# The Orlando Service Area

# Ryan White HIV/AIDS Program

# Quality Management Plan

# 2019

Revised: July 2019

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## Executive Summary

The Orlando Eligible Metropolitan Area (EMA) and the Area 7 Consortium, which makes up the Orlando Service Area (OSA), are ultimately responsible for assuring that quality services are being delivered in tandem with our network of service providers. The purpose of the Orlando Service Area Quality Management Program (QMP) is to:

1. Assist HIV/AIDS providers in assuring that grant supported services adhere to established HIV clinical practice standards and Public Health Services (PHS) Guidelines

2. Ensure that strategies for quality improvement of medical care and support services include the appropriate access and retention to HIV care

3. Verify that available demographic, client satisfaction, and service utilization information is used to monitor the HIV continuum of care

The OSA Quality Management Plan (QM Plan) is a written document that outlines the Ryan White HIV/AIDS Program (RWHAP) recipient- wide quality management program. This adaptable program provides a systematic process for assessing and improving the quality of care. Meaningful data is identified, collected, and reviewed to assure that progress toward evidence-based outcomes is realized. Resources are dedicated to support the activities, and there is continuous evaluation and assessment of the process.

Quality activities are included as part of the procurement process and service contracting. This approach ensures that each individual sub-recipient establishes and maintains its own Quality Management Program. Data from multiple sub-recipients across the service area network are aggregated to establish a trending care-continuum, highlighting RWHAP recipient-wide patterns and providing concrete baselines for improvement activities. Sub-recipients are responsible for establishing a separate QM Plan and reporting progress to the Recipient and Lead Agency on a monthly basis. Trending patterns aid sub-recipients, RWHAP Part A Recipient and the RWHAP Part B Lead Agency to work collaboratively in improvement processes to achieve goals such as client retention and viral load suppression among persons living with HIV (PLWH) in the communities served.

The HIV/AIDS Bureau (HAB) has defined “quality” as the degree to which a health or social service meets or exceeds established professional standards and user expectation. Evaluation of the quality of care in this plan considers a) the quality of the inputs, b) the quality of the service delivery process, and c) the quality of outcomes, in order to continuously improve systems of care for the population served.

The Quality Management Program focuses on sustaining open communication between the

RWHAP Part A Recipient, the Lead Agency, sub-recipients, and clients regarding the expectations for addressing outcome improvement. This continuous process has identified leadership and dedicated resources to ensure accountability to the Quality Management Program.

## Description of Quality Management

The OSA Quality Management Program is based on the HRSA Quality Management Technical Assistance Manual, the Clinical Quality Management Policy Clarification Notice (PCN) #15-02, and other HRSA guidance documents. The plan outlines a collaborative effort between the RWHAP Part A Recipient Office, the Area 7 Consortium Lead Agency, the Planning Council, the sub-recipient community, and other RWHAP funded entities in the region. This collaboration will serve to enhance the system of care and be responsive to changing trends in the HIV epidemic.

The goal of the OSA Quality Management Program is to ensure continuous performance improvement in the delivery of quality HIV medical and support services in the service area. The program is designed to identify needs in services, such as accessibility of programs, and ensure that treatments are delivered in accordance with the most current Public Health Service (PHS) treatment guidelines. The Quality Management Program will also assess the effects of the RWHAP-funded resources on the health outcomes of clients, and ensure services are delivered in an efficient and cost-effective manner. The program is driven by the current Public Health Services (PHS) guidelines, local Service Standards, Ways to Best Meet Needs (Directives) as defined by the Planning Council, and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Clinical Quality Management (CQM) requirements and guidelines.

## Authority and Accountability

The Ryan White HIV/AIDS Treatment Extension Act of 2009 legislation requires that a recipient shall provide for the establishment of a clinical quality management program to:

- Assess the extent to which HIV health services provided to clients under the grant are consistent with the most recent Public Health Services (PHS) 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 health services.

The OSA's RWHAP Part A Recipient and the RWHAP Part B Lead Agency leadership are dedicated to the quality improvement process and have the ultimate responsibility for assuring high quality of care through the development of a comprehensive Quality Management Program. However, both offices and the sub-recipient network assume a vital role in the implementation of the QM Plan leading to excellence in service delivery.

## Resources

The Orlando EMA RWHAP Part A Recipient has allocated 2% of its budget and the RWHAP Part B Lead Agency has allocated 5% of its budget for evaluation and quality improvement activities.

## Quality Statement

The mission of the Quality Management Program is to continuously improve the quality of care for PLWH receiving care from RWHAP funded programs in the OSA. This will be accomplished through monitoring, measuring, and implementing the delivery of medical and support services for PLWH.

The OSA Quality Management Program's vision is "to create a strong and varied system of care that mirrors the diverse client base, promotes diverse community partnerships, maximizes resources, and ensures continuous quality in the delivery of care." The program is designed to objectively assess and evaluate the quality of care, to pursue opportunities in improving care, and to resolve identified challenges within our service delivery system. The Quality Management Program strives to continuously improve services through a multidisciplinary team approach.

The Quality Management Program will:

1. Provide tools for quality improvement to sub-recipients, clients, and community representatives across the OSA
2. Provide a means of accountability with documented and quantitative measures of performance for all services provided to PLWH
3. Monitor the OSA's compliance with the National HIV/AIDS Strategy (NHAS) and the HAB performance measures

Seven strategic goals serve as the organizing framework for performance measurement:

- Improve Access to Health Care
- Improve Health Outcomes
- Improve the Quality of Health Care
- Eliminate Health Disparities
- Improve Public Health and Heath Care Systems
- Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Achieve Excellence in Management Practices

## Annual Quality Goals and Objectives

***Establishment of Annual Quality Goals and Objectives***

The objectives of the OSA Quality Management Program are:

1. Evaluate the effectiveness of programs and services in relation to their stated purpose
2. Provide the OSA's stakeholders with objective data to assess program performance in relation to established criteria of acceptability
3. Ensure appropriate utilization, accessibility, satisfaction, and cost of services
4. Provide meaningful data to facilitate planning services and identify areas for improvement
5. Monitor progress regarding service improvement
6. Encourage collective decision support among the workgroup and administration

The following four steps assist the Orlando OSA recipient and lead agency to identify and establish annual goals for the HIV quality management plan:

Assess the current state: Analysis of performance measure data to identify areas of strength and weaknesses where improvements may be needed the most. Knowing this information will permit us to develop baselines and eventually benchmarks. Sources for data to be considered include performance measure data, client satisfaction survey results, staff input, quality management technical workgroup input and external benchmarks.

