Approved on [Date]

2024

QUALITY MANAGEMENT PLAN

Ryan White HIV/AIDS Program

Orlando Service Area

Heart of Florida United Way

Table of Contents

Signatures

RWHAP Part B Clinical Quality Manager _____ Date _____

RWHAP Part B Lead Agency Representative _____ Date _____

RWHAP Part A Health Planner _____ Date _____

RWHAP Part A Health Planner _____ Date _____

RWHAP Part A Recipient Representative _____ Date _____

Subrecipient Workgroup Representative _____ Date _____

Executive Summary

The Orlando Eligible Metropolitan Area (EMA) and the Area 7 Consortium, which comprises the Orlando Service Area (OSA), are ultimately responsible for delivering quality services across our network of subrecipients in Brevard, Lake, Orange, Osceola, and Seminole counties. The OSA Quality Management Plan is a written document that outlines the Ryan White HIV/AIDS Program (RWHAP) system-wide quality management program. 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 Health and Human Services (HHS) Guidelines
2. Ensure that strategies for quality improvement of medical care and support services include the appropriate access to and retention in HIV care
3. Verify that available demographic, client satisfaction, and service utilization information is used to monitor the HIV continuum of care

The QMP focuses on sustaining open communication between the RWHAP Part A Recipient, the Part B Lead Agency, subrecipients, and clients regarding the expectations for addressing outcome improvement. Quality activities are part of the procurement process and service contracting. The OSA QMP approach ensures that each individual subrecipient establish and maintain its own quality management program. Subrecipients are responsible for establishing a separate QM Plan and reporting progress to the Recipient and Lead Agency on a quarterly basis.

Description of Quality Management

The OSA Quality Management Program is based on HRSA Quality Technical Assistance Manual, the Clinical Quality Management Policy Clarification Notice (PCN) #15-02, other HRSA HAB guidance documents, local Service Standards, and Ways to Best Meet Needs (Directives) as defined by the Central Florida HIV/AIDS Planning Council. The QMP outlines a collaborative effort between the RWHAP Part A Recipient, the Area 7 Consortium Lead Agency (the local RWHAP Part B office), the Planning Council, the subrecipient 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 QMP is to ensure continuous performance improvement in the delivery of quality HIV medical and support services in the service area. 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 the quality of inputs, of the service delivery process, and of health outcomes in order to continuously improve systems of care for the population served.

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 grant-funded HIV health services provided to clients are consistent with the most recent 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 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 QMP. Both offices and the subrecipient network assume a vital role in the implementation of the QM plan leading to excellence in service delivery.

Resources

Funds for RWHAP Part A Clinical Quality Management activities are administered through Part A formula, supplemental, and Minority AIDS Initiative (MAI) allocations. Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.

Funds for RWHAP Part B Clinical Quality Management activities are administered through Part B Consortia and General Revenue Patient Care Network (PCN) allocations. The Orlando EMA RWHAP Part A Recipient has allocated 3% of its budget and the RWHAP Part B Lead Agency has allocated 5% of its budget for evaluation and quality improvement activities.

Quality Statement

Vision:

To create a Ryan White service area where service providers embrace an organizational culture, rooted in quality management, that exchanges ideas and tools to promote improvements to services, thereby delivering effective and efficient client care.

The responsible parties will accomplish the vision of the QM Program through monitoring, measuring, and implementing the delivery of medical and support

services for PWH. The program is designed to objectively assess and evaluate the quality of care, to identify and pursue opportunities in improving care, and to address and resolve identified challenges within our service delivery system through a multidisciplinary team approach.

The Quality Management Program will:

- Provide tools and training for quality improvement to subrecipients, clients, and community representatives across the OSA
- Provide a means of accountability with documented and quantitative performance measures for services provided to PWH based on PCN 15-02
- Monitor the OSA's compliance with the National HIV/AIDS Strategy (NHAS), the HAB performance measures, and the Ending the HIV Epidemic: A Plan for America (EHE)

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

Establishment of Annual Quality Goals

The objectives of the OSA Quality Management Program are to:

- Evaluate the effectiveness of programs and services in relation to their stated purpose
- Provide the OSA's stakeholders with objective data with which to assess program performance in relation to established criteria of acceptability
- Ensure appropriate utilization, accessibility, satisfaction, and cost of services
- Provide meaningful data to facilitate planning services and identify areas for improvement
- Monitor progress regarding service improvement
- Encourage collective decision-making among the Quality Management Technical Workgroup and administration

- Develop a recognition program for outstanding quality improvement initiatives

The following four steps assist the Orlando OSA Part A Recipient and Part B Lead Agency to identify and establish annual goals for the HIV QM plan:

Step One: Assess the Current State

- Analyze performance measures data to identify areas of strength and weaknesses where improvements may be needed the most. Sources for data include performance measure data, client satisfaction survey results, staff input, quality management technical workgroup input, and external benchmarks.

Step Two: Understand the Parameters

- Identify the basic outline of the OSA HIV program and the community it serves in order to focus QI efforts, including services, patient demographics, and contractual expectations.

Step Three: Identify Program Goals

- The HAB performance measures, client satisfactions survey data, and the annual assessment of the QMP serve as the foundation of the clinical and service goals. QM staff and the technical workgroup may identify additional annual goals as needed.

Step Four: Quantify Where We Want to Be

- Annual HIV quality goals need to be measurable and stated in quantitative terms.

Annual Quality Goals 2024

The goals of the QM Plan for 2024 are:

1. To increase the viral load suppression percentage of RWHAP Part A clients from 91% as measured in 2023 to 94%; to increase the viral load suppression percentage of RWHAP Part B clients from 79% as measured in 2023 to 82%.
2. To refine the recognition program for QI achievements and the process for implementing QI awards
3. Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5.

Quality Infrastructure

The QMP is guided by the RWHAP Part A Recipient, the Area 7 Consortium Lead Agency, the Central Florida HIV Planning Council, and the Quality Management Technical Workgroup. The RWHAP Part A Recipient and the Area 7 Lead Agency Administrator dually manage the overall responsibility for the HIV clinical quality management program. 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.

