ensure that services fully maintain efforts to ensure access, adherence, and retention in high quality OAMC. RFPs and subrecipient contracts require that all Part A subrecipients participate in the CQM initiatives. These efforts include, but are not limited to, participation in the Networks, desktop reviews of clinical data, and trainings. Subrecipients participate in the CQM program by: (1) participation in the Networks that are responsible for evaluating efficiency and efficacy of systemwide service delivery, and (2) developing HIV QM infrastructure, preparing written HIV QM plans, and designing annual work plans that guide internal CQM processes. To further this effort, Recipient CQM staff assesses subrecipients' CQM programs to: (1) identify the extent they have undertaken key components of QM implementation; (2) evaluate their QM infrastructure; (3) ascertain strengths and weakness of QM programs; and (4) determine the extent to which training and TA are needed. The assessment results help guide development and implementation of subrecipients' QM programs.

The Recipient sponsors subrecipient QI trainings to ensure they are prepared to participate in QIPs. While these activities are mandatory, subrecipients participate actively, with the common goal of systemwide excellence in core medical and support services. CQM staff provides ongoing TA via monthly subrecipient teleconferences on data collection, analysis, reporting, and QI operations. CQM staff train subrecipient personnel on various PE reports to monitor agency performance and collect required data. CQM staff conducts annual monitoring visits and reviews quarterly subrecipient reports to monitor compliance with contract requirements. Subrecipients must submit a quarterly outcome report that includes reporting on the progress of the subrecipient's internal QM processes. The quarterly outcome report helps to ensure compliance with subrecipients' QM programs and QM plans. The outcome report also allows agencies to explain internal QIPs and process improvements that are being conducted for the quarter to enhance program services. Findings gained through this comprehensive process are shared with the QMC and the Networks to address needed improvement.

Evaluation of QIPs:
Recipient CQM staff ensures that active QIP updates are a standing item on monthly QMC agendas. CQM support staff facilitate this process by collecting and analyzing clinical quality measurement data, then report findings and progress to the QMC. The Quality Network will share internal QIP progress at quarterly Quality Network meetings and make modifications as necessary.

VI. EVALUATION

Evaluation of the Ryan White Part A System:
Each quarter of the fiscal year, CQM staff, the QMC, and the Networks evaluate the CQM Annual Work Plan to assess progress made toward achievement of the goals outlined in the CQM Plan. Other data from provider quarterly outcome reports, annual Recipient program evaluations, and chart reviews are also used in the quarterly progress review. As CQM staff collects and analyzes CQM performance measures, they report findings and recommendations to the QMC, QualityNetwork, and service category Networks as necessary. The QMC and Quality Network review all service category client- and system-level outcomes and performance measures to assess incremental improvement and achievement of benchmarks and identify potential QIPs. Additionally, CQM staff provides data relative to the achievement of performance measures and improvement in health outcomes to the QMC and all Networks.

Fundamental to evaluation of the CQM Plan is the solicitation of consumer input via focus groups, key informant interviews, satisfaction surveys, and participation in the QMC and Networks. CQM staff solicits input from the QMC and service categoryNetworks regarding topics to be covered in client focus groups and satisfaction surveys. Subrecipients are also required to design their own CQM evaluation processes, including consumer satisfaction assessments. Recipient CQM staff provide capacity development and TA to providers in these activities.

Evaluation of the CQM Program:
At the beginning of each fiscal year, the CQM Plan will be evaluated for the ability to support and sustain QI activities in the Broward EMA. Evaluation of the CQM program is led by the QMC Chair and Committee with support from CQM program staff. Evaluation will be completed using the *Organizational Assessment for Ryan White HIV/AIDS Program Part A Grantees* tool (*Appendix C*) developed by the National Quality Center (NQC). The organizational assessment tool aims to evaluate the CQM program to ensure all key organizational components are in place to meet key improvement milestones. The results of the evaluation will be used to modify the CQM Plan or processes, if needed, and shared with the QMC, Quality Network, and CQM staff.