Understand the parameters: Identify the basic outline of the OSA HIV program and the community it serves. Putting together a succinct description of the program, including the aspects of HIV care currently delivered, the demographics of patients served and the external expectations of funding/regulatory agencies helps to identify where to focus quality improvement efforts.

Identify program goals: The HAB performance measures as well as client satisfaction survey data serve as the foundation of the clinical and service goals. Additional possible annual goals will be identified as needed by QM staff and the technical workgroup.

Quantify where we want to be: Annual HIV quality goals need to be measurable. Based on the information gathered in the previous three steps, the annual quality goals need to be restated in quantitative terms such as "85% adherence to antiretroviral therapy for all PLWH receiving HAART" or "To reduce client 'no shows' by 15%."

Based on available performance measure data the technical workgroup will prioritize quality management activities.

***Annual Quality Goals (2019)***

The focus of the QM Plan for 2019 is:

- Revise service standards and outcome measures to reflect current professional and federal guidelines
- Promote continuous quality improvement in the EMA using PDCA models in coordinated efforts with all sub-recipients. These PDCA efforts will be applied to the HAB performance measures of HIV Medical Visit Frequency and Viral Load Suppression. Other key indicators will be agreed upon by the Recipients and the Quality Management Technical Workgroup.
- Administer client satisfaction surveys quarterly. All sub-recipients will participate in the administering of the surveys. Report sharing will occur at the PLWH Community Meeting, the Planning Council, Provider Network, and the Quality Management Committee called the Quality Management Technical Workgroup meetings. Data are used to help improve client services throughout the Orlando Service Area and to benchmark the outcomes achieved.

## Quality Infrastructure

The Quality Management Program is guided by the RWHAP Part A Recipient and the Area 7 Consortium Lead Agency, the local Planning Council, the PLWH Community Group, and the Quality Management Technical Workgroup to comprise the clinical management structure necessary for monitoring services.

***RWHAP Part A Recipient:*** The RWHAP Part A Recipient is responsible for coordinating healthcare services in the Orlando EMA. The overall responsibility for the HIV clinical quality management program is dually managed by the RWHAP Part A Recipient and the Area 7 Lead Agency Administrator, together they guide, endorse, support, and champion the CQM program. Additionally, they authorize the Recipient and Lead Agency quality management staff to direct and facilitate the Quality Management Committee, known as the QM Technical Workgroup. The RWHAP Part A has 1 FTE, the Health Planner position dedicated to the Quality Management Program. This position provides training and technical assistance (TA) to the RWHAP Part A sub-recipients to ensure that their Quality Management Program is in line with that of the area as well as complies with PCN # 15-02. This position along with the RWHAP Part B Lead Agency's position staffs the QM Technical Workgroup meetings.

***RWHAP Part B Lead Agency for Area 7*:** The Area 7 Consortium Lead Agency Administrator is responsible for coordinating and improving healthcare services in Area 7. Together with the RWHAP Part A Recipient, the Lead Agency Administrator guides, endorses, supports, and champions the CQM program and. is responsible for the overall HIV Clinical Management Program for the area. The Lead Agency has 1 FTE, the Clinical Quality Manager position dedicated to the Quality Management Program. This position provides training and

technical assistance (TA) to the RWHAP Part B sub-recipients to ensure that their Quality Management Program is in line with that of the area's as well as complies with PCN # 15-02. This position along with the RWHAP Part A Health Planner position staffs the QM Technical Workgroup meetings.

***Planning Council:*** The Central Florida HIV Planning Council assists with development and revision of the OSA service standards annually. The Council reviews CQM data and provides input for improvement efforts in the OSA, including suggestions for studies to determine areas where data indicates possible barriers to care for PLWH.

***PLWH Community Group:*** The PLWH (People Living with HIV) Community Group conducts monthly community meetings to review and provide feedback on all actions that will be brought before the Planning Council for a decision. The PLWH Community Group provides valuable insight through client representation in meeting the needs of clients and ensuring satisfaction with services rendered in the OSA. Outcome data is reported to this group on a quarterly basis and quality improvement (QI) initiatives discussed. Feedback from this group is presented to the QM Technical Workgroup for incorporation into their activities.

***RWHAP Sub-recipients:*** Sub-recipient staff are members of the QM Technical Workgroup and assumes an active role in the implementation of quality improvement activities in their respective agencies and within the Orlando Service Area (OSA).

***Quality Management Technical Workgroup:*** This group serves as the Quality Management Committee for the combined RWHAP Parts A and B Clinical Quality Management Program. The Quality Management Technical Workgroup develops the Quality Management Plan and provides oversight, prioritizes and directs planning, and assesses outcomes for improving organizational performance. The Workgroup oversees the performance improvement plan and review quality improvement activities during its regular meetings. Ongoing quality improvement reports are provided to community stakeholders via the Planning Council. The program is designed to address Quality Improvement content regarding the following major functional areas and important aspects of care:

- Clinical Primary Care
- Patient and Staff Education
- Continuity of Care
- Patient Satisfaction
- Case Management
- Oral Health
- Medical Record/Information Systems
- Managed Care/Utilization Review

The Director of the Orange County Government's Health Services Department who endorses and supports the Quality Management Program champions the Workgroup. The workgroup is chaired by the Epidemiologist of the Orange County Health Services Department. The membership of the workgroup reflects the diversity of disciplines within

the OSA sub-recipient network. The members of the committee include quality managers, two medical providers, two case managers, one mental health/substance use treatment representative, two Planning Council members, one peer counselor, and at least two clients. Sub-recipients are contractually required to provide staff to represent specific service categories as members of the Workgroup when requested by the RWHAP Part A recipient or the Lead Agency. The RWHAP Part A Recipient Administrator and the Area 7 Lead Agency Administrator collaboratively approve membership. The OSA Quality Management Technical Workgroup meets at least once per quarter at a time that will allow attendance by all members. The Workgroup is staffed by the RWHAP Part A Health Planner and the Lead Agency's Clinical Quality Manager.

Role of the OSA Quality Management Technical Workgroup:

1. Develop and revise the Quality Management Plan (QMP)
2. Monitor implementation of the QMP
3. Oversee specific program and team projects
4. Monitor and measure performance of service standards with regard to clinical treatment, case management and related services to determine the effectiveness of the service standards
5. Educate the sub-recipient network and team members on the tenants of the Quality Management Program
6. Authorize performance improvement initiatives and set forth quality expectations for ongoing monitoring.

The Quality Management staff members are responsible for composing the meeting agendas, facilitating the meetings in the absence of the Chair and recording the minutes. Minutes of meetings are distributed to each member of the workgroup and to all necessary Orlando OSA network wide committees. A written summary of the meeting is routinely made available to staff and clients.

