



**Division of Disease Control & Health Protection Bureau of
Communicable Diseases HIV/AIDS Section
Patient Care Clinical Quality Management Plan**

Version 4.0

2026–2030

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SECTION 1: Introduction

The HIV/AIDS Section operates within the Bureau of Communicable Diseases, under the Division of Disease Control and Health Protection. Among its three core programs is the HIV/AIDS Patient Care and Treatment Access Program, which implements key initiatives funded by the federal Ryan White HIV/AIDS Treatment Extension Act of 2009, pharmaceutical rebates, and state general revenue. This program delivers life-saving services to low-income Floridians living with HIV/AIDS who lack sufficient health insurance and are ineligible for Medicaid, Medicare, or other public insurance programs. Services administered by the Patient Care and Treatment Access Program include Ryan White Part B, AIDS Drug Assistance Program (ADAP), and Housing Opportunities for Persons with HIV/AIDS (HOPWA). These services have a profound impact on both individual health outcomes and public health by improving quality of life through viral load suppression and reducing disease transmission.

The Florida Department of Health (DOH) is the recipient of the Ryan White (RW) Part B grant, awarded by the Health Resources and Services Administration (HRSA). A key requirement of this grant is for recipients to establish a Clinical Quality Management (CQM) program to ensure high-quality healthcare services for people living with HIV.

In alignment with the HRSA HIV/AIDS Bureau (HAB) RW Part B Manual, the Florida Department of Health maintains a department-wide quality improvement program aimed at continuous learning and organizational transformation. This program focuses on: (1) systematically identifying opportunities for improvement, (2) implementing data-driven improvement projects, (3) sharing best practices, and (4) assessing measurable impacts on strategic priorities.

This plan outlines the HIV/AIDS Patient Care CQM Program, which is housed in the Patient Care & Treatment Access Program. The plan is reviewed by the Patient Care Clinical Quality Management Executive Committee and the Florida Comprehensive Planning Network. It is effective from March 2026 through April 2030. The HIV/AIDS Patient Care CQM plan can be reviewed and revised at any time.

The Quality Management Program has been established with ongoing input from stakeholders and communities affected by HIV. The specific goals include a) improving health outcomes for PLWH; b) advancing the quality of HIV supportive services across Part B-funded providers; c) ensuring that available performance data are used to monitor trends in Florida epidemic and to create momentum for improvement; d) aligning with national public health priorities and external clinical quality management (CQM) expectations, including the HRSA HIV/AIDS Bureau Policy Clarification Notice (PCN) #15-021.

If you have any questions or feedback concerning this plan, please contact RW Part B CQM staff at 850-245-4973 or email FLHIVCQMSupport@flhealth.gov.

Quality Statement

Purpose

- Promote a commitment to quality improvement throughout the Ryan White Part B Care Continuum.
- Describe the Part B quality management infrastructure.
- Identify Part B-specific aims for quality improvement based on health outcomes in Florida.
- Guide the development of structured activities that will enhance the delivery of services to PLWH receiving care from all Ryan White Part B-funded sub-recipients; and
- Communicate the roles, responsibilities, and expectations of the Ryan White

Vision

To achieve a future where all individuals living with HIV consistently receive high-quality of life. Establish accessible care across the continuum with the hope of leading to optimal health outcomes and a significant reduction in HIV-related disparities through continuous quality improvement and collaborative efforts with stakeholders.

Mission

- To ensure all Ryan White eligible PLWH in Florida have equitable access to high-quality health care and supportive services by:
- Implementing an effective and sustainable Ryan White Part B Quality Management Program
- Ensuring Ryan White Part B-funded services align with national public health priorities and internal quality management expectations, including [Policy Clarification Notice #15-02](#).
- Providing ongoing collaboration and coordination with internal and external stakeholders, including sub-recipients and clients of Ryan White Part B services; and
- Using available data to monitor health outcomes and strategize improvement activities to end the epidemic.

Clinical Quality Management (CQM) Program

FDOH CQM program is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction. To be effective, a CQM program requires:

- Collaborative approach that uses data analysis, chart abstraction, and outcome reporting to provide high-quality care
- Set of activities that includes quality improvement (QI)
- Program that includes a CQM plan, quality expectations, and a method for tracking outcomes.
- Program that includes monitoring of provider compliance with treatment guidelines.
- Program that includes periodic peer review to assess the quality of health services.
- Uses a proven CQM methodology to implement a successful CQM plan.
- Use of data and measurable outcomes to determine progress and make improvements to achieve the aims cited above.

The following components are vital to the effectiveness of and provide the overall structure for the Ryan White Part B Quality Management Plan:

- Infrastructure: the backbone of a quality management program, detailing leadership roles, quality management staff, quality committee structure, resources, client and stakeholder involvement, and evaluation of the quality management program, among others.
- Performance Measurement: collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual and population level, and patient satisfaction.
- Quality Improvement: the development and implementation of improvement activities to make changes to the program in response to the performance-driven results.

SECTION 2: Clinical Quality Management Infrastructure

The HIV/AIDS Planning and Performance Management Unit is comprised of a manager and three staff members. This unit is responsible for strategic planning, operational planning, performance measurement, performance improvement, and statewide CQM plan activities. Its duties include implementing the Patient Care CQM Program and ensuring that the program aligns with DOH policies on quality improvement.