VII. CAPACITY BUILDING

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

Central to this process is the ability of the CQM staff to work in a supportive and facilitative method with the QMC, Networks, and individual subrecipients to facilitate QIPs and the receipt of TA. CQM staff arranges for CQM capacity development to address subrecipients' needs.

VIII. COMMUNICATION

Communication with key stakeholders in the Broward EMA will include dissemination of CQM information through: email correspondence, HIVPC Committee meetings, reporting, conference presentations, trainings at Network meetings or regional meetings, social media, webinars, and conference calls.

As CQM staff collect and analyze CQM performance measures, they report findings and recommendations to the QMC and respective Networks each quarter in the fiscal year. The QMC reviews service category client- and system-level outcomes and performance measures to assess incremental improvement and achievement of benchmarks and to identify potential QIPs. The Quality Network reviews systemwide and service category-specific data quarterly to identify agency-specific disparities and potential QIPs. Service category Networks review abbreviated systemwide data quarterly to gain a better understanding of trends occurring in the system. CQM staff provides data relative to the achievement of quality outcomes and performance measures to the QMC and Quality Network. CQM staff also presents an annual Quality Report to the HIVPC and other advisory boards that summarizes the findings and results from activities conducted by the QMC and Networks. Additionally, CQM program information is disseminated to community stakeholders through media campaigns, social media outlets, and presentations at local and national conferences.

APPENDIX A – PERFORMANCE MEASURES

Systemwide						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Ever in Care:	HIV+ clients that ever had medical care service* documented.	All Ryan White Part A clients.	99.0%	100.0%		FLDOH
In Care:	HIV+ clients that had a medical care service* documented within reporting period.	All Ryan White Part A clients.	87.7%	90.0%		FLDOH
Retention in Care:	HIV+ clients that had two or more medical care service* at least three months apart in reporting period.	All Ryan White Part A clients.	60.8%	70.0%	*Patients newly enrolled in care during last six months of the measurement year.*	FLDOH
On ARV Therapy:	HIV+ clients that have ARV therapy set to one or more at any time during reporting period.	All Ryan White Part A clients.	91.7%	95.0%		FLDOH
Virally Suppressed:	HIV+ clients with most recent viral load as of end of reporting period less than 200 copies/mL.	All Ryan White Part A clients.	81.2%	85.0%	*Patients with unknown or unreported viral loads.*	FLDOH
***Medical Care Service:** *At least one documented viral load or CD4 lab, medical visit, or prescription pickup since HIV diagnosis.*						

Outpatient/Ambulatory Medical Care (OAMC)						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
CD4 Count and Prescription of ART:	Clients in the denominator who were on ART according to their most recent HIV history record prior to the end of the reporting period.	Clients that received OAMC during the reporting period, and had a most recent CD4 count <500 prior to the end of the reporting period.	91.0%	94.0%		Broward Indicator
Impact of ART on Viral Load:	Clients in the denominator whose most recent viral load test result prior to the end of the reporting period was <200 copies/mL.	Clients that received OAMC during the reporting period, and was on ART for more than six months as of the end of the reporting period.	86.1%	89.0%		Broward Indicator
Viral Load Suppression:	Number of patients in the denominator with a viral <200 copies/mL at last viral load test during the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.	-	85.0%		HAB
Prescribed ART:	Number of patients from the denominator prescribed ART during the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.	-	98.0%		HAB
Medical Visits Frequency:	Number of patients in the denominator who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior six-month period and the last medical	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first six months of the 24-month measurement period.	-	85.0%	*Patients who died at any time during the 24-month measurement period.*	HAB