Workgroup Participants	Position	Responsibility
RWHAP Part A Recipient	Health Planner (2.0 FTEs)	Provides training and technical assistance (TA) to the Part A subrecipients
RWHAP Part B Lead Agency	Clinical Quality Manager (1.0 FTE)	Provides training and technical assistance (TA) to the Part B subrecipients
Central Florida HIV/AIDS Planning Council (CFHPC)	Planning Council Support Committee chairs	Assists with the annual development and revision of the OSA service standards, reviews CQM data, and provides input and feedback on improvement efforts
Subrecipients	Service providers of Ryan White services for the Orlando Service Area	Assume an active role in the implementation of quality improvement activities
Quality Management Technical Workgroup	Members shall include: • Two medical providers • Two case managers • One mental health / substance use treatment representative • Two CFHPC members • One peer counselor • Min. two people with HIV	• Develop and revise the Quality Management Plan (QM Plan) • Monitor implementation of the QM Plan • Oversee specific program and team projects • Educate the subrecipient network and community stakeholders on the tenets of the Quality Management Program • Authorize performance improvement initiatives and set forth quality expectations for ongoing monitoring

Participation of Stakeholders

Summary reports of quality committee meetings are shared with stakeholders to ensure open communication flow within the HIV program. A basic training session about QI principles shall be offered to clients on an annual basis, or as often as deemed necessary by the Workgroup. Key data findings shall be incorporated into the OSA newsletter. 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 and 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 Planning & Quality Committee (SSPQ) and the Ryan White Community Meeting. The SSPQ Committee acts in an advisory capacity to both the RWHAP Part A Recipient and the Area 7 Lead Agency to ensure that the QM Plan is implemented at the system level.

Subrecipient Staff

The subrecipient staff members assume an active role in the implementation of QI activities in their respective programs and within the OSA through service delivery and championing a culture of quality.

Planning Council

The Planning Council reviews service outcomes in the prioritization and allocation of the RWHAP Part A and RWHAP Part B awards for the OSA. The SSPQ committee is primarily responsible for identifying gaps in service delivery, planning specific responses to identified gaps, and evaluating the processes of the Planning Council itself, including the annual Priority Setting and Resource Allocation processes.

Client Responsibility

Clients are active participants in the evaluation of quality activities in the OSA through their participation in satisfaction surveys, consumer advisory boards, Planning Council meetings, and Workgroup meetings.

Quality Management Technical Workgroup

The Quality Management Technical Workgroup meets at least quarterly to discuss, plan, and implement project-level activities within the OSA. The Workgroup includes representatives from outpatient ambulatory health services (OAHS) subrecipients, case management subrecipients, RWHAP Part A recipient staff, RWHAP Part B Lead Agency staff, clients, and quality management staff.

Evaluation

The Part A Recipient, the Lead Agency, and the QM Technical Workgroup are collectively responsible for the annual evaluation of the OSA Quality Management Program.

- The QM team reports activity updates to the Planning Council quarterly
- Evaluation results are derived from the program monitoring processes, client satisfaction surveys, and the quarterly tracking of performance measures
- An Organizational Assessment of the QMP is conducted annually using a version of NQC Organization Assessment Tool for RWHAP Recipients (Part A and Part B)
- An Organizational Assessment of all subrecipients is conducted annually using the NQC Organizational Assessment Tool for RWHAP Part C/D Recipients
- QM staff reviews the evaluation & assessment results and recommends a plan for improvement to the QM Technical Workgroup and the Planning Council

Workgroup staff and members review performance measures & QI projects throughout the year to evaluate service provision. Interventions include training and education of stakeholders, review of quality-related subrecipient policies, and development of new policies. When a measure indicator reaches a satisfactory level of improvement, the Workgroup discontinues the project, but continues to conduct periodic monitoring of discontinued project indicators to ensure sustained compliance with the agreed-upon threshold.

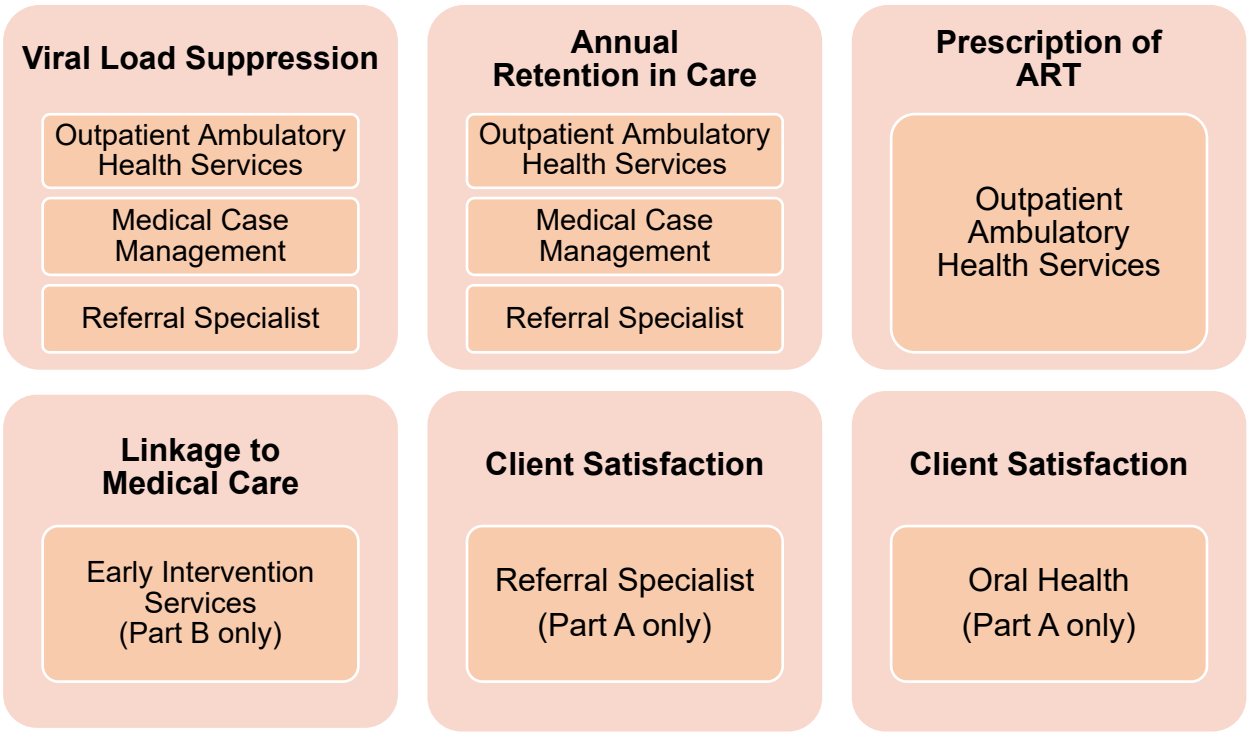
Performance Measurement

Utilization Rate	Required Measures
Service accessed by ≥50% of clients*	2
Service accessed by <50% but ≥15% of clients*	1

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 local RWHAP-funded programs. The Workgroup decides on performance measures annually based on utilization data, and monitors core and support services for the OSA using the HRSA/HAB measures and the OSA Service Standards.

Outcome data is stratified and reviewed quarterly to determine whether measures are meeting or exceeding established targets, as well as assess the quality of care, disparities in care, and to inform QI activities. The Recipient and Lead Agency, the Planning Council, the PWH Community Group, and the Quality Management Technical Workgroup are all responsible for reviewing HRSA/HAB performance measure outcomes. The Workgroup staff collects outcome data for each specified service category for each provider receiving funding for that service. Staff then aggregate the individual performance measure outcomes to determine overall outcomes for the OSA's chosen measures.

The following HAB performance measures (See Appendix: HAB Performance Measure Definitions) are measured via Provide Enterprise (PE) and CAREWare 6 (CW) based on 2023 utilization for Part A and Part B providers:



Part A EMA Exclusion

No exclusions.

Part B Brevard County Exclusion

Health Insurance Premium & Cost-Sharing

Rationale: There is an anticipated decrease in utilization for 2024 due to ADAP expanding which plans are eligible for partial assistance and the expansion of eligibility to 50% FPL from 75% FPL.

Table 1. Orlando Service Area RWHAP Performance Measures and Targets

Performance Measure	Outcomes								Target
	2020		2021		2022		2023		2024
Outpatient Ambulatory Health Services									
Viral Load Suppression	EMA: 92%	MAI: 90%	EMA: 93%	MAI: 81%	EMA: 93%	MAI: 80%	EMA: 91%	MAI: 90%	Increase by 3% to 93%
	Brevard: 86%		Brevard: 86%		Brevard: 89%		Brevard: 86%		Increase by 3% to 89%
Prescription of ART	EMA: 95%	MAI: 94%	EMA: 93%	MAI: 93%	EMA: 94%	MAI: 94%	EMA: 97%	MAI: 99%	Increase by 1% to 98%
	Brevard: 89%		Brevard: 97%		Brevard: 93%		Brevard: 94%		Increase by 2% to 96%
Annual Retention in Care	EMA: 96%	MAI: 87%	EMA: 73%	MAI: 79%	EMA: 72%	MAI: 79%	EMA: 76%	MAI: 83%	Increase by 3% to 79%
	Brevard: 68%		Brevard: 66%		Brevard: 72%		Brevard: 71%		Increase by 3% to 74%
Medical Case Management									
Viral Load Suppression	EMA: 88%		EMA: 88%		EMA: 85%		EMA: 82%		Increase by 3% to 85%
	Brevard: 74%		Brevard: 70%		Brevard: 80%		Brevard: 57%		Increase by 3% to 60%
Annual Retention in Care	EMA: 83%		EMA: 60%		EMA: 61%		EMA: 67%		Increase by 3% to 70%
	Brevard: 44%		Brevard: 32%		Brevard: 56%		Brevard: 59%		Increase by 3% to 61%

Table 1. Orlando Service Area RWHAP Performance Measures and Targets

Performance Measure	Outcomes				Target
	2020	2021	2022	2023	2024
Referral for Health & Support Services / Non-Medical Case Management					
Viral Load Suppression	EMA: 91%	EMA: 91%	EMA: 93%	EMA: 91%	Increase by 3% to 94%
	Brevard: 79%	Brevard: 85%	Brevard: 85%	Brevard: 80%	Increase by 3% to 83%
Annual Retention in Care	EMA: 83%	EMA: 65%	EMA: 65%	EMA: 69%	Increase by 3% to 72%
	Brevard: 48%	Brevard: 49%	Brevard: 61%	Brevard: 59%	Increase by 3% to 62%
Client Satisfaction	EMA: N/A	EMA: N/A	EMA: N/A	EMA: 97%	Increase by 1% to 98%
	Brevard: N/A	Brevard: N/A	Brevard: N/A	Brevard: N/A	N/A
Oral Health (EMA Only)					
Client Satisfaction	EMA: 100%	EMA: 99%	EMA: 94%	EMA: 100%	Maintain 100%
	Brevard: N/A	Brevard: N/A	Brevard: N/A	Brevard: N/A	N/A
Early Intervention Services (Brevard Only)					
Linkage to Care	Brevard: N/A	Brevard: N/A	Brevard: N/A	Brevard: N/A	Baseline TBD

Data Collection Plan

To the extent possible, data for the chosen performance measures are extracted from Provide Enterprise (PE), CAREWare (CW), and client satisfaction surveys. The responsibility for generating all reports for review falls to the Quality Management staff members. The staff provide data materials to the Quality Management Technical Workgroup in advance of the quarterly meetings for their review. Members participate in discussions during the meeting to determine the root causes for lagging outcomes.

Timeline for Data Collection and Reporting			
Data Source	**Parties Responsible**	**Collection Method**	**Reporting Date**
HAB Performance Measures	RWHAP subrecipients, Quality Management staff	Provide Enterprise, CAREWare, submitted by subrecipients	May August November February
Client Satisfaction Survey Data	RWHAP subrecipients, Quality Management staff	Surveys	May August November February
NQC Organizational Assessments	RWHAP subrecipients, Quality Management staff	Surveys	November

Quality Improvement

Once the Workgroup has identified an opportunity, QMW staff works together with subrecipient staff and the Quality Management Technical Workgroup to analyze the process and develop improvement plans. Staff and members make every attempt to ensure the process is collaborative. Participants use the Continuous Quality Improvement Methodology including, but not limited to, the following:

- Plan-Do-Study-Act (PDSA)
- Flowchart analysis
- Brainstorming
- Observational studies/patient flow
- Activity logs

Staff document the improvement plans in the Workgroup minutes, in a PDSA chart, in the annual work plan, and communicated to stakeholders as deemed appropriate. Scheduled meetings, electronic mail, memos, and informal verbal

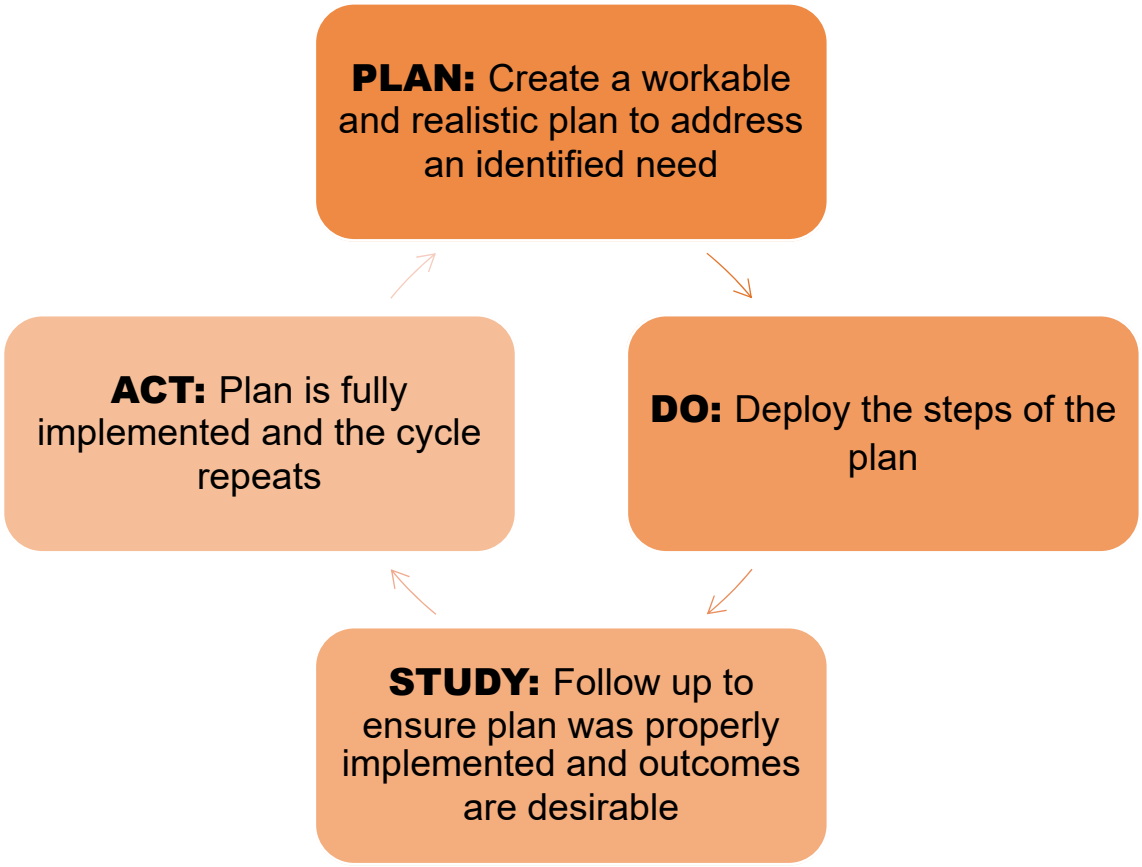
communication are all considered appropriate methods to communicate the Workgroup's activities and improvement plans.

This team-oriented approach allows the network of subrecipients to identify corrective action methods and collaborate on creative improvement solutions. The project cycle provides evidence and data as to whether the project achieved the intended impact and informs future components of the project cycle. The cycle consists of six steps based on the PDSA model:

1. Review, collect, and analyze project data
2. Investigate the process
3. Plan and test changes
4. Evaluate results with key stakeholders
5. Systematize changes

Plan-Do-Study-Act (PDSA) Model

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



Quality Improvement Activities

The Workgroup has approved three improvement projects CY 2024:

1. To increase the viral load suppression percentage of RWHAP Part A clients from 91% as measured in 2023 to 94%; to increase the viral load suppression percentage of RWHAP Part B clients from 79% as measured in 2023 to 82%.
2. To refine the recognition program for QI achievements and the process for implementing QI awards
3. Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5.

Process to Update Quality Management Plan

At the final meeting of the calendar year, the Workgroup staff facilitates the completion of the Organizational Assessment Tool. At the beginning of the new calendar year, the Workgroup staff uses the final performance measure data, the status of the previous year's goals, and results of the Organizational Assessment Tool to develop the upcoming performance measure targets and QI projects. During the first meeting of the year, the Workgroup will review those same materials, provide feedback, and vote on the proposed targets and projects. The updated Plan is shared with the Planning Council for review. The Part A Recipient and the Part B Lead Agency provide final approval of the plan.

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 Addenda 1 for the current calendar year Work Plan). The Quality Management Technical Workgroup updates progress made on the Work Plan quarterly, and these updates are reported to all stakeholders.

Sustaining Improvements

Regular feedback regarding QI 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 will remain successful over time.

Capacity Building

The Part A and Part B Quarterly Providers' meetings shall offer discussion on quality improvement activities, performance measure findings, opportunities for QI training, technical assistance, and additional QI support. Subrecipient monthly monitoring calls offer another space in which to discuss challenges, successes, and TA requests.

