Clinical Quality Management Program
Ryan White Part A/MAI, Miami-Dade County

Ryan White Part A/MAI Program
Miami-Dade County

INTERIM DRAFT
CLINICAL QUALITY MANAGEMENT PLAN

FY 2020-2021

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H89HA00005, CFDA #93.914 – HIV Emergency Relief Project Grants, for $26,596,944 as of June 30, 2020, of which 0% was financed with nongovernmental sources. This information or content are those of the author(s) and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

BEHAVIORAL SCIENCE RESEARCH CORPORATION
2121 Ponce de Leon Boulevard, Suite 240
Coral Gables, FL 33134
hiv-aidsinfo@behavioralscience.com

CONTENTS

I. INTRODUCTION 3

I.A LEGISLATIVE AND CONDITION OF AWARD REQUIREMENTS 3
I.B DEFINITION OF QUALITY 3
I.C COORDINATION WITH NATIONAL HIV/AIDS STRATEGY 3
I.D CQM AIM AND PRIORITIES 3

II. CQM INFRASTRUCTURE 6

II.A BSR STAFF RESOURCES 7
II.B CQM COMMITTEE AND MAI CQM TEAM 7
II.C OTHER CQMC SUPPORT 8

III. PERFORMANCE MEASUREMENT 9

III.A RWP CLINICAL QUALITY MANAGEMENT PERFORMANCE REPORT CARD 11
III.B RYAN WHITE PART A/MAI PROGRAM CLIENT SATISFACTION SURVEY (CSS) 12
III.C MONTHLY VIRAL LOAD (VL) COMPARATIVE REPORT 14
III.D SYSTEMIC CLIENT-CENTERED REPORTS FOR THE INTEGRATED PLAN 14

IV. QUALITY IMPROVEMENT PROJECTS 15

IV.A A REVIEW OF OAHS PROCEDURES IN AN UNDER-PERFORMING RWP SUBRECIPIENT 15
IV.B ASSESSING SIX-MONTH RETENTION OF NEW-TO-CARE CLIENTS AS A BASIS FOR POTENTIAL QI INTERVENTION. 16
IV.C SUBRECIPIENT-INITIATED QI PROJECTS 16
IV. D PRIORITIZING SUBRECIPIENT QI INITIATIVES BASED ON CQM PERFORMANCE DATA 17

V. MINORITY AIDS INITIATIVE (MAI) CLINICAL QUALITY MANAGEMENT SERVICES 17

V.A CAPACITY BUILDING FOR NEW MAI-FUNDED SUBRECIPIENTS 18
V.B MAI QI INITIATIVE: IMPROVING RETENTION IN CARE FOR DISPARITY POPULATIONS 18

VI. QI TECHNICAL ASSISTANCE AND TRAINING 19

VI.A TECHNICAL ASSISTANCE (TA) 19
VI.B TRAINING 20
VI.B.1 Introductory Quality Improvement Training for New Medical Case Managers 20
VI.B.2 Medical Case Manager Supervisor Quality Improvement Training 21
VI.B.3 Subrecipient Forums 21
21

VII. CONSUMER AND STAKEHOLDER ENGAGEMENT 21

VIII. EVALUATION 22

VIX. ANNUAL WORK PLAN 23

I. INTRODUCTION

I.A Legislative and Condition of Award Requirements

Section 2604(h)(5)(A) of Title XXVI of the Public Health Service (PHS) Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires Ryan White Part A Program Recipients to establish a clinical quality management (CQM) program to: (1) assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infection (https://aidsinfo.nih.gov/guidelines); and (2) to develop strategies for ensuring that such services are consistent with HRSA guidelines for improvement in the access to and quality of HIV health services.

As a Condition of Award, this CQM Program plan adheres to U.S. Department of Health and Human Resources, Health Resources and Services Administration, HIV/AIDS Bureau's (DHHS/HRSA/HAB) CQM guidance as stated in HRSA's Ryan White HIV/AIDS Program Part A Manual (https://hab.hrsa.gov/sites/default/files/hab/Global/happartamanual2013.pdf) and Policy Clarification Notice #15-02 (https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters), as may be amended.

I.B Definition of Quality

Miami-Dade County, the Recipient of local Ryan White Part A and Minority AIDS Initiative (MAI) grant funds, and Behavioral Science Research Corporation (BSR), the County's subrecipient contracted to provide Quality Management Program services, concur with HRSA's definition of quality: "The degree to which a health or social service meets or exceeds established professional standards and user expectations." The following description of this Eligible Metropolitan Area's (EMA) CQM Program strives to ensure that people with HIV (PWA) in Miami-Dade County receive quality medical care and support services through easy access to medical care that is current and appropriate for the treatment of HIV and opportunistic infections, so that PWH can achieve better health outcomes.

I.C Coordination with National HIV/AIDS Strategy

The Miami-Dade County EMA CQM Program incorporates the following National HIV/AIDS Strategy (NHAS) 2020 goals: (1) Reducing new infections; (2) Improving access to care and health outcomes; (3) Reducing HIV-related health disparities; and (4) Achieving a more coordinated local response to the epidemic.

I.D CQM Aim and Priorities

The overarching CQM mission of the Miami-Dade EMA CQM team – the Recipient, BSR and the Clinical Quality Management Committee (CQM Committee) – is to ***constantly, continuously and consistently improve the quality of the services afforded to the people with HIV whom we serve as clients in the Ryan White Program.*** The activities undertaken by the CQM team are necessarily in accordance with the Ryan White HIV/AIDS Program

legislation and HRSA Policy Clarification Notice (PCN) #15-02, and include several focus points in our activity.

- The CQM team focuses on enhancing the service delivery processes in the RWP to improve measurable HAB/HRSA client outcomes: (1) increased retention in medical, medical case management and oral health care, (2) reduced viral loads, and (3) increased client satisfaction. These are benchmark indicators, the "vital signs" of a client-centered care system that seeks to improve the quality of life for the persons with HIV who are served by the Miami-Dade RWP.

- The CQM process seeks to continually promulgate, develop and celebrate a culture of quality improvement in the RWP service delivery system. This culture is a constant process of problem identification, baseline data measurement, root cause diagnosis, QI intervention and post-intervention evaluation among subrecipients throughout the local Part A and MAI care and treatment systems. This is more than "doing a QI project:" this is a process of creating a QI way of thinking among subrecipients, intentionally re-thinking and continuously improving every aspect of the service delivery process.

- The CQM process continuously improves the data the RWP depends on for client measurement and outcome evaluation. This includes effectuating the transition from Casewatch to Provide Enterprise® (PE) as the client data management information system supporting service delivery documentation, continuously improving the data used in the CQM performance measurement, and helping subrecipients create interactive dashboards to facilitate QI measurements of client outcomes and assessment of service improvement.

- Through cooperative arrangements with SF-SEAETC (see below), the CQM team assesses the extent to which HIV health services provided to clients under Part A and MAI funding are consistent with the most recent Public Health Services guidelines (otherwise known as the HHS guidelines) for the treatment of HIV disease and related opportunistic infections.

The work of this Plan is **directed by** the Recipient, **implemented by** BSR, and **coordinated by** the CQM Committee. The three overall aims of the Miami EMA CQM Plan are to: (1) help PWH achieve and maintain viral suppression; (2) improve patient care by ensuring that a network of experienced professionals provide appropriate, high quality medical care and support services; and (3) strive for optimal PWH satisfaction with that care.

This is no simple task, as the Miami-Dade County's Ryan White Part A/MAI service delivery system is large and complex. The local Ryan White Part A/MAI Program served 9,031 PWH in Fiscal Year (FY) 2019-20, through a decentralized network of 14 subrecipient organizations employing hundreds of direct service staff throughout the Miami-Dade EMA. A substantial majority of the Ryan White Part A/MAI Program (RWP) client base received a full spectrum of services directly from the RWP, including Medical Case Management (MCM) and Outpatient/Ambulatory Health Services (OAHS), plus ancillary core and supplementary services; others received a more limited set of services, either (a) because the RWP has transitioned medical care support for almost 2,000 clients to Affordable Care Act (ACA) Marketplace medical providers (while retaining RWP MCM and other services not included by marketplace providers); or (b) because changes in the State of Florida's Medicaid program have resulted in changes in the mix of case management and oral health services provided through Medicaid and the RWP for an additional 2,446 RWP clients.

