Quality Management Program

Ryan White Program – Miami-Dade County

Ryan White Part A/MAI Program

Miami-Dade County

CLINICAL QUALITY MANAGEMENT PLAN

FY 2018-2019

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I. INTRODUCTION

I.A LEGISLATIVE AND CONDITION OF AWARD REQUIREMENTS

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

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

I.B DEFINITION OF QUALITY

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

I.C COORDINATION WITH NATIONAL HIV/AIDS STRATEGY

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

I.D CQM AIM AND PRIORITIES

The overall mission of the Miami EMA CQM Plan is to coordinate the client care activities of the subrecipients funded by the local Ryan White Part A and Minority AIDS Initiative (MAI) Program to improve the quality of client care, improve health outcomes for the clients in care, and improve client satisfaction with the services received. The work of this Plan is **directed by** the Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program (the Recipient) and **implemented by** Behavioral Science Research Corporation (BSR), the contracted CQM subrecipient currently serving as the executor of the Recipient's vision. Various

consumers and stakeholders are involved in the local CQM process along with the Recipient and the contracted CQM subrecipient.

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

This is no simple task, as the Miami-Dade County's Ryan White Part A/MAI service delivery system is large and complex. The local Ryan White Part A/MAI Program served 9,883 PLWHA in Fiscal Year (FY) 2017-18, through a decentralized network of 14 subrecipient organizations employing hundreds of service providers at several locations throughout the Miami-Dade EMA. A substantial number of the Ryan White Part A/MAI Program (RWP) client base receives a full spectrum of services directly from the RWP; others receive a more limited set of services, either because the RWP has transitioned medical care support to Affordable Care Act (ACA) Marketplace medical providers for some 1,700 PLWHA clients; or because changes in the State of Florida's Medicaid program have resulted in changes in the mix of services provided through Medicaid and the RWP for an additional 2,446 RWP clients. An additional pending change in Medicaid's oral health care service benefits in FY 2018-19 will further complicate RWP service planning and delivery while ensuring the RWP is the payer of last resort.

In order to focus RWP CQM activities, the CQM plan has several key guiding priorities:

- The evaluation of service quality and the improvement of service processes is fundamentally driven by the over-arching goal of improving client health outcomes. Specifically, every effort is made to improve the performance of the RWP Part A/MAI system of care by improving the performance of individual subrecipients in two major arenas: ***retention in care,*** and ***reduction in viral loads (VL).*** If a measurement activity or process improvement is not ultimately directed toward either of these two outcomes, it does not belong in this CQM plan.

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

- PLWHA and stakeholder involvement is a priority in the CQM process. This is articulated in the CQM plan by increasing the level of stakeholder and PLWHA involvement (e.g., more members; enhanced, active participation in CQM discussions; implementation and evaluation of CQM activities; etc.) in the CQM Committee (see discussion, below); as well as by holding quarterly Integrated Plan review meetings with subrecipient and PLWHA stakeholders from the FDOH-MDC Prevention Committee and the RWP Strategic Planning committee, quarterly Subrecipient Forums at which CQM findings and implications are reviewed and improvement strategies are discussed, and an active Part A / FDOH-MDC linkage workgroup that brings testing, outreach and medical case management personnel together on a monthly basis to identify quality improvement opportunities in the linkage to care process.

- PLWHA receiving services from any RWP-funded subrecipient agency or direct service provider -- even if the services provided to the client are less than the full range of RWP services available -- are entitled to the same high quality of care as RWP clients who are eligible for and receiving all necessary core medical and support services through the RWP. For example, although ACA enrollment transitioned 1,700 clients from the RWP to the Health Insurance Marketplace in 2017-18, thereby removing these clients from RWP-funded Outpatient/Ambulatory Health Services and Local Pharmaceutical Assistance Program services, these clients are still receiving Medical Case Management, Mental Health Services, and Oral Health Care through the RWP. The RWP CQM concerns with retention in care and VL suppression are as compelling for these clients as they are for clients who are receiving a full range of services through the RWP.

The Miami-Dade County CQM Program plan is defined below and addresses: (1) Infrastructure, with Quality Improvement Activities; and (2) Performance Measurement.