	visit in the subsequent six-month period.					
Gaps in Medical Visits:	Number of patients in the denominator who did not have a medical visit in the last six months of the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first six months of the measurement year.	-	18.0%	*Patients who died at any time during the measurement period.*	HAB
PCP Prophylaxis:	Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm^3, Numerator 2: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm^3 or a CD4 percentage below 15%, Numerator 3: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis at the time of HIV diagnosis. *Aggregate numerator: Sum of three numerators*	Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm^3, who had at least two visits during the measurement year, with at least 90 days in between each visit; and, Denominator 2: All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm^3 or a CD4 percentage below 15%, who had at least two visits during the measurement year, with at least 90 days in between each visit; and, Denominator 3: All patients aged 6 weeks through 12 months with a diagnosis of HIV, who had at least two visits during the measurement year, with at least 90 days in between each visit. *Aggregate denominator: Sum of three denominators*	-	85.0%		HAB
HIV Drug Resistance Testing Before Initiation of Therapy:	Number of patients who had an HIV drug resistance test performed at any time before initiation of ART.	Number of patients, regardless of age, with a diagnosis of HIV who were prescribed ART during the measurement year for the first time and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	-	60.0%		HAB
Cervical Cancer Screening:	Number of patients in the denominator who were screened for cervical cancer in the last three years.	Number of female patients with a diagnosis of HIV who had at least one medical visit with provider with prescribing privileges and were > 21 years old in the measurement year.	39.1%	42.0%	*Patients who had a hysterectomy for non-dysplasia/non-malignant indications.*	HAB
Hepatitis B Vaccination:	Number of patients with a diagnosis of HIV with documentation of having ever completed the vaccination series for Hepatitis B.	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	-	80.0%	1. *Patients newly enrolled in care during the measurement year.* 2. *Patients with evidence of current HBV infection (Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody or Hep B DNA).*	HAB

					3. Patients with evidence of past HBV infection with immunity (Hep B Surface Antibody without evidence of vaccination).	
Hepatitis C Screening:	Number of patients with a diagnosis of HIV who have documented HCV status in chart.	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	87.4%	90.0%		HAB
HIV Risk Counseling:	Number of patients with a diagnosis of HIV, as part of their primary care, who received HIV risk counseling.	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	-	85.0%		HAB
Lipid Screening:	Number of patients who had a fasting lipid panel in the measurement year.	Number of patients, regardless of age, who are prescribed ART and who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	89.8%	93.0%		HAB
Oral Exam:	Number of patients with a diagnosis of HIV who had an oral exam by a dentist during the measurement year, based on patient self-report or other documentation.	Number of patients with a diagnosis of HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year.	37.9%	43.0%		HAB
Syphilis Screening:	Number of patients with a diagnosis of HIV who had a serologic test for syphilis performed at least once during the measurement year.	Number of patients with a diagnosis of HIV who were >18 years old in the measurement year or had a history of sexual activity <18 years, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	84.0%	87.0%	*Patients who were <18 years old and denied a history of sexual activity.*	HAB
TB Screening:	Patients for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection.	All patients aged three months and older with a diagnosis of HIV/AIDS, who had at least two visits during the measurement year, with at least 90 days in between each visit.	87.0%	90.0%	*Documentation of Medical Reason for not performing a TB screening test (e.g., patients with a history of positive PPD or treatment for TB).*	HAB
Chlamydia Screening:	Number of patients with a diagnosis of HIV who had a test for chlamydia.	Number of patients with a diagnosis of HIV who were either a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months, and had a medical visit with a provider with prescribing privileges at least once in the measurement year.	75.4%	80.0%	*Patients who were <18 years old and denied a history of sexual activity.*	HAB
Gonorrhea Screening:	Number of patients with a diagnosis of HIV who had a test for gonorrhea.	Number of patients with a diagnosis of HIV who were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months; and had a medical visit with a provider with	63.7%	68.0%	*Patients who were <18 years old and denied a history of sexual activity.*	HAB