The CQM plan is informed by several key guiding priorities:

- **Evaluation of quality is driven by the goal of improving client health outcomes.** Every effort is made to improve the performance of the RWP Part A/MAI system of care by improving the performance of individual subrecipients in three major arenas: ***retention in medical/case management/oral health care, suppression of viral loads (VL), and increasing client satisfaction.*** If a measurement activity or process improvement is not ultimately directed toward these client outcomes, it does not belong in this CQM plan.

- **CQM activities conducted under this plan are related to performance goals or strategies in the Ryan White Program/Florida Department of Health 2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan ("Integrated Plan").** While the Integrated Plan includes objectives, strategies, and activities that are outside the purview of the RWP – e.g., activities relating to HIV prevention, testing, and related counseling provided by the Florida Department of Health in Miami-Dade County (FDOH-MDC) – other activities and objectives require close coordination between the RWP and FDOH-MDC. For example, the Test and Treat/Rapid Access (TTRA) protocol initiated by the FDOH-MDC to facilitate same-day engagement in Medical Case Management, Outpatient/Ambulatory Health Services and provision of anti-retroviral prescription medications for new-to-care and returned-to-care PWH cannot operate without close coordination between FDOH-MDC testing and RWP service provision. When the TTRA protocol results in immediate linkage to medical and pharmaceutical services for new-to-care and returned-to-care PWH, it directly affects the joint Integrated Plan goals of increasing VL suppression levels in the Miami-Dade PWH community, and reducing disparities in client health outcomes. The TTRA protocol also includes same day access to a mental health provider visit for the purpose of identifying if there is an underlying mental health condition that is (or may become) a barrier to HIV treatment adherence.

- **PWH and stakeholder involvement is a priority in the CQM process**. This is articulated in the CQM plan by (1) increasing the level of stakeholder and PWH involvement in the CQM Committee and MAI CQM Team (e.g., recruiting more PWH members; enhanced active participation in CQM discussions; implementation and evaluation of CQM activities; etc.: see discussion, below); (2) holding periodic Joint Integrated Plan Review meetings with subrecipient and PWH stakeholders from both the FDOH-MDC Prevention Committee and the RWP Strategic Planning Committee; and (3) semiannual Subrecipient Forums at which CQM findings and implications are reviewed and improvement strategies are discussed.

- **PWH receiving limited services from any RWP-funded subrecipient agency or direct service provider are entitled to the same high quality of care as RWP clients who are eligible for and receiving all necessary core medical and support services through the RWP.** For example, although ACA enrollment transitioned 1,700 clients from the RWP to ACA Marketplace insurance providers in 2017-18, thereby removing these clients from RWP-funded OAHS and Pharmaceutical Assistance services, these clients are still receiving MCM services, Oral Health Care (OHC), Mental Health Services, Oral Health Care, and Outpatient Substance Abuse Treatment through the RWP. The RWP CQM concerns with retention in care and VL suppression are as

compelling for these clients as they are for clients who are receiving a full range of services through the RWP.

Please note that some of the scheduling of planned meetings and recurring deliverables in this plan may be affected because of the 2020 COVID-19 pandemic. While we note these throughout the document, evolving circumstances related to this historical event may make further adjustments necessary.

II. CQM INFRASTRUCTURE

The Miami EMA's CQM Program includes the RWP Recipient, Behavioral Science Research Corporation (BSR) and the RWP CQM Committee. The RWP Recipient is ultimately responsible for all CQM-related activities and authorizes BSR's CQM staff and the CQM Committee to plan, implement, and evaluate subrecipient performance quality improvements in the Miami-Dade County EMA (see I.B, above).

The Miami-Dade EMA uses the "Model for Improvement" – as expanded by the Institute for Healthcare Improvement – as a Quality Improvement (QI) model. This model asks core questions about improving the efficiency and effectiveness of systems of quality, using data to evaluate the reality of service delivery shortfalls, determining the likely root causes of quality and service delivery shortfalls, and measuring the impact of QI responses. In the FY 2019-2020 CQM implementation, BSR found that the disciplines of the QI process are still not fully understood among most of the subrecipients providing RWP services in the Miami-Dade EMA, and that developing a disseminated and articulate "QI culture" in the Miami-Dade EMA requires more than graphic presentations on the PDSA cycle. There is a need to connect ***the measurement of health outcomes at the system level*** with ***specific interventions at the subrecipient level*** that will impact those outcomes. This will require that subrecipients establish baseline measures within their agency's clinical care environments and use these baseline performance indicators to evaluate the impact of QI interventions.

There is a need to more fully involve front-line personnel in "seeing opportunities for improvement" by critically examining their clinical processes, evaluating their data, and determining whether the existing systems actually operate to the benefit or detriment of client outcomes. Improving the quality of care requires a shared understanding of the problem being addressed, as well as its "root causes," and interventions should not be initiated without a plan to evaluate the impact of these interventions on actual client outcomes.

This CQM Plan includes two distinct components: 1) Part A CQM activities related to assessment of system-wide service quality, identification of QI opportunities and facilitation of QI interventions, including technical assistance and capacity building; and 2) MAI CQM activities (see Section V, below), embedded in the Part A CQM superstructure as regards major CQM conceptual organization and training, but with specialized project emphases related to service initiatives for minority clients served in the Miami-Dade RWP.

BSR's "Part A CQM" and "MAI CQM" functions overlap. Both the Part A and MAI funded CQM activities are subject to oversight by the Recipient. Both are guided by teams of subrecipient service providers, stakeholders and persons with HIV -- the CQM Committee and MAI CQM Team (see II.B, below). Both are described in the Integrated Plan, which uses data from the subrecipients and BSR to generate progress reports, reviews of strategies and strategic

planning for the future, and which focuses attention on the Integrated Plan disparity populations, since these disparity populations comprise over 90% of the clients served in the RWP and are served by all of the Part A- and MAI-funded subrecipients in all service categories. The critical difference is that MAI-funded subrecipients are required to develop and implement innovative projects focused on improving health outcomes of specific subsets of disparity populations (e.g., Black/African American MSM, Haitian females, Hispanic MSM) as opposed to large minority populations (e.g., Hispanic) that may be served under the Part A Program. The Part A CQM Committee remains the workhorse side of the local CQM process, providing a steady stream of subrecipient-oriented and client-centered measurement of client satisfaction and clinical client outcomes, all of which inform the RWP's activities within the Integrated Plan.

The CQM infrastructure includes: 1) the ***Clinical Quality Management Committee*** *(CQM Committee; see Section V),* the RWP's advisory body for Quality Improvement (QI) projects; 2) the ***MAI Clinical Quality Management Team*****,** a sub-unit of the CQM Committee; 3) ***Groupware Technologies, Inc.'s Provide® Enterprise Miami (****hereafter,* ***Provide®),*** the local RWP's client data management system; 4) ***South Florida-South East AIDS Educational and Training Center (SF-SEAETC),*** resource for HIV training, technical assistance, and/or capacity building assistance; and 5) ***Miami-Dade County (Recipient)***.