## Participation of Stakeholders

Quality management staff participates in the technical workgroup. Summary reports of quality committee meetings are shared with stakeholders to ensure open communication flow within the HIV program. A basic training session about quality improvement principles are offered to clients on a quarterly basis, or more often as deemed necessary by the Workgroup. Key data findings are incorporated into the OSA newsletter.

Throughout the year, the QM staff collaborates with service providers, clients, technical workgroup members and the Planning Council to continuously work together to improve care. The various stakeholders and their prospective roles in the QMP are defined below:

Administration: The RWHAP Part A Recipient and the Area 7 Consortium Lead Agency has the overall administrative responsibility for the quality of care and services

delivered. The Planning Council is updated on QM activities on a quarterly basis via the RWHAP Part A Recipient and Lead Agency Reports.

Recipient/Lead Agency QM Staff: The RWHAP Part A Recipient's Health Planner and the Lead Agency's

Clinical Quality Manager lead the quality management technical workgroup in the absence of the Chair. They also serve as liaisons to the two committees of the Planning Council that are most involved in the QMP - the Service Systems & Quality Committee and the Needs Assessment & Planning Committee. The Service Systems & Quality Committee acts in an advisory capacity to both the RWHAP Part A Recipient and the Area 7 Lead Agency to ensure that the QMP is implemented at the system-wide level.

Sub-recipient Staff: The sub-recipient staff assume an active role in the implementation of quality improvement activities in their respective program and within the OSA.

Planning Council: The Planning Council reviews service outcomes in the prioritization and allocation of RWHAP Part A and Part B awards for the OSA. The Needs Assessment & Planning Committee is primarily responsible for identifying gaps and planning specific responses The Service Systems & Quality Committee evaluates the processes of the Planning Council itself; including the priority setting and resource allocation processes.

Client Responsibility: Clients are active participants in the evaluation of quality activities in the OSA.

Quality Management Technical Workgroup: The Quality Management Technical Workgroup meets at least quarterly to discuss, plan and implement project level activities in the OSA. The workgroup includes representatives from OAHS sub-recipients, case management sub-recipient representatives, RWHA Part A Recipient staff, RWHAP Part B Lead Agency Staff, clients, quality management staff.

## Evaluation

The RWHAP Part A Recipient, the Lead Agency and the QM Technical Workgroup collectively is responsible for evaluating the annual OSA Quality Management Program.

- Evaluation results are derived from the program monitoring processes, client satisfaction surveys, and the tracking of performance measures quarterly
- QM staff reviews the evaluation and recommends a plan for improvement to the QM Technical Workgroup and the Planning Council
- The QM team reports activity updates to the Planning Council quarterly
- An Organizational Assessment of the Quality Management Program is conducted annually using the "NQC's :Organizational Assessment Tool for RWHAP Part A Recipients" – both at the Recipient and sub-recipient levels.

Projects are evaluated as outlined in the Data Collection section. Performance measures continue to be reviewed to ensure high levels of service provision.

OSA interventions include: training and education of stakeholders, review of quality-related sub-recipient policies, and development of new policies. When a measured indicator reaches a satisfactory level of improvement, the project is discontinued. Periodic monitoring of discontinued project indicators are reviewed to ensure continued compliance with the agreed upon threshold.

## Performance Measurement

The OSA has developed performance measures based on the most recent HRSA/HAB Core Performance Measures, the HIV Continuum of Care, and the OSA Service Standards additional quality measures for the RWHAP funded programs. Performance measures are chosen annually based on outcomes data. Outcome data is reviewed quarterly to determine whether or not they are meeting or exceeding established targets as well as to determine ongoing relevance and need. Performance measures data are analyzed and stratified quarterly to assess quality of care as well as disparities in care and used to inform quality improvement activities. Performance measures are monitored continuously through annual chart reviews to determine root cause and analysis of data in the data management systems in order to determine the direction of the program. HRSA/HAB performance measure outcomes are reviewed by the Recipients, the local Planning Council, the PLWH Community Group, and the Quality Management Technical Workgroup quarterly.

Core and support services for the OSA are monitored utilizing HRSA/HAB measures and the OSA service standards each grant year. At least two (2) Performance Measures are required for funded service categories that are utilized by 50% or greater of the clients accessing RWHAP-funded services and services used by at least 15% of clients but less than 50% are required to have at least one (1) Performance Measure. Outcome data are aggregated along each service category performance measure indicator and are scored by performance measure outcome for each provider receiving funding for that service. The individual performance measure outcomes are then aggregated by HAB measure to determine the overall QI score for the OSA targeted goals. Sub-recipients are able to review and compare their individual performance measure scores as well as their overall HAB measure scores for the OSA.

The following HAB performance measures are measured via Provide Enterprise (PE) and CAREWare:

- Viral Load Suppression
- Retention in Medical Care
- Prescription of HAART
- Linkage to Medical Care
- HIV test results

- Client satisfaction of services

The following table provides the mechanisms necessary to achieve the activities listed in the HIV Care Continuum below that focuses on the 2019 objectives of the QM Plan:

***2019 Care Goals (HIV Care Continuum):***

1. **Diagnosed:** PLWH in the OSA diagnosed with HIV (100%)
2. **Linked to Care:** PLWH in the OSA connected to an HIV healthcare provider (95%)
3. **Retained in Care:** PLWH in the OSA receiving regular HIV medical care (85%)
4. **Prescribed ART:** PLWH in the OSA prescribed ART (95%)
5. **Virally Suppressed:** PLWH in the OSA with a viral load below 200 copies/mL (90%)

| | *Table 1: RWHAP Outcomes and Targets* | | | |
|---|---|---|---|---|
| **Goal** | **HIV Care Continuum 2016** | **HIV Care Continuum 2017** | **HIV Care Continuum 2018** | **Target 2019** |
| | ***NHAS Goal*** | | | |
| Increase % of PLWH in continuous care (HIV Medical Visit Frequency HAB Measure) (NHAS: 73% to 80%) | In Care = 73.9%<br>Retained in Care = 66.1% | In Care = 75%<br>Retained in Care = 67.4% | In Care =<br>Retained in Care = | **Improve by 10%** |

| | *Table 1: RWHAP Outcomes and Targets (continued)* | | | |
|---|---|---|---|---|
| **Goal** | **HIV Care Continuum 2017** | **RWHAP Part A & Part B Program Outcomes 2017** | **RWHAP Part A & B Program Outcomes 2018** | **Target 2019** |
| | | ***HAB Performance Measures in OSA*** | | |
| **OAHS (Core)** | | | | |
| Viral load suppression | VLS = 62.7% | 89% *(MAI = 91%)*<br>*Brevard: 83.05%* | *91% (MAI =92% )*<br>*Brevard: 85.63%* | **Improve by 5%** |
| Prescribed HAART | ART = Not available | 88% *(MAI = 85%)*<br>*Brevard: 76.51%* | *87% (MAI =84% )*<br>*Brevard: 91.70%* | **Improve by 10%** |
| Retention in Care | MV = 67.4% | 59% *(MAI = 61%)*<br>*Brevard: 51.49%* | *61% (MAI =69% )*<br>*Brevard: 53.31%* | **Improve by 10%** |
| Gap in Medical Visits | Gap in MV = Not available | 18% *(MAI = 17%)*<br>*Brevard: 24.93%* | *16% (MAI =13% )*<br>*Brevard: 17.15%* | **Decrease by 10%** |
| PCP Prophylaxis | PCP = Not available | 23% *(MAI = 25%)*<br>*Brevard: N/A* | *12% (MAI =9% )*<br>*Brevard: N/A* | **Improve by 10%** |
| Medical Case Management | Viral Suppression<br><br>Retention in Care | 87%<br>Brevard: 78.26%<br>56%<br>Brevard: 30.97% | 90%<br>Brevard: 71.54%<br>53%<br>Brevard: 30.88% | **Improve by 5% (10% Brevard)**<br><br>**Improve by 10%** |

| | | | | |
|---|---|---|---|---|
| Oral Health | Client Satisfaction | Not Available | Not Available | **Establish Baseline** |
| LPAP | VLS | 89%<br>Brevard: 68.54% | 96%<br>Brevard: 71.37% | **Improve by 2% (Brevard 10%)** |
| Psychosocial Support | VLS | 84% | 92% | **Improve by 5%** |
| Referral for Health & Support Services | VLS<br>Retention in Care | 90%<br>63% | 92%<br>58% | **Improve by 5%**<br>**Improve by 10%** |
| Food Bank | Client Satisfaction | Not Available | 88% | **Improve by 10%** |

***Data Collection Plan***

To the extent possible, data for the aforementioned performance measures are extracted from Provide, CAREWare, and client satisfaction surveys. The responsibility for generating all reports for review falls to the Quality Management staff members. Reports are presented to the Quality Management Technical Workgroup and the Planning Council via the Administrators. In the event that the data does not reflect the targeted outcomes, a representative number of chart reviews are conducted to identify the root cause(s) for clients not meeting the identified outcome.

Selection of performance measures for the major functional areas require regular review of data from a variety of sources as outlined in the attached schedule. The Quality Management staff members coordinate these activities. Data reports are presented for review to the Quality Management Technical Workgroup and shared with sub-recipients. Data collection is implemented using appropriate sampling methodologies and includes both concurrent and retrospective review.

Additional data sources include:

- Sub-recipient reports on Initial Wait Time
- Continuous Quality Improvement (CQI) Organizational Assessment

The timeline for data collection and reporting is as follows:

| | | | |
|---|---|---|---|
| HAB Performance Measures | OAHS Sub-recipients, Quality Management Staff | PE, CAREWare, OAHS Sub-recipients | April, July, October & January of each year |
| Client Satisfaction Survey Data | Sub-recipients, Quality Management Staff | Surveys | July and January of each year |
| CQI OA | Sub-recipients, Quality Management Staff | Surveys | December each year for sub-recipients and Workgroup |

***Quality Improvement***

Once an opportunity for improvement has been identified, QM staff works together with sub-recipient staff and the QM Technical Workgroup to analyze the process and develop improvement plans. In addition, the technical workgroup uses a project prioritization matrix to determine which QI initiatives to recommend for implementation. The matrix allows for the selection of optimal improvements projects against their weighted value based on benefit to the client/patient. The matrix also determines relative costs of the project if any. The matrix is based on the Lean Six Sigma 15 criteria for selecting a viable DMAIC (Define, Measure, Analyze, Improve and Control) Project. Every attempt is made to ensure the process is collaborative. The Continuous Quality Improvement Methodology is utilized and includes,

but is not limited to, the following:

- PDCA (Plan/Do/Check/Act)
- Flow Chart Analysis
- Brainstorming
- Observational Studies/patient flow
- Activity Logs

Quality Committee/Team Meeting Record Improvement Plans are developed and implemented by the teams. Improvements may include:

- System Redesign
- Education (Staff/Patients)
- Clinical Guidelines review, revision or development
- Procedure and policy changes
- Form development or revision
- Improvement outcomes

Improvement plans are documented in the QM Workgroup minutes, in a PDCA/PDSA chart, incorporated into the annual work plan and communicated to all stakeholders as deemed appropriate. Scheduled meetings, electronic mail, memos, and informal verbal communication are all considered appropriate methods to communicate the team's activities and improvement plans.

The team-oriented approach allows the network of sub-recipient to identify corrective action methods and develop creative solutions for improvement. The quality and utility of an evaluation are dependent upon a well-designed and implemented project. The project cycle provides evidence and data as to whether the intended impact was achieved and informs future components of the program cycle. The project cycle consists of six steps that is based on the PDCA model:

1. Review, Collect and Analyze Project Data.
2. Develop a Project Team.
3. Investigate the Process.
4. Plan and Test Changes.
5. Evaluate Results with Key Stakeholders.
6. Systematize Changes.

***Plan/Do/Check/Act Model***

The PDCA model is a widely used framework for testing change on a small scale. The diagram below illustrates the four steps required to assess change within the OSA.

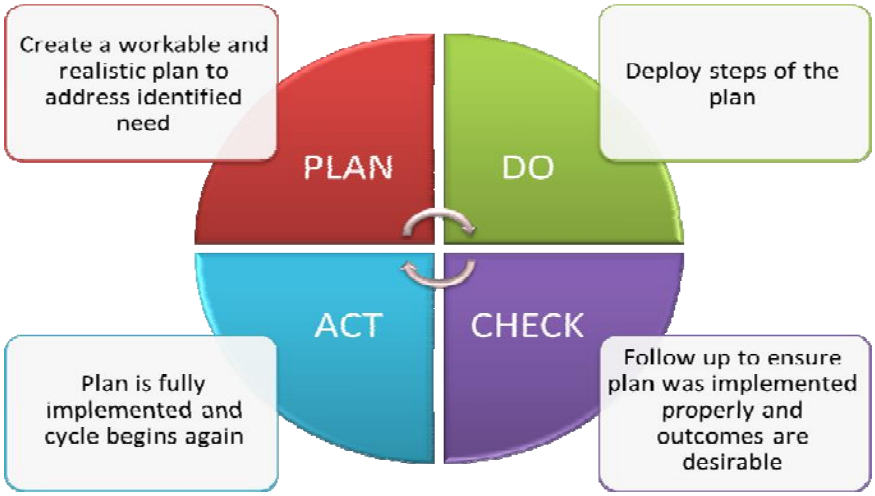


*Figure 1. PDCA Model*

1. **Plan** – Create a workable and realistic plan to address identified need. Quality Improvement Plans consist of the following:
    - Statement of Need
    - Action Steps
    - Identification of Responsible Parties
    - Target Dates
    - Follow Up/Completion Status
2. **Do** – Deploy steps of the plan.
3. **Check** – Follow up to ensure plan was implemented properly and outcomes are desirable. Management follow-up on quality improvement initiatives, and corrective action plans are the responsibility of the RWHAP Part A Health Planner, the RWHAP Part A Program Manager, and the Area 7 Lead Agency Clinical Quality Manager.
4. **Act** – Plan is fully implemented and cycle begins again. At this time, the issue or need continues to be measured and reviewed to ensure that the needs were met by the plan and action of the quality improvement team.

### *Quality Improvement Activities*

Quality Improvement activities are aimed at improving patient care, health outcomes, and client satisfaction, and are conducted by the Recipient Office and the Lead Agency for at least one funded service category at any given time. All funded services are assessed through performance measurement to evaluate the effectiveness of the service. If the performance measure is not meeting expectations, a Quality Improvement project is implemented to address the service.

For FY 2019-2020 three improvement projects have been chosen: 1) to increase viral suppression rates among minority patients through the provision of Peer supports services; 2) to increase the viral suppression rate for the community by piloting at least one effective Evidence-Based Intervention (EBI); and 3) to increase retention rate by piloting at least one effective EBI (see the Addenda #s 2-4 for the

PDCA worksheets).

## Capacity Building

Quality Improvement capacity building of providers are assessed through the NQC: Organizational Assessment Tool and recommendations for improvement are tracked and reported to sub-recipients via QM staff.

Quality Improvement activities are also discussed during the network provider meetings. Performance measures findings and quality improvement initiatives are shared with sub-recipients. In addition, opportunities for QI training activities, technical assistance and support for quality improvement activities are discussed.

Sub-recipients are required to identify at least two Quality Improvement initiatives on an annual basis. Progress on these initiatives are documented in a monthly report to the RWHAP Part A Recipient and the RWHAP Part B Lead Agency. Additionally, challenges, successes and the need for TA pertaining to implemented QI initiatives are discussed during the monthly monitoring calls with sub-recipients. On an annual basis, subrecipients are required to complete a self-assessment of their QM Program using the NQC Organizational Assessment tool prior to revising/updating their QM Plan. The self-assessment is reviewed by QM staff and TA provided based on the results of the assessment. Subrecipients are then required to develop an Action Plan, if applicable.

## Process to Update QM Plan

The quality management plan is assessed against its goals at every technical workgroup meeting to determine if any alterations should be made. All quality improvement projects are reviewed to assess progress towards meeting our goals and an annual organizational assessment is performed.

The QMP receives a formal update by the Quality Management Team within 30 days after the close of the calendar year. The updated plan is reviewed by the Quality Management Technical Workgroup and shared with key stakeholders – including Planning Council and the RWHAP sub-recipients. The RWHAP Part A recipient office and the Area 7 Lead Agency office provide final approval of the plan.

## Communication

QM data and performance measure outcomes are reviewed by the Recipients, the Planning Council, the PLWH Community Group, and the Quality Management Technical Workgroup during their respective quarterly meetings. Clients, sub-recipients, other stakeholders, and other RWHAP recipients are members of the Planning Council and participate in the QM Workgroup. The QM Workgroup reviews data from the annual chart abstraction outcomes presented and the PDCA outcomes for specific HAB performance measures quarterly during

regular meetings. The Quality Management Technical Workgroup reviews performance measure outcomes for the OSA to provide feedback for QI initiatives to be implemented in the OSA. The performance measures data is used during the Planning Council's Priority Setting and Resource Allocation processes annually to determine the best models of care to be implemented. Planning Council meetings are open to the public and meeting minutes are available to the public.

## Quality Management Plan Implementation

The Quality Management Plan identifies the accountable participants and specifies the timeline for implementation. The annual work plan dictates the details of specific quality improvement projects (see the Addenda # 1 for the FY 2019-2020 Work Plan). The progress on the Work Plan is updated quarterly by the QM Technical Workgroup and reported to all stakeholders.

## Sustaining Improvements

Regular feedback regarding improvement projects is critical to the success in sustaining improvements over time. Once an improvement plan has been successful a regular monitoring schedule is implemented to determine whether the plan remains successful over time.

## Glossary of Terms

| TERM | DEFINITION |
|---|---|
| **Accountability** | Establishing a systematic method to assure stakeholders (policy-makers and the public) that the organizational entities are producing desired results. Accountability includes establishing common elements that are applied to all participants. These should include clear goals, progress indicators, and measures, analysis of data, reporting procedures, and help for participants not meeting goals, and consequences and sanctions.<br>(Source: American Society for Quality) |
| **Action Plan** | An action plan with specific steps to implement and achieve the objectives. Plans usually include the following: key activities for the corresponding objective; lead person for each activity; timeframes for completing activities; resources required; and evaluation indicators to determine quality and effectiveness of the activities in reaching the strategy.<br>(Source: Adapted from *The Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.) |
| **Analyze** | To study or determine the nature and relationship of the parts of by analysis.<br>(Source: Merriam-Webster Online Dictionary) |
| **Barriers** | Existing or potential challenges that hinder the achievement of one or more objectives.<br>(Source: *The Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.) |
| **Benchmarking** | Benchmarks are points of reference or a standard against which measurements can be compared. In the context of indicators and public health, a benchmark is an accurate data point, which is used as a reference for future comparisons (similar to a baseline). Also referred to as "best practices" in a particular field. Communities compare themselves against these standards. Many groups use benchmark as a synonym for indicator or target.<br>(Source: Norris T, Atkinson A, et al. *The Community Indicators Handbook: Measuring Progress toward Healthy and Sustainable Communities*. San Francisco, CA: Redefining Progress; 1997) |
| **Best Practice(s)** | The best clinical or administrative practice or approach at the moment, given the situation, the client or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices which may be defined as clinical or administrative practices for which there is considerable practice-based evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence.<br>(Source: *National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms*, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf) |
| **Continuous Improvement** | Includes the actions taken throughout an organization to increase the effectiveness and efficiency of activities and processes in order to provide added benefits to the customer and organization.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Data** | Quantitative or qualitative facts presented in descriptive, numeric or graphic form.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Evaluate** | To systematically investigate the merit, worth or significance of an object, hence assigning "value" to a program's efforts means addressing those three inter-related domains: Merit (or quality); Worth (or value, i.e., cost-effectiveness); and Significance (or importance).<br>(Source: CDC – *A Framework for Program Evaluation*) |
| **Evidence-based Practice** | Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned.<br>(Source: Brownson, Fielding and Maylahn. *Evidence-based Public Health: A Fundamental Concept for Public Health Practice*. Annual Review of Public Health) |

| TERM | DEFINITION |
|---|---|
| **Goal** | A statement of general intent, aim, or desire; it is the point toward which management directs its efforts and resources in fulfillment of the mission; goals are usually non-quantitative.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Implement** | To put into action; to give practical effect to and ensure of actual fulfillment by concrete measures<br>(Source: Adapted from Merriam-Webster.com) |
| **Indicators** | Predetermined measures used to measure how well an organization is meeting its customers' needs and its operational and financial performance objectives. Such indicators can be either leading or lagging indicators.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Lean Six Sigma** | **Lean Six Sigma** is a methodology that relies on a collaborative team effort to improve performance by systematically removing waste; combining lean manufacturing/lean enterprise and Six Sigma to eliminate the eight kinds of waste (poda): defects, overproduction, waiting, non-utilized talent, transportation, inventory, motion, extra-processing |
| **Objective** | Specific, quantifiable, realistic targets that measure the accomplishment of a goal over a specified period of time. (Source: The *Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.)<br><br>Objectives need to be **S**pecific, **M**easurable, **A**chievable, **and Relevant** and include a **T**imeframe (SMART). |
| **Opportunity for Improvement** | Agents, factors, or forces in an organization's external and internal environments that can directly or indirectly affect is chances of success or failure.<br>(Source: Adapted from BusinessDictionary.com) |
| **Outcomes** | Long-term end goals that are influenced by the project, but that usually have other influences affecting them as well. Outcomes reflect the actual results achieved, as well as the impact or benefit of a program. |
| **Performance Improvement** | An ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, outcomes. |
| **Performance Indicators** | Measurement that relates to performance but is not a direct measure of such performance (e.g. the # of complaints is an indicator of dissatisfaction but not a direct measure of it) and when the measurement is a predictor (leading indicator) of some more significant performance (e.g. increased customer satisfaction might be a leading indicator of market share gain.) (Source: 2013 Sterling Criteria for Performance Excellence) |
| **Performance Measures or Metrics** | Tools or information used to measure results and ensure accountability; specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance.<br>(Source: Lichiello, P. *Turning Point Guidebook for Performance Measurement*, Turning Point National Program Office, December 1999) |
| **Performance Report** | Documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback. The report should provide information in four categories: facts, meaning, assessments, and recommendations.<br>(Source: *Turning Point Performance Management*, National Excellence Collaborative, 2004) |
| **Plan-Do-Check-Act (PDCA)** | Also called: PDCA, Plan–Do–Study–Act (PDSA) cycle, Deming Cycle, Shewhart Cycle. The Plan–Do–Check–Act cycle is a four–step model for carrying out change. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous improvement.<br>(Source: ASQ.org) |
| **Priorities** | Strategically selected areas on which the department focuses resources (human, financial, other). In some instances, priorities are further identified as those responsibilities expressly assigned statutorily to the department. |
| **Quality Improvement** | Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving |

| TERM | DEFINITION |
|---|---|
| | population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.<br>(Source: Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. "Defining Quality Improvement in Public Health". *Journal of Public Health Management and Practice.* January/February 2010) |
| **Quality Improvement (QI) Plan** | A QI plan describes what an agency is planning to accomplish and reflects what is currently happening with QI processes and systems in that agency. It is a guidance document that informs everyone in the organization as to the direction, timeline, activities, and importance of quality and quality improvement in the organization. The QI plan is also a living document and should be revised and updated regularly as progress is made and priorities change. The QI plan provides written credibility to the entire QI process and is a visible sign of management support and commitment to quality throughout the health department. (Source: Davis MV, Mahanna E, Joly B, Zelek M, Riley W, Verma P, Solomon Fisher J. "Creating Quality Improvement Culture in Public Health Agencies." *American Journal of Public Health*. 2014. 104(1):e98-104)<br><br>The Public Health Accreditation Board requires a QI plan as documentation for measure 9.2.1 A of the Standards and Measures Version 1.5. |
| **Quality Management (QM)** | Quality management ensures that an organization, product or service is consistent. It has four main components: quality planning, quality assurance, quality control and quality improvement. Quality management is focused not only on product and service quality, but also on the means to achieve it. |
| **Quality Management Program (QMP)** | A quality management program is an **all-encompassing system** that is designed to **increase the quality of a deliverable** to the level that is required by the scope of the project. To do this effectively, the program should give the user the tools to accomplish this goal. |
| **Quality Tools** | Seven Basic Tools: Seven Basic Tools - Quality Management Tools \| ASQ<br><br>Seven New Planning & Management Tools: Seven Management & Planning - New Management Tools \| ASQ |
| **Reporting (performance)** | A process which provides timely performance data for selected performance measures/indicators which can then be transformed into information and knowledge. |
| **Resources** | Personnel, equipment, facilities, and funds available to address organizational needs and to accomplish a goal. |
| **Sustainability** | Sustainability gauges the likelihood that improvements can be maintained over time. It involves how well processes are defined and documented with the goal of being repeated, how outputs and outcomes of the process are measured and monitored, whether ongoing training of those process and standards for implementation is provided, and whether the standards for the process are reviewed periodically as a part of continuous quality improvement. |
| **System** | A network of connecting processes and people that together perform a common mission.<br>(Source: *The Quality Improvement Handbook*, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.) |
| **Targets** | Desired or promised levels of performance based on performance indicators.<br>They may specify a minimum level of performance or define aspirations for improvement over a specified time frame. |
| **Validate** | To confirm by examination of objective evidence that specific requirements and/or a specified intended use are met.<br>(Source: Florida Sterling *The Quality Improvement Handbook*, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.) |