II. INFRASTRUCTURE

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

II.A LEADERSHIP AND ACCOUNTABILITY (guide, endorse, and champion the CQM program)

II.A.1 Activities and direction from the Ryan White Part A/MAI Program Recipient

The RWP Recipient is Miami-Dade County, overseeing the Ryan White Program through the Office of Management and Budget-Grants Coordination/Ryan White Program. The Recipient provides leadership and oversight of CQM activities, ensures system-wide programmatic compliance with County and HRSA requirements, encourages adherence to service and quality standards of care, and enforces compliance with CQM performance measures and quality improvement activities. Ultimately, the Recipient is accountable for the development,

implementation, and evaluation of the local CQM Program. However, this cannot be accomplished based on Recipient staffing resources alone.

Working hand–in-hand with BSR and the CQM Committee, the Recipient staff oversees BSR's CQM work and provides guidance and oversight in implementing CQM improvements identified in BSR's research. While BSR and the CQM Committee may conduct research evaluations and design and recommend CQM improvements in the management of services to PLWHA, the Recipient has the sole power to enforce changes in subrecipient activity based on these data, as per requirements stated in the corresponding Professional Service Agreements (contracts) with RWP-funded subrecipients. The CQM plan -- along with review of data, improvement activities, and evaluation results -- is also communicated among various stakeholders and the Miami-Dade HIV/AIDS Partnership (Partnership), the local HIV planning council, to ensure a coordinated and community-wide understanding of the jurisdiction's level of quality in and satisfaction with the HIV service delivery system, barriers affecting retention in care and VL suppression, and recommendations to improve the system of care.

II.B CQM COMMITTEE

II.B.1 Structure and Role of the CQM Committee

In FY 2018-19, the existing Performance Improvement Advisory Team (PIAT) will undergo a restructuring and expansion to become the Clinical Quality Management Committee (CQM Committee), in accordance with HRSA's CQM recommendations and requirements per Policy Notice #15-02. This will involve broadening the invited membership of the PIAT/CQM Committee to include additional stakeholders and PLWHA, and more firmly establishing the CQM Committee as a working quality improvement resource for the Recipient, BSR, and the RWP as a whole. As of this CQM update, the CQM Committee is addressing its expanded composition: provisionally, the committee membership will be expanded by seven (7) new members, as shown in the table below.

Expanded Membership Composition of the CQM Committee (under discussion by the Committee)		
	Existing PIAT	**Restructured CQM Committee**
RWP Recipient	1	1
BSR CQM senior staff	3	2
Part A MCM/MCM Supervisors	2	2
Part A Subrecipient CQM personnel	3	3
FDOH-MDC (Test and Treat/Rapid Access)	1	1
Part C	1	1
Part D	1	1
Part A Linkage to Care Outreach Worker	1	2
Persons Living With HIV/AIDS (PLWHA)	1	3
Part A MD/PA/ARNP provider	0	1
Part A Subrecipient Program Administrator	0	1
Part A Pharmacy provider	0	1
ADAP Program Administrator	0	1
Non-Part A CQM/Evaluation practitioner	0	1
TOTAL	**14**	**21**

Meeting on a monthly basis, the CQM Committee functions as a quality improvement conduit to and from the subrecipient community, as well as the community of RWP consumers. As was the case with the former PIAT, the CQM Committee does not operate under the purview of the Partnership, but is an independent CQM review and advisory group, making recommendations by consensus and enlisting discussion and recommendations from a broad spectrum of subrecipient representatives, non-Part A/MAI providers, FDOH-MDC representatives and community stakeholders and interested parties. While the composition of the CQM Committee is being broadened, the committee itself is not a closed group with membership limitations and distinctions between voting members and non-voting members.

The CQM Committee acts as an internal check assessing the effectiveness of CQM activities and outcomes as implemented by BSR staff, subrecipients, and the Recipient (see Evaluation section, below). Overall, CQM-generated improvement activities are designed to improve access to care, retention in care, and reduction in viral loads for PLWHA, including improved linkages among care providers in key points of entry, reduction in barriers affecting access to care, seamless provision of clinical services that are in line with current PHS guidelines for the treatment of HIV and related opportunistic infections, elimination of disparities in clinical outcomes, and increasing client satisfaction with services received. As service deficiencies and client dissatisfactions are uncovered by BSR's CQM research, the CQM Committee will provide insights into potential training and staff development resources to help shape and guide capacity building efforts.