		prescribing privileges at least once in the measurement year.				
Hepatitis B Screening:	Number of patients for whom Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity.	Number of patients, regardless of age, with a diagnosis of HIV and who had at least two medical visits during the measurement year, with at least 60 days in between each visit.	92.3%	95.0%		HAB
Influenza Immunization:	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization during the current season.	All patients aged 6 months and older seen for a visit between October 1 and March 31.	-	75.0%	*Documentation of medical reason for not receiving influenza immunization (e.g., patient allergy, patient declined, vaccine not available, other medical reasons).*	HAB
Pneumococcal Vaccination:	Number of patients with a diagnosis of HIV who ever received pneumococcal vaccine.	Number of patient with HIV who had no documented evidence of vaccination and a medical visit with a provider with prescribing privileges at least once in the measurement year.	-	80.0%	*Patients with CD4 counts <200 cells/mm3 within the measurement year.*	HAB
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.	-	40.0%	1. *Patient Reason(s) - Patient refuses to participate.* 2. *Medical Reason(s) - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.* 3. *Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.*	HAB
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.	All patients aged 18 years and older.	-	95.0%	*Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).*	HAB
Substance Use Screening:	Number of new patients with a diagnosis of HIV who were screened for substance use within the measurement year.	Number of patients with a diagnosis of HIV who were new during the measurement year and had a medical visit with a medical provider with	-	95.0%		HAB

		prescribing privileges at least once in the measurement year.				
ARV Therapy for Pregnant Women:	The patients in the denominator that were taking ARV during the second and third trimester (pregnancy record –week started was before 26th week).	HIV/AIDS women (client profile gender) that received OAMC during the reporting period and prior to date of most recent pregnancy start date and became pregnant prior to end of the 3rd quarter of the reporting period where the pregnancy is still "active" or was ended with a live birth during the reporting period.	-	**-**		HAB *ARCHIVED*
CD4 T-Cell Count:	The patients in the denominator that had at least two CD4 tests more than 90 days apart during the reporting period.	HIV/AIDS clients that received OAMC during the reporting period and prior to six months before end of reporting period.	82.6%	-		HAB *ARCHIVED*
HAART:	The patients in the denominator that were on HAART at some point during the reporting period.	AIDS clients that received OAMC during the reporting period and prior to three months before end of reporting period.	96.1%	**-**		HAB *ARCHIVED*
Medical Visits:	The patients in the denominator that had at least two medical visits within the reporting period more than 90 days apart.	HIV/AIDS clients that received OAMC during the reporting period and prior to six months before end of reporting period.	74.4%	**-**		HAB *ARCHIVED*
PCP Prophylaxis:	The patients in the denominator that were prescribed PCP Prophylaxis during the reporting period.	HIV/AIDS clients that received OAMC during the reporting period and prior to three months before end of reporting period and had at least one CD4 test result <200 during the reporting period that was not followed by a subsequent CD4 count within 90days that was >200.	-	**-**		HAB *ARCHIVED*
Adherence Assessment and Counseling:	The patients in the denominator that had at least two adherence assessment and counseling services at least three months apart.	HIV/AIDS clients that received OAMC during the reporting period at least once before six months prior to end of reporting period and started ARV therapy during last six months of reporting period.	-	**-**		HAB *ARCHIVED*
Toxoplasma Screening:	The patients in the denominator that had a toxoplasma screening completed during the reporting period.	HIV/AIDS clients that received OAMC during the reporting period and did not have a toxoplasma diagnosis in their chart.	-	**-**		HAB *ARCHIVED*
MAC Prophylaxis:	The patients in the denominator that had MAC Prophylaxis during the reporting period.	HIV/AIDS clients that received OAMC during the reporting period and had a CD4 count <50 during the reporting period and did not have a MAC diagnosis during the reporting period.	-	-		HAB *ARCHIVED*