Administrator, HIV/AIDS Section

The Section Administrator holds primary responsibility for coordinating state programs, services, and activities related to HIV. This role involves overseeing the state's HIV surveillance, prevention, care, and treatment services for people living with HIV (PLWH). As a member of the CQM Committee, the administrator provides public health guidance to the Clinical Quality Management (CQM) Program. Key responsibilities include leading the development of clinical guidelines, providing direction for Ryan White Part B CQM activities, and overseeing CQM initiatives for the Section that extend beyond the Ryan White Part B programs.

Patient Care and Treatment Access Program Director, HIV/AIDS Section

As the principal investigator for Florida's Ryan White (RW) Part B funding, the Patient Care and Treatment Access Program Director provides strategic direction and management for the Patient Care and Treatment Access Program. This program collaborates with county health departments (CHDs) and community-based organizations (CBOs) to deliver healthcare and support services. The Program Director also oversees the AIDS Drug Assistance Program (ADAP), the Housing Opportunities for Persons with AIDS (HOPWA) program. Additionally, the Director oversees the Clinical Quality Management (CQM) Program and serves as a member of the CQM Committee.

Quality and Operations Manager, Patient Care and Treatment Access Program, HIV/AIDS Section

The quality and operations manager is responsible for implementation oversight of the CQM Plan. The quality and operations manager ensures quarterly review of clinical indicators and identification of improvement opportunities. The quality and operations manager provides oversight of program evaluation and quality improvement projects conducted within the Section.

CQM Liaison, HIV/AIDS Section

The CQM Liaison reports to the Quality and Operations manager and is responsible for providing consultation, education, and guidance to county health departments for the RW Part B Program. This role supports the adoption of clinical quality performance

measures and promotes quality improvement projects. The liaison is also expected to build strong relationships with Patient Care and Treatment Access programs, as well as surveillance and prevention staff, to enhance service delivery and improve individual health outcomes.

People with HIV Involvement

The HIV/AIDS Section highly values input in the planning, implementation, evaluation, and quality improvement of its policies, programs, and services from people with lived experience. The CQM Program gathers feedback through local planning bodies, the Florida Comprehensive Planning Network (FCPN), satisfaction surveys, and the Department's website.

Stakeholder Involvement

Stakeholder involvement consists of input from subrecipients, other regional recipients, planning body members, and committee members in guiding CQM activities.

CQM Committee

The purpose of the Ryan White Part B Clinical Quality Management Committee is to provide input for the development and implementation of the CQM Program, as well as to ensure sufficient staffing for its effective execution and monitoring. The committee comprises medical experts, providers, sub-providers, patient and community advocates, and state program administrators. Members are carefully selected to ensure comprehensive representation of all components of the healthcare system including quality improvement initiatives and projects based on available data and trends, and to address areas for improvement utilizing best practices and improvement methods, including the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles.

The Part B Quality Management Committee meets quarterly four (4) times in a year (March, June, September, December). The meetings are facilitated by the CQM Liaison and extensive minutes are kept and archived.

The following section outlines the structure, membership, responsibilities, and requirements of the Ryan White Part B Quality Management Committee.

Committee Leadership

- HIV/AIDS Section Administrator
- HIV/AIDS Medical Director
- Patient Care and Treatment Access Program Director
- Patient Care and Treatment Access Program Quality and Operations Manager-Committee Chair

Committee Membership

- HIV/AIDS Section, ADAP program staff
- HIV/AIDS Section, CQM liaison

- HIV/AIDS Section, Prevention program representative
- HIV/AIDS Section, Patient care program representative
- HIV/AIDS Section, Surveillance program representative
- HIV/AIDS Section, Minority AIDS Coordinator representative
- HIV/AIDS Section, Medical director
- HIV/AIDS Section, Information Technology representative
- HIV/AIDS Section, Fiscal representative
- County Health Department, HIV/AIDS Program Coordinators
- County Health Department, ADAP staff
- Patient Care Lead Agency
 - Representatives
 - Subrecipients

Membership Requirements:

Members are allowed absences per grant year and need to notify CQM Liaison or Quality and Operations Team in advance of your absences. Subrecipient representatives may allow other agency staff to attend in their place. If needed, members may contact the Florida Department of Health Quality & Operations Manager for committee to request a withdrawal or leave of absence from the committee.

Committee Roles and Responsibilities

- Actively participate in Committee meetings to address Part B service-specific quality.
- Annually review and provide feedback on the Ryan White Part B Quality Management Plan.
- Coordinate with other internal and external stakeholders.
- Make recommendations for improved standards of care, the committee process, performance measures based on available data, and the overall Quality Management Program.
- Identify and prioritize Part B wide improvement goals and performance indicators based on performance measurement results and emerging national, state, and local public health priorities.
- Provide input on proposed and ongoing quality improvement (QI) activities.
- Review performance measures and identify key indicators for assessing and enhancing performance.
- Initiate local projects that align with the Statewide CQM Plan.
- Report on the status, progress, and recommendations of QI activities.
- Review and provide feedback on proposed changes to the annual CQM plan.
- Recommend appropriate training and educational opportunities related to QI topics.
- Identify the need for subcommittees and guide their work plans.
- Evaluate the effectiveness of ongoing CQM activities.

- Recommend and oversee the implementation of QI plans.
- Ensure that improvements are effectively implemented and sustained.

CQM Committee Work Plan

The CQM Committee Work Plan details the activities required to achieve the program's objectives and goals. It covers key elements such as (a) infrastructure, (b) priorities, (c) performance measures, (d) quality improvement activities, (e) an action plan with timelines and responsible parties, and (f) an evaluation of the CQM program. Each activity is assigned a specific timeline and responsible parties. The CQM Committee reviews progress on these activities during meetings and/or calls.

The CQM Committee Work Plan is an internal document used by the CQM Committee and is reviewed and updated as needed.

CQM Goals and Objectives

The CQM goals and objectives outlined in Tables 1 and 2 are informed by:

- Findings and recommendations from the HRSA HIV/AIDS Bureau Comprehensive Site Visit Reports of March 2023 and March 2024.
- Strategies and activities from the State of Florida Integrated HIV Prevention and Care Plan for 2025.

Table 1: HIV/AIDS Section (Recipient) Goals and Objectives

The implementation period for each objective is marked with an "X." "FY" refers to the Ryan White grant fiscal year, which runs from April 2026 to March 2027.

Goal 1: Maintain a CQM program infrastructure to support a systematic process with lead agencies and subrecipients, quality planning and accountability, and dedicated resources.												
Objective 1.1: By March 30, 2026, improve the CQM program infrastructure to support RWHAP Part B recipient and lead agencies.												
Action Plan	Quarter 1 2026 – 2027			Quarter 2 2026 – 2027			Quarter 3 2026 – 2027			Quarter 4 2026 – 2027		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
1.1.1. Reassess the infrastructure, including resources and staffing needs of lead agencies to successfully meet CQM expectations.												
1.1.2. Hold quarterly or as needed CQM meetings with liaison to identify TA needs.												
1.1.3. Provide at least two training opportunities (virtual/in-person) to build												

the capacity of lead agencies and subrecipients specifically around CQM activities (high level training/expectations of CQM) and CAREWare functions to meet baseline and target goals. FCPN venue will be used for in person meetings.												
1.1.4. CQM Committee and/or Executive Committee will meet monthly to review and analyze CQM performance measures												
1.1.5. Restructure process and mechanism quarterly report card/dashboard to communicate CQM performance data to lead agencies												
1.1.6. Develop CQM website accessible to internal and external subrecipients where all training modules will be housed.												
1.1.7. Conduct annual QM program assessment (CQII-based RWHAP Part B Recipient Assessment)												

Goal 2: Use performance data to identify opportunities for improvement; develop and implement measures to evaluate quality improvement initiatives; align initiatives; monitor program status; and ensure accurate, timely data and information are available.

Objective 2.1 By the end of each grant year, conduct two quality improvement projects for at least one funded service category.

Action Plan	Quarter 1 2026 – 2027			Quarter 2 2026 – 2027			Quarter 3 2026 – 2027			Quarter 4 2026 – 2027		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
2.1.1. Identify at least one performance measure for each												

RWHAP Part B funded service category based on PCN guidance.													
2.1.2. Adopt PDSA or PDCA & QI Project Storyboard for all QI Projects and initiatives.													
2.1.3. Identify and implement at least one quality improvement project.													

Goal 3: Implement a robust process improvement methodology to achieve program goal and maintain long-term high levels of performance.

Objective 3.1: Adopt PDSA or PDCA

Action Plan	Quarter 1 2026 – 2027			Quarter 2 2026 – 2027			Quarter 3 2026 – 2027			Quarter 4 2026 – 2027		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
3.1.1. Provide at least two training opportunities (virtual/in-person) to build the capacity of lead agencies and subrecipients specifically Quality Improvement Tools.												
3.1.2. Provide at least two training opportunities (virtual/in-person) to build the capacity of DOH staff and Patient Care team specifically around 8 Basic Quality Improvement Tools.												
3.1.3. QI Project Storyboard documentation for quality improvement projects/initiatives.												
3.1.4. Adopt and implement SMART GOAL Framework standard template for work plans.												

Goal 4: Provide the framework from which processes and outcomes are measured by developing standards of care for every funded service category for all regions of the state.												
Objective 4.1 Reassess standards of care for at least the five most highly utilized/funded categories in the state.												
Action Plan	Quarter 1 2026 – 2027			Quarter 2 2026 – 2027			Quarter 3 2026 – 2027			Quarter 4 2026 – 2027		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec
4.1.1. Each grant year, implement and monitor performance measures as determined by the state RWHAP Part B CQM program.												
4.1.2. Timely submission of RW Services Report (RSR) data for use in performance measurement of the RWHAP Part B CQM Program to FDOH. At a minimum, subrecipients funded for all services must be entered												
4.1.3. Review performance data quarterly to identify clients that need additional support in staying in medical care or maintaining viral suppression.												
4.1.4. Each fiscal year participate in relevant capacity building and QI activities as directed by the RW Part B CQM Program.												
4.1.5. In coordination with the RWHAP Part B CQM Program, conduct QI projects.												

Goal 5: By March 31, 2027, Evaluate the extent to which the CQM program is meeting the identified program goals related to quality improvement planning, priorities, and implementation.												
Objective 5.1 Conduct annual evaluation of the CQM Program.												
Action Plan	Quarter 1 2026 – 2027			Quarter 2 2026 – 2027			Quarter 3 2026 – 2027			Quarter 4 2026 – 2027		
	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec

<p>5.1.1 Implement NQC Organization Assessment Tool for RWHAP Part A-D recipients to evaluate the CQM Program`s infrastructure, activities, processes, and systems.</p>												
<p>5.1.2 Implement annual status report based on the findings of monitoring and evaluation detailed in work plan to ensure the CQM program continues to respond to identified goals and activities.</p>												

Capacity Building

The CQM Committee will coordinate webinars and training opportunities on quality management for CQM staff, committees, lead agencies, and subrecipients. Local/Area CQM staff members responsibilities include:

- Conducting monthly check-ins with each lead agency via phone or email.
- Providing technical assistance to lead agencies as needed monthly or quarterly.
- Updating the supervisor quarterly on lead agency progress with CQM implementation.
- Analyzing lead agency performance measure data quarterly.
- Reviewing data analysis with lead agency personnel quarterly to assess if adjustments are needed to meet target measures.
- Collaborating with lead agencies to identify potential quality improvement (QI) projects.
- Developing a fundamental understanding of CAREWare and its performance measure module.
- Participating in the CQM Committee.
- Assisting Community-Based Organization (CBO) lead agencies in developing an annual CQM plan.

Training materials and resources from the Center for Quality Improvement and Innovation (CQII) and the Institute for Healthcare Improvement will be utilized as appropriate.

Evaluation of CQM Program

The CQM Committee will conduct an annual evaluation of the CQM Program using the Center for Quality Improvement and Innovation’s (CQII) Organizational Assessment Tool for Ryan White HIV/AIDS Program-funded Part B recipients.

Additionally, the CQM plan will be assessed using the Clinical Quality Management Plan Evaluation, a CQII-based assessment tool.

SECTION 3: Data Sources

AIDS Drug Assistance Program (ADAP)

ADAP maintains a database as a centralized client and program data repository. Data is collected from the system to analyze the ADAP performance measure, Viral Load Suppression. ADAP contracts with a pharmacy benefits managers (PBMs) and coordinates with pharmacies to dispense ADAP formulary medications to eligible clients. The PBMs use proprietary systems for all ADAP-related data collection and reporting. The PBMs are required to submit dispense data to the ADAP database. Medication pick-up reporting can then be run by county, area, or statewide. This report supports adherence activities related to retention in care and supports viral load suppression.

CAREWare System

All Florida RW Part B providers either manually enter or import their data into CAREWare, a centralized HIV client management and service tracking system. Providers funded by other RW parts or HOPWA in Florida also use CAREWare. CAREWare provides a comprehensive data infrastructure for program reporting and monitoring. Reports generated from CAREWare are used to guide program planning, improve service delivery, evaluate provider/contractor performance, and comply with HRSA reporting requirements for HAB Performance Measures and the RW Services Report (RSR). The Section currently uses CAREWare to measure and report on CQM and contract compliance indicators.

Chart Reviews

Client chart reviews may be conducted as needed to inform CQM activities.

Florida RW Portal

The Florida RW Portal serves as an internal, secure, and scalable centralized eligibility system designed for individuals with HIV, specifically utilized by Ryan White providers. The portal plays a pivotal role in collecting essential data to analyze supportive service performance measures, aiding in program planning, enhancing service delivery, evaluating provider/contractor performance, and ensuring compliance with HRSA (Health Resources and Services Administration) reporting requirements.

This application is designed to streamline contract and case management processes, enabling users to efficiently manage and monitor client services. The application will have two key modules: Contract Management and Case Management, which will be integrated to ensure seamless operations for service delivery to clients.

Modules

Contract Management Module (RW Contracts)

This module is dedicated to managing and storing RW contracts, where users can input details related to contractual agreements between the organization and the client.

Case Management Module

This module is for managing the cases associated with service delivery to clients. Each case will be associated with a RW contract and QlikSense will be used to track the progress and completion of services promised within those contracts.

The system will have a Performance Measure feature that will track and provide detailed insights into client services. This will be based on data from the Contract and Case Management modules and will include the following key functions:

Client Analysis

The application will analyze client data (e.g., services delivered, satisfaction metrics, contract compliance) to assess client performance over time.

An eligible client is an individual that meets the specific qualifications or requirements to receive services, or benefits that are funded by the Ryan White Part B programs.

Reports and dashboards will be available to provide users with actionable insights on client behavior, service history, and outcomes.

Allocated Amount Tracking

The performance measure module will link service performance to allocated amounts for each client.

This feature will help track how well services are being delivered relative to the allocated budget or service costs in the contract.

Performance Measures

Performance Item Codes: These are specific elements tied to contract performance that will be tracked and measured in the new system. The codes might be related to service milestones, deliverable completion, or client satisfaction metrics.

This enhanced system aims to improve both service delivery and performance tracking by bringing all relevant data into a unified platform for better decision-making, client management, and internal operations.

Data Communication

The HIV/AIDS Section uses Advanced Reporting tool Qlik Sense to generate

Dashboard from CAREWare data to highlight subrecipients' programmatic and CQM data. Liaisons will generate and distribute these profiles quarterly to assist subrecipients with identifying areas for program improvement and resolving data issues. These reports will be reviewed with subrecipients at the annual monitoring site visits.

This dashboard will be an essential tool for monitoring the effectiveness and efficiency of services provided to clients. By focusing on high-usage items, integrating detailed client information, offering flexibility in reporting periods, and tracking disparities, the dashboard will allow for comprehensive performance monitoring. The data validation mechanisms ensure that the information is accurate and meaningful, while the trend monitoring and disparity tracking will help guide improvements in service delivery.

The goal of this dashboard is to provide a more comprehensive and user-friendly view of client data, not just focusing on numerical figures, but also integrating detailed client-specific information. The purpose of this enhanced dashboard is to allow stakeholders to track and monitor both the overall performance and service utilization in a much more granular and informative way.

Key Features and Functionality

Detailed Client Information

The advanced dashboard will go beyond the basic numerators and denominators traditionally shown in the original version. Instead of just raw numbers, it will display detailed information such as:

Client Names

Each client included in the report.

URN (Unique Reference Number)

To easily identify and cross-check client details.

Additional Client Information

Such as service dates, specific interventions received, and any other relevant client data.

This information will not only provide a clearer picture of who the clients are but will also help verify that the data validation checks are properly satisfied. The goal is to ensure that the dashboard is as transparent and accurate as possible.

Performance Measures Inclusion Criteria

The data dashboard more focused and relevant, we will only include performance measures for those items that show higher service utilization rates. The inclusion of each performance measure will be governed by the Utilization Report.

If the utilization rate is less than 15% , no performance measures will be included for that item.
For a utilization rate between 15%-50% , only one item code related to the performance measure will be selected.
If the utilization rate is above 50% , two or more item codes will be chosen for performance measures, giving a broader picture of high-use services.
This approach ensures that the dashboard is focused on areas that are being actively utilized and where there is a strong data-driven basis for inclusion.

Quarterly Data Inclusion

Once the initial version of the dashboard is built and tested by area users, the next step will be to incorporate Quarterly Data. This will provide insights over different time spans.

Standard Quarterly Data

Data for a 3-month period and aligning data with traditional fiscal quarters.

Rolling 12-Month Data

There will also be an option to run the report on a quarterly basis, but instead of just the past 3 months, this option will provide data from the previous 12 months for each selected quarter. This feature offers a broader perspective of trends over a longer period.

Tracking Disparities

A key aspect of the dashboard is the ability to track and monitor disparities in the data based on age, sex, and race/ethnicity. By incorporating this information, the dashboard will highlight whether there are any significant variations or gaps in service provision or performance measures among different demographic groups. This will allow decision-makers to address any inequities in service delivery.

The system will automatically calculate and present disparities in the performance measures, which can then be further explored using the visual tools integrated into the dashboard.

Data Visualization and Trend Monitoring

To make the data actionable and easily interpretable, a chart will be included to visually monitor and track trends over time.

Performance measures trends over the selected periods (quarterly, rolling 12 months, etc.).

Disparities trends for different demographic groups, so that users can monitor how well different populations are being served and whether certain disparities are increasing or decreasing.

This visualization will provide a clear, easy-to-understand view of the data, making it simpler for stakeholders to make informed decisions based on the trends.

External communications with stakeholders will occur through presentations and updates to the FCPN, monthly updates bulletins, and updates to the local planning council.

Performance Measures

The CQM Committee will review and analyze data on any chosen performance measure quarterly. The indicators and goals were chosen to align with HRSA HIV/AIDS Bureau (HAB) performance measures, National HIV Strategy goals, and Florida's Integrated Plan for 2022-2026. The measurement year is the calendar year (January 1 to December 31).

Table 3: HIV Care Program Performance Measures by Service Category

The CQM Committee has identified the following indicators as appropriate measures for each of the service categories. The indicators are defined the same way as the general program indicator but are restricted to clients who have received the identified service. Data points for both the numerator and denominator, specific to the Ryan White Part B programs, will be provided by Health Resources and Services Administration (HRSA). These values will be used to calculate the percentage, which will then be compared against the established target goal.

SERVICE CATEGORY	CRITERIA/INDICATORS	2026	2027	2028	2029	2030 Target
ADAP Clients	Percentage of ADAP Clients with Some Sort of Insurance					60%
	HIV Viral Load Suppression					90%
	Prescription of ART					100%
	Adherence to ART Treatment					91%
ADAP Insured Clients	HIV Viral Load Suppression					97%
	Prescription of HIV ART					95%
	Adherence to ART Treatment					90%
	Marketplace Insurance Retention					90%
ADAP Uninsured Clients	HIV Viral Load Suppression					90%
	Prescription of ART					100%
	Adherence to ART Treatment					90%
Ambulatory/Out patient	Percentage of Patients on ART					95%
	Medical Visits					80%
	Gap in HIV Medical Visits					15%
	Viral Load Suppression					90%

Case Management (Medical)	Frequency of Medical Case Management Client Contact					70%
Case Management (Non-Medical)	Timeliness of Eligibility Completion					50%
Food Bank/Home Delivered Meals	Frequency of Food Bank Service					60%
Health Insurance Premium/Cost Sharing	Health Insurance Services Patients Receiving 3 or Fewer Premium Payments					99%
Local Pharmaceutical Assistance (LPAP)	LPAP Services Patients Prescribed ART					85%
Medical Transportation	Medical Visits					55%
Oral Health Service	Preventative Oral Health Service					80%
Referral for Health Care/ Supportive Service	Linkage to Care					60%
Emergency Financial Assistance	Emergency Financial Assistance Patients Receiving 3 or More Medication Services					30%
Home Health Care	Viral Load Suppression					25%
Medical Nutrition Therapy	Medical Visits					75%
Mental Health Services	Medical Visits					50%
Housing Services	Housing Services Patients Receiving 3 or More Rental or Utility Assistance Services					80%

HRSA CQM Benchmark Measures

The HRSA Clinical Quality Measures is the standard measure process for the Florida Department of Health. FDOH strive continuously to improve each area to meet HRSA service category target goal standards.

Annual CQM Benchmark Measures

The Annual Clinical Quality Measures is part of the FDOH State office measures process. This will be in a form of continuous improvement document and working with the area to make yearly increase towards a service category that may needs improvement for the HRSA standards.

Quality Improvement Projects

The CQM Program seeks to use performance measure results to identify and implement needed QI projects aimed at improving patient care, health outcomes, and patient satisfaction. The CQM Committee will select and prioritize RW Part B activities for QI projects for at least one funded service category at any given time. Refer to **Figure 1** for the process of determining Ryan White Part B quality improvement projects.

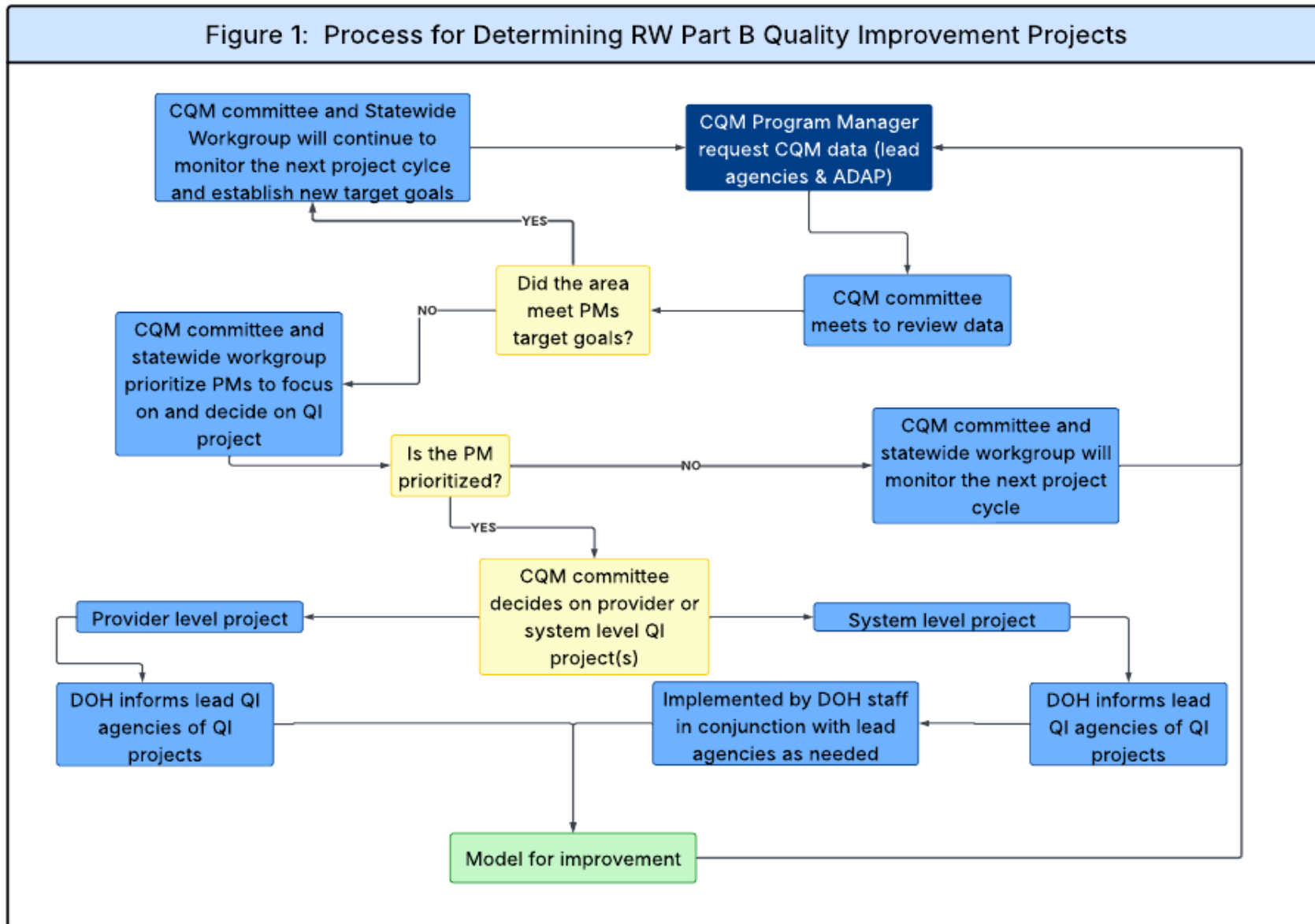


Figure 2: Quality Project Storyboard Template



Florida Department of Health in <insert county name> County
Quality Improvement (QI) Project Title: <XXXXX>
Project Start and End Date: <Month/Year – Month/Year>

PLAN	<p>TEAM LEAD CONTACT: Name: XXX Phone Number: XXX Email Address: XXX</p>	DO	<p>IMPROVEMENT ACTION STEPS: <Insert a list of improvement action steps (i.e., potential solutions).></p>
	<p>PROBLEM STATEMENT: <Insert description of the issue that has been identified.></p>		<p>SELECTION OF SOLUTION FOR IMPLEMENTATION: <Insert a description of the process to prioritize which solution is best to address the issue.></p>
	<p>AIM STATEMENT: <Insert team's desired outcome using <u>SMART criteria</u> (specific, measurable, achievable, relevant, and time-oriented).></p>		<p>RESULTS: <Insert a description of QI project outcomes, including progress toward the measurable objective(s) established in the AIM statement.> <Insert a chart/graph that illustrates progress toward meeting the measurable objective established in the AIM statement.></p>
	<p>CURRENT PROCESS: <Insert a description of how the current process works and identify the potential issue(s) or opportunity for improvement.> <Optional: Insert a visual e.g., flowchart/process map that documents how the process is currently operating.></p>	CHECK	<p>EXAMPLE:</p>
	<p>ROOT CAUSE ANALYSIS: <Insert an explanation of the core issue that ultimately led to the problem.> <Insert QI tool that depicts root causes and factors that contribute to the issue under review.></p>	ACT	<p>LESSONS LEARNED: <Insert a brief explanation of key takeaways throughout the project.></p>
<p>EXAMPLE:</p>	<p>NEXT STEPS: <Insert a description of the steps the team will take to continue moving forward in the process to ensure the project is a success. The description must explicitly state whether the project was adopted, adapted, or abandoned. Additionally, please indicate if the project resulted in the identification of a potential best practice that will be submitted to your performance management council for review.></p>		

Monitoring of Lead Agency (Subrecipient) QI Projects

Once the CQM Committee prioritizes activities for QI projects, CQM staff will communicate these decisions to subrecipients. Subrecipients that do not meet established benchmarks will be expected to participate in focused technical assistance webinars and then implement at least one QI project to improve the performance measure for the prioritized activity. The CQM Committee will meet quarterly to review subrecipients' data and progress in improving the performance measures.

For subrecipients who are not able to improve after the focused technical assistance webinars and implementation of the QI project, CQM staff will follow up and provide individualized technical assistance. Subrecipients will have an opportunity to provide detailed descriptions of their QI projects in the semiannual progress reports. CQM staff will follow up and provide feedback and technical assistance as needed.

SECTION 4: Methodology

PDSA or PDCA Model

Plan-Do-Study-Act or Plan-Do-Check-Act is a tool use to plan and document progress with tests of change conducted as part of chartered performance improvement (PIPs). While the charter will have clearly established the goals, scope, timing, milestones, and team roles and responsibilities for a project, the PIP team asked to carry out the project will need to determine how to complete the work. This tool should be completed by the manager or coordinator with review and input by the project team. A PIP will usually involve multiple PDSA or PDCA cycles in order to achieve your aim. Refer to **Figure 2** for a detailed view of the storyboard template, which provides a more comprehensive breakdown of the PDCA process.



Process to Update CQM Plan

CQM staff will create a draft revision, if necessary, of the CQM plan. This draft will be circulated for input among the CQM Committee, FCPN members, and any other identified stakeholders. The final revision will be approved and released. The CQM plan is evaluated annually using the Clinical Quality Management Plan Evaluation, an CQII-based assessment tool. The FCPN Statewide QM Advisory and Executive committees will review evaluation results to identify strengths, opportunities for improvement, and lessons learned for the year.

Feedback

Any questions or feedback concerning this plan should be communicated to DOH RW Part B CQM staff at 850-245-4973 or FLHIVCQMSupport@flhealth.gov.

APPENDIX: Key Terms

Action Plan: Specific steps intended to impact short- and long-term strategic objectives. Action plans include the details of who, what, when, and how. Action planning reduces the objective to achievable, measurable steps. Action steps drive toward an objective. Objectives, in turn, drive toward a goal.

Analysis: The examination of facts and data to provide a basis for effective decision making. Analysis often looks at a cause-effect relationship.

Baseline: The current condition that exists in a situation or representation (model) of a situation. Baselines are usually used to differentiate between a current and a future representation.

Benchmarks: Accepted industry standards. Benchmarks are often used as comparative data points for below average, average, or above average performance.

Capacity Building: Training and development of human resources. Capacity building encompasses human, scientific, technological, organizational, and institutional resource capabilities. It seeks to equip individuals with understanding, skills, and access to information, knowledge, and training that enables them to participate and contribute effectively.

Center for Quality Improvement and Innovation's (CQII) Organizational

Assessment Tool: An organization that offers leadership, technical assistance, tools, and research to drive systematic improvements in the quality and safety of services while enhancing outcomes.

Champion/Sponsor: Acts as a resource to remove barriers and helps expedite changes made during a project.

Customer: Actual and potential users or beneficiaries of the products or services of the organization. Customers also include stakeholders and partners.

Data: Information, statistics, facts, figures, and/or numbers that inform decision making and the establishment of objectives. Data is also used to quantify performance levels.

Deployment: The depth and breadth at which actions are carried out to meet the strategic objective.

Evaluation: The structured interpretation and giving of meaning to predicted or actual impacts of proposals or results. Evaluation is looking at original objectives and at what

is either predicted to be accomplished or what was accomplished and how and then making a judgment about the treatment, amount, number, or value of something.

Facilitator: Guides and teaches the quality improvement processes before, during, and after an event.

Goal: A future condition or performance level the organization intends to achieve. Goals are ending that guide objectives and action steps and can be short- or long-term. Long-term goals are referred to as “strategic,” “breakthrough,” or “key.”

Integration: The harmonization or synchronization of plans, processes, decisions, actions, communications, and results with key or strategic goals. Integration is achieved when individual units or sections act to support key goals.

Indicator/Measure: Numerical information or data that quantifies input, output, performance, and outcomes. Indicators can be simple (referring to one action) or composite.

Leadership: How direction, guidance, and support are exercised, formally and informally, to carry out and accomplish strategic goals. It is the basis for how key decisions are made, communicated, and carried out. Leadership sets high but achievable performance expectations; models values, ethical behavior, and teamwork; and creates opportunities for future leadership development. The leadership team develops the culture of continuous self-assessment and quality improvement.

Measure/Indicator: Numerical information or data that quantifies input, output, performance, and outcomes. Measures can be simple (referring to one action) or composite.

Mission: The organization’s overall function or purpose. The mission states the intended accomplishment of the organization.

Objective: An organization’s desired accomplishment. Objectives can be short- or long-term. Long-term objectives are referred to as “strategic objectives.” Action steps drive toward an objective. Objectives, in turn, drive toward a goal. A strategic objective is a significant and necessary step in accomplishing a goal.

Outcome: Intended or achieved results. The intended results can be referred to as the ultimate outcome.

Performance: Outcomes resulting from processes, services, or work relative to the stated objective or goal. Performance is quantifiable and stated in measurable terms. “Operational performance” refers to human resources, Leadership, and organizational and ethical performance relative to effectiveness, efficiency, and accountability. “Performance excellence” often refers to a culture within the workplace that routinely

looks for opportunities for individual and organizational improvement.

Plan-Do-Study-Act (PDSA) Cycle: A widely used framework for testing change on a small scale, where information is analyzed to identify areas that hold the opportunity for change. The change is tested on a small scale; the results of that test are analyzed with the potential outcomes; the change is adopted on a wider scale or is abandoned; and the PDSA cycle begins again.

Process: A set of linked activities with the purpose of producing a product, service, or outcome. Processes may involve people, machines, tools, techniques, and materials in a sequence of defined steps. Process may also include a general understanding of reaching a desired end.

Quality: The degree to which a health or social service meets or exceeds established professional standards and user expectations. Evaluation of the quality of care should consider the quality of the inputs, the quality of the service delivery process, and quality-of-life outcomes.

Quality Assurance: A broad spectrum of continuous evaluation activities designed to ensure compliance with minimum quality standards.

Quality Culture: A set of values that guide improvements to working practices and outputs for a group. A mature culture of quality is exhibited by an agency where quality improvement (QI) is fully embedded into the way business is done across all levels. Leadership and staff are fully committed to quality, and the results of QI efforts are communicated internally and externally to all stakeholders. Even if leadership changes, the basics of QI are so ingrained in staff that root causes of problems are always identified. Sustainability of a quality culture throughout change is reflective of a strong quality culture.

Quality Improvement: The ongoing monitoring, evaluation, and improvement process. It includes a client-driven philosophy and process that focuses on preventing problems and maximizing quality of care or services.

Quality Management: The integration of quality throughout an organization or agency. Quality management is a larger concept than quality, encompassing continuous quality improvement activities and the management of systems that foster such activities: communication, education, and commitment of resources. The quality management program embraces both quality assurance and quality improvement in an interdisciplinary, collaborative way.

Quality Management Program (QMP): A system incorporated into a programs or agency's existing structure that reflects program- or agency-wide goals and objectives. The QMP incorporates quality improvement principles, tools, and techniques into the day-to-day culture and operations of the organization. The QMP provides an effective method to evaluate its performance and promotes a coordinated approach to problem

solving.

Results: The measurable outputs and outcomes achieved. Results are used to inform next steps in planning.

SMART Goal Framework: Developing objectives Specific, Measurable, Achievable, Relevant, and Timely.

Sponsor/Champion: Acts as a resource to remove barriers and helps expedite changes made during a project.

Stakeholders: Individuals or organizations that might be affected by actions or successes. Stakeholders include employees, customers, partners, and policy makers.

Sustainability: An organization's ability to meet current customer and stakeholder needs while preparing to meet future needs. Sustainability involves proactive visioning and planning.

Targets: Realistic and achievable goals or objectives. They can be short-term or long-term.