II.C DEDICATED STAFFING (responsible for CQM duties and resources)

II.C.1 Oversight of the CQM Plan (Recipient)

Oversight of the CQM Plan rests with the Recipient. A portion of the time and effort of the Recipient's Program Director (OMB Assistant Director), Program Administrator, and Fiscal Administrator is allocated to conduct this oversight as part of Recipient Administration duties; not under CQM funding. The Program Administrator also participates in regular CQM Committee meetings and activities.

II.C.2 Implementation of the CQM Plan [Contracted Subrecipient; Behavioral Science Research Corporation (BSR)]

BSR is tasked with evaluating the capacity and performance of subrecipient providers in delivering clinical care to the PLWHA in the Miami-Dade RWP, and working with the subrecipients to improve the quality of that care. BSR recognizes that it is not responsible for testing, evaluating, or enforcing compliance with subrecipient operating standards, which lie under the purview of the Recipient, but is responsible for creating and implementing systems of data collection from subrecipients, reviewing and analyzing data from the Service Delivery Information System (SDIS), creating analytical frameworks for applying the data to identification of shortfalls in the quality of care, and providing a continual flow of service quality information to the CQM Committee, the Recipient, the FDOH-MDC as the principal non-RWP stakeholder, the Partnership's Prevention, Care and Treatment, and Strategic Planning Committees, and the joint FDOH-MDC/Part A Integrated Plan review committee.

BSR's dedicated CQM staffing in FY 2018 consists of 4.6 FTE, as shown in the table below, including both Part A and MAI. The BSR direct service staff is supplemented by South Florida – Southeast AIDS Education and Training Center (SF-SEAETC) clinical record reviewers (see II.D, below), extramural consultants and subject matter experts, part-time research assistants, client satisfaction interviewers, and other clerical personnel, as needed to complete the tasks outlined in the CQM Program plan.

The responsibilities of BSR's CQM direct service staff appear after the table directly below.

Position/Role	BSR Personnel	% of Time in CQM (Part A & MAI combined)
Project Director	Robert Ladner, PhD	70%
Director of Research	Petra Brock-Getz, MS	95%
CQM Coordinator/Lead Trainer	Sandra Sergi, CCM	100%
CQM Coordinator/Linkage Facilitator	Susy Martinez, MSW	100%
CQM Research Assistant	Kevin Otway	100%

The Project Director, Dr. Robert Ladner, PhD, is responsible for overall management of all CQM processes, with particular emphasis on primary and secondary CQM research functions. He is responsible for administrative/financial decisions for the CQM project, with approval from the Recipient in accordance with the contract. Dr. Ladner works closely with the FDOH-MDC to improve linkages to care by strengthening the integration of HIV/AIDS prevention and testing activities of the FDOH-MDC with the activities of the RWP Outreach Workers and Medical Case Managers, and works with the Recipient and the ADAP in facilitating access to mainstream medical care through the enrollment of RWP clients into the ACA Health Insurance Marketplace. Along with the Director of Research, Dr. Ladner occupies a designated seat on the CQM Committee. Dr. Ladner has been working in service quality improvement processes since 1981, when he underwent training by the Japanese Union of Scientists and Engineers (JUSE) as part of a Deming Award evaluation and corporate development process, and in CQM evaluation processes in the RWP since 1991.