Disease Case Management (DCM)						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Retention in Medical Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received MCM services during the reporting period that are not new to care (first service was over a year form the end date of the reporting period).	-	90.0%		Broward Indicator
Plan of Care (POC) Goal Attainment:	Clients in the denominator whose closed action plan goal was successful, and was completed by the target date.	Clients that received MCM services during the reporting period, and had at least on action plan goal closed during the reporting period.	-	90.0%		Broward Indicator
Medical Case Management (MCM) Care Plans:	Number of MCM patients who had a MCM Care Plan developed and/or updated two or more times which are at least three months apart in the measurement year.	Number of MCM patients, regardless of age, with a diagnosis of HIV who had at least one MCM encounter in the measurement year.	-	100.0%	1. *MCM patients who initiated MCM services in the last six months of the measurement year.* 2. *MCM patients who were discharged from MCM services prior to six months of service in the measurement year.*	HAB
MCM Medical Visits:	Number of MCM patients in the denominator who had at least one OAMC visit in each six month period of the 24-month measurement period with a minimum of 60 days between first OAMC visit in the prior six month period and last medical visit in the subsequent six month period.	Number of MCM patients, regardless of age, with a diagnosis of HIV with at least one OAMC visit in the first six months of the 24-month measurement period.	-	85.0%	1. *MCM patients who dies at any time during the 24-month measurement period.*	HAB

Non-Medical Case Management (Non-MCM)						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Achieving POC Goals:	Clients in the denominator whose closed action plan goal was successful, and was completed by the target date.	Clients that received non-MCM services during the reporting period, and had at least one action plan goal closed during the reporting period.	87.5%	90.0%		Broward Indicator
Retention in Care:	Clients in the denominator that had documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received non-MCM services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).	87.1%	90.0%		Broward Indicator

Oral Health Care						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Identification and Treatment of Caries:	Clients in the denominator who had a 75% reduction in unrestored caries based on the "number of caries at start" compared to the "number of caries at end".	Clients that received oral health care during the reporting period, had a Phase I episode of care completed during the reporting period, and had at least one caries reported.	99.0%	100.0%		Broward Indicator
Reduction in Bleeding Sites:	Clients in the denominator who had a 50% reduction in the number of bleeding sites based on the "number of bleeding sites at start" compared to the "number of bleeding sites at end."	Clients that received oral health care during the reporting period, had an episode of care completed during the reporting period, and had at least one bleeding site.	98.7%	100.0%		Broward Indicator
Oral Health Education:	Number of HIV-infected oral health patients who received oral health education at least once in the measurement year.	Number of HIV-infected oral health patients that received a clinical oral evaluation at least once in the measurement year.	-	95.0%	*1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.* *2. Patients who were <12 months old.*	HAB
Periodontal Screening or Examination:	Number of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year.	Number of HIV-infected oral health patients that received a clinical oral evaluation at least once in the measurement year.	-	100.0%	*1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.* *2. Edentulist patients (complete).* *3. Patients who were <13 years.*	HAB

AIDS Pharmaceutical Assistance						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Prescription Pick-Up:	Clients in the denominator that have the "client contact" in a prescription record set to "attempted" or "made" and the "date contact attempted" is within 14 days from the "date returned to stock".	Clients that have a prescription record during the reporting period in a status of "returned to stock".	100.0%	100.0%		Broward Indicator
Provider Referral for Medication Pick-Up/ Follow-Up:	Clients in the denominator that have the "referred to provider" field in the prescription record set to "yes".	Clients that have a prescription record during the reporting period in a status of "returned to stock" who have the "client contact" field in the prescription record set to "not attempted" or "attempted".	97.2%	100.0%		Broward Indicator

Centralized Intake and Eligibility Determination (CIED)						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Scheduled Appointments Every Six Months:	Clients in the denominator that had an appointment record for "medical care" that was created within one day of the "date completed" in the Ryan White certification.	Clients that received a CIED service during the reporting period, who had a Ryan White certification completed during the reporting period and who had not had a medical appointment in the status of "kept" in the six months prior to the certification "date completed".	90.4%	95.0%		Broward Indicator
Eligibility Criteria for 3rd Party Benefits:	Clients in the denominator that had an "access application" that had an "access application" in a status of "submitted" or "processed" during the reporting period.	Clients that received a CIED service during the reporting period.	0.39%	95.0%		Broward Indicator

Mental Health						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Plan of Care Goals:	Clients in the denominator whose closed action plan goal was successful, and was completed by the target date.	Clients that received mental health services during the reporting period, and had at least one action plan goal closed during the reporting period.	72.0%	85.0%		Broward Indicator
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received mental health services during the reporting period that are not new to care (first service was over a year form the end date of the reporting period).	98.5%	100.0%		Broward Indicator