II.A BSR Staff Resources

BSR serves as the County-contracted CQM provider supporting and coordinating day-to-day CQM activities supporting the CQM plan. These activities are carried out by the following staff:

- Project Director (Robert Ladner, PhD; 0.60 FTE Part A CQM, 0.03 FTE MAI CQM);
- Program Administrator (Geoffrey Downie, DrPH; 1.0 FTE Part A CQM);
- Director of Research (Petra Brock, MS; 0.27 FTE Part A CQM);
- Quality Management Coordinator (Sandra Sergi; 1.0 FTE Part A CQM);
- Quality Management Coordinator (Susana Martinez, MSW; 0.10 FTE Part A CQM, 0.9 FTE MAI CQM);
- Quality Management Research Associate (Clarice Evans, MA; 0.75 FTE Part A CQM, 0.05 MAI CQM); and
- Office Administrator/Internal Accountant (Morela Lucas; 0.32 FTE Part A CQM)

II.B CQM Committee and MAI CQM Team

The CQM Committee is organized in accordance with HRSA PCN #15-02; and will normally meet monthly during FY 2020-2021, unless postponed by the impact of COVID-19 pandemic on subrecipient operations. Performance data are generated by BSR in a manner consistent with guidelines provided in PCN #15-02, using Part A and MAI program data from Provide ® and data from the CQM Performance Report Card (see Section III.A, below) to help identify potential quality improvement issues. The data and emergent issues are shared with the CQM Committee, which reviews the issues that need to be addressed, prioritizes which issues or measures will be part of the CQM process for the year, re-prioritizes the issues as needed, proposes timelines to complete the PDSA cycles and evaluations, and provides direction for the QI activities. The CQM Committee also reviews and provides ongoing input into the RWP CQM plan, serves as an infrastructure resource to BSR's CQM process, provides recommendations about the implementation of pilot replications of subrecipient best practices, and adds CQM

oversight from a broad cross-section of stakeholders and people with HIV. The CQM Committee will review the Integrated Plan in October 2020, in conjunction with the Joint Integrated Plan Review Team's (JIPRT) semiannual review of progress toward IP objectives scheduled for November, 2020. ***Please note that under normal circumstances, the first semiannual JIPRT review would be in May, summarizing the previous calendar year's progress towards the Integrated Plan, with a review by the CQM Committee in April before presentation to the JIPRT in May. In the current contract year, the May JIPRT review was cancelled to allow work by the team on the Ending the HIV Epidemic (EHE) plan with the FDOH.*** The CQM Committee will review the CQM Plan annually when the Plan is provided to the Recipient for review, to understand the complexity of the CQM process and their role in the process. The CQM Committee will review existing data from BSR and from RWP subrecipients and will facilitate and oversee the QI projects outlined below (see Section IV).

In the Recipient's 2019-2020 Request for Proposals (RFP) cycle, the County awarded a set of contracts for RWP MAI services that re-arranged the MAI subrecipient lineup for several service categories beginning in FY 2020-2021, and directed the new MAI subrecipients to develop innovative programs for delivering services to the MAI disparity populations described in the RWP's Early Identification of Individuals with HIV/AIDS (EIIHA) activities and the Integrated Plan, both of which interface extensively with the Florida Department of Health in Miami-Dade (FDOH-MDC). As a mechanism for CQM innovation in this new environment, BSR is re-purposing an existing FDOH-MDC/RWP CQM team (the "Retention and Relinkage Team) to concentrate on minority issues in service delivery and concentrate on the MAI initiatives proposed by the MAI subrecipients in the areas of MCM and OAHS. This team will be discussed in more detail in the MAI CQM section, below (see Section V).

II.C Other CQMC Support

Groupware Technologies' Provide®: In FY 2019-2020, the County's aforementioned RFP process resulted in a transition of its client data system from Automated Case Management Systems' Service Delivery Information System (SDIS) to Groupware Technologies' Provide® system, with a go-live date of March 1, 2020. As the transition from SDIS to Provide® continues, BSR's CQM staff members have assisted the Recipient, funded subrecipients with CQM initiatives, and Groupware Technologies to ensure a smooth transition of the performance measurement elements of the Provide® system into a thoroughly capable database environment. This includes building the capacity of the County and BSR to conduct basic extraction-transformation-load (ETL) processes that provide direct access to the Provide® data system by the County RWP and BSR's CQM program, and to help funded subrecipients improve their internal QI processes by having direct access to the Provide® data. Three members of the BSR CQM staff have experience with structured query language (SQL) data extraction processes, transformation of unstructured data through the creation of calculated variables and other data transformation procedures, and loading extracted data into a local data model that will support performance measurement and QI rapid cycle data analysis, data visualization, and reporting, using SPSS and Microsoft Power BI. These processes have already begun as of the fourth quarter of FY 2019-20, and will continue under the present contract.

SF-SEAETC: This organization is a vital resource for the conduct of targeted outpatient medical record reviews when the input of trained physicians and other clinical providers is needed to assess the QI needs and opportunities of subrecipients experiencing challenges in their outpatient medical service delivery.

Recipient: Miami-Dade County, through its Office of Management and Budget, provides oversight of the local CQM process and ensures compliance with program legislation and HRSA CQM guidelines.

III. PERFORMANCE MEASUREMENT

Performance measurement refers to the periodic evaluation of indicator data, consistent with HRSA Performance Measures (https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio), and includes three levels of assessment: 1) individual client-level measurement of client health outcomes; 2) subrecipient-level performance measurement, using aggregate client-level data; and 3) system-level quality indicators. Measures can be identified as **structural** (characteristics and resources of subrecipient providers and the system of care); **procedural** (operating procedures for provision of high-quality core medical and support services); and **outcome-related** (e.g., client satisfaction, short-term and long-term retention in care, viral load suppression). BSR CQM staff will use performance measurement data to help the CQM Committee identify opportunities for quality improvements in service delivery and to evaluate the effectiveness of QI interventions (described in Section III.A, below). Performance measurement data will be collected and analyzed regularly (e.g., monthly, quarterly, etc., depending on the QI project or activity). The selected performance measures are identified in the CQM Performance Report Card, incorporated herein by reference, as may be amended. The CQM Committee and BSR's CQM staff follow HRSA PCN #15-02, as may be amended, in choosing the number of **performance measures** to study by service category for each grant fiscal year, using **Table 1**, below, as a guide. **Table 2**, immediately following, illustrates the performance measures to be used in FY 2020-2021.

Note that in addition to the approved HRSA/HAB performance outcome measures for Outpatient/Ambulatory Health Services (OAHS), Medical Case Management (MCM) and Oral Health Care (OHC) services in **Table 1** and **Table 2**, BSR is including the following three additional subrecipient-level measures for FY 2020-2021:

- **Six-month retention in medical case management relationship for new clients in care,** hereafter "six-month MCM retention", a modification of the HAB/HRSA *Gap in HIV Medical Visits* measure. This is an outcome measure directed toward measuring the rate with which an RWP provider turns new-to-care PWHs into ongoing MCM clients, receiving both an updated Client Assessment by their MCM and a semi-annual OAHS visit (and recertification for ADAP), both of which are scheduled for approximately six months after the first billable RWP service. As of the close of FY 2019-20, the six-month MCM retention rate for new-to-care clients was close to 50%, indicating substantial opportunities for QI across the local RWP system of care. While the six-month medical visits have been more irregular in FY 2020-21 because of COVID-19, the relationship with the MCM continues as a vital form of client engagement. Note that while this measure is similar to the HAB/HRSA Gap in HIV Medical Visits measure (https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/coremeasures.pdf), this outcome measure places the locus of engagement squarely on the shoulders of the MCM.

- **Virologic failure,** formerly "persistently unsuppressed VL levels" over the course of a 12-month period, based on retrospective measurements of first-and-last VL suppression

rates in one-month cohorts. These analyses were produced on a monthly basis in FY2019-2020 by BSR's CQM team; as a CQM performance measure, they will be grouped in three-month cohorts and shown in the CQM Performance Report Cards. This outcome measurement reflects both on the work of the MCMs and the providers of OAHS services, and will be reported for both service categories within subrecipient.