Subrecipients are required to identify at least one QI initiative on an annual basis. Progress on the initiative is documented in a monthly report to the RWHAP Part A Recipient and the Area 7 Lead Agency. Subrecipients must complete a self-assessment of their Quality Management Program annually using the NQC Organizational Assessment Tool prior to revising or updating their QM Plan. Appropriate quality management staff reviews the self-assessment and provides technical assistance based on the results. Subrecipients are then required to develop an Action Plan to implement QM Plan goals.

Appendix

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 applied to all participants. These should include clear goals, progress indicators, measures, analysis of data, reporting procedures, help for participants not meeting goals, consequences, and sanctions. (Source: American Society for Quality)
Action Plan	Details specific steps to implement and achieve stated objectives. Plans usually include the following: key activities for the corresponding objective; lead person for each activity; timeframes for completing activities; resources requires; and evaluation indicators to determine quality and effectiveness of the activities in reaching the strategy. (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 by analysis. (Source: Merriam-Webster Online Dictionary)
Barriers	Existing or potential challenges that hinder the achievement of one or more objectives. (Source: The Executive Guide to Facilitating Strategy: Featuring the Drivers Model. Michael Wilkinson. 1st Ed.)
Benchmark	Points of reference or a standard against which measurements can be compared by both data analysts and communities. In the context of indicators and public health, a benchmark is an accurate data point used as a reference for future comparisons, similar to a baseline. Also referred to as *best practices*, *indicators*, or *targets*. (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	The best clinical or administrative practice or approach at the moment, given the situation, client or community needs and desires, evidence-based solutions, and available resources. Related to the concept of *promising practice*, which identifies a clinical or administrative practice for which there is considerable practical evidence and/or expert consensus, but no strong scientific evidence. (Source: National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf)

Continuous Improvement	Actions taken throughout an organization intended to increase the effectiveness and efficiency of activities and processes in order to provide added benefits to the client and the organization. (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. (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. To assign *value* to a program's efforts means addressing those interrelated domains of merit (quality), worth (cost-effectiveness), and significance (importance). (Source: CDC – A Framework for Program Evaluation)
Evidence-Based Practice	Involves making decisions based on the best available scientific evidence, systematically using data and information systems, applying program-planning frameworks, engaging the community in decision-making, conducting sound evaluation, and disseminating results. (Source: Brownson, Fielding and Maylahn. Evidence-based Public Health: A Fundamental Concept for Public Health Practice. Annual Review of Public Health)
Goal	A statement of general intent, aim, or desire. The point toward which management directs its efforts and resources in fulfillment of the stated mission. Goals are usually non-quantitative. (Source: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)
Implement	To put into action; to give practical effect to an objective or task. Implementation should be followed by evaluation by concrete measures to ensure appropriate fulfillment. (Source: Adapted from Merriam-Webster.com)
Indicators	Predetermined measures used to measure how well an organization is meeting its clients' needs, operational objectives, and financial performance targets. Such indicators can be either *leading* or *lagging* indicators. (Source: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)
Lean Six Sigma	A methodology that relies on a collaborative team effort to improve performance by systematically removing waste through the combination of lean manufacturing/lean enterprise and Six Sigma. There are eight kinds of waste (poda): defects, overproduction, waiting, non-utilized talent, transportation, inventory, motion, and extra-processing. (Source: Decoding Lean Six Sigma, kennesaw.edu)

Objective	Specific, quantifiable, realistic targets that measure the accomplishment of a goal over a specified period. (Source: The Executive Guide to Facilitating Strategy: Featuring the Drivers Model. Michael Wilkinson. 1st Ed.) Objectives need to be Smart, Measurable, Achievable, Relevant, and Timely (SMART).
Opportunity for Improvement	Agents, factors, or forces in an organization's external and internal environments that can directly or indirectly affect its chances of success or failure. (Source: Adapted from BusinessDictionary.com)
Outcomes	Long-term end goals that are influenced by a project, as well as external influences. Outcomes reflect both the actual results achieved and 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. (Source: acqnotes.com)
Performance Indicator	A measurement that related to performance, but is not a direct measure of such performance (e.g., a certain quantity of complaints is an indicator of dissatisfaction but not a direct measure of it). Indicators that appear to predict significant performance are known as *leading indicators* (e.g., increased satisfaction might be a leading indicator of market share gain). (Source: 2013 Sterling Criteria for Performance Excellence)
Performance Measures or Performance Metrics	Tools or information used to measure results and ensure accountability. The specific quantitative representation of capacity, process, or outcome deemed to be relevant to performance assessment. (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, along with the sharing of such information through feedback. The report should provide information in four categories: facts, meaning, assessments, and recommendations. (Source: Turning Point Performance Management, National Excellence Collaborative, 2004)
Plan-Do-Study-Act (PDSA)	A four-step model for carrying out change that is performed on a cycle to ensure continuous improvement. Also referred to as Plan-Do-Check-Act (PDCA) cycle, Deming Cycle, Shewhart Cycle. (Source: ASQ.org)
Priorities	Strategically selected areas on which a provider focuses its resources (human, financial, etc.).
Quality Improvement (QI)	The use of a deliberate and defined improvement process, such as the PDCA cycle, which focuses on activities that are responsive to community needs and in the interest of improving population health. QI is characterized by continuous and ongoing efforts to achieve measurable improvements in the efficiency,

	effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes that achieve equity and improve community health. (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 Plan	A QI Plan describes what an agency is planning to accomplish and reflects what is currently happening with processes and systems within that agency. The plan 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 plan provides written credibility to the QI process and is a visible sign of management support and commitment to quality through the agency. 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. (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)
Quality Management (QM)	Quality management ensures that an organization, product, or service is consistent. QM has four components: quality planning, quality assurance, quality control, and quality improvement. QM is focused on not only product and service quality, but also the means to achieve it. (Source: Wikipedia)
Quality Management Program	A quality management program is a systematic process with identified leadership, accountability, and dedicated resources. The program uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. (Source: Quality Management Technical Assistance Manual, HRSA)
Quality Tools	Tools that help an organization understand their processes to improve them. These include: cause and effect diagrams, check sheets, control charts, flowcharts, histograms, Pareto charts, and scatter diagrams. (Source: ASQ Quality Glossary)
Reporting (performance)	A process that provides timely performance data for selected performance measures/indicators that 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 processes 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. (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. Targets may specify a minimum level of performance or define aspirations for improvement over a specified timeframe.
Validate	To confirm by examination of objective evidence that specific requirements and/or specified intended uses are met. (Source: Florida Sterling The Quality Improvement Handbook, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.)