The Director of Research. Petra Brock-Getz, M.S., oversees the data collection and analysis associated with monitoring subrecipient performance in the QM performance measures (see attached direct service subrecipient contract excerpt: Exhibit A, Client-level Outcomes/Performance Measures) and the HIV Care Continuum Indicators (see below), and generates reports and data summaries for the Recipient, the CQM Committee, the Integrated Plan review team, and the Partnership. Her activities include producing the quarterly CQM Performance Report Card (see Section III, below); designing and implementing the annual RWP Client Satisfaction Survey; generating periodic client-centered reports (many of which are used to monitor RWP progress within the Integrated Plan); conducting the annual Service Utilization Analysis for the Needs Assessment process; generating the Program Outcome/Performance Measures Reports for the Recipient, and the CQM Committee, and generating other supplemental data reports as needed by the Project Director, the Recipient, the CQM Committee, various stakeholders, and stakeholder committees in order to improve engagement in care, retention in care, and reductions in VL among PLWHA residing in the RWP. These various reports and their timetables are outlined in more detail in Section II.E.2, following. Ms. Brock-Getz has worked at BSR as principal data analyst and research manager on health

systems projects and RWP CQM since 1992.

The CQM Coordinator/Lead Trainer, Sandra Sergi, CCM (Certified Case Manager), has three important CQM functions. In conjunction with the Project Director, Director of Research, and the CQM Coordinator/Linkage Facilitator, she prioritizes service quality areas where subrecipient clinical outcomes and service delivery performance are below standards, reviews corrective action plans provided by the subrecipients, and conducts on-site technical assistance visits to assist the subrecipients in improving service quality mechanisms. As the Lead Trainer, she coordinates training/capacity building activities for MCM. peer support personnel and supervisors (see Section II.E.5 below), to improve their clinical knowledge, improve case management and communication skills, identify reasons clients drop out of care or are non-adherent to ARV regimens; and works with these front-line care personnel to address those issues and potential barriers. She conducts the annual medical case manager proficiency examination to ensure that clients have same MCM service quality regardless of which subrecipient agency they use to enter care. She also serves as the active liaison with the SF-SEAETC to coordinate specialty trainings and clinical reviews for RWP-funded OAHS and OHC subrecipients. Each year, during the re-enrollment/new enrollment period for PLWHA eligible for coverage in ACA Marketplace health insurance plans funded under the RWP, she coordinates communications between and among subrecipient agencies, ADAP, the Recipient and PLWHA ACA enrollees to ensure that RWP clients are not lost to care in the transition from RWP OAHS to ACA-provided medical care (see CQM Support to the Recipient, II.E.6, below). Ms. Sergi provided HIV-related MCM and MCM supervisory services in Miami-Dade County for nine years before joining BSR as the lead CQM Coordinator and Lead Trainer in 2007.

The CQM Coordinator/Linkage Facilitator, Susy Martinez, MSW, has three important CQM functions. In conjunction with the Project Director, Director of Research, and the CQM Coordinator/Lead Trainer, she prioritizes service quality areas where subrecipient client outcomes or service delivery performance fall below standards, conducts on-site CQM technical assistance visits to assist the subrecipients in improving service quality and raising levels of RWP client outcomes, and reviews corrective action plans provided by the subrecipients to address quality deficiencies. As the Linkage Facilitator, Ms. Martinez spearheads the joint FDOH-MDC / RWP linkage workgroup that focuses on improving 30-day linkage to care rates, reducing VL levels, and connecting new clients in care. As an administrative function, she is the principal linkage process liaison between the RWP and FDOH-MDC, and serves as staff support to the CQM Committee. Ms. Martinez provided HIV-based direct services as an MCM for five years before joining BSR as a CQM Coordinator in 2008.

The CQM Research Assistant, Kevin Otway, assists the Project Director and Director of Research in data management of the Client Satisfaction Survey, the monthly Missing Viral Load report, and other CQM data analysis projects as needed.

II.D DEDICATED RESOURCES (for training and capacity building)

The Recipient and BSR have access to the following resources to assist in carrying out CQM activities, especially related to training subrecipients on current clinical guidelines for the treatment of HIV and related opportunistic infections:

- Research, data collection, data analysis, and training knowledge and experience of the existing, contracted BSR CQM staff noted above.

- Access to staff and clinical resources of the SF-SEAETC, housed within the University of Miami Miller School of Medicine (http://hivaidsinstitute.med.miami.edu/partners/se-aetc/South-FL-SE-AIDS-Education-and-Training-Center), to provide guidance on clinical guidelines, identify areas where improvement is needed among local clinical providers, provide technical assistance, and provide access to clinical training program webinars.

- Access to internet resources:

  - **HAB Performance Measures** – guidance on HRSA-approved performance measures (https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio):
    - Core
    - All Ages
    - Adolescent/Adult
    - Children
    - HIV-Exposed Children
    - Medical Case Management
    - Oral Health Care
    - AIDS Drug Assistance Program (ADAP)
    - Systems-Level

  - **National Guidelines Clearinghouse** - internet-based repository of Clinical Practice Guidelines (http://www.guideline.gov)

  - **HIV Medicine Association** – links to various Continuing Medical Education (CME) Resources (https://www.hivma.org/CME.aspx)

  - **National HIV Curriculum** – a free education web site from the University of Washington and the AETC National Coordinating Resource Center, with some modules offering CNE and CME credit (https://www.hiv.uw.edu/); topics include:
    - Basic HIV Primary Care
    - Antiretroviral Therapy
    - Co-Occurring Conditions
    - Prevention of HIV
    - Special Populations (modules coming soon for the following populations):
      - HIV in infants and children
      - Women and HIV
      - HIV and Corrections
      - HIV in Sexual and Gender Minority Populations
      - HIV in Adolescents and Young Adults
      - HIV in Older Adults
      - HIV in Racial and Ethnic Minority Populations
      - HIV-2 infection

  - **Southeast AIDS Education and Training Centers (SEAETC)** – Online Learning Curriculum (https://www.seaetc.com/modules/):

    - SEAETC online training in Medical Case Management and Cultural Competency is facilitated through BSR and is required for all new RWP hires in MCM and Outreach.

- A Practice Transformation Curriculum is made available to all RWP MCMs and Outreach workers.

- **Care Act Target Center** – online resources of standards, guidelines, best practices and related information (https://targethiv.org/) for:
  - Case Managers
  - Clinicians
  - Consumers
  - Program Managers & Administrators

- **National Quality Center – Quality Academy** - internet-based modular learning program on quality improvement, including theories, methodologies, real world examples, and tutorials (http://nationalqualitycenter.org/nqc-activities/qualityacademy/)

BSR also has the ability to subcontract with subject matter experts in a timely manner for additional clinical quality improvement needs that cannot be met using the staffing resources indicated above (cf. II.C.2, above). BSR staff also provides guidance to direct client service staff on how to access, understand, and use client-level performance reports in the local RWP's data management information system, the Service Delivery Information System (SDIS), for the benefit of improved service delivery.

II.E. CQM PLAN ACTIVITIES

II.E.1 Introduction

Activities performed by the contracted BSR CQM staff are organized into three major functional areas:

1) **Quality assurance/service improvement activities.** These include three elements:

A. Consistent with the goals of the National HIV/AIDS Strategy (NHAS 2020), the HIV Care Continuum, and program activities outlined in the Integrated Plan, monitoring RWP Part A/MAI client outcome and core performance indicators by individual subrecipients, by service categories, and by client characteristics, to provide recommendations to address client and subrecipient barriers impacting access to care, retention in care, adherence to antiretroviral medication regimens, viral load suppression rates, and disparities in clinical outcomes among minorities enrolled in the RWP. Because there are multiple background factors affecting client behavior statistics, BSR's CQM research in this area will necessarily go beyond the CQM Performance Report Card data outlined below in Section III. This monitoring includes analyses of viral load suppression rates, co-occurring conditions, risk factors related to HIV infection, linkage and retention in care rates, client demographics, and other client-based and system-wide variables, both in multivariate analyses and the subrecipient-based CQM Performance Report Cards. These analyses may be *scheduled periodic studies* (e.g., periodic missing viral load reports, client satisfaction reports, ACA enrollment reports) or may be targeted studies requested by the Recipient or the CQM Committee, based on

service quality or treatment outcome issues that surface during the course of subrecipient performance review or emergent issues in PLWHA client care. These reports are discussed in greater detail in Section II.E.2 below, as well as in the Performance Measurement section (Section III) following.

In addition, BSR CQM staff will provide support/guidance to subrecipients, medical providers, and other payer systems (Medicaid, private insurance, etc.) to ensure clients continue to have coordinated access to quality medical care and support services. For example, BSR CQM staff will work with the Recipient and Medicaid care coordinators to develop seamless referral processes for clients undergoing transition from the now defunct Medicaid Project AIDS Care (PAC) Waiver case management program to a Medicaid Managed Medical Assistance plan. BSR CQM staff will also to a, as well as those clients enrolling and transitioning into an Affordable Care Act (ACA) Marketplace health insurance plans during the annual enrollment period retain appropriate access to medical care.

B. Providing technical assistance (TA) for the remediation of identified service quality problems, including (but not limited to) targeted subrecipient record reviews related to subrecipient service delivery or client health outcome improvements, either as a direct BSR activity (using its staffing or subcontracted expertise or the dedicated resources indicated above in section II.D) or in conjunction with the South Florida – Southeast AIDS Education and Training Center (SF-SEAETC). These TA activities are discussed in greater detail in Section II.E.3, below.

C. Identifying best practices or quality improvement responses that can be replicated elsewhere in the RWP system. Quality improvement opportunities may be uncovered during BSR's TA visits, going beyond immediate problem-solving to pilot-test specific interventions as potentially replicable, or a subrecipient may present data on a potentially replicable best practice. These activities are necessarily subject to CQM contract and budgetary limitations and subrecipient constraints (see Section II.E.4, below).

2) **Training/capacity building.** These efforts aim to improve clinical health outcomes, improve viral suppression among RWP clients, and ultimately lower HIV transmission rates by providing ongoing training support to newly-hired and experienced Medical Case Managers (MCM), MCM Supervisors, peers and outreach workers. Training for medical providers is coordinated with the SF-SEAETC, as needs arise. This is discussed in greater detail in Section II.E.5, following.

II.E.2 Periodic Service Quality Monitoring Reports

The following reports are included as part of BSR's annual contractual CQM Scope of Work, for the purpose of monitoring quality of services and client health outcomes.

1) Ryan White Part A/MAI Program Client Satisfaction Survey

BSR will conduct an annual survey of Ryan White Part A/MAI Program clients actively enrolled in RWP Medical Case Management services for at least three months prior to the survey date, and produce and report quantitative descriptions of client satisfaction

with the following funded services: (A) Medical Case Management (MCM, including Treatment Adherence Services), (B) Outpatient/Ambulatory Health Services (OAHS), (C) Mental Health Services, (D) Oral Health Care, (E) Substance Abuse Outpatient Care; (F) Substance Abuse Services (Residential), (G) AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP) services, (H) AIDS Drug Assistance Program (ADAP) services, and (I) Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (Health Insurance Assistance) services including health premium assistance and wraparound services (e.g., copayments and deductibles). Note that in some cases, client satisfaction measures may be derived for service delivery categories that may not entirely be under the direct control of the RWP Part A/MAI system of care (e.g., satisfaction with Medical Case Management when the MCM services are provided by State of Florida General Revenue-funded case managers or Medicaid care coordinators, or satisfaction with pharmacy services when the client is accessing medications through ADAP pharmacy services), but these services are part of the overall HIV or RWP service network and are not always separable in the minds (or experiences) of the Part A/MAI program clients.

The interviews will be conducted in English, Spanish, or Créole. Basic demographic information, quality of life information, and history of HIV diagnosis and treatment questions are presented to the clients at the onset of the survey. Clients are advised that their answers will be kept completely anonymous and that none of their answers will disqualify them from receiving any services at any time during the clients' enrollment in the RWP in Miami-Dade County. A discrimination scale was recently added to the survey in hopes of developing a better understanding of whether client perceptions of discrimination towards them by others (including subrecipient service providers, community agencies, pharmacies and other arenas where the clients interface with treatment support personnel) affects their adherence to treatment and retention in care.

BSR's Director of Research will oversee the design, implementation, data analysis, and reporting of the survey. Statistical analyses will link client characteristics to treatment satisfaction, barriers to care, and other care-related issues to provide insights into service improvement measures and ways to improve client retention and treatment adherence. The results of the survey will be reviewed with the Recipient as well as the CQM Committee and other appropriate committees. Based on these reviews, opportunities for capacity building among RWP subrecipients to address low levels of client satisfaction will be identified. As stated above in the CQM Committee role section, the CQM Committee will work with BSR's QM staff to research and explore various training resources available to help shape and guide capacity building efforts.

The survey process will begin in March 2018 with data expected to be available by June 2018. At a minimum, preliminary data will be reported at the September 2018 Care and Treatment Committee Meeting. Completed data will be presented at the November 2018 Joint Integrated Plan meeting.

2) Periodic Client-Centered Reports

In grant FY 2017-2018, BSR began generating numerous client-centered data reports consistent with the 2017-2018 RWP Scope of Work and initial implementation of the Integrated Plan. BSR will continue generating these reports in FY 2018-2019; however, the scheduling of these reports (both in terms of frequency and presentation date) will be

predicated on Integrated Plan implementation deadlines ratified by the Strategic Planning Committee in March 2018. Reports to be provided to the Recipient, the CQM Committee, the Strategic Planning Committee, and the joint Integrated Plan Review Team will include:

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

- An annual evaluation of viral load (VL) suppression rates, including historical trends and subrecipient- and client-characteristic-related factors impacting VL, going beyond the quarterly subrecipient-based CQM Performance Report Card data outlined in Section III, below.

- A client-characteristic-related summary evaluation of clients with persistently unsuppressed (i.e., not suppressed in 12 consecutive months) VL levels, going beyond the monthly subrecipient performance-based tracking of MCM clients with persistent not suppressed VL levels to determine potential etiologic factors;

- An annual analysis of HIV-related co-occurring conditions and their impact on client treatment outcomes.

These reports provide a context for program planning, CQM measurement and overall trends in RWP program performance, and will be reviewed with the Recipient, the CQM Committee, the Integrated Plan Review Team and all appropriate Partnership committees.

3) “New Clients in Ryan White Program Care” Report

BSR CQM staff will generate new-to-care (i.e., new to the local RWP) reports on a monthly basis, subdivided by the subrecipient agency at which the new clients received their first Miami-Dade County Ryan White Part A or MAI Program-funded service. The reports will describe these new clients by risk factor, gender, age group, and viral load suppression rate. These reports will be distributed to the Recipient and subrecipients, as well as to the Partnership and its appropriate Committees. The new-to-care reports will be used to monitor changes in the risk factor profiles of new clients in the system, and to inform Partnership, the CQM team, and the Recipient of the risk factors of greatest frequency for purposes of planning and prioritizing services and funding allocations, as appropriate to the responsibilities of each entity, for the purpose of developing necessary interventions or programmatic changes.

4) Monthly Missing Viral Load Comparative Analysis Report

On a monthly basis, Automated Case Management Systems (ACMS), the Recipient’s data systems managers, generates a “Missing CD4/VL Analysis” report. This report tracks clients who received a billed RWP service during a specified time period (e.g., July 1, 2017 through February 5, 2018), but did not have a CD4 or VL entered into Service Delivery Information System (SDIS), the local RWP data management system, during

the same year. The data are reported by Medical Case Management site, and include the program's unique client identification (i.e., CIS) numbers and whether or not the client had a CD4 or viral test load result during the review period). The report only includes clients who are missing at least one of the two lab tests in the report period. The reports are provided to BSR CQM staff and to the subrecipients' Medical Case Management Supervisors for review and follow-up. BSR then merges the individual subrecipient reports and generate a monthly comparative report. The Missing Viral Load Comparative Analysis Report includes the overall missing VL data rates, total number of RWP clients per analysis, and the total number of missing VL data points. The comparative report will be sent un-blinded to the Recipient for review and blinded to all subrecipients. The report will also be used as a tool by the CQM team for the purpose of monitoring improvements in client health outcomes by agency and identifying areas where TA is needed to address client access to medical care and medications to achieve viral suppression (see Section II.E.3, below).