- **OHC clients retained in care**, the proportion of RWP clients receiving OHC who stay under the care of a RWP OHC provider, operationally defined as keeping an OHC appointment for a basic oral examination twice over a defined in-care period, examining clients who had such an examination in FY 2018-2019 and determining the proportion of these clients who had such an examination in FY 2019-2020. This is a complicated measure, open to considerable discussion by the Medical Care Subcommittee and the CQM Committee in August/September, 2020, since a proportion of the clients receiving OHC through out-of-network referrals do not have a RWP MCM and the issue for service quality improvement lies with the OHC provider/subrecipient and not necessarily with the MCM provider. Because this measure requires tracking OHC care across two fiscal years, it is a sluggish measure and may not be directly applicable to QI interventions.

TABLE 1: NUMBER OF PERFORMANCE INDICATORS SPECIFIED FOR SERVICE CATEGORIES (Source: SDIS DATA, FY 2019-20)

Review Group	% RW clients receiving ≥ 1 unit of service for a RWHAP-funded service category	Minimum number of performance measures required	Threshold number of clients for each Review Group, based on 9,031 clients in RWP care in FY 2019-20	Service Category Review Group for FY 2020-21 based on # of RWP clients served in FY 2019-20
1	≥ 50%	2	>/= 4,515 clients served	-- Medical Case Management (8,116) -- Outpatient/Ambulatory Health Services (5,317)
2	> 15% to < 50%	1	>/=1,345 - 4514 clients served	-- Oral Health Care (3,170)
3	≤ 15%	0	</= 1,355 clients served	-- Health Insurance Premium Assistance (1,335) -- Food Bank (720) -- AIDS Pharmaceutical Assistance (605) -- Medical Transportation (720) -- Outreach Services (472) -- Mental Health Services (274) -- Substance Abuse Services (Residential) (95) -- Substance Abuse Outpatient Care (55) -- Other Professional Services (Legal) (66)

TABLE 2: 2020-21 SPECIFIC PERFORMANCE INDICATORS FOR SERVICE CATEGORIES	
Service Category	Subrecipient-Based Performance Measures
Outpatient/Ambulatory Health Services (>50% of clients)	✓ HIV Viral Load Suppression (HRSA/HAB) † ✓ Retention: 24-month HIV Medical Visit (HRSA/HAB) ✓ Retention: 12-month HIV Medical Visit (RWP Integrated Plan)† ✓ 12-month Client Satisfaction (RWP Integrated Plan) ✓ % clients with virologic failure (persistently unsuppressed VL)*
Medical Case Management (>50% of clients)	✓ HIV Viral Load Suppression (HRSA/HAB) † ✓ Retention: 24-month HIV Medical Visit (HRSA/HAB) ✓ Retention: 12-month HIV Medical Visit (RWP Integrated Plan)† ✓ Retention: 6-month MCM retention* ✓ 12-month Client Satisfaction (RWP Integrated Plan) ✓ % clients with virologic failure (persistently unsuppressed VL) *
Oral Health Care (>15% - 50% of clients)	✓ Oral Health Education (including Smoking Cessation counseling) (HRSA/HAB)† ✓ Retention: 12-month % past FY OHC clients with OHC in current FY) ‡ ✓ 12-month Client Satisfaction (RWP IP)

† Currently reported on CQM Performance Report Card for all subrecipients from FY 2019-20 forward
* Accepted by CQM Committee as CQM Report Card performance measure, beginning in FY 2020-21
‡ Under consideration by CQM Committee and Medical Care Subcommittee

III.A RWP Clinical Quality Management Performance Report Card

Four times per year, BSR will conduct subrecipient-based analyses of RWP client outcome indicators along the HIV Care Continuum, including linkage to RWP care, retention in care, prescribed use of antiretroviral therapy, and achieved viral load suppression, for RWP clients receiving at least one unit of service during the 12 months prior to the end of the period of analysis. The CQM Performance Report Card for the three-month period ending February 29, 2020, will be issued by July 2020, after billed units of services provided by the subrecipients have been cleared (post closeout) by the Recipient and data have been analyzed. The remaining CQM Report Cards for FY 2020-21 are scheduled to be generated in July/August 2020 (60 days after the closeout of the March–May 2020 quarter), October 2020 (60 days after the closeout of the June-August 2020 quarter), and January, 2021 (60 days after the closeout of the September-November 2020 quarter (see **Summary of Deliverables,** Table 3, I.3).

The CQM Report Card will serve as a key mechanism for periodic CQM-directed analyses of client-centered and subrecipient performance trends affecting client health outcomes during the FY 2020-2021 reporting period. The quarterly, annual and monthly analyses will enable the ongoing review of key quality indicators and measurement of outcomes that impact successful engagement in care and overall client health. The core analyses will be based on (1) clients receiving Medical Case Management (MCM) within the Part A/MAI-funded subrecipient agencies, using the client/MCM relationship as the fulcrum for intervention and client support; (2) clients receiving RWP OAHS, using the medical provider relationship as the fulcrum for medication monitoring and adherence, and medical detection and response to viral load measurement and virologic failure; and (3) clients receiving OHC through an RWP OHC

provider, using the oral health provider relationship as the basis for continual OHC counseling, smoking cessation counseling, and (subject to approval by the MCSC and CQM Committee) maintenance of the client in ongoing OHC. BSR CQM staff will identify RWP subrecipients whose outcome data in the CQM Report Cards is poor (e.g., an "F" grade on a particular MCM performance indicator), or whose viral load suppression rates or retention in medical care rates are below either (a) the threshold goal levels specified in the Integrated Plan (80% for VL suppression, 90% for retention in medical care), or (b) are lower than 1.645 standard deviations below the RWP averages on a particular performance indicator. The CQM Committee will look at all subrecipients with these QI red flags and will prioritize them for technical assistance and/or QI project development (see Section VI. A, below). Note that the un-blinded data provided to the CQM Committee for service quality evaluations and to the Miami-Dade HIV/AIDS Partnership's (Partnership) Strategic Planning Committee for Integrated Plan reporting will not be used to evaluate subrecipient compliance with Recipient contract provisions, but will be used to contextualize individual subrecipient performance and facilitate identification of QI opportunities.

> *Note that deadlines for CQM Report Cards and other CQM activities (as well as scheduled meeting dates for CQM and Staff Support committee meetings) are likely to be impacted by the COVID-19 pandemic due to related local "social distancing" and "safer at home" measures. The deadlines outlined here are best-case estimates and may be modified based on the development of quarantines and RWP treatment modifications arising from the pandemic. The CQM Plan itself will be subject to amendment as COVID-19 circumstances dictate.*

III.B Ryan White Part A/MAI Program Client Satisfaction Survey (CSS)

Consistent with QI imperatives to listen to the "voice of the customer," BSR will conduct an annual survey of Ryan White Part A/MAI Program clients actively enrolled in RWP Medical Case Management services for at least one year prior to the survey date. Unlike previous Client Satisfaction surveys (CSS), in which approximately 500 completed face-to-face interviews were conducted by BSR in March, April and May of the program year, the disruption in subrecipient operations and the need for "social distancing" occasioned by the COVID-19 pandemic (see III.C, above) necessitates modifying the sample size, administration and timing of the CSS for FY 2020-21 and following.

- In FY 2020-21, the CSS will be conducted by telephone with approximately 300 RWP clients in September-November 2020.

- In FY 2021-22, the CSS will move to two administrations, in the spring and fall of the year, with approximately 300 respondents per administration. The route of administration – telephone surveys or face-to-face surveys – will depend on COVID-19 best practices. ***Note that this modification in administration has a salutary effect on using the CSS as a QI measurement tool: instead of a single annual administration, client satisfaction will be measured more frequently and may be used as an outcome measure for QI initiatives. This is consistent with HRSA recommendations included in PCN #15-02.***

- Respondents will be provided with a Walmart e-gift card as an incentive for their participation. In accord with HRSA requirements and BSR's contract with the County, CSS respondents will be required to agree that they will not use this gift card for the

purchase of prohibited goods (e.g., firearms, alcohol or illegal drugs) and will not exchange them for cash.

- Only RWP clients who have expressly given their consent to be contacted by BSR for research, as documented in the Provide® data system, will be included in the Part A/MAI Client Satisfaction Survey (CSS) process. This is not an opt-out process.