Performance Measure Definitions[1]

HIV Viral Load Suppression

Description: Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.

Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one visit (OAHS, MCM, or RS)[2] in the measurement year

Annual Retention in Care

Description: Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.

Numerator: Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year

Denominator: Number of patients, regardless of age, with a diagnosis of HIV who had at least one OAHS visit within the 12-month measurement year

Prescription of HIV Antiretroviral Therapy

Description: Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year

Numerator: Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year.

Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one visit (OAHS, MCM, or RS) in the measurement year.

[1] Performance measure indicators may vary from HAB measure definitions across providers, services, and funding streams due to differences in data management systems.
[2] Visit is dependent on the service category being measured

Linkage to Medical Care (Part B only)

Description: The percentage of Early Intervention Services clients, regardless of age, who successfully completed a first medical clinic visit within one month (30 days) after HIV diagnosis.

Numerator: Number of clients from the denominator who completed a medical visit within 30 days of diagnosis

Denominator: Number of EIS clients, regardless of age, with a new diagnosis of HIV in the measurement year *and* who made contact with EIS

Client Satisfaction of Services

Description: The percentage of patients with a diagnosis of HIV who are satisfied with the HIV-related services they receive.

Numerator: Number of patients from the denominator who agree or strongly agree with feeling satisfied with their HIV services

Denominator: Number of patients, regardless of age, with a diagnosis of HIV who completed a client satisfaction survey in the measurement year

QM Plan Addenda

QM Plan Addendum #1: Work Plan CY 2024

Goal 1: To increase the viral load suppression percentage of RWHAP Part A clients from 91% as measured in 2023 to 94%; to increase the viral load suppression percentage of RWHAP Part B clients from 79% as measured in 2023 to 82%.

Opportunity identified by progress on 2023 QM Plan Goal 1

Action Step	Measure of Progress	Responsible Party	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1.a. Monitor & evaluate frequency and type of client contact.	• # of units (Part A) • # of services (Part B)	Recipient's Office, Lead Agency		X	X	X	X	X	X	X	X	X	X	X
1.b. Monitor & evaluate Individualized Care Plans.	• % of care plans (Part A) • Completion of ICM-MCM Monitoring Tool (Part B)	Recipient's Office, Lead Agency		X	X	X	X	X	X	X	X	X	X	X
1.c. Monitor and evaluate impact of client contact frequency, type of contact, and care plans on viral load suppression among MCM-ICM managed clients.	• Increase in VLS	Recipient's Office, Lead Agency		X	X	X	X	X	X	X	X	X	X	X

Goal 1: To increase the viral load suppression percentage of RWHAP Part A clients from 91% as measured in 2023 to 94%; to increase the viral load suppression percentage of RWHAP Part B clients from 79% as measured in 2023 to 82%. *Opportunity identified by progress on 2022 QM Plan Goal 1*					
Action Step	**Measure of Progress**	**Responsible Party**	**CY 2023**	**CY 2024**	**CY 2025**
1.d. Finalize Implementation of Intensive Case Management services	• Reduced case loads	Recipient's Office, Lead Agency	**X**		
1.e. Refresh ICM service training	• # of completed training sessions, # of ICMs trained	Recipient's Office, Lead Agency, ICM Trainer		**X**	
1.f. Enhance coordination between ICM and community-based system of care	• Increase in VLS and retention in care	Recipient's Office, Lead Agency			**X**

Goal 2: To refine the recognition program for QI achievements and the process for implementing QI awards.

Opportunity identified by progress on 2023 QM Plan Goal

Action Step	Measure of Progress	Responsible Party	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2.a. Establish schedule for submissions and awarding. Re-open awards	• Approved schedule • Revised guidelines	Ad hoc awards committee, QM Workgroup, Lead Agency Recipient's Office		X	X	X								
2.b. Recruit scoring committee members. Provide training on submission & scoring guidelines.	• Committee formation • Training session	Ad hoc awards committee, QM Workgroup, Lead Agency, Recipient's Office				X	X	X						
2.c. Host scoring session with scoring committee. Decide on award recipients.	• Award recipient selection	Ad hoc awards committee, Lead Agency, Recipient's Office						X	X	X				
2.d. Present Quality Care Awards to recipients at designated meetings in 2024.	• Award presentation	Ad hoc awards chair									X			

Goal 2: To refine the recognition program for QI achievements and the process for implementing QI awards. *Opportunity identified by progress on 2023 QM Plan Goal*					
Action Step	**Measure of Progress**	**Responsible Party**	**CY 2023**	**CY 2024**	**CY 2025**
2.e. Maintain subrecipient recognition program	• Quality Care Awards	QM Workgroup, Lead Agency Recipient's Office	**X**		
2.f. Engage staff by sharing QI projects and benchmarking performance	• Subrecipient QM deliverables	Lead Agency, Recipient's Office		**X**	
2.f. Develop sustainability plans and acknowledgement process for staff and subrecipients	• Award recipient selection	Lead Agency, Recipient's Office			**X**

Goal 3: Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5. *Opportunity identified by B.1. of the 2023 Organizational Assessment Tool*														
Action Step	**Measure of Progress**	**Responsible Party**	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
3.a. Develop curriculum to include timeline, topics, registration process, training schedule, and post-training requirements with ad hoc TOT committee	• Establish ad hoc TOT committee • Approval of curriculum	Ad hoc TOT committee, Lead Agency, Recipient's Office		**X**	**X**	**X**	**X**	**X**						
3.b. Identify and confirm presenters for curriculum topics.	• Presenter confirmation	Ad hoc TOT committee, Lead Agency, Recipient's Office				**X**	**X**	**X**						
3.c. Distribute training details among OSA providers. Open registration for participants through 2024.	• Development of application	Ad hoc TOT committee, Lead Agency, Recipient's Office					**X**	**X**	**X**					
3.d. Host Training-of-Trainers program in 2024.	• Event	Ad hoc TOT committee, Lead Agency, Recipient's Office								**X**				
3.e. Post-training deliverables check-in with participants in 2024.	• Review of post-training deliverables by ad TOT committee	Ad hoc TOT committee, Lead Agency, Recipient's Office										**X**	**X**	**X**

Goal 3: Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5. *Opportunity identified by B.1. of the 2023 Organizational Assessment Tool*					
Action Step	**Measure of Progress**	**Responsible Party**	**CY 2023**	**CY 2024**	**CY 2025**
3.f. Establish Training-of-Trainers program.	• Program implementation	QM Workgroup, Lead Agency Recipient's Office	**X**		
3.g. Host Training-of-Trainers program.	• Creation of plan	Lead Agency, Recipient's Office		**X**	
3.h. Develop sustainability plan for TOT program. Increase TOT participation across subrecipients	• Number of registrants	Lead Agency, Recipient's Office			**X**

QM Plan Addendum #2: PDSA Worksheets

Intensive Case Management (ICM) PDSA

HAB Measure: HIV Viral Load Suppression – percentage of clients, regardless of age, with an HIV diagnosis, with an HIV viral load of less than 200 copies/mL at last HIV viral load test of the measurement year.

OSA HIV 2022 Care Continuum Outcome: According to the latest epidemiological data provided by the Florida Department of Health, the OSA viral load suppression for all PWH within the OSA is 73.3% as of June 30, 2022. Review of data of the 30 clients enrolled in Project Zero and receiving intensive case management (ICM) services indicates that 65% achieved viral suppression. Therefore, expanding the ICM services should result in an overall increase in viral load suppression.

Cycle: Three

PLAN-DO-STUDY-ACT

The OSA Quality Management Technical Workgroup plans to: continue to monitor the implementation of ICM services in the OSA to evaluate the impact of increased contact frequency and monthly care plans on viral load suppression rates.

We hope this produces:

- Viral load suppression: a 3% increase of virally suppressed PWH in the RWHAP system of care; at least 94% of EMA clients and 82% of Brevard clients achieving viral load suppression

Revised steps to execute:

1. Monitor and evaluate the frequency of ICM contacts.
2. Monitor and evaluation frequency and quality of monthly care plans.
3. Measure and monitor viral load suppression rates of ICM clients.

PLAN-**DO**-STUDY-ACT

What did you do?

In 2022, all medical case managers across Part A and Part B providers completed ICM-MCM training via Aspire Consulting. In 2023, case managers completed both online and in-person components. QM staff collected viral suppression rates and reported on trends during quarterly Workgroup meetings.

PLAN-DO-**STUDY**-ACT

What did you learn? Did you meet your measurement goal?

The table below reflects the 2023 quarterly viral load suppression rates for MCM-ICM clients.

Region	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Orlando EMA	84%	83%	82%	82%
Brevard	58%	60%	63%	59%

The 2023 goals of 88% VLS in the EMA and 71% VLS in Brevard County were not met.

PLAN-DO-STUDY-**ACT**

What did you conclude from this PDCA cycle?

The 2023 Orlando EMA viral suppression rates decreased in Q2 through Q4. Brevard County rates were impacted by a significant reclassification project in which the number of clients qualified as Intensive Case Managed/Medically Case Managed decreased significantly by 2023 Q1. The numbers are also affected by the prioritization of clients with an unsuppressed viral load for ICM services. In 2024, the Workgroup will complete a third cycle of the ICM PDSA monitoring the system-wide viral load suppression.

Quality Improvement Recognition Program PDSA

Organizational Assessment Tool:

- Section A.1.
  - Score: Full systematic approach to quality management in place
    - Criteria: Encourage subrecipient innovation through QI awards and incentives

Cycle: Three

PLAN-DO-STUDY-ACT

OSA QM Program: To refine the recognition program for staff and subrecipient performance in QI achievements and the process for implementing QI awards.

We hope this produces:

A culture of quality that engages core staff in QI projects that achieve significant improvements in care. Projects are aimed to increase annual retention and viral load suppression rates.

Steps to execute:

1. Establish a schedule for submissions and awarding.
2. Recruit scoring committee members with the intention to provide an annual training on submission and scoring guidelines.
3. Host a scoring session with the scoring committee to finalize and decide on the award recipients.
4. Present the Quality Care Awards to the recipients at designated meetings in 2024.

PLAN-DO-STUDY-ACT

What did you observe?

The Orlando Service Area implemented the Quality Care Awards process in 2022, involving members of the workgroup to establish award categories, award criteria, the process for submission and review, and the process for awards. In 2023, the CQM Technical Workgroup established the ad hoc awards committee with two workgroup members serving as chairs. Unfortunately, the submissions that closed on February 1, 2024 resulted in only two submissions.

PLAN-DO-**STUDY**-ACT

What did you learn? Did you meet your measurement goal?

In 2023, the CQM Technical Workgroup established the ad hoc awards committee with two workgroup members serving as chairs. A new scoring rubric was developed to improve scoring fairness and effectiveness. Due to a low amount of submissions, the workgroup chose to extend the deadline.

PLAN-DO-STUDY-**ACT**

What did you conclude from this PDCA cycle?

The scoring committee should be made up of community members and non-Workgroup members as much as possible. The publicization of the Awards should be increased. The presentation of the Awards should be in a more public venue.

Training-of-Trainers Program PDSA

Organizational Assessment Tool:

- Section B.1.
  - Score: Full systematic approach to quality management in place
    - Criteria: Subrecipients hold at least quarterly trainings on topics in QI that are self-directed and not mandated by the recipient.

Cycle: Two

PLAN-DO-STUDY-ACT

OSA QM Program: Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5. of the 2023 Organizational Assessment Tool.

We hope this produces:

A pool of trained Ryan White professionals and clients who are capable and confident in providing quality management trainings to the Orlando Service Areas to champion a culture of quality in the system of care.

Steps to execute:

1. Develop curriculum to include timeline, topics, registration process, training schedule, and post-training requirements.
2. Identify and confirm presenters for curriculum topics.
3. Distribute training details among OSA providers. Open registration for participants through 2024.
4. Host Training-of-Trainers program in 2024.
5. Post-training deliverables check-in with participants in 2024.

PLAN-DO-STUDY-ACT

What did you observe?

Multiple provider staff representing at least four agencies have been participating actively in the TOT ad-hoc committee. The committee developed a vision statement, curriculum structure, and rough draft of curriculum topics.

PLAN-DO-**STUDY**-ACT

What did you learn? Did you meet your measurement goal?

The committee was able to meet once. The Lead Agency and recipient staff met with the Center for Quality Innovation & Improvement for guidance.

PLAN-DO-STUDY-**ACT**

What did you conclude from this PDCA cycle?

There was higher-than-expected interest from the community and providers in this program. The initial timeline was too short, and expanding the timeline helped to better achieve the establishment of the committee.

Peer Certification Impact PDSA - Concluded

HAB Measure: HIV Viral Load Suppression – percentage of clients, regardless of age, with an HIV diagnosis, with an HIV viral load of less than 200 copies/mL at last HIV viral load test of the measurement year.

Cycle: One

PLAN-DO-STUDY-ACT

OSA QM Program: Implement the Certified Peer Specialist in HIV Program Curriculum developed by the North Florida AIDS Education and Training Center (NF AETC) to increase viral suppression rates of clients enrolled in the RWHAP.

We hope this produces: Certified Peer Specialists in HIV, professionals who use their lived experience of HIV to support others. Peer Specialists in HIV assist others by providing information, service navigation and guidance, using evidence-based HIV disease management strategies, to maximize the health and wellness of people with HIV and/or prevent new HIV infections. Certified Peer Specialists in HIV support PWH to successfully engage in all parts of the HIV care continuum, resulting in a measurable decrease in detectable and highly detectable viral loads.

Steps to execute:

1. Implement the AETC Certified Peer Specialist Training to train a cohort of Certified Peer Specialists in HIV
    a. The peers will complete the certification training in May 2023.
    b. After completing the training, the Peers will gain hands on experience through a 45-hour preceptorship.
2. Collect and compare viral load suppression numbers for both certified and not-yet-certified Peer clients via reports from Provide Enterprise and CAREWare.

PLAN-DO-STUDY-ACT

What did you observe?

There were unexpected challenges in the administrative side of the peer certification program that led to a significant change in the program structure.

PLAN-DO-STUDY-ACT

What did you learn? Did you meet your measurement goal?

The workgroup learned to not establish goals based on external party projects, as the goal could not be met due to changes implemented by this external party.

PLAN-DO-STUDY-ACT

What did you conclude from this PDCA cycle?

There was significant interest from the peers in the OSA to receive a certification for their role.

QM Plan Addendum #3: Status Report

2023	Activity	Outcome
ICM-MCM Services	Finalize Implementation of Intensive Case Management services	**Met**
QI Recognition Process	Maintain subrecipient recognition program	**Met**
Training-of-Trainers	Establish local Training-of-Trainers (TOT) on Quality Improvement to build capacity among providers to support the achievement of B.1.5.	**In Progress**
Peer Certification Monitoring	Monitor the impact of the new Peer Certification Program (education and preceptorship) on the viral load suppression of Peers-supported clients in comparison to those clients whose Peers have not yet completed the program.	**Unmet**
Conditions	N/A	
Challenges	Vacancies in quality management staff roles External party made structural changes to peer certification project	
2022	**Activity**	**Outcome**
ICM-MCM Services	Expand the implementation of ICM services in the OSA to monitor and evaluate the impact of increased contact frequency and monthly care plans	**Part A: Met** **Part B: Unmet**
QI Recognition Process	Implement a formal process for recognizing staff and subrecipient performance in QI to increase retention in care and viral suppression rates of clients enrolled in RWHAP	**Met**
Value-Based Funding	Develop a methodology and formula for implementing a funding process that prioritizes patient care outcomes	**Unmet**
Conditions	N/A	
Challenges	Data integrity issues with Part B medical case managed clients; Vacancies in quality management staff roles	

2021	Activity	Outcome
Project Zero (ICM)	Increase VLS and Retention in Care through implementation of Intensive Case Management Services	**Unmet**
Peer Support	Increase VLS and Retention in Care through implementation of E2D2 Peer Support intervention in Brevard County	**Unmet**
Conditions	COVID-19	
Challenges	Unavailability of E2D2 Peer Support intervention training; delay in state Peer Certification training program; MCM and peer staff vacancies; Reliability and integrity of performance measure data.	

2020	Activity	Outcome
Project Zero	Increase VLS of PWH in system of care and 95% of enrolled PWH will achieve VLS	**Partially Met**
E2D2 Peer Support	Increase retention in care of PWH and decrease in detectable and highly detectable VL	**Unmet**
Conditions	COVID-19	
Challenges	Unavailability of E2D2 Peer Support intervention training; unavailability of lab services; MCM and peer staff vacancies; Reliability and integrity of performance measure data.	

2019	Activity	Outcome
Support Groups EBI	Increase retention in care for MMSC of color and youth through E2D2 peer support group	**Met**
VLS EBI Education	Increase VLS for MMSC of color and youth PWH using E2D2	**Unmet**
Minority PWH	Increase retention in care of minority PWH in the EMA; Decrease in detectable and highly detectable VL	**Met**
Conditions	N/A	
Challenges	System and mapping errors; process gaps; MCM and peer staff vacancies; Reliability and integrity of performance measure data.	

2018	Activity	Outcome
EBI Intervention	Increase retention in care through implementation of pilot EBI and adherence groups to transgender individuals	**Met**
VLS EBI Education	Increase VLS of PWH in the EMA	**Met**
Conditions	N/A	
Challenges	System and mapping errors; process gaps; MCM and peer staff vacancies; Reliability and integrity of performance measure data.	
2017	**Activity**	**Outcome**
Minority PWH	Increase retention in care of minority PWH in the EMA; Decrease in detectable and highly detectable VL	**Met**
Conditions	N/A	
Challenges	Local planning bodies not yet integrated; lack of integrated QM staff	