**QM Plan Addenda**

# QM Plan Addendum # 1

## Orlando Service Area - CQM Work Plan

**Year 2019-2020**

| # | ACTION STEP | | Measure of compliance or Progress | Responsible person or Champion | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Quarter 1 | | | Quarter 2 | | | Quarter 3 | | | Quarter 4 | | |
| **Opportunity: 2017 data reflect that retention in care for PLWH is at 66.4%, which is below our target of 85% by 2021.** | | | | | | | | | | | | | | | | |
| #1 | **Goal:** To Increase the percentage of PLWH retained in care from 66% to 75% by increasing the retention rates of MSM of color and youth (ages 13-24 yrs.) the two subpopulations with the greatest disparity in retention rates. | | | | | | | | | | | | | | | |
| | 1.a | Develop PDCA process that includes at least one Evidence Based Intervention (EBI) | PDCA developed and approved | CQM Work Group | | | | X | | | | | | | | |
| | 1.b | Discuss PDCA with sub- recipient network | Meeting with sub-recipients | Health Planner/QM Manager | | | | X | | | | | | | | |
| | 1.c | Provide training on identified the Peer Support intervention as identified in the CDC's Every Dose Every Day (E2D2). | Providers training completed | CQM Work Group | | | X | | | | | | | | | |
| | 1.d | Work with sub-recipients to develop internal QI teams to | % of PLWH retained in care | Health Planner QM Manager CQM Consultant | | | | X | X | | X | X | | X | | |

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| | | implement and monitor | | | | | | | | | | | | | | |
| | 1. e | Evaluate | Increase in retention rate | Workgroup | | | | | | | | x | | X | | |
| **Opportunity: 2017 data reflect community viral load suppression for PLWH is at 62%, which is below our target of 75% by 2021.** | | | | | | | | | | | | | | | | |
| #2 | **GOAL:** To increase the community viral suppression rate from 62% to 72% by increasing the viral suppression rates of MSM of color and youth (ages 13-24 yrs.) the tow subpopulations with the greatest disparity in viral suppression rates. | | | | | | | | | | | | | | | |
| | 2.a | Develop PDCA process that includes at least one Evidence Based Intervention (EBI) | PDCA developed and approved | CQM Work Group | | | | X | | | | | | | | |
| | 2.b | Discuss PDCA with sub- recipient network | Meeting with sub-recipients | Health Planner/QM Manager | | | | X | | | | | | | | |
| | 2.c | Provide training on the Partnership for Health intervention as identified in the CDC's Every Dose Every Day (E2D2). | Providers training completed | CQM Work Group | | | X | X | | | | | | | | |
| | 2.d | Work with sub-recipients to develop internal QI teams to implement and monitor | % of PLWH With viral load suppression | Health Planner/QM Manager | | | | X | X | | X | | | X | | |
| | 2. e | Evaluate | Increase in viral suppression | Workgroup | | | | | | | X | X | | X | | X |

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| **Opportunity: 2017 data reflect community viral load suppression for minority PLWH is at 56.4% which is below our target of 75% by 2021.** | | | | | | | | | | | | | | | | | |
| # 3 | **GOAL**: To increase the community viral suppression rate for minority PLWH from 56% to 76%. | | | | | | | | | | | | | | | | |
| | 3.a | Work with subrecipient providing psychosocial support services implement a QI initiative to increase viral load suppression among minority PLWH. | QI initiative identified | Health Planner | | | | X | X | | | | | | | |
| | 3.b | Work with subrecipient to develop referral MOU with OAHS providers to refer minority clients with unsuppressed viral load. | MOUs developed | Health Planner | | | | | X | X | X | | | | | |
| | 3.c | Implement QI activity with referred clients | QI activity implemented | Subrecipient | | | | | | X | X | X | X | X | X | X |
| | 3.d | Monitor viral suppression rates | Viral suppression rate increased | Health Planner/Subrecipient | | | | | | | | X | | | | X |
| **Opportunity: Cultivate a culture of quality and improve CQM programs among the sub-recipients.** | | | | | | | | | | | | | | | | | |
| #4 | **GOAL:** To ensure that at least 95% of sub-recipients have a CQM program that adheres to HRSA/HAB revised PCN # 15-02. | | | | | | | | | | | | | | | | |
| | 4.a | Work with sub-recipients to conduct self-assessment of their Quality Management | Assessments completed | Health Planner/QM Manager | | X | X | X | X | | | | | | | |

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| | | Program (QMP) | | | | | | | | | | | | | | |
| | 4.b | Develop Action Plans for Improving sub-recipients QMP. | Action Plans developed | Sub- recipients/ Health Planner/QM Manager | | X | X | X | X | | | | | | | |
| | 4.c | Reassess to determine improvement | Reassessment completed | CQM Work Group | | | | | | | | | | | | X |
| | 4.d | Provide Training/TA to sub-recipients regarding QMP activities | Training/TA ongoing | Health Planner/QM Manager | | | X | X | X | | | | | | | |
| | 4.e | Wok with sub-recipients to identify and implement QI initiatives | At least 2 QI initiatives per sub-recipient implemented | Health Planner/QM Manager | | | | X | X | X | X | X | X | X | X | X |
| | 4.f | Evaluate | Improvement demonstrated | Sub- recipients/ Health Planner/QM Manager | | | | | | | X | | | | X | |
| **Opportunity: The Orlando Service Area lacks informed clients to participate in Quality management activities.** | | | | | | | | | | | | | | | | |
| # 5 | **GOAL:** To increase the number of PLWH who are active members of the RWHAP Part A CQM Program. | | | | | | | | | | | | | | | |
| | 5.a | Provide Training to Clients on Quality (TCG) to increase client participation throughout the service area. | # PLWH trained | TCQPlus Team | | | | | | | | X | | | | X |
| | 5.b | Encourage trained clients to participate | # PLWH actively participating on QM | Health Planner/QM Manager | | | | | | | | X | X | X | X | X |

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| | | on subrecipients' QM Committees. | Committees. | | | | | | | | | | | | | |
| | 5.c | Provide additional training as needed to keep clients engaged. | # PLWH engaged in QM activities | TCQPlus Team | | | | | | | | | | | X | |
| | 5.d | Evaluate | Determine any improvements required | TCQPlus Team | | | | | | | | | | | | X |

# QM Plan Addendum # 2
# PDCA Worksheet

**EMA Quality Management Program**
**Date of Report: April 22, 2019**

**HAB MEASURE:** ***HIV Viral Load Suppression*** *- Percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.*

**EMA HIV 2017 HIV Viral Suppression Study***: According to the findings of the study, minorities were more likely to have a detectable (> 51 copies/ml) or highly detectable (>100,000 copies/ml) viral load (VL) and that lack of retention in care was significantly associated with having a detectable or highly detectable VL at some point during the study period.*

**CYCLE:** Quarterly (beginning April 1, 2019 through June 30, 2020)

**PLAN**

**The EMA QM Program**: Identify and implement strategies to increase retention in care minority PLWH thus reducing their VL.