Substance Abuse						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Plan of Care Goals:	Clients in the denominator whose closed action plan goal was successful, and was completed by the target date.	Clients that received substance abuse services during the reporting period, and had at least one action plan goal closed during the reporting period.	50.0%	85.0%		Broward Indicator
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received substance abuse services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).	96.9%	98.0%		Broward Indicator

Food Bank						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received food bank services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).	88.8%	91.0%		Broward Indicator
Not Retained in Care:	Clients in the denominator that had a referral record during the reporting period for one of the applicable service types (i.e. medical care, mental health, or substance abuse).	Clients that received food bank services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period) who did not have a "kept" medical appointment during the six months of the reporting period.	100.0%	100.0%		Broward Indicator

Legal						
Performance Measure	**Numerator**	**Denominator**	**Baseline – FY 16-17**	**Target – FY 18-19**	**Exclusions**	**Source of Measure**
Cases Remanded:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received legal services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).	0.0%	60.0%		Broward Indicator
Improving Financial Stability:	Clients in the denominator who won their case.	Clients who received legal services for representation at a Social Security Administrative Law Judge hearing during the reporting period.	100.0%	100.0%		Broward Indicator

APPENDIX B – CQM ANNUAL WORK PLAN

Broward EMA CQM Annual Work Plan 2017 (March 1, 2017-Febuary 28, 2018)													
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 QI Networks to address disparities in care and areas of improvement.													QMC
Goal 2: Evaluate the CQM program, including the CQM Plan, QI Network Work Plans, 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 QI 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 and QI Network Work Plans.						X						X	CQM Staff, QMC, Networks
4. Provide a quarterly QI 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. QI Networks implement and evaluate two QIPs in the fiscal year.						X						X	Networks
Goal 4: Communicate CQM data, evaluation, and improvement methods to the QMC, QI Networks, and stakeholders.													
1. Conduct biannual evaluations of data review and presentation methods to ensure all data is effectively communicated.						X						X	All CQM Staff
2. Disseminate data dashboards quarterly and publish annual quality report.	X			X			X			X			All CQM Staff
3. Provide quarterly CQM program updates to the HIVPC.	X			X			X			X			All CQM Staff
4. Disseminate CQM program information quarterly to community stakeholders through media campaigns and social media outlets.				X				X				X	All CQM Staff
5. Conduct annual QMC retreat.												X	All CQM Staff
6. Hold annual "All Networks Retreat" among QI Networks and celebrate accomplishments.	X												All CQM Staff

Broward EMA CQM Annual Work Plan 2017 (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
Goal 4: Communicate CQM data, evaluation, and improvement methods to the QMC, Networks, and stakeholders.													
1. Conduct biannual evaluations of data review and presentation methods to ensure all data is effectively communicated.						X						X	All CQM Staff
2. Disseminate data dashboards quarterly and publish annual quality report.	X			X			X			X			All CQM Staff
3. Provide quarterly CQM program updates to the HIVPC.	X			X			X			X			All CQM Staff
4. Disseminate CQM program information quarterly to community stakeholders through media campaigns and social media outlets.				X				X				X	All CQM Staff
5. Conduct annual QMC retreat.												X	All CQM Staff
6. Hold annual "All Networks Retreat" among Networks and celebrate accomplishments.	X												All CQM Staff

"X" indicates completed objectives
indicates in progress/on target

Meeting Topics Survey

In order to facilitate more productive meetings geared toward Quality Improvement initiatives, please list at least two topics, discussion points, or issues related to Quality Improvement you would like to see explored this year.

1. Topic #1

2. Topic #2

3. Additional Topics

Support Services: Case Study

Viral Load:	
History of Viral Load	
Mode of Transportation:	
Housing Status:	
Insurance Status:	
Length of Time in Care:	
Other Medical Conditions:	
Support System (Family, Friends, etc.):	
Other Barriers to Care:	

Client History:

Client Issues: