Miami-Dade County EMA
Ryan White Part A/MAI Program
Grant #: H89HA00005

CLINICAL QUALITY MANAGEMENT PLAN
Grant Fiscal Year 2023 (March 2023 – February 2024)

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TABLE OF CONTENTS

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I. Overview / Background

Since the earliest days of the Ryan White HIV/AIDS Program (RWHAP), the Miami-Dade County (MDC) Eligible Metropolitan Area (EMA) has been an area of intense HIV concern. The MDC EMA continues to lead the State of Florida in the total number of people with HIV – 26,538 people with HIV in Calendar Year (CY) 2020 – and for nine of the past 10 years, the South Florida Metropolitan Statistical Area (MSA) has led the nation in the annual new-infection rate for HIV. (For Part A, the jurisdiction is referred to as the Miami-Dade County EMA; for Part B, the jurisdiction is referred to as Area 11A.)

With a high proportion of minority adults in Miami-Dade – over 90% of the adults in MDC and in the RWHAP are Hispanic, Black/African American, or Haitian – and complicated by crushing economic pressures of low household incomes, high documented and undocumented immigration rates, rising food costs, and skyrocketing housing costs, MDC faces significant challenges in addressing the HIV epidemic. In grant Fiscal Year (FY) 2022, MDC's Part A Program, including Minority AIDS Initiative (MAI) funding, served a combined 8,590 unduplicated clients, while helping clients (including non-minorities) navigate these challenges. Notably, of the 8,590 clients served by MDC's Part A and MAI Programs:

- 92% were in care with at least one medical visit or proxy lab test (CD4 or Viral Load);
- 72% were retained in care with at least two medical visits or proxy lab tests (CD4 or Viral Load); and
- 82% were virally suppressed.

In FY 2023, MDC's Ryan White Part A/MAI Programs continue to offer access to a combination of 13 core medical and support service categories for low-income persons with HIV through a network of 17 contracted service organizations. The MDC's Part/MAI Program achieves a holistic approach to care by working alongside several funding partners, including, but not limited to, the Florida Department of Health in Miami-Dade County (FDOH-MDC). Ryan White Part B Program allocations from the Recipient (State of Florida) are provided to the community through FDOH-MDC as the Lead Agency for Area 11A. With more limited resources than Part A, the FDOH-MDC utilizes its Part B (non-ADAP) allocation to "fill in" where Part A services are not available. Collaboration is further encouraged and necessitated due to several subrecipient organizations receiving both Part A and Part B funding. Accordingly, FDOH-MDC is a partner in this Clinical Quality Management (CQM) Plan.

In FY 2023, FDOH-MDC is again utilizing these Part B funds to provide limited support for the rapid start process [known locally as the Test and Treat / Rapid Access (TTRA) protocol], as follows:

- Emergency Financial Services to 9 subrecipients to support short-term access to antiretrovirals on the local TTRA formulary, rent and utility assistance, and transportation services;

- Mental Health Services to 2 subrecipients (not funded by Part A) to support access to behavioral health services during the TTRA process; and

- Medical Case Management services to 1 subrecipient (not funded by Part A) to support linkage to and retention in care for clients accessing services through TTRA in far south Miami-Dade.

FDOH-MDC also manages funding for access to HIV/AIDS education, prevention services, as well as testing and linkage in cooperation with Part A. Several CQM activities outlined in this work plan represent the collaboration between the FDOH-MDC and RWHAP, in order to provide a seamless CQM process.

A second critical area of FDOH-MDC and RWHAP collaboration – emphasized in this CQM work plan – is the ***2022-2026 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan*** (Integrated Plan). The Integrated Plan is a product of a broad collaboration among the FDOH-MDC, MDC's Part A/MAI Program, the Miami-Dade HIV/AIDS Partnership (Partnership; the Miami-Dade County advisory board serving as the RWHAP Planning Council), numerous people with HIV (including RWHAP clients and peer educators), and a broad spectrum of community stakeholders, including representatives of RWHAP Parts C and D; the AIDS Drug Assistance Program (ADAP); the prevention and planning workgroups within the FDOH-MDC; the Florida Agency for Health Care Administration (Florida Medicaid), and stakeholders from non-RWHAP agencies involved with advocacy and care (e.g., TranSOCIAL, the Positive People Network, and Project Access Foundation). The Integrated Plan incorporates the goals, objectives, strategies, and activities of local and state initiatives to achieve the national HIV goal, "Reducing the number of new HIV infections in the United States by 75% by 2025, and then by at least 90% by 2030." The Integrated Plan collaboration has substantially altered the scope and direction of MDC's RWHAP CQM work.

RWHAP-funded subrecipients are contractually required to have active participation in the local CQM process, including, but not limited to, attending monthly CQM Committee meetings and actively engaging in quality improvement (QI) projects each grant fiscal year.

MDC's CQM Plan is a living document that describes all aspects of the CQM program including vision, mission, goals, infrastructure, performance measures, quality improvement (QI) activities, and evaluation. This CQM Plan is reviewed annually, and updated as needed. This CQM Plan may be revised and updated more frequently based on results from QI activities, CQM-related issues arising from subrecipient monitoring, or new HRSA policies.

II. Authority and Accountability

Title XXVI of the Public Health Services Act, known as the Ryan White HIV/AIDS Treatment Extension Act of 2009 legislation, requires RWHAP Parts A through D to establish a CQM process. This requirement is further addressed in HRSA's Policy Clarification Notice (PCN) #15-02 (https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-15-02-cqm.pdf), which requires RWHAP Parts A through D to establish a CQM program to:

- Assess the extent to which HIV health services provided to patients [clients] under the grant are consistent with the most recent Public Health Service guidelines (otherwise known as the HHS guidelines) for the treatment of HIV disease 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.

MDC's RWHAP Part A Recipient (managed through Miami-Dade County's Office of Management and Budget), along with its contracted CQM subrecipient (Behavioral Science Research Corporation; BSR), and RWHAP Part B leadership at the FDOH-MDC work collaboratively and communicate regularly to further the objectives of the local CQM Plan. RWHAP Part A and Part B leadership in MDC are dedicated to the quality improvement (QI) process and are ultimately responsible for assuring high quality of care through the development and implementation of a comprehensive CQM Plan, which is reviewed and updated annually. MDC's RWHAP Part A and Part B leadership also ensures the participation of contracted subrecipients in the CQM process through contractual requirements.

III. Resources

Funds for CQM activities are allocated by the Part A/MAI Recipient to its contracted subrecipient (BSR) to manage the day-to-day aspects of implementing the jurisdictions CQM plan and process. Approximately 2.54% of MDC's combined FY 2023 Part A/MAI award is allocated to CQM activities. Part A/MAI Recipient staff time and effort is not charged to the CQM allocation since their roles are to oversee the process to ensure compliance with contractual requirements and keep subrecipient QI projects from straying into administrative quality assurance activities.

Additional funds from Part B are being identified to help support the combined Part A and Part B activities. It is anticipated that Part B will contribute just under $35,000 in FY 2023 to help support CQM efforts. FDOH-MDC staff will also participate in overseeing the CQM process and ensuring the activities are in line with federal and state requirements.

IV. Quality Statement: Vision and Mission

Vision Statement: To help people with HIV achieve and maintain an undetectable HIV viral load by providing barrier-free access to a coordinated, comprehensive, and quality system of HIV care that supports diversity.

Mission Statement: The mission of the local CQM Program is to continuously improve the quality of care for people with HIV who receive services from RWHAP-funded programs in MDC. MDC's CQM Program will continuously develop/enhance, review/monitor, analyze, measure, implement, and evaluate the delivery of core medical and support services provided to program-eligible clients. Local CQM efforts will improve client care by following Public Health Service treatment guidelines for HIV, helping clients achieve optimal health outcomes, and improving client satisfaction; through an array of core medical and support services, with the

ultimate goal of helping clients link to care, stay in care, adhere to their treatment regimen, get virally suppressed, then achieve and maintain an undetectable viral load.

The local RWHAP aims to achieve the vision and mission statements above by using clinical quality improvement measurements and interventions to identify and address service shortfalls, disparities in treatment outcomes among priority populations of focus, and unmet service quality needs within the local system of care.

MDC's initial priorities are to improve client retention in medical care, viral load suppression, use of comprehensive oral health care services, and satisfaction with the services they receive through the collaborative efforts of the Ryan White Part A, MAI, and Part B Programs.

These activities will be provided in the contexts of three important quality processes:

1) Constant interfacing with HRSA RWHAP Part A/MAI and Part B service delivery standards, to ensure that quality improvement activities and client health outcome goals are always consistent with HRSA standards and clinical guidelines;

2) Regular feedback from the clients in care, through recruitment and retention of clients in the process of Integrated Plan implementation, as well as active participation in CQM Committee activities, special client input (focus) groups, annual needs assessments, targeted listening sessions, and client satisfaction surveys; and

3) Encouragement of a culture of quality among RWHAP subrecipients in a constant program of CQM capacity building training, technical assistance with QI projects engaged in by subrecipients in response to identified CQM needs, and maintaining the conceptual language of CQM in all Integrated Plan activities.

V. Annual Quality Goals (FY 2023)

Annually, the CQM Committee reviews and assesses progress on prior year CQM goals, reviews various data sources (e.g., service utilization data, demographic data, comorbidity data, client satisfaction survey results, CQM Committee input, etc.) to identify program goals and priorities for the current FY. Using a data-driven approach, the goals must be quantifiable and measurable.

The CQM quality goals for FY 2023 are as follows:

1) **ENHANCE THE CQM INFRASTRUCTURE TO ENSURE PEOPLE LIVING WITH HIV ARE ACTIVELY INVOLVED IN THE CQM PROCESS (e.g., PLANNING, QI ACTIVITIES, AND EVALUATION):** by February 2024, identify and implement a CQM Committee strategy to increase CQM representation by members of the affected community, with the goal of adding at least three (3) members of the affected community to the CQM deliberation process;

2) **IMPROVE SYSTEM-WIDE SERVICE QUALITY:** by February 2024, raise average RWHAP levels of retention in medical care (RiMC) and viral load (VL) suppression to the target levels specified by the CQM Committee and benchmarked in the quarterly Clinical Quality Management Performance Report Card (CQM Report Cards: see **Section VII, Performance Measurement**, below), as follows:

   a. For clients receiving Medical Case Management (MCM): achieve target goals of ≥ 90% RiMC (vs. 83% RWHAP average at close of FY 2022) and ≥ 90% VL suppression (vs. 88% RWHAP average at the close of FY 2022); and

   b. For clients receiving Outpatient/Ambulatory Health Services (OAHS): achieve target goals of ≥ 90% RiMC (vs. 87% RWHAP average at close of FY 2022) and 90% VL suppression (vs. 88% RWHAP average at the close of FY 2022).

3) **INCREASE CQM CAPACITY AND STRENGTHEN SUBRECIPIENT COMMITMENT TO QUALITY IMPROVEMENT:** by February 2024:

   a. Provide or coordinate at least three (3) CQM / QI-related training and technical assistance opportunities for subrecipients; and

   b. Ensure completion of at least one (1) data-driven QI project per each of the Part A subrecipients with an active CQM process in place. [Note: this does not include the Public Health Trust of Miami-Dade County's (PHT) participation in the Center for Quality Improvement & Innovation's (CQII) Impact Now Collaborative project, which is an 18-month project ending in mid-2024. However, PHT is tasked with providing regular progress updates to the CQM Committee on progress, QI tools obtained, interventions used, and lessons learned.] *Note that future QI activities for these subrecipients will depend on identification of the specific subrecipient as a "top quintile" or "bottom quintile" client outcome performer in the Integrated Plan Disparity Population section (NHAS Goal 3), and prioritization by the CQM Committee.*

4) **IMPROVE CLINICAL OUTCOMES FOR DISPARITY CLIENT POPULATIONS (NHAS GOAL 3) AND SPECIAL CLIENT POPULATIONS OF FOCUS (NHAS GOAL 2):** by February 2024:

   a. Determine root causes and QI intervention strategies for at least one subrecipient prioritized by the CQM Committee on the basis of low RiMC and VL suppression rates for disparity population clients receiving MCM and OAHS services (Integrated Plan, NHAS Goal 3); and

   b. Identify and implement a QI project for at least one Integrated Plan special client population of focus prioritized by the CQM Committee (Integrated Plan, NHAS Goal 2) in July 2023. These special client populations of focus include transgender persons, men who have sex with men (MSM) and have co-occurring sexually

transmitted infections, women, persons over 50 years of age, and persons who are homeless or unstably housed.

5) **SUPPORT ONGOING ASSESSMENTS OF PATIENT CARE, HEALTH OUTCOMES, AND SATISFACTION DATA THROUGH SUBRECIPIENT MONITORING:** by February 2024, the Part A and Part B Recipients will report to the CQM Committee any concerns identified through subrecipient monitoring that could benefit from a QI intervention to 1) improve the provision of HIV medical care following PHS treatment guidelines, 2) enhance client access to care, 3) reduce/eliminate stigma, and 4) support a client-friendly environment and positive client experience. Quality assurance issues of a contractual or administrative nature will not be a part of this CQM process.

The CQM goals noted above are informed by the following:

- The HRSA, HIV/AIDS Bureau (HAB) Policy Clarification Notice 15-02 and corresponding FAQ document, which can also be found at https://ryanwhite.hrsa.gov/grants/policy-notices;

- Results from CQII's Part B Organizational Assessment Tool; and

- MDC's CQM Report Card.

Note that these goals do not represent the totality of QI activity during FY 2023, but represent the most pressing QI concerns. Note that all of these goals are scalable and may be expanded in succeeding years as the Integrated Plan is implemented, and as the CQM Committee continues to examine progress and prioritize future QI initiatives.

VI. Quality Infrastructure

The quality infrastructure of the MDC CQM Program includes: (1) the RWHAP Part A/MAI Recipient; (2) the FDOH-MDC (Part B Lead Agency); (3) the CQM Committee; (4) Behavioral Science Research Corporation (BSR, the RWHAP's contracted CQM provider); (5) Groupware Technologies LLC's Provide® Enterprise Miami (PE Miami) data management system, the client information system shared by Part A/MAI and Part B; (6) South Florida-Southeast AIDS Education and Training Center (SF-SEAETC), providing clinical training services and medical record reviews to the CQM program; and (7) the Center for Quality Improvement and Innovation (CQII), providing CQM training and technical assistance through HRSA funding.

1) Leadership

Primary leadership in the MDC CQM Program resides mainly within:

- The **RWHAP Part A/MAI Program Administrator (Part A Recipient),** whose principal role is to direct BSR's work as the CQM provider and to ensure that every aspect of the CQM program is conducted in compliance with HRSA policy guidelines.

The Part A/MAI Recipient is responsible for coordinating the delivery and improvement of core medical and support services in the EMA (Miami-Dade County). This leader also helps to oversee the CQM process and provides guidance on program-allowable services, ensure compliance with federal and local guidelines, support the CQM efforts of Part A/MAI-funded subrecipients, champion the entire CQM process, and highlight high-achieving subrecipients through an annual CQM awards "ceremony";

- The **FDOH-MDC Public Health Services Manager (Part B STD/HIV Coordinator)**, who supervises senior FDOH-MDC staff who provide continual input on issues related to HIV prevention, testing, and linkage to the CQM Committee, the Integrated Plan workgroups and evaluation teams, to the Strategic Planning and Prevention Committees, and to the Partnership itself. The Part B Lead Agency is also responsible for coordinating and improving healthcare services in Area 11A (Miami-Dade County). This leader also helps to oversee the CQM process and provide guidance on program-allowable services, ensure compliance with federal and state guidelines, support the CQM efforts of Part B-funded subrecipients, champion the entire CQM process, and highlight high-achieving subrecipients through an annual CQM awards "ceremony";

- The **Miami-Dade HIV/AIDS Partnership (Partnership)** assists with the annual development and revision of service category standards. The Partnership receives and reviews CQM data and provides suggestions for improving services and removing barriers to care as well as re-allocating funds to support the recommendations, where possible;

- The **Community Coalition** provides input from people with HIV regarding service barriers, satisfaction and general client concerns; and

- The **BSR Project Director**, who provides top-level QI consultation, supervises construction of QI interventions, directs the Data Analyst in the conduct of CQM-related analyses and investigations based on PE Miami data, and oversees a staff of three additional BSR persons with direct QI responsibilities. This leader participates in identifying the high-achieving subrecipients to be highlighted through the annual CQM awards "ceremony." At least one BSR staff member attends every meeting of both the Integrated Plan Evaluation Workgroup and the CQM Committee. BSR staff contributed to updating the CQM Plan.

Secondary leadership comes from:

- MDC Part A/MAI Recipient's Program Director and contract management staff [to further champion the improvements of the Part A and Part B Programs among County leadership (i.e., County Mayor and Board of County Commissioners) and to assist subrecipients in the vital distinctions between administrative quality assurance and CQM, respectively]; and

- FDOH-MDC staff (including, but not limited to, the Medical-Health Care Program Analyst and the Planner II) working as integral components of the Partnership's Strategic Planning and Prevention Committees, the CQM Committee, and the Integrated Plan Evaluation Workgroup), and from BSR's staff of CQM practitioners, data analysts, and operations managers (staffing the CQM Committee, providing technical assistance to Part A and MAI subrecipients, and generating performance data and periodic reports).

2) CQM Committee Organization: Membership, Roles, Responsibilities, and Expectations

The CQM Committee is organized in accordance with HRSA PCN #15-02; and meets monthly via a Zoom virtual meeting platform.

a. Membership. The CQM Committee includes representatives from all funded subrecipients providing one or more of the Part A/MAI and/or Part B service categories requiring periodic performance measurements (see **Section VII, Performance Measures**, below). For FY 2023, these performance measure service categories include Medical Case Management (MCM), Outpatient/Ambulatory Health Services (OAHS), Oral Health Care (OHC), and Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals (HIPCSA). These CQM Committee member representatives may be designated QI personnel or senior Medical Case Managers within their respective organizations. In addition, the MDC's Part A/MAI Recipient attends CQM Committee meetings, as do two or more representatives from the FDOH-MDC Part B Lead Agency for Area 11A. The members are expected to participate in all discussions (see Section IV, 2) c., *Member Responsibilities and Expectations,* below). Outside stakeholders are invited to attend the CQM Committee meetings. These meetings are open to the public, meeting information is regularly distributed to the Partnership's listserv (2,000+ email addresses), notice of the meetings also appears on the Partnership's monthly calendar. The Zoom meeting invitations are posted openly.

b. CQM Committee Roles: Structure and Administration. The CQM Committee has a Chair and a Vice Chair. For FY 2023, the Chair is a lead Medical Case Manager from a funded subrecipient organization; the Vice Chair is an Associate Director of Contract Administration from another funded subrecipient provider organization. The committee chair and vice chair are elected by the CQM Committee members once a year. Remaining members have a role of active participation in the CQM process and at CQM Committee meetings. Part A and Part B Recipient staff have an oversight role in the CQM plan development and implementation process, and actively participate in CQM discussions. BSR CQM personnel manage meeting logistics, send out meeting notices, generate the meeting material for distribution (posted on the CQM tab of the Partnership website, www.aidsnet.org, in advance of the meetings), follow the agenda, facilitate discussion in the meetings, take minutes of the meetings, and maintain a publicly-accessible record of minutes, presentations, data, and agendas on the CQM page of the Partnership's website.

As noted above, BSR is the contracted subrecipient of CQM support for RWHAP Part A/MAI as well as for those elements of the CQM Plan that include Part B. Normally, the BSR Project Director and/or Associate Director attend the meetings, as well as one of the BSR QM Coordinators and the BSR Data Analyst (see **Section VI, 3), CQM Staff,** below).

Attendance is taken by roll call and minutes are taken and distributed prior to the next meeting and available on the Miami Dade HIV/AIDS Partnership website in the CQM section. The meetings are recorded, and minutes are reviewed and approved by the members at the following CQM Committee meeting before being posted on www.aidsnet.org for public access under the Quality Management tab (see web link above). Data related to the HAB/HRSA continuum for each agency is disseminated at each meeting in the form of a score card. At each monthly meeting one or two agencies present CQI projects.
CQM Committee decisions are made by consensus rather than by formal voting; there are no quorum requirements.

c. **CQM Committee Priorities, Responsibilities, and Expectations.** The CQM Committee combines oversight, prioritization, and QI review for *both Part A and MAI subrecipients* (and Part B, as appropriate). BSR generates subrecipient-level and overall RWP QI performance data for review – these data are generated consistent with guidelines provided in PCN #15-02, using HAB/HRSA outcome measures and additional service quality indicators from PE Miami summarized on the CQM Report Card to help identify potential QI issues (see **Section VII, Performance Measurement**, below). Other responsibilities and expectations of the CQM Committee include:

- ***Priorities:***

    - Assess 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 for the treatment of HIV disease and related opportunistic infections;
    - Develop strategies to ensure improvements in client access to and quality of HIV services;
    - Focus on enhancing Part A and MAI service delivery processes to improve client retention in care, reduced viral loads and increased client satisfaction;
    - Raise awareness of — and capacity for — the CQM 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; and
    - Continuously improve the data the RWP depends on for quality improvement under the Provide Enterprise® Miami (PE Miami) client data management information system, supporting service delivery

documentation, measurement of client outcomes, and assessment of service improvement.

- ***Responsibilities and Expectations:***

    - Attend and actively participate in the CQM Committee meetings and related processes;
    - Set annual CQM goals, priorities, and targets;
    - Provide suggestions for QI projects, tools, and interventions;
    - Focus on enhancing Part A/MAI and Part B service delivery processes to improve client retention in care, reduce viral loads, and increase client satisfaction;
    - Monitor progress of QI projects;
    - Identify the extent to which HIV health care provided to clients under the RWHAP are consistent with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections;
    - Receive and respond to QI and MAI presentations by subrecipient providers, and provide feedback to the subrecipients;
    - Identify potential QI opportunities through client outcome performance data, and prioritize them for attention by BSR or the Integrated Plan Evaluation Workgroup;
    - Evaluate performance data from Ryan White Program subrecipients.
    - Prioritize (or re-prioritize) QI projects;
    - Develop the timeline to complete QI related projects [e.g., Plan-Do Study-Act (PDSA) cycles, etc.];
    - Increase capacity for the CQM process of problem identification, baseline data measurement, root cause diagnosis, and QI intervention;
    - Provide input into elements of the CQM Plan, and review the completed plan when it has passed review by the Recipient and HRSA;
    - Evaluate the impact of QI initiatives on subrecipient-level and RWHAP-level client health outcomes;
    - Evaluate the progress and effectiveness of the activities of the CQM Committee, BSR, and the Part A/MAI and Part B Recipient activities over the past year;
    - Identify QI training needs and opportunities;
    - Recruit members of the affected community as participants in the CQM process; and
    - Share best practices and determine future goals.

3) Staff Positions Responsible for Developing and Implementing the CQM Program

Although the CQM Committee, the FDOH-MDC, and the Integrated Plan Evaluation Workgroup make substantial contributions to the content of the CQM Plan and the CQM Program, the bulk of the organizational work and day-to-day implementation of the CQM Plan is the responsibility the contracted subrecipient (BSR), which oversight and guidance from the Part A/MAI Recipient.

a. Through the Miami-Dade County Office of Management and Budget, the **Recipient** provides oversight of the local CQM process and ensures compliance with program legislation and HRSA CQM guidelines. The Recipient manages the operational and contractual relationships between BSR (and other subrecipients) and the PE Miami client information system, oversees BSR's sub-contractual relationships with interviewers and other independent contractors instrumental in the annual Client Satisfaction Surveys and other research projects directed toward QI efforts.

b. **BSR** is the contracted subrecipient organization supporting the RWHAP Part A/MAI and Part B CQM Program. Under the Part A and MAI CQM staffing allocated by BSR to this project, the following BSR staff members provide services as outlined below:

- **BSR Project Director** (PD): 0.68 Part A CQM, 0.04 MAI CQM. The PD is responsible for overall direction of the Part A Clinical Quality Management (CQM) program, including coordinating Part A CQM activities with MAI and Part B. The PD oversees the work of all subordinate BSR staff, provides guidance on QI methodologies and statistical analyses, prepares CQM-related reports and summaries, assists with the provision of technical assistance to subrecipients, and oversees research projects that aid in identifying RWHAP problem areas (e.g., HIV treatment guidelines, client satisfaction, service delivery, etc.) to be addressed through subrecipient QI projects. The PD will also identify existing best practices or design appropriate new interventions for Part A-funded subrecipients to use in their QI projects; test the effectiveness of CQM and QI interventions based on data review and survey and focus group results to determine level of improvements in client satisfaction and client health outcomes; and conduct the CQM evaluation process. The PD directly oversees the work of the BSR Associate Director, QM Coordinators, Data Analyst/Research Associate, and Operations Manager/Administrator in support of the Part A/MAI CQM functions.

- **BSR Associate Director** (AD): 0.77 Part A CQM, 0.03 MAI CQM. The AD is responsible for assisting the PD in all aspects of the management and operation of the Part A and MAI CQM activities, with particular emphasis on translating CQM data into QI opportunities and coordinating with the Integrated Plan Evaluation Workgroup on the QI components of the Integrated Plan. In addition, the AD is responsible for providing guidance to the QM Coordinators to aid funded subrecipients in designing, implementing, and evaluating effective QI projects for the RWHAP.

- **Quality Management Coordinator/Training Coordinator** (QMC/TC): 1.0 FTE Part A CQM. The QMC/TC assists the PD and AD with Part A CQM activities directed toward Part A QI projects, providing technical assistance to subrecipients with ongoing QI interventions as well as additional QI projects as prioritized by the CQM Committee. The QMC/TC's work particularly includes responding to systemic QI opportunities related to RiMC, VL Suppression and the provision of

HIPCSA services, and facilitating CQM training, care coordination, and technical assistance directed to RWP Medical Case Managers and their Supervisors.

- **Quality Management Coordinator/MAI Coordinator** (QMC/MAI): 0.75 FTE MAI CQM, 0.25 FTE Part A CQM. The QMC/MAI assists the PD and AD with Part A CQM activities, including managing CQM Committee capacity development, and developing QI strategies related to the Integrated Plan's Linkage to Care / TTRA initiatives (NHAS Goal 2). The majority of the QMC/MAI's time is directed toward coaching, training, and providing technical assistance to MAI CQM services. The QMC/MAI facilitates the monthly CQM Committee meetings.

- **Data Analyst/Research Associate** (DA): 0.55 FTE Part A CQM, 0.05 FTE MAI CQM. The DA is responsible for the implementation, maintenance, and improvement of the performance measurement system, reflected in the quarterly CQM Report Card, as well as providing monthly subrecipient client data extract files from the PE Miami data management system in support of Part A and MAI subrecipient QI initiatives, analyzing data from the Client Satisfaction Survey, and responding to QI data needs from the RWHAP Part A/MAI Recipient and from the FDOH-MDC. The DA is also tasked with developing and maintaining the CQM Report Card dashboard.

- **Operations Manager/Administrator** (OM): 0.50 FTE Part A CQM (40% direct, 10% indirect). The OM assists the PD, AD, CQM Coordinators, and DA with database management, statistical analysis (under the direction of the DA), client satisfaction survey project management, and other direct CQM-related tasks necessary to ensure completion of CQM activities described herein.

4) Production of the CQM Plan

The CQM Plan is drafted by the contracted Part A/MAI CQM subrecipient, based on current QI projects, identified QI intervention needs, and evaluation feedback from the CQM Committee members. A final draft is submitted to the Part A/MAI Recipient and Part B Lead Agency for a technical review to ensure quality, consistency, and adherence to local, state, and federal guidelines. Once approved by the Part A/MAI Recipient and Part B Lead Agency, the final CQM Plan is shared with the CQM Committee and other stakeholders. This process is expected to be conducted annually.

The CQM Plan is moving from a once-a-year written document to an iterative process of performance measure review, subrecipient QI project review, and QI project prioritization, by the CQM Committee, the Recipient and BSR, and (beginning in FY 2023) a congruence review with the Integrated Plan through the Integrated Plan Review Workgroup. In the past, production of the CQM Plan had been an annual process of updating and refreshing a set of CQM activities directed toward identified client disparity populations, concentrated in the offices of the MDC Part A/MAI Recipient and BSR, and reviewed and passed by the CQM Committee before full implementation. This changed with the development (in FY 2022) and implementation (in FY

2023) of the Integrated Plan by the RWHAP and FDOH-MDC: the Integrated Plan contained numerous CQM overlays and emphases on special stand-alone populations suggested by the FDOH-MDC, the Florida Comprehensive Planning Network, and other MDC stakeholders during the plan development process. In addition, the CQM planning process was expanded to integrate Part B and FDOH-MDC into the sphere of influence for the Part A/MAI CQM Plan, and this will necessitate some reconfiguration of the CQM Committee.

With the assistance of the CQM Committee and input from the FDOH-MDC and other stakeholders, the BSR Project Director and the RWHAP Recipient will engage in an ongoing dialog with the Integrated Plan Evaluation Workgroup and the CQM Committee to examine and update the various activities in the CQM Plan and its Work Plan, and summarize these activities in an annual update to the CQM Plan. The key elements to be formally updated in the annual CQM Plan will be the overarching Annual Quality Goals for the CQM Program (see **Section V**, above) and the workplan and schedule of deliverables for BSR as the contracted CQM implementation entity (see **Section IX**, below). Some of the CQM Plan elements to be reviewed by BSR and the Recipient in FY 2023, and discussed and prioritized by the CQM Committee, include:

a. CQM Performance indicators, as reported in the CQM Report Card as measurement issues and possible subrecipient service performance shortfalls raise this item as part of our CQM plan. Note that in FY 2022, based on the success of the RWHAP in enrolling clients into the ACA marketplace, the number of clients receiving HIPCSA exceeded the 15% threshold for a service category to require a reported outcome measure: the CQM Committee settled on RiMC as their outcome indicator of choice, and authorized BSR to begin reporting subrecipient statistics on this measure beginning in Cycle 1 of the FY 2023 program year. These data will be reviewed by the CQM Committee in July 2023, after the Cycle 1 data are reported by PE Miami.

b. Prioritization of QI projects outlined in the Integrated Plan, for services directed toward specialty population groups (NHAS Goal 2) and disparity populations (NHAS Goal 3). Data from FY 2022 and Cycle 1 of FY 2023 for VL suppression and RiMC for four Integrated Plan specialty population groups (e.g., transgender persons, MSM with co-occurring STIs, women in care, males and females over 50 years of age); will be provided to the CQM Committee by subrecipient service site in July 2023, for evaluation and recommendation for QI project development within the CQM Plan. Data for disparity population VL suppression and RiMC, by subrecipient site, will be provided to the CQM Committee in August 2023, for evaluation and recommendation for QI project development within the CQM Plan.

c. A comprehensive training agenda will be provided to the CQM Committee for comment and/or modification in July 2023, to modify the placeholder CQM training topics in this workplan.

The CQM Plan draft for FY 2024 will be provided to the CQM Committee, the Part A/MAI Recipient, and the Part B Lead Agency by the BSR Project Director in January 2024, for comment and discussion, in order to structure the scope of work, budget, and activities for FY 2024.

5) Involving People with HIV in the CQM Process

Involvement by RWHAP clients or non-client people with HIV is strongly encouraged at all levels of the CQM planning, implementation, and evaluation processes. Notably, the Partnership's Strategic Planning Committee and the Integrated Plan Evaluation Workgroup include members of the affected community as participants; affected community from the CQM Committee are invited to attend the Subrecipient Forums as well. (Note: Subrecipient Forums are held to discuss essential topics of importance to the local RWHAP, including service delivery issues, discussing ideas to improve efficiency and effectiveness of programs, exchanging information, problem-solving, and networking among subrecipients in the Miami-Dade HIV system of care. Ryan White Part A/MAI and Part B-funded subrecipient's senior level staff members – Executive Directors and/or Program Directors/Coordinators – attend Subrecipient Forums. Specifically, decision-makers at the subrecipient organization who are responsible for ensuring service quality and compliance with programmatic and contractual requirements are required to attend these meetings.) With specific reference to CQM, people with HIV – both clients and non-clients – are brought into CQM Program discussions through several avenues. In FY 2023:

a. People with HIV comprise six of the 22 members of the Partnership – including the newly elected Chair (see Stakeholder chart, below). All of them receive the CQM reports and summary data provided to the Partnership, including CQM Report Card summaries and needs assessment data.

b. BSR CQM staff attend regularly scheduled meetings of the Community Coalition Roundtable – the Partnership committee that essentially serves as the Community Advisory Board for the Partnership – to present CQM QI project results and solicit input on RWHAP service delivery issues. On average, 14 people with HIV attend these monthly meetings, of whom roughly half are long-term RWHAP clients.

c. The CQM Committee is reviewing two ways to encourage QI involvement by people with HIV: 1) asking service provider subrecipients with Community Advisory Boards (CAB) to designate a member of the CAB as a CQM Liaison [with a focus that includes, but is not limited to, engaging members from subpopulations of focus (e.g., transgender persons, MSM with co-occurring STIs, women in care, males and females over 50 years of age, etc.], to attend CQM Committee meetings, and raise issues related to service delivery quality; and 2) to create a CQM affinity group drawn from subrecipient staff Peer Educators. The Peer Educator affinity group is especially attractive to the CQM Committee, since peers are people with lived HIV experience as well as being involved in direct service and with high levels of contact with other RWHAP clients.

6) Stakeholder Engagement with QI

All aspects of the CQM Program are discussed with the Miami-Dade HIV/AIDS Partnership (Partnership; planning council) and its Prevention, Care and Treatment, and Strategic Planning Committees, both with respect to Integrated Plan activities and the results of CQM data from QI projects, the annual Client Satisfaction Survey, Needs Assessment findings on the "state of the RWHAP service quality," and historical findings on subrecipient service delivery effectiveness from previous Integrated Plans. Stakeholders in all CQM review activities include subrecipients actually involved in service delivery, non-RWP service providers, FDOH-MDC, ADAP, Florida regulatory agencies (e.g., AHCA/Florida Medicaid), and local colleges and universities. An inventory of the stakeholders in the Partnership is shown in **Table 1**, below:

TABLE 1
Miami-Dade HIV/AIDS Partnership Stakeholder Composition

#	Membership Category	Sex	Race/ Ethnicity	Provider or Grantee Affiliation
1	Non-Elected Community Leader, not an HIV provider (Partnership Chair)	F	B/NH	None
2	Representative of the Affected Community (Partnership Vice-Chair)	M	H	None
3	Representative of the Affected Community	F	B/NH	None
4	Representative of the Affected Community	M	B/NH	None
5	Representative of the Affected Community	M	H	None
6	Former Inmate of local, state, or federal prison	M	B/NH	None
7	Local Health Department Representative	M	W/NH	FDOH-MDC
8	RW Part B Grantee Representative	M	H	Grantee/DOH
9	HIV Prevention Provider	F	H	FDOH-MDC
10	Part A Local Grantee Representative *(Note: this seat is in the process of changing to a County government representative that is not affiliated with management of the grant; a required County Ordinance change is pending.)*	M	W/NH	Grantee
11	Medicaid Agency Representative	F	H	AHCA
12	Part D Grantee Representative	F	B/NH	UM-Ob/Gyn
13	Other Federal HIV Program Representative (CDC)	M	W/NH	University of Miami
14	Housing, Homeless or Social Service Provider	M	W/NH	Better Way of Miami
15	Health Care Provider Representing FQHC	F	B/NH	CHI
16	Mental Health Provider	M	W/NH	Concept House
17	Housing, Homelessness or Social Service Provider	M	H	Homeless Trust
18	Florida General Revenue Grantee Representative	F	H	Jackson Health System

TABLE 1 Miami-Dade HIV/AIDS Partnership Stakeholder Composition				
#	Membership Category	Sex	Race/ Ethnicity	Provider or Grantee Affiliation
19	Community Based / AIDS Service Organization (CBO/ASO)	M	W/NH	New Hope C.O.R.P.S.
20	Part C Grantee Representative	M	W/NH	Borinquen CHC
21	Other Federal HIV Program Grantee (Part F)	M	W/NH	Care Resource CHC
22	Other Federal HIV Grantee (HOPWA)	M	Asian	City of Miami

As outlined in **Section VI, 2)**, above, the CQM Committee is itself a stakeholder-driven enterprise, with subrecipient providers and the FDOH-MDC as integral parts of CQM decision-making.

7) Evaluation

Evaluation of the CQM program will involve four elements in FY 2023:

a. **Bi-monthly status reports on the progress of Part A/MAI and Part B initiatives and innovations undertaken by the Part A, MAI, and Part B subrecipients will be provided to the Part A/MAI Recipient, Part B Lead Agency, and to the members of the CQM Committee.** Every 60 days, BSR will provide a summary status report on the progress of individual QI projects and MAI innovations, to be provided to the members of the CQM Committee and to the Recipient.

b. **Semi-annual CQM reports on progress of CQM QI and Integrated Plan activities, including outcome measurements for specialty groups and disparity populations.** These reports will be provided by BSR to the scheduled semi-annual meetings of the CQM Committee and the Joint Integrated Plan Review Team (JIPRT). The JIPRT meetings are provisionally calendared for October 2023 and March 2024.

c. **A semi-annual evaluation survey provided to CQM Committee members,** itemizing the major deliverables to have been provided by BSR, the CQM Committee, the Part A/MAI Recipient, and Part B Lead Agency over the preceding fiscal year, and soliciting feedback as to their effectiveness in accomplishing these objectives. Two versions of this survey will be distributed: one survey will be provided to the Part A/MAI Recipient, Part B Lead Agency, subrecipient members, and other stakeholders of the CQM Committee, and one survey will be provided to the subrecipients who were challenged to provide Part A/MAI and Part B CQM deliverables during FY 2023. This survey is scheduled for twice-yearly distribution in August 2023 and March 2024, after review and approval of survey format by the Recipient.

d. **Evaluation surveys for participants at scheduled CQM training events and at each Subrecipient Forum**. This evaluation form will be patterned after the evaluations used by Partnership Staff Support in the evaluation of Needs Assessment and Joint Integrated Plan Review Team meetings and presentations.

Shortfalls in deliverables will be addressed constructively in the CQM Committee meetings, and revised goals and deadlines may be negotiated. Prolonged or repeated shortfalls will be addressed between the Part A/MAI Recipient, Part B Lead Agency, and individual subrecipient, as appropriate.

In addition to the reporting noted in this Evaluation section (above), summaries of successes, challenges, and next steps regarding CQM Committee activities, subrecipient QI projects, improvements in client health outcomes, and results of CQM evaluations will be shared with stakeholders (e.g., Ryan White Part A-D recipient and subrecipient leadership and staff, people with HIV, funders, Partnership and Committee members, County leadership, local colleges and universities, and the HIV community at large). These summaries will be shared through the Partnership's Community Newsletter, posting on the Partnership website's CQM page, at Partnership and Committee meetings, and through emails. This reporting will be completed semiannually (in September 2023 and March 2024) and is expected to reach more than 2,000 people.

VII. Performance Measurement

Performance measurement refers to the periodic evaluation of indicator data, consistent with HRSA Performance Measures (https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio).

1) Performance measures are generated according to the percentage of the RWHAP client base included in each service category (see listing of performance measures **in Table 2**, below). The performance measures are drawn from HRSA's HIV/AIDS Bureau Performance Measure Portfolio, see web link directly above, as may be modified by the CQM Committee to meet local CQM needs. For example, the CQM Committee compressed the time period for "Gap in HIV Medical Visits" variable for clients in MCM care from "visits within the last six months of the program year" to "visits within most recent 90 days," in order to make this outcome variable better suited as an early warning for clients who may be in danger of dropping out of care. "Medical Case Management: Care Plan" was added as an outcome variable by the CQM Committee to more accurately reflect the need for actual case planning at the time of the MCM visits, rather than simply counting MCM encounters as an indicator of case management.

2) The performance measurement data are generated by the PE Miami data management system, used by both Part A and Part B as the primary source of local RWHAP data and a mechanism for accounting for client service activity. The PE Miami system generates a relational billing-based database, with the data entered by the individual MCMs and other staff or uploaded from the subrecipients' electronic medical record system (for medical

procedures) or obtained as file transfers from commercial laboratories (for VL suppression data). The aggregated PE Miami data are queried for QI purposes using Structured Query Language (SQL) queries by the BSR Data Analyst. The data from these queries are used to produce Excel data tables for analysis. Periodic cross-checking is done by the Part A/MAI Recipient and the BSR Data Analyst, to ensure that the results obtained by the BSR SQL queries and/or by the Recipient's PE Miami pre-programmed reports are the same, and discrepancies are referred to Groupware Technologies LLC technicians for reconciliation. The BSR Data Analyst also creates dashboards for each subrecipient based on data from PE Miami.

Subrecipients are not "engaged" in the production of QI data *per se:* the MCMs and OAHS providers are engaged in documenting their service delivery activities in such a way as to provide the Recipient with an accurate accounting of the billable activities they engage in on behalf of their clients. During annual comprehensive site visits and through periodic Quality Assurance desk audits by the Part A/MAI Recipient, the accuracy of the PE Miami data are assessed.

3) Results and findings from BSR's SQL queries are organized and presented according to MCM, OAHS and OHC service sites in the CQM Report Card, which is distributed via email on a quarterly basis to stakeholders within the MDC Ryan White Program, on or after the 20th day of each subsequent month following the close of a grant fiscal quarter.

- The CQM Report Card serves as a key mechanism for periodic CQM-directed analyses of client-centered and subrecipient performance trends affecting client health outcomes. The quarterly analyses enable the ongoing review of key quality indicators (clinical and non-clinical) and measurement of outcomes that impact successful engagement in care and overall client health. The core analyses are based on clients receiving one or more units of MCM care during the reporting period, using the client/MCM relationship as the fulcrum for intervention and client support. Secondary analyses are conducted among clients receiving one or more units of OAHS service during the period, one or more units of OHC service during the period, or one or more units of service of any type during the reporting period.

- In FY 2022, the CQM Committee requested a modification to the CQM Report Card to group the RWP subrecipients into four peer groups:

    - MCM service sites with under 100 clients (five providers);
    - MCM service sites with between 101 and 200 MCM clients (nine providers);
    - MCM service sites with between 201 and 600 MCM clients (five providers); and
    - MCM service sites with over 601 MCM clients (three providers).

This allows more precise CQM activities and a more equitable comparison among RWP subrecipients. The "peer group" CQM Report Card data are illustrated in the attached file for FY 2022.

- Additionally, BSR provides customized subrecipient-specific client-level outcome data on a quarterly basis in the form of a QI Dashboard. The QI Dashboard includes annual retention and viral load suppression data as well as demographic information for each client receiving MCM or OAHS services within that particular agency, including age, race, ethnicity, and disparity population. The QI Dashboard enables stakeholders to identify health disparities and focus on client populations of greater need.

- The responsible individual for analyzing and articulating these findings is BSR's Data Analyst. The most recent data available as of the time of this writing is that of FY 2022, Quarter 4: data from the first cycle (quarter) of FY 2023 (March-May 2023) will not be available until after all invoices have been processed from activity in May 2023.

- The CQM Report Card data have been disseminated to the Part A/MAI Recipient, all members of the CQM Committee, all case management supervisors and CQM champions in individual subrecipient agencies, and FDOH-MDC. Note that one of the subrecipients shown in the MCM data is designated as a Part B service site (see **Table 2**, below).

4) The CQM Committee and BSR's CQM staff follow HRSA PCN #15-02, as may be amended, in choosing the minimum number of **performance measures** to study by service category, using **Table 2**, on the next page, as a guide. **Table 3**, immediately following Table 2, illustrates the performance measures to be used for FY 2023.

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TABLE 2
Minimum Number of Performance Indicators Specified
For Service Categories

Review Group	% RW Part A/MAI clients receiving ≥ 1 unit of service per category	Minimum performance measures required	Threshold number of clients, based on 8,590 clients served in FY 2022	Service Category Review Group for FY 2023 based on number of RWP clients reported as served in BSR's CQM Report Card for FY 2022 (limited to certain encounter types)
1	≥ 50%	2	≥ 4,295 clients served	-- Medical Case Management (6,650 Part A, 198 Part B) -- Outpatient/Ambulatory Health Services (5,278)
2	15% to 49%	1	1,289 - 4,209 clients served	-- Oral Health Care (2,577) -- Health Insurance Premium and Cost Sharing Assistance (1,440)
3	< 15%	0	< 1,289 clients served	-- Food Bank (1,130) -- Local AIDS Pharmaceutical Assistance (157) -- Medical Transportation (743) -- Outreach Services (158) -- Mental Health Services (107) -- Substance Abuse Services (Residential) (72) -- Substance Abuse Outpatient Care (22) -- Other Professional Services (Legal) (103)

NOTE: Although Emergency Financial Assistance as funded by the FDOH-MDC is a much needed service for people with HIV, this service is a one-time event or short-term resources lasting less than 6 months. For this reason, EFA was excluded from the QI process for FY 2023.

TABLE 3 FY 2023 Performance Indicators for Service Categories	
Service Category	Subrecipient-Based Performance Measures Tracked on the CQM Report Card
Outpatient/Ambulatory Health Services (≥50% of clients)	1. HIV Viral Load Suppression (HRSA/HAB) 2. Retention in Medical Care: 12-month HIV Medical Visit or proxy lab test (CD4 or viral load) (HRSA/HAB)
Medical Case Management (≥50% of clients)	1. HIV Viral Load Suppression (HRSA/HAB) 2. Retention in Medical Care: 12-month HIV Medical Visit or proxy lab test (CD4 or viral load) (HRSA/HAB) 3. Retention: 3-month Gap in MCM/Medical Visits (HRSA/HAB, modified to improve RiMC early warning)
Oral Health Care (15% - 49% of clients)	1. % of OHC clients with annual clinical oral examination (HRSA/HAB, OHC providers only)
Health Insurance Premium and Cost Sharing Assistance (15% - 49% of clients)	1. Retention in Medical Care: 12-month HIV Medical Visit or proxy lab test (CD4 or viral load) (HRSA/HAB) *

* Non-comparatively reported on the CQM Report Card.

VIII. Quality Improvement: Scope of CQM Program

QI Methodology. The CQM Program will use various methods and tools to help improve access to quality care and client satisfaction with the local service delivery system of care. The main methods and tools to be used are as follows:

1) The **"Model for Improvement" (MFI)** – as expanded by the Institute for Healthcare Improvement as its primary framework for improvement in healthcare – will be used as a QI guide. The MFI Plan-Do-Study-Act (PDSA) implementation sequence leads QI teams to ask simple questions about problems that appear in their client care statistics, to improve their understanding of client care processes by looking at issues affecting segmented populations and identifying possible root causes (see the MFI "Three Questions," below). These questions guide QI teams through establishing indicators, detecting differences, understanding what success looks like, using data to measure the reality of change, and focusing on what is necessary to export the change idea to other parts of their health care organization. The reader is directed to Langley et al., *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, a reference book used by every CQM practitioner at BSR. Attached to this CQM Plan, please find templates used to facilitate QI projects using MFI and PDSA tools (i.e., Appendix 1, Model for Improvement template; and Appendices 2a, 2b, and 2c, Plan-Do-Study-Act templates).

Figure 1: Model for Improvement

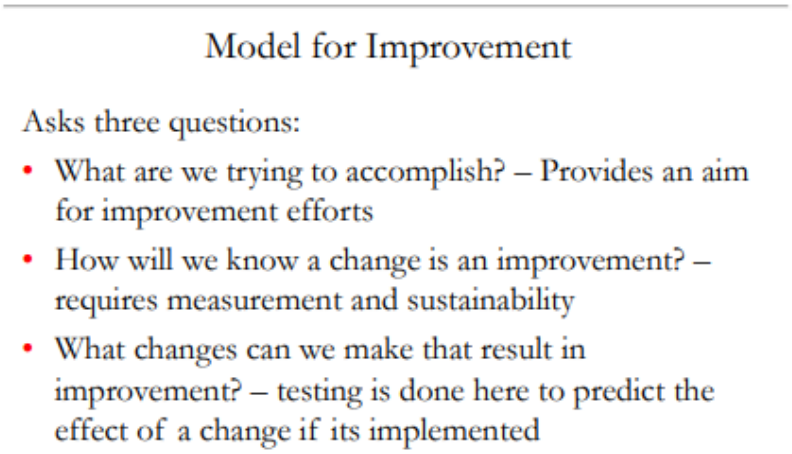

Figure 2: Plan-Do-Study-Act (PDSA)

2) **Data-driven; CQM Report Card.** Individual QI projects begin with comparison of client outcome data for specific subpopulations in care. Because the Integrated Plan concentrates on VL suppression and RiMC among key ethnic disparity populations – e.g., Black/African American males and females, Hispanic MSM, Haitian men and women – it is not difficult to find some subgroups who are doing well and others who are not. Likewise, in a treatment environment with over 23 service sites, it is not hard to find some sites doing better than others. CQM Report Card data are provided to all subrecipients, and comparisons are provided to the CQM Committee; in the context of the Integrated Plan's focus on specialty populations as well as key ethnic disparity populations, outcome data drawn from PE Miami and summarized in QI Dashboards by BSR are useful in prioritizing QI projects. In FY 2023, since subrecipients are required to do only one QI project at a time, the CQM Committee will be called upon to set these priorities. The Part A/MAI Recipient has determined that subrecipients receiving MAI funding (and who are responsible for developing innovative care models for their MAI clients) should not be required to engage in both a QI intervention as well as an MAI care innovation, especially as the same disparity population(s) are likely to be involved with

both care quality improvement efforts. In some cases, a specialty client population of focus receiving services at one subrecipient agency is already involved in a QI or MAI innovation at another agency (e.g., one MAI subrecipient is targeting VL non suppression among persons with HIV over 50 years of age).

The documentation data for all PDSA cycles and data from baseline and post-intervention measurements are maintained in subrecipient QI project files by subrecipients and by the BSR QM Coordinators. As the provider of QI capacity building and technical assistance, BSR will provide internal subrecipient QI project status reports to the Recipient and the CQM Committee every two months in FY 2023 (see **Section IX, Work Plan,** below).

3) **Training and technical assistance** needs are assessed at least once per year in the CQM Committee's evaluation process, and are constantly re-assessed on an individual subrecipient basis during the monthly technical assistance (TA) calls provided by BSR's QM Coordinators and Data Analyst. Based on the system-wide and subrecipient-specific training and TA needs identified in FY 2022, BSR has drafted a training agenda for FY 2023. These training needs include: 1) establishing an on-line library (including links to existing resources) of self-paced QI skills training, to allow subrecipients to train their new staff in rudimentary CQM skills using standardized training materials; 2) providing instruction in basic data analysis techniques, showing CQM participants how to think through client outcome data and tease out root causes; and 3) refresher instruction on planning a QI intervention and documenting the impact (or lack) of a QI intervention on client outcomes. This will be augmented by training and technical assistance needs identified by the Integrated Plan Evaluation Workgroup and the CQM Committee (see **Section IX, Work Plan,** below).

4) Where appropriate, BSR CQM staff are able to offer **Lean Six Sigma** guidance to QI Projects. Two of BSR's CQM staff are certified Green Belts. Lean Six Sigma can be used to help improve performance while eliminating the waste of resources; streamlining processes and increasing efficiencies to improve employee and client experiences.

Figure 3: (Lean) Six Sigma

5) **Other QI tools.** QI projects may benefit from Root Cause Analysis tools such as the "5 Whys", fishbone diagrams (cause and effect), and process mapping. Driver diagrams may also be used to identify 1) the ultimate aim of the QI project, 2) the drivers which will affect accomplishing the aim, and 3) the interventions that affect the identified drivers. These tools along with other CQM resources that are available at TargetHIV (https://targethiv.org/library/topics/clinical-quality-management) may be utilized.

IX. Workplan

The elements in the workplan below are drawn from the CQM Plan narrative in Sections I – VIII, above. While numerous references are made in this narrative to the teamwork that exists between BSR as the contracted CQM provider, the RWHAP Part A/MAI Recipient, FDOH-MDC (Part B), the Partnership, the Integrated Plan Evaluation Workgroup, and the CQM Committee, ***BSR is the responsible party for coordinating the completion of the tasks outlined in this section.***

The workplan is divided into two sections:

1) IX-A (Tasks 1 – 16) includes tasks which are part of the ongoing CQM work that BSR provides as part of the CQM infrastructure of the RWHAP in Miami-Dade County. These include the management of the CQM Committee functions, performance measure updates and modifications, the production and dissemination of the CQM Report Card and QI Dashboard data sets, the conduct of an annual Client Satisfaction Survey and Needs Assessment data analyses through PE Miami, ongoing training and monthly technical assistance meetings with the Part A, MAI, and Part B-funded subrecipients, and periodic reports to the Recipient, the FDOH-MDC, the Partnership, the CQM Committee, the Integrated Plan Evaluation Workgroup, and other key stakeholders.

2) IX-B (Tasks 17-38) includes tasks which are extensions or expansions of BSR's CQM work occasioned by the creation and implementation of the Integrated Plan, with the tasks keyed to the specific activities and strategies of the Integrated Plan. These tasks are listed as "pending" only because the internal priority orders are still pending review and negotiation between the CQM Committee and the Integrated Plan Evaluation Workgroup: note that of this writing, the first Integrated Plan review by HRSA for the document submitted in December 2022 has only recently been received by the Recipient, and this review may have important consequences for the strategies, activities and data elements specified in the Integrated Plan and their CQM counterparts. As noted above, the CQM Plan operates in conjunction with the Integrated Plan, and major changes to the Integrated Plan have significant implications for the conduct of the CQM Program in Miami-Dade County.

Notwithstanding these caveats, the CQM Plan's work plan as outlined below is intended as a roadmap to the performance measurements, ongoing QI projects and MAI innovations, provision of technical assistance and training, and reporting by BSR for the balance of FY 2023. ***Upon review of this CQM Plan by HRSA and modification or clarification of the CQM Plan pursuant to that review, the modified CQM Plan will be provided to the CQM Committee for the work of prioritizing activities and supervising outcomes, and interfacing this Plan with the strategies, activities and measurements of the Integrated Plan. The CQM Committee will receive a copy of the CQM Plan marked in Draft form until it is final. While the results of the CQM activities, QI projects and MAI innovations may be shared with the Partnership and to subrecipients through Subrecipient Forums, the CQM Plan is an internal working document and should not be disseminated beyond the CQM Committee until it is final.***

TABLE IX-A Part A/MAI CQM Core Workplan Elements				
#	**Task** *(CQM Plan section in parentheses)*	**Planned Frequency** *(monthly, semiannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, Ongoing, Pending, Completed)*
1	**CQM Committee meetings** (VI.2)	Monthly	March 2023 to February 2024	Ongoing
2	**CQM Plan updates** (VI.4)	Annual	May 2023, December 2023	Ongoing
3	**Performance Measurement production, review, dissemination:** CQM Report Card (VII.A)	Quarterly	April 2023 (Cycle 4, FY 2022); June 2023 (Cycle 1, FY 2023); September 2023 (Cycle 2, FY 2023); December 2023 (Cycle 3, FY 2023)	Ongoing: Year-end (Cycle 4) FY 2022 completed
4	**Performance Measurement:** VL suppression and RiMC analysis for IP Special Populations: transgender persons, MSM with co-occurring STIs; women; males and females over 50 years of age. (VI.4.b: see also IX-B)	Semiannual	July 2023	Pending
5	**Performance Measurement:** Data for disparity population VL suppression and RiMC, by subrecipient site. (VI.4.b)	Semiannual	August 2023	Pending

TABLE IX-A Part A/MAI CQM Core Workplan Elements				
#	**Task** *(CQM Plan section in parentheses)*	**Planned Frequency** *(monthly, semiannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, Ongoing, Pending, Completed)*
6	**Performance Measurement:** Listening sessions through CCR and general RWHAP, directed toward needs and service delivery for clients over 50 years of age (Integrated Plan SP) (VII.B)	Once in FY 2023	July 2023	Pending
7	**Performance Measurement:** Annual Client Satisfaction Survey: 500 Part A/B clients in MCM/OAHS care, with special questions for persons over 50 years of age (VII.C).	Annually in FY 2023	Survey construction July 2023, data collection September-November 2023	Not started
8	**Part A QI Project Technical Assistance for Subrecipients**	Monthly	March 2023 to February 2024	Ongoing
9	**MAI Innovation Technical Assistance for MAI funded Subrecipients**	Monthly	March 2023 to February 2024	Ongoing
10	**QI Training for MCMs and Peers:** Introductory QI Training for new MCMs and Peer Educators; periodic MCM supervisor training	Multiple times per year	April 2023; July 2023; August 2023; November 2023; December 2023	Ongoing
11	**QI Training:** Enhanced QI training and workshops, per CQM Committee	Multiple times per year	TBD	Pending
12	**QI Training:** Coordination of Subrecipient/Recipient Forums	Twice a year	August 2023, February 2024	Not started
13	**Evaluation of CQM Process**	Semiannual (CQM program and CQMC evaluations)	August 2023, February 2024	Not started
14	**Evaluation of MAI CQM Process** (subtask of Evaluation of CQM Process, item #13, above)	Semiannual (MAI program and MAI evaluations)	August 2023, February 2024	Not started

TABLE IX-A Part A/MAI CQM Core Workplan Elements				
#	**Task** *(CQM Plan section in parentheses)*	**Planned Frequency** *(monthly, semiannually, quarterly, annually)*	**Deadline** *(deadline is last day of month unless otherwise indicated)*	**Status** *(Not started, Ongoing, Pending, Completed)*
15	**Internal Status Reports on Part A QI projects progress to CQC Committee and Recipient**	Bimonthly	July 2023, September 2023, November 2023, January 2024	Ongoing
16	**Internal Status Report on MAI Innovation progress to CQC Committee and Recipient**	Bimonthly	July 2023, September 2023, November 2023, January 2024	Ongoing
17	**Share results of the CQM and Integrated plan successes, challenges, and next steps with stakeholders** (see Section VI., 7), Evaluation section, above)	Semiannually	September 2023, March 2024	Pending

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TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES
(Pending HRSA review of the IP and priority review by the CQM Committee)

R1.1.a. Establish early MCM lost to care trigger point warning in PE Miami at 75 days without MCM contact, and alert MCMs through PE Miami. (Target 95% by 12/31/2026.)				
		Planned Frequency	**Deadline**	**Status**
1	# and % of RWHAP MCM clients with no contact in 75 days, by subrecipient, as tracked in PE Miami	Semiannual	October 2023, March 2024	Pending
2	# and % of clients with no MCM contact in 90 days who are referred to Outreach by MCMs, as tracked in PE Miami	Semiannual	October 2023, March 2024	Pending
R1.1.b. Reengage a minimum of 75% of identified eligible clients by MCMs within 30 days of report of client eligibility by Outreach Worker.				
3	# and % of unreached clients with contact attempted by Outreach within 30 days of receiving referral from MCM, as tracked in PE Miami	Semiannual	October 2023, March 2024	Pending
4	# and % of clients in item #3, above, contacted by Outreach, whose cases may be closed by the MCM (e.g., left RWP, moved from M-DC).	Semiannual	October 2023, March 2024	Pending
5	# and % of eligible clients in item #3, above, located and re-engaged by the MCM after Outreach follow-up	Semiannual	October 2023, March 2024	Pending
SP1.1.d Examine client outcome data specifically for women in order to identify potential QI opportunities to improve service to women.				
6	# of MCM and OAHS providers with identified women sub-populations with identified sub-par treatment outcomes	Semiannual	October 2023, March 2024	Pending
SP2.1.d Examine client outcome data specifically for persons over 50 years of age in order to identify potential QI opportunities to improve service to this population.				
7	# of MCM and OAHS providers with identified over-50 sub-populations with identified sub-par treatment outcomes	Semiannual	October 2023, March 2024	Pending

TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES (Pending HRSA review of the IP and priority review by the CQM Committee)				
SP5.1.b. Identify barriers to care or below-average client treatment outcomes among MSM clients with STIs as co-occurring conditions.				
8	Facilitate access for BSR to use Part B or ADAP medical care data in PE Miami to determine accurate STI status of MSM clients receiving OAHS.	Semiannual	October 2023, March 2024	Pending
9	# of MSM clients identified with STIs as co-morbidities.	Semiannual	October 2023, March 2024	Pending
10	# and % of MSM + STI clients with unsuppressed VL	Semiannual	October 2023, March 2024	Pending
11	# and % of MSM + STI clients identified with other co-morbidities or treatment barriers that may contribute to poor outcome.	Semiannual	October 2023, March 2024	Pending
SP5.1.c. Provide service enhancements to improve treatment outcomes among MCM clients with STIs				
12	# of MSM clients with STIs with improved viral load after receiving services to overcome barriers to care.	Semiannual	October 2023, March 2024	Pending
13	# of MSM clients with STIs with improved other health care conditions after receiving services to overcome barriers to care.	Semiannual	October 2023, March 2024	Pending
DR1.1.a. Semiannually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males. (Increase RIMC from 81% to 90% by 12/31/2026.)				
14	Measurement of RiMC rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
15	# and % of OAHS and MCM service sites that have attained 90% RiMC for this target population	Semiannual	October 2023, March 2024	Pending

TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES (Pending HRSA review of the IP and priority review by the CQM Committee)				
DR1.1.b. Document and disseminate best practices for RiMC for B/AA males among OAHS and MCM providers with top-quintile RiMC rates for this target population.				
16	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DR1.1.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for B/AA males among OAHS and MCM providers with bottom-quintile RiMC rates for this target population.				
17	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DR1.2.a. Semiannually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females. (Increase RIMC from 88% to 90% by 12/31/2026.)				
18	Measurement of RiMC rates for B/AA females, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
19	# and % of OAHS and MCM service sites that have attained 90% RiMC for this target population	Semiannual	October 2023, March 2024	Pending
DR1.2.b. Document and disseminate best practices for RiMC for B/AA females among OAHS and MCM providers with top-quintile RiMC rates for this target population.				
20	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DR1.2.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for B/AA females among OAHS and MCM providers with bottom-quintile RiMC for this target population.				
21	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending

TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES (Pending HRSA review of the IP and priority review by the CQM Committee)				
DR1.3.a. Semiannually track RiMC rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Hispanic MSM clients (Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026)				
22	Measurement of RiMC rates for Hispanic MSM clients, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
23	# and % of OAHS and MCM service sites that have attained 90% RiMC for this target population	Semiannual	October 2023, March 2024	Pending
DR1.3.b. Document and disseminate best practices for RiMC for Hispanic MSM clients among OAHS and MCM providers with top-quintile RiMC rates for this target population.				
24	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DR1.3.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for low RiMC for Hispanic MSM clients among OAHS and MCM providers with bottom-quintile RiMC for this target population. (Increase RiMC rates from 85% in 2021 to 90% by December 31, 2026.)				
25	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DV1.1.a. Track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA males. (Increase the annual VL suppression rates from 81% in 2021 to 90% by December 31.)				
26	Measurement of VL suppression rates for B/AA males, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
27	# and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population	Semiannual	October 2023, March 2024	Pending

TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES (Pending HRSA review of the IP and priority review by the CQM Committee)				
DV1.1.b. Document and disseminate best practices for VL suppression for B/AA males among OAHS and MCM providers with top-quintile VL suppression rates for this target population.				
28	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DV1.1.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for B/AA males among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.				
29	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DV1.2.a. Semiannually track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to B/AA females. (Increase the annual VL suppression rates from 84% in 2021 to 90% by December 31.)				
30	Measurement of VL suppression rates for B/AA females, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
31	# and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population	Semiannual	October 2023, March 2024	Pending
DV1.2.b. Document and disseminate best practices for VL suppression for B/AA females among OAHS and MCM providers with top-quintile VL suppression rates for this target population.				
32	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending

TABLE IX – B INTEGRATED PLAN CQM ACTIVITIES (Pending HRSA review of the IP and priority review by the CQM Committee)				
DV1.2.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for B/AA females among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.				
33	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DV1.3.a. Track VL suppression rates among RWHAP Part A and MAI subrecipient providers of OAHS and MCM services to Haitian males and females. (Increase the annual VL suppression rates from 86% in 2021 to 90% by December 31.)				
34	Measurement of VL suppression rates for Haitian males, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
35	Measurement of VL suppression rates for Haitian females, by subrecipient service site providing OAHS and/or MCM services to this target population	Semiannual	October 2023, March 2024	Pending
36	# and % of OAHS and MCM service sites that have attained 90% VL suppression goal for this target population	Semiannual	October 2023, March 2024	Pending
DV1.3.b. Document and disseminate best practices for VL suppression for Haitian males and females among OAHS and MCM providers with top-quintile VL suppression rates for this target population.				
37	# of top-quintile (top 20%) of subrecipients reporting best practices to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending
DV1.3.c. Conduct and disseminate root cause analyses (determination of co-occurring conditions or service delivery shortfalls) for VL non-suppression for Haitian males and females among OAHS and MCM providers with bottom-quintile VL suppression rates for this target population.				
38	# of bottom-quintile (bottom 20%) of subrecipients reporting root cause analyses to CQM Committee, Subrecipient Forum(s) or Partnership	Semiannual	October 2023, March 2024	Pending

APPENDICES:

During FY 2023, at a minimum, the following templates will be used by the CQM program in Miami-Dade County:

- Appendix 1: Model for Improvement
- Appendix 2a: PDSA "Plan" Step
- Appendix 2b: PDSA "Do" Step
- Appendix 2c: PDSA "Study" and "Act" Steps

CQM Program
Ryan White Part A/MAI
Miami-Dade County

APPENDIX 1

QI Project

Insert (Name of Project)

Model for Improvement & PDSA Stages

PROBLEM STATEMENT

BACKGROUND

PRIORITY POPULATION IDENTIFIED (INCLUDE TABLE)

CQM Program
Ryan White Part A/MAI
Miami-Dade County

QI Project

Insert (Name of Project)

Model for Improvement & PDSA Stages

THREE QUESTIONS FOR IMPROVEMENT

1. WHAT ARE YOU TRYING TO ACCOMPLISH? (WORKING TOWARD AN AIM STATEMENT)

ROOT CAUSE ANALYSIS

DRILL DOWN ON THE DATA. CREATE A TABLE OF REASONS/CAUSES (EXAMPLE – 5 WHY'S, FISHBONE)

CQM Program
Ryan White Part A/MAI
Miami-Dade County

QI Project

Insert (Name of Project)

Model for Improvement & PDSA Stages

AIM STATEMENT

2. HOW WILL YOU KNOW THAT A CHANGE IS AN IMPROVEMENT?

3. WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?

WHAT SPECIFIC CHANGE CONCEPT WILL ACHIEVE THE AIM?

PLAN

Plan your test and describe your plan for collecting data.

What change are you testing?
Goal:
What do you predict will happen? Why?
Provide details on the test: Who will be involved, what resources are needed, what should be the time periods for the test, what are the details on action steps needed, and who is responsible for each.
<u>Who will be involved:</u>

What resources are needed:

Consider the strengths each team member brings—look for engaged, forward-thinking staff.

Time Period for the test

Action steps and who is responsible for each step:

Provide details on what data will be collected and how.

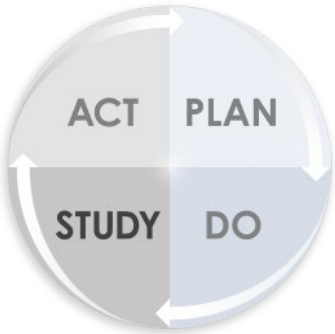
Quality Improvement Project Sample Model for Improvement & DO Stage Template

DO

Run your test on a small scale

Describe what happened when you executed the test, including problems and unexpected results. Perform the Plan that the team has outlined above and be sure to study and document what happened along the way (both good and bad outcomes).
Problems/Challenges:

Collect appropriate data. Possible tools to use in this phase: check sheets, control charts, flow charts, gantt chart, tracking sheets, histogram, or run charts.

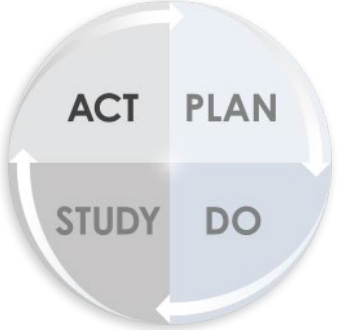


STUDY

APPENDIX 2 c

Analyze results you measured, compare to predictions

Study and analyze the data.
Determine if change resulted in outcomes you expected.
Were there surprises or unintended outcomes?
Summarize what you learned.



ACT

Decide what modifications you should make – either:

- Adapt – modify changes and repeat the PDSA cycle.
- Adopt – if change brought positive results, consider expanding more broadly in your organization.
- Abandon – change your approach entirely and execute a new PDSA cycle.

What did you conclude? Plan your next step (Adapt, Adopt, or Abandon)?