This 300-case client-based survey will allow comparisons among MCM, OAHS and OHC RWP subrecipient providers (the three service categories with the largest utilization levels in the RWP: see Table 1, above), and AIDS Pharmaceutical Assistance (Part A and ADAP). The MCM category will include a Peer Education and Support Network component for treatment adherence quality measurement. The MCM category may include client satisfaction measures for MCM services provided by SFAN State of Florida General Revenue-funded case managers operating in a RWP milieu. These services are part of the overall RWP service network and are not always separable in the minds (or experiences) of the Part A/MAI clients. Likewise, although AIDS Pharmaceutical Assistance itself represents only a small part of the Part A services mix, it is inseparable from ADAP in the minds of the RWP clients, and because ARV use is such a pervasive part of the RWP client experience (the FY 2019-20 percentage of RWP clients on ARVs was 95%), the APA/ADAP combination makes this a high-incidence service category.

With the reduced sample size, low-incidence service categories (Mental Health Services, Substance Abuse Outpatient Care, and Substance Abuse Services-Residential) will not have a utilization base sufficiently large to allow statistically valid comparisons in the FY 2020-21 CSS. However, specific questions on the survey will explore the reasons for under-utilization of mental health services.

The CSS interviews will be conducted in English, Spanish, or Haitian Créole, the most requested languages of clients in the Miami-Dade RWP. Basic demographic information, quality of life information, and history of HIV diagnosis and treatment questions are presented to the clients at the onset of the survey. Clients are advised that their answers will be kept completely confidential, and that none of their answers will disqualify them from receiving any services at any time during the clients' enrollment in the RWP in Miami-Dade County. Additional questions will be asked concerning cell phone use, texting, Internet use and social media use to facilitate future contact with clients and suggest avenues for improving retention in care and treatment adherence.

BSR's Project Director, Director of Research and QM Research Associate will oversee the design, implementation, data analysis, and reporting of the survey. Statistical analyses will link client characteristics to treatment satisfaction, barriers to care, and other care-related issues to provide insights into service improvement measures and ways to improve client retention and treatment adherence. Survey data will be used to inform one or more related PDSA cycles during the grant fiscal year. The results of the survey will be reviewed with the Recipient as well as the CQM Committee and other appropriate Partnership committees. These reviews are intended to aid the CQM Committee in identifying opportunities for QI projects, capacity building and QI intervention activities among RWP subrecipients. Concerns and emergent issues identified through the CSS results will be presented by BSR to the CQM Committee to determine if the issues need to be added to the list of QI priorities for the year, or if other projects need to be placed on hold to accommodate the emergent issues.

III.C Monthly Viral Load (VL) Comparative Report

Because the CD4/VL data are an important proxy CQM measure for linkage to and retention in medical care, unblinded viral load suppression data (i.e., rates of viral suppression, rates of missing VL data and virologic failure rates) for all subrecipients will be reported on a monthly basis to all subrecipient executive officers, to MCM supervisors, and to the Recipient for review and follow-up. BSR will aggregate these data for every CQM Report Card cycle (see III.A, above). Concerns and emergent issues identified through these reports will be presented by BSR to the CQM Committee to determine if the issues need to be added to the list of QI priorities for the year and if other projects need to be placed on hold to accommodate the emergent issues.

III.D Systemic Client-Centered Reports for the Integrated Plan

Consistent with QI imperatives to understand the dynamics of changes in the population of the 9,000+ clients in RWP care, BSR will conduct several multi-year analyses of client trends on an annual basis using data from Provide®, to be reviewed by the Recipient, the CQM Committee, the Strategic Planning Committee, and the Joint Integrated Plan Review Team. These data will be used by the CQM Committee to identify and prioritize related QI opportunities and will be used as a basis to inform one or more PDSA cycles throughout the year. The following are planned during this grant fiscal year:

- An annual evaluation of the factors affecting retention in RWP medical care, including historical trends and subrecipient- and client-characteristic-related factors, going beyond the quarterly subrecipient-based CQM Report Card data outlined in Section III.A, above;

- An annual evaluation of the factors affecting viral load (VL) suppression rates, including historical trends and subrecipient- and client-characteristic-related factors impacting VL, going beyond the quarterly subrecipient-based QM Report Card data outlined in Section III,A, above;

- An annual client-characteristic-related evaluation of the factors associated with virologic failure (persistently unsuppressed VL levels), going beyond the monthly subrecipient performance-based tracking of MCM and OAHS clients with persistently unsuppressed VL levels to determine potential etiologic factors, for review by the CQM Committee and the Joint Integrated Plan Review Team;

- An annual comparison of ACA-transitioned and non-ACA RWP OAHS clients, examining the client characteristics of the two groups to determine ethnic/gender/risk factor similarities and differences, and determine the impact of various OAHS delivery channels on treatment outcomes, for review by the Joint Integrated Plan Review Team; and

- An annual analysis of HIV-related co-occurring conditions as subrecipient-independent predictors of treatment outcomes, leading to the continued development and refinement of a client HIV acuity measures to be used to measure the levels of MCM services provided to RWP clients.

The reports will include data describing the RWP client base as a whole; and are a core component of the “data infrastructure” of local CQM activities. As necessary to address the objectives of the Integrated Plan, the activities of the Strategic Planning Committee, and the QI

initiatives of the CQM Committee or the Recipient, these data may also be analyzed by key client characteristics (i.e., gender, ethnicity, age, risk factors, Florida Department of Health "life zones" for Miami-Dade County, co-occurring conditions and related acuities, length of time in the RWP, and by subrecipient). The results of the reports will be reviewed with the Recipient and all appropriate Partnership committees. Concerns and emergent issues identified through the review of the system client-centered reports will be presented by BSR to the CQM Committee to determine if the issues need to be added to the list of QI priorities for the year, or if other projects need to be placed on hold to accommodate the emergent issues.

III.E Targeted CQM PHS Medical Record Reviews as part of the QI process)

As outlined above, individual subrecipients whose performance data raise CQM concerns during the course of CQM Report Card analyses – and who are prioritized by the CQM Committee -- will be provided with technical assistance and QI initiative site visits by BSR CQM personnel. Medical records for clients who have persistently not suppressed viral loads or have had challenges in retention in care will be reviewed at these subrecipient agencies, comparing certain key elements of client care with Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections. Such a process was initiated with a RWP subrecipient in FY 2019-2020 (see Section IV.A, below), based on CQM Report Card findings and discussed with the CQM Committee and the Recipient, and this process will continue to completion in FY 2020-2021. BSR will enlist the support of the SF-SEAETC for these reviews. The SF-SEAETC will also provide related technical assistance to medical practitioners at the identified OAHS subrecipient agencies, subject to need and their availability.

IV. QUALITY IMPROVEMENT PROJECTS

Quality Improvement (QI) refers to the continuous improvement of clinical care and RWP client experience through proactive interventions to improve clinical processes and systems. Following the Plan-Do-Study-Act (PDSA) process that is central to the *Model for Improvement,* BSR's coordination and implementation of Miami-Dade County's Ryan White CQM Program on behalf of the Recipient has initiated several QI projects in FY 2019-2020, and will continue these into implementation in FY 2020-2021 as appropriate. The related PDSA cycles will be documented in a worksheet format developed by BSR, the County and the CQM Committee, and will become part of the Quality Management Plan. These existing projects include:

IV.A A review of OAHS procedures in an under-performing RWP subrecipient

Arising out of a pervasive pattern of high levels of unsuppressed VLs over a 24-month period, coupled with demonstrated issues in retention in care and low levels of MCM contact, BSR and the Recipient met with the management team of the under-performing RWP subrecipient and with SF-SEAETC to develop a QI reconnaissance, including staff analyses, medical record reviews, OAHS case file reviews and a detailed analysis of data related to clinical outcomes by medical care providers. The clinical medical record reviews are being coordinated with the SF-SEAETC to identify if the medical practitioners are following PHS guidelines in scheduling appointments, ordering appropriate labs in a timely manner to monitor viral loads, identifying

possible medication sensitivities and options to change to a more effective treatment regimen (e.g., viral load, CD4, genotype, phenotype, etc.); and following up in a timely manner on missed appointments, critical lab values, not suppressed viral loads, etc. The review team will also look to whether practitioner case load numbers affect quality of care and client health outcomes. The SF-SEAETC chart review process will occur in the third quarter of FY 2020-2021 (September – November): in the context of COVID-19 restrictions on physical meeting, SF-SEAETC has agreed to use the subrecipient's Electronic Medical Record (EMR) system to review OAHS records, and negotiations are underway with the subrecipient to allow this access. As SF-SEAETC analyses are completed and records indicate a QI intervention at this subrecipient, at least one specific QI intervention will be identified with this agency by the close of the third quarter of the FY 2020-21 program year. Status updates will be brought before the CQM Committee for further prioritization and implementation at other agencies that may be experiencing similar problems with viral suppression rates in their MCM or OAHS client populations.

IV.B Assessing six-month retention of new-to-care clients as a basis for potential QI intervention.

The issues surrounding retention of new clients in RWP care include: (1) short-term retention rates of new clients in care through the Test and Treat (T&T) process vs. through new clients simply entering the RWP as "new in care" (NIC) clients, with as many as 50% of new clients dropping out of care before they had become fully embedded in the RWP system, and differential rates of six month MCM retention for T&T vs. NIC; and (2) differential rates of six-month MCM retention for some RWP subrecipients and for some disparity groups. These will be the focus of QI root cause analyses and intervention activities in FY 2020-2021. These two issues will be addressed separately by the Part A CQM Committee and the MAI CQM Team. The Part A CQM focus will be on the refinement and use of the six-month MCM retention performance indicator as a CQM Report Card performance measure, the differences between T&T and NIC client six-month MCM retention rates, and the basis for QI intervention among subrecipients with lower than average new client retention. The MAI CQM team focus will be on the differential long-term retention rates for minority clients in care (see Section V, below), consistent with disparity population concerns in the Integrated Plan, and the potential development of QI initiatives among subrecipients with lower rates.

Note that although the concern with new-to-care retention originally started with the Retention and Relinkage Team (now, the MAI CQM Team), the high incidence of new clients dropping out during the first year of care has been a persistent system-wide concern of the RWP. Because the CQM Committee is tasked with evaluation of new QI performance measurements, this is an appropriate locus for a systemic QI evaluation of factors influencing new client dropout rates, and the root causes of differences in new client dropout rates by subrecipients. Based on the identification of low-performing subrecipients, this assessment will yield at least one active QI project prioritized and initiated by the close of the third quarter of the FY 2020-21 program year.

IV.C Subrecipient-Initiated QI Projects

The RWP requires subrecipient participation in the Part A CQM Program. While the QI projects described above focus on system-level improvement efforts, these will be complemented by a portfolio of projects potentially initiated within subrecipient agencies, either as a response to identified CQ problems (prioritized by the CQM Committee or MAI CQM Team), or as responses by the CQM personnel at the subrecipient agency. The role of BSR in subrecipient-initiated QI projects is to serve as a technical assistance resource and to align subrecipient projects with

Part A and MAI system-level activities, which collectively should lead to improvements in health outcomes among target populations. BSR will work with subrecipients to assure that:

- QI problems are well-defined and accompanied with baseline measures
- Projects are documented using OMB-approved reporting forms
- Results are communicated to the CQM Committee or the MAI CQM Team
- Projects are aligned with annual goals approved by the CQM Committee or project parameters specified by the MAI CQM Team.

In establishing a portfolio of subrecipient-initiated QI projects, BSR will document an implementation schedule for all subrecipients, and will also document expected completion dates.

IV. D Prioritizing Subrecipient QI Initiatives Based on CQM Performance Data

In addition to these ongoing QI projects, the CQM Committee and MAI CQM Team may review and prioritize additional QI projects for the future as time and resources permit. The identification of new areas of focus for subrecipient QI intervention would typically follow the criteria outlined in the performance measurement outlined in III.A, above: the CQM Committee or the MAI CQM Team would identify opportunities for QI initiatives based on CQM Report Card scores, a client-centered report indicates a downward trend in client outcomes that opens the door to discussion of QI initiatives, or the Recipient identifies the need for a performance improvement. Each of these pathways can generate proposed QI interventions, which are vetted and prioritized through the CQM Committee. Once vetted and prioritized by the CQM Committee, subsequent QI intervention activities will be initiated to address the root cause of the problem, the subrecipient(s) and BSR would be expected to develop and implement a QI project to address the identified problem, as required per their corresponding Professional Services Agreement with the County for Ryan White Program services.

The CQM Committee and MAI CQM Team will need to face the difficult challenge of going public with their prioritizations, and efforts to do so in FY 2020-21 have met with resistance from subrecipients attending these meetings. Without this prioritization, however, the number of potential QI initiatives will rapidly become unmanageable and unattainable.

V. MINORITY AIDS INITIATIVE (MAI) CLINICAL QUALITY MANAGEMENT SERVICES

As a new subcomponent of the Part A quality management program, the MAI quality management program (MAI-CQM) will concentrate on (1) building the CQM infrastructure of the subrecipients providing MAI-funded services beginning in FY 2020-2021, and (2) conducting a QI intervention directed toward increasing the retention in care for new-to-care minorities entering the RWP. MAI CQM activities represent a subset of the overall RWP activities addressing identifiable disparity groups among all of the minority-serving direct service subrecipients funded through the RWP, but will be concentrating on the specific MAI-funded MCM and OAHS projects and subrecipients funded in FY 2020-2021.

V.A Capacity Building for New MAI-Funded Subrecipients

In FY 2020-2021, the RWP has funded several subrecipients to provide MCM and OAHS services through the MAI program, directing these agencies to develop innovative mechanisms for service delivery to minority populations in their care. A total of six subrecipients were funded in this way, the majority of whom were funded for both MAI MCM and MAI OAHS, as follows:

Borinquen Health Care Center	MCM and OAHS
Care 4 U Community Health Center	MCM and OAHS
Care Resource Community Health Centers	MCM and OAHS
Empower U Community Health Center	MCM only
Miami Beach Community Health Center	OAHS only
University of Miami	MCM and OAHS

BSR's MAI CQM task is to assist in the development of an MAI-project QI infrastructure for the subrecipients funded in these service categories, in particular building Model for Improvement QI mechanisms into the structure of the newly-planned initiatives. BSR's MAI CQM services initiative seeks to address this by (a) committing to conduct initial TA visits to all MAI-funded subrecipient providers – both newly funded (e.g., Care 4 U Community Health Center) and experienced agencies. BSR will assist the MAI-funded subrecipients by telephone and Zoom meetings in structuring (or restructuring) their innovative MAI services to build client QI measurements and interventions into their processes. As of this writing, MAI service delivery planning is underway at two of these agencies, with other MAI providers coming on board in August and September.

V.B MAI QI Initiative: Improving Retention in Care for Disparity Populations

The MAI CQM Team – a sub-unit of the full CQM Committee – began developing and refining a QI initiative in FY 2019-2020, focused on identifying and overcoming vulnerabilities of new-to-care minority RWP clients who were dropping out of care before they had become fully-embedded in the RWP system (see discussion of the six-month MCM retention measure, above). This initiative arises from the high levels of co-occurring conditions (e.g., drug abuse, homelessness, very low income, co-morbid/co-occurring health conditions, etc.) that accompany entry into HIV care for RWP clients from specific disparity groups, most notably Black/African American males (both MSM and heterosexually identified) and Black/African American females, and *which affect not only the six-month MCM retention rates for new clients in care but viral load suppression and long-term retention for members of these disparity served by the RWP.*

Data from FY 2019-20 showed that within the same subrecipient provider, treatment success rates differed across ethnic disparity groups (e.g., at Borinquen, viral load suppression was 73.3% among Black/African American MSM, but 89.2% among Haitian males; at Empower U, 65% of Black/African American females showed VL suppression, vs. 85.7% among Haitian males). The disparities in treatment outcomes by ethnic group within the same subrecipient raise questions as to the equivalency of treatment, or the impact of client ethnicity or co-occurring conditions on treatment outcomes across subrecipients, and open the door to evaluating QI initiatives to reduce treatment disparities.

The venue for this discussion (and the locus of activity for a potential QI intervention) is the former Retention and Relinkage (R&R) Team, a CQM-oriented work group, now designated as the MAI CQM Team. The MAI CQM Team has been expanded to include representation from all

six MAI subrecipients, and these subrecipients have been thoroughly briefed by the Recipient as to what will be expected of them with funding for specific service categories.

Based on data on differential rates of viral load suppression and retention in care for Integrated Plan disparity populations, the MAI CQM Team will be asked to prioritize subrecipients with identified QI opportunities. A minimum of two such opportunities will be prioritized and BSR will work with these subrecipients to design and facilitate at least two such interventions during FY 2020-21.

VI. QI TECHNICAL ASSISTANCE AND TRAINING

As quality improvement priorities are identified, BSR will provide or coordinate the provision of targeted training and technical assistance designed to address the desired improvement goal. TA/Training activities will include:

VI.A Technical Assistance (TA)

When subrecipient service quality issues are encountered through performance measurement or as part of a QI project (either as a QI project prioritized by the CQM Committee or through the quarterly CQM Report Cards cited in Section III.A, above), the quality issues are understood as opportunities for quality improvement and not simply an occasion for corrective action. The essence of BSR's Technical Assistance is to facilitate improvement in service delivery by assisting subrecipients in identifying root causes and potential QI interventions, developing an action plan to address the QI intervention, and conducting a follow-up measurement to check whether the intervention was successful in improving the service delivery process. The CQM Committee will be essential in helping to identify and prioritize the areas in greatest need for improvement (see Section II.B, above). With the support of leadership across subrecipient agencies, testing changes through iterative PDSA cycles will enhance the quality of care clients receive. Specific activities may include:

- TA for Outpatient/Ambulatory Health Services, provided by SF-SEAETC based on concerns found in a related review of medical data (see Section IV.A, above). BSR CQM staff will consult with and coordinate this TA provided by the SF-SEAETC, but the clinical QI process will be largely determined by the SF-SEAETC record review. BSR may also coordinate additional TA as needed.

- TA for Medical Case Management services, provided or coordinated by BSR CQM staff as appropriate to the QI intervention needed (based on the CQM Performance Report Cards cited in Section III.A, above).

- TA for Oral Health Care may also be provided or coordinated by BSR CQM staff or SF-SEAETC as appropriate to the QI intervention needed (see Section III, above) based on CSS data or the CQM Report Cards.

The Recipient and the subrecipient's assigned OMB Contracts Officer will be notified when QI interventions result in an on-site TA visit (whether at BSR, the subrecipient's location, or

remotely by phone or virtual meeting), and a summary of the visit and any recommendations will be provided to the Recipient when the TA is completed. BSR will conduct follow-up measurements after 90 days through comparison of the CQM Report Cards, to determine whether the QI intervention has produced the desired improvement.

VI.B Training

In order to create and support a CQM culture in the EMA, and to provide the capacity to implement and sustain QI interventions, a robust infrastructure for capacity building and training is required The activities outlined below will provide the EMA with a mechanism to: (1) anticipate and identify emerging issues that might impact the quality of RWP services; (2) support the implementation of QI interventions; (3) assist RWP subrecipient staff in adapting to changes relating to QI interventions; and (4) provide targeted technical assistance for subrecipient agencies based on declines in performance measures. As quality improvement projects and activities identify areas of improvement, BSR CQM staff will provide or coordinate the provision of targeted training and technical assistance designed to address the desired process changes identified as part of the PDSA cycle(s).

Capacity building and training activities are directed toward new Medical Case Managers, Medical Case Manager Supervisors, and subrecipient leadership. Educating Medical Case Management staff in the tools and techniques of quality improvement will enable them to connect recurring problems in clinical care to their root causes. As the underlying causes of these problems are identified, QI interventions will be identified and implemented. As performance measurement activities identify areas of improvement in clinical processes, training interventions with Medical Case Managers will focus on process changes that are anticipated to improve the quality of care. BSR and the Recipient will also use the guidance and resources provided by HRSA's contracted CQM TA provider, the Center for Quality Improvement and Innovation (CQII).

BSR maintains an email list of all RWP Medical Case Managers and Case Manager Supervisors, enabling training communications to be sent directly to individual MCMs as well as to the official RWP contact person in each subrecipient Medical Case Management agency. BSR will continue to keep records of all training topics, locations, handouts, attendee logs, and evaluations.

The following trainings are planned during FY 2020-2021 as follow up to prior QI project interventions:

VI.B.1 Introductory Quality Improvement Training for New Medical Case Managers

BSR's Ryan White Program Introductory Quality Improvement Training (MCM Basic QI Training) consists of an 8-hour training seminar conducted at various times throughout the fiscal year. The Introductory QI Training focuses on the role of QI in the RWP, basic QI concepts, and the role of performance measurement in identifying areas of process improvement in clinical care. The instruction will be provided by BSR's QM training staff, supplemented by external contracted trainers if appropriate. CQII's guidance and resources will also be used. Local pharmaceutical community liaisons will offer current HIV treatment information and non-branded educational information as available and as needed to ensure the Medical Case Managers have current HIV treatment information. The MCM Basic QI Trainings will provisionally be offered in August 2020 and January 2021 (note that the April 2020 Basic QI Training was cancelled because of COVID-19 issues).

VI.B.2 Medical Case Manager Supervisor Quality Improvement Training

Capacity building regarding quality improvement for MCM Supervisors and Lead Case Managers will be provided at least two times throughout the grant fiscal year, using virtual Zoom meetings as necessary in response to COVID-19 concerns. Every attempt will be made to schedule training sessions to accommodate supervisors' time constraints. As in the case of the basic QI MCM training, training activities and exercises provided by BSR may be supplemented by external contracted training as appropriate. Trainings will include an introduction to QI methodology, basic QI concepts, and the role of performance measurement in identifying areas of process improvement along the HIV Care Continuum. In collaboration with ADAP staff, MCM Supervisor trainings will also focus on early detection of lapses in adherence and persistently unsuppressed viral loads (see Integrated Plan activity V1.3.a., incorporated herein by reference), and the development of a QI orientation to supervision of MCMs. The MCM Supervisors' training will be provisionally conducted in October 2020, and February 2021, as rescheduled because of COVID-19 issues.

VI.B.3 Subrecipient Forums

BSR will organize and staff at least two Subrecipient Forums during the program year, in person or by virtual meeting, to sharpen the QI focus of all RWP-funded subrecipients, contributing to the development of a QI culture by familiarizing subrecipients with the concepts and tools of the Model for Improvement, encouraging dialogue on the impact of QI initiatives on subrecipient provision of care, and facilitating additional QI intervention activities. Subrecipients will be introduced to and reminded of the language of PDSA, Ishikawa ("fishbone") root cause analysis, Pareto charts, process mapping, control charting, QI data feedback and other QI. The instruction will be combined with breakout session exercises. Presenters will include BSR and the Recipient staff, subrecipients, local researchers, and contracted consultants as deemed necessary. The Subrecipient Forums are planned for November 2020, and January 2021, subject to relaxation of COVID-19 meeting restrictions for in-person meetings; or can be held in a virtual meeting format.

VII. CONSUMER AND STAKEHOLDER ENGAGEMENT

Involvement by RWP clients or non-client members of the affected population is strongly encouraged at all levels of the CQM planning, implementation, and evaluation processes. At least five identified members of the affected community are members of the CQM Committee and/or MAI CQM Team, but only two are unaffiliated with a subrecipient agency. Note that the Strategic Planning Committee and the Joint Integrated Plan Review Committee include members of the affected community as participants; affected community from the CQM Committee and MAI CQM Team are invited to attend the Subrecipient Forums as well. As the RWP must adhere to the Florida in the Sunshine Law, all meetings are noticed and open to the public.

The local Ryan White Part A/MAI Program (RWP) has an open and permeable planning and data sharing process, cooperating and collaborating fully with ADAP/Part B and Part C, as well as non-Ryan White Program-funded entities (e.g., FDOH, Florida General Revenue) in Miami-

Dade County. The periodic Subrecipient Forums – at which CQM activities, data, barriers, challenges, and improvement strategies are discussed in detail – are attended by Part A/MAI subrecipients, ADAP/Part B representatives, and Part C provider senior executives as well as Medical Case Management supervisors and other direct service personnel. Furthermore, the CQM Committee has representation from ADAP, Part C, and Part D providers who have a strong interest in the CQM activities, and whose cooperation is frequently solicited when data need to be collected outside the Part A/MAI system for comparison and planning purposes.

All aspects of the CQM Program are also discussed with the Partnership and its Prevention, Care and Treatment, and Strategic Planning Committees, based on the topic or QM activity. This ensures a coordinated approach during the Client Satisfaction Survey, Needs Assessment / Priorities and Allocations, and Integrated Plan activities. CQM data are regularly shared between ADAP, FDOH-MDC, and the RWP. ADAP provides data to the CQM Program on Part A/MAI clients who are ADAP service recipients and who may be in danger of disenrollment (i.e., losing access to antiretroviral and other ADAP medications) because of delays in eligibility re-certification. The data are uploaded into the RWP's Provide® data system and disseminated to Part A/MAI-funded Medical Case Managers, who can alert their clients of the deadline and importance for maintaining ADAP eligibility. ADAP's notification process has been synchronized through an automated data system interface, so that notifications are sent electronically directly to the assigned MCMs. These collaborative efforts and processes help ensure on-going access to quality care and treatment for RWP clients.

VIII. EVALUATION

BSR, the CQM Committee (including its embedded MAI CQM Team) and the Recipient are vital parts of the management of the CQM process, from collectively providing input into the future construction and modification of the CQM plan, to evaluating the progress of BSR and the CQM Committee in implementing the Plan and providing feedback as to the reasonableness of specific objectives in the Plan, and its intertwining with the FDOH-MDC / RWP Integrated Plan that forms the basis of programmatic activities in the RWP.

Twice a year, the CQM Committee will assess its own progress, the progress of subrecipients, the progress of BSR and the work of the Recipient toward the CQM processes outlined above, seeking to measure: (1) the progress of the various CQM initiatives prioritized by the CQM Committee and implemented by BSR or by subrecipients; (2) progress in raising the competency level of subrecipients and CQM Committee members in the concepts and techniques of QI; (3) the willingness of subrecipients to become more organizationally transparent as regards their QI strengths and weaknesses; and (4) the responsiveness of the Recipient and BSR to QI inquiries, concerns or requests for assistance by the members of the CQM Committee or subrecipients undergoing QI project implementation. This evaluation was initiated in FY 2019-20; for FY 2020-21, the first of the two annual evaluations was scheduled to be conducted in March, 2020 as a review of the previous Fiscal Year activities, but was delayed until June, 2020 because of COVID-19 scheduling disruptions. The second evaluation survey will be conducted in December 2020, after the presentation of CQM findings in the November Integrated Plan progress report.

VIX. ANNUAL WORK PLAN: SUMMARY OF DELIVERABLES

I. Clinical Quality Management (Part A)

#	Task	**Planned Frequency** *(monthly, biannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, In progress, Completed)*
1	**CQM Committee meetings**	Monthly, unless postponed due to COVID-19	March to May postponed; start June 2020 through February 2021	In progress
2	**CQM Plan updates**	Annually	Draft submitted to Recipient 60 days from approval of BSR's Scope of Work.	Draft submitted herein
3	**Performance Measurement:** CQM Report Card and related Technical Assistance (TA)	Four three-month cycles per year	June 2020 July/August 2020 October 2020 January 2021	In progress: June 2020 and August 2020 completed
4	**Performance Measurement:** Client Satisfaction Survey: 300 clients in care for FY 2020-21	Annually in FY 2020-21	February 2021: Data collection postponed to September 2020	In progress
5	**Performance Measurement:** Targeted CQM Record Reviews (e.g., OAHS Record Review)	At least one during grant year	November 2020	In progress: SE-SFAETC developing review tool
6	**Performance Measurement:** 6-month MCM retention rate for new clients	Quarterly (first report in October, 2020	October 2020 January 2021	In progress: measure approved by CQMC
7	**Performance Measurement:** VL suppression levels: Virologic Failure (VF); Missing Viral Load (MVL) Comparative Reports	Monthly VF and MVL; Quarterly VF on CQM Report Card in October 2020	CQM RC: June 2020 July/August 2020 October 2020 January 2021	In progress: measure approved by CQMC

#	Task	**Planned Frequency** *(monthly, biannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, In progress, Completed)*
8	**Performance Measurement:** Comparison of ACA/non-ACA RWP clients in care (Integrated Plan)	Annually	September 2020, as part of the annual HRSA grant application and November 2020 Integrated Plan	In progress
9	**Performance Measurement:** Retention of Oral Health Care clients in care (CQM Report Card annual measure)	At least one during grant year	November 2020	Pending approval by Medical Care Subcommittee and CQMC
10	**Performance Measurement:** Minority retention in care and VL suppression comparative reports for MCM and OAHS (MAI CQM and Integrated Plan)	Semiannually	June 2020 (MCM analysis: MAI CQM Team review) October 2020 MCM and OAHS analysis for November 2020: JIPRT)	June 2020 completed; October 2020 in progress
11	**Performance Measurement:** Other Client-centered reports for the Integrated Plan	Semiannually	May 2020 and October 2020 (note May 2020 JIPRT cancelled)	In progress
12	**QI Project 1:** Related to outcomes of the Targeted CQM Record Review	At least one during grant year	February 2021	In progress
13	**QI Project 2:** Related to six-month MCM retention of new-to-care clients	At least one during grant year	February 2021	In progress
14	**QI Project 3:** QI project directed to low-performing MCM or OAHS subrecipient, as prioritized by CQM Committee	At least one during grant year	February 2021	Not started CQM Committee prioritized three sites in August 2020
15	**CQM Subrecipient Training and QI Intervention Technical Assistance**	Ongoing, as needed	Ongoing, as needed	In progress

17	**CQM Training:** Introductory QI Training for New Medical Case Managers (MCM)	Semiannually	August 2020 (rescheduled from July 2020 because of COVID-19); January, 2021	In progress
18	**CQM Training:** MCM Supervisor QI Training	Semiannually	October 2020 February 2021	In progress
19	**CQM Training and Technical Assistance:** Coordination of Subrecipient Forums	Semiannually	November 2020 January 2021	In progress
20	**Evaluation of CQM Process**	Semiannually	June 2020 *(normally done in March; delayed due to COVID-19)* December 2021	June evaluation completed.

II. Clinical Quality Management (MAI)

#	**Task**	**Planned Frequency** *(monthly, biannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, In progress, Completed)*
1	**MAI CQM Team meetings**	Monthly, unless postponed due to COVID-19		In process
2	**Capacity Building Technical Assistance Visits** (virtual or on-site) for New MAI-funded Subrecipients	At least twice per MAI subrecipient	First visit by close of September, 2020	In progress
3	**MAI QI Project 1:** Improving short-term and long-term linkage/retention	Once per year	February 2021	Not Started
4	**Evaluation of MAI CQM Process**	Biannual	Part of the CQM Committee evaluations	In progress
NOTE: Data will come from related Performance Measurement activities noted in the Part A CQM section above.				