**We hope this produces***: a 10% increase in retention in care of minority PLWH in the EMA with a subsequent decrease in detectable and highly detectable VL.*

**Steps to execute:**

1. *Work with the subrecipient providing psychosocial support services to identify a QI initiative to be implemented with minority clients*
2. *Notify sub-recipients of the new focus of the service category*
3. *Develop MOUs with OAHS providers for referral of clients with detectable viral loads*
4. *Measure & monitor retention in care for minority PLWH and their VL via reports from Provide Enterprise and CAREWare.*

**DO**

**What did you observe?** *The Planning Council identified Peer mentoring as the strategy to be used and during the PSRA process on August 31, 2018 MAI funds were allocated to Psychosocial Support services to implement in March of 2019***.** *The recipient notified current sub-recipients of Psychosocial Support funding of the change at a provider meeting held December 7, 2018. Effective March 1, 2019, Psychosocial Support services providers will begin targeting minority PLWH with a detectable or highly detectable VL. Monthly reports from Provide Enterprise and CAREWare will be reviewed and aggregated quarterly for reporting to the QM Workgroup.*

**Compare each monthly outcome with an aggregate quarterly end outcome to determine effectiveness of Plan.**

**CHECK**

**What did you learn?** ***Did you meet your measurement goal? This is filled in at the end of the first cycle. If the plan worked and you saw the anticipated increase as you described above, you list your plan to continue this action for another quarter cycle to ensure increased outcome results. If you did not see any increase in your outcomes, this is where you indicate the new "plan" for the next cycle.***

List each month's outcome as below:

MAI funding allocated to implement strategy
Providers informed of change in focus
Peer Mentoring for minority PLWHs implemented March 1, 2019
Data review schedule established

Aggregate review total of (list all data) in first cycle = xx%

*Based on the data reviews, are there still areas that indicate a need for continued review*. List the plan with any changes you recommend.

**ACT**

**What did you conclude from this cycle?** ***Again, if the cycle indicated an outcome result as predicted, remain constant with the action plan. If no change is seen, note that the action plan was not successful and list the new action plan for the next cycle with the outcome prediction.***

# QM Plan Addendum # 3
# PDCA Worksheet

**OSA Quality Management Program**
**Date of Report: April 22, 2019**

**HAB MEASURE:** ***HIV Viral Load Suppression*** *- Percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.*

**OSA HIV 2017 CARE CONTINUUM OUTCOME***: According to the latest epidemiological data provided by the Florida Department of Health, the OSA viral suppression for all PLWH in the EMA is 61.7% as of December 31, 2017. Review of disparities data indicates that MSM of color and youth (13-24 yrs.) demonstrates the greatest disparities in viral suppression.*

**CYCLE:** Quarterly - beginning *April 1, 2019 through June 30, 2020*

**PLAN**

**The OSA QM Technical Workgroup plans to**: increase EMA-wide education regarding HIV and Viral Suppression in the community and pilot one the PfH Evidenced-based Intervention for MSMs of color and youth.

**We hope this produces***: a 10% increase of virally suppressed MSM of color and youth PLWH in the EMA.*

**Steps to execute:**

1. *Work with the selected subrecipients to ensure staff completes the e-training module to implement the Partnership for Health for Medication Adherence (PfH) strategy as described in CDC's Every Dose Every Day (E2D2) effective Behavioral Interventions.*
2. *Notify sub-recipients of the target sub-populations (MSM of color & youth) for enrollment in the intervention*
3. *Measure & monitor retention in care for PLWH and their VL via reports from Provide Enterprise and CAREWare.*

**DO**

**What did you observe?** *Measurements should be done monthly during the cycle and reported to the OSA QM Technical Workgroup by end of first quarter***.**

**Compare each monthly outcome with an aggregate quarterly end outcome to determine effectiveness of Plan.**

**CHECK**

**What did you learn?** ***Did you meet your measurement goal? This is filled in at the end of the first cycle. If the plan worked and you saw the anticipated increase as you described above, you list your plan to continue this action for another quarter cycle to ensure increased outcome results. If you did not see any increase in your outcomes, this is where you indicate the new "plan" for the next cycle.***

List each month's outcome as below:

Review (list data reviewed/chart abstraction/desktop review for each month) = xx%

Aggregate review total of (list all data) in first cycle = xx%

*Based on the data reviews, are there still areas that indicate a need for continued review*. List the plan with any changes you recommend.

**ACT**

**What did you conclude from this cycle?** ***Again, if the cycle indicated an outcome result as predicted, remain constant with the action plan. If no change is seen, note that the action plan was not successful and list the new action plan for the next cycle with the outcome prediction.***

# QM Plan Addendum # 4
# PDCA Worksheet

**OSA Quality Management Program**
**Date of Report: April 22, 2019**

**HAB MEASURE:** ***HIV Medical Visit Frequency*** *- Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.*

**OSA HIV 2016 CARE CONTINUUM OUTCOME***: According to the latest epidemiological data provided by the Florida Department of Health, the OSA retention in care for all PLWH in the EMA is 66.4% as of December 31, 2017. Analysis of disparity data documented that MSM of color and youth (ages 13-24 yrs.) had the greatest disparities in retention in care.*

**CYCLE:** *April 1, 2019 through June 30, 2018 (quarterly thereafter)*

**PLAN**

**The OSA QM Technical Workgroup plans to**: increase EMA-wide support groups in the community and pilot one EBI.

**We hope this produces***: a 10% increase of PLWH retention in care of MSM of color and youth in the EMA.*

**Steps to execute:**

5. *Work with the selected subrecipients to ensure staff completes the e-training module to implement the Peer Support strategy as described in CDC's Every Dose Every Day (E2D2) effective Behavioral Interventions.*
6. *Notify sub-recipients of the new focus of the service category*
7. *Measure & monitor retention in care for minority PLWH and their VL via reports from Provide Enterprise and CAREWare.*

**DO**

**What did you observe?** *Measurements should be done monthly during the cycle and reported to the OSA QM Technical Workgroup by end of first quarter***.**

**Compare each monthly outcome with an aggregate quarterly end outcome to determine effectiveness of Plan.**

**CHECK**

**What did you learn?** ***Did you meet your measurement goal? This is filled in at the end of the first cycle. If the plan worked and you saw the anticipated increase as you described above, you list your plan to continue this action for another quarter cycle to ensure increased outcome results. If you did not see any increase in***

***your outcomes, this is where you indicate the new "plan" for the next cycle.***

List each month's outcome as below:

Review (list data reviewed/chart abstraction/desktop review for each month) = xx%

Aggregate review total of (list all data) in first cycle = xx%

*Based on the data reviews, are there still areas that indicate a need for continued review*. List the plan with any changes you recommend.

**ACT**

**What did you conclude from this cycle?** ***Again, if the cycle indicated an outcome result as predicted, remain constant with the action plan. If no change is seen, note that the action plan was not successful and list the new action plan for the next cycle with the outcome prediction.***