II.E.3 Technical Assistance and Record Reviews

1) Record Reviews

CQM record reviews are directed toward two major goals: (1) assuring the RWP Recipient and the CQM Committee of the clinical adequacy of medical services provided to program clients such that OAHS providers are adhering to Public Health Service primary care HIV treatment guidelines and local RWP Primary Medical Care Standards; and (2) assuring the RWP Recipient and the CQM Committee that RWP MCM providers are adhering to the local RWP standards of care in delivery of MCM services.

A. **Comprehensive OAHS record reviews.** All RWP subrecipient providers offering OAHS will be reviewed for adherence to PHS guidelines and the RWP primary medical care chart standards. Note that these standards are reviewed and approved by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee annually at a minimum (last updates approved in early FY 2018). Reviews will be conducted by SF–SEAETC clinical reviewers, scheduled such that all providers will be reviewed every two years. Providers will be prioritized for review based on the rates of unsuppressed VL lab results for the clients in care: VL data will be calculated for each clinical provider of OAHS, and provider agencies with the highest unsuppressed VL rates will be reviewed first.

B. **Targeted MCM record reviews.** Targeted MCM record reviews will be managed by BSR CQM staff when CQM Performance Report Card data indicate lower than average retention in care rates or VL suppression rates. The targeted MCM record reviews will verify problematic issues, determine the inflection points for a CQM intervention (e.g., adherence counseling, appropriate utilization of peer support, following up on cases where clients have persistent unsuppressed VL), and suggest corrective action Targeted reviews will also monitor existing services and assess client needs (e.g., tracking retention in care factors reported as barriers to care; identifying subrecipient-based barriers to care; and analyzing co-occurring conditions (acuities) among clients receiving medical case management services to address retention-in-care issues.

It is important to distinguish between record reviews as part of compliance audits (the responsibility of the Recipient) and record reviews for the purpose of identifying CQM service delivery improvement opportunities (the responsibility of BSR and the CQM Committee). The purpose of BSR and BSR/SF-SEAETC record reviews is to ensure compliance with RWP service delivery requirements related to health outcomes for PLWHA clients, not to review subrecipient compliance with RWP administrative or contractual requirements.

The Recipient and the assigned OMB Contracts Officer for any MCM or OAHS subrecipient will be notified via email of scheduled record reviews, and a copy of the report with a summary of the findings and any corrective action recommendations will be provided to the Recipient and Contracts Officer when the review is completed.

2) Technical Assistance (TA)

The Miami-Dade County Ryan White Program System-Wide Standards of Care, Primary Medical Care Standards of Care, Oral Health Care Standards and Medical Case Management Standards of Service set the foundation for services provided by contracted subrecipients. These established guidelines set defined performance measures and outcomes for each service category funded by the local RWP. When subrecipient service quality issues are encountered by the Recipient, by a subrecipient, through a scheduled record review, or through other CQM activities, BSR CQM staff and/or SF-SEAETC will provide targeted technical assistance (TA) by telephone, on-site visits, or consultation at BSR, based on the needs of the subrecipient and the complexity of the needs to address the concerns. For example, BSR CQM staff may provide TA to Ryan White Program Outreach Service providers to help facilitate client access to HIV/AIDS outpatient medical care and support services, and improve retention in care for eligible clients not currently engaged in care and treatment. Medical Case Management subrecipients may require guidance and training to help understand improvements or changes in HIV care standards (i.e., medication changes, new vaccine guidelines, etc.), to identify and implement strategies for helping clients improve treatment adherence and achieve viral suppression, as well as to provide best practice guidance on developing comprehensive health assessments and appropriate care plans. BSR will also identify and assist with implementing quality improvement solutions.

- ***OAHS service provision TA*** when warranted as a result of concerns or deficiencies found in a medical record review. BSR CQM staff will consult with and coordinate this TA provided by the SF-SEAETC.

- ***MCM service provision TA*** will concentrate on improving missing viral load lab results, gaps in HIV medical visits, as well as timely and appropriate medical case management care plan updates. Note that these TA visits may also be triggered by findings reported in the quarterly CQM Performance Report Cards (see Section III, below) generated by the CQM team.

- ***Outreach TA*** will concentrate on improving timely access to HIV/AIDS primary outpatient medical care and support services for newly diagnosed and lost to care clients. These TA visits will focus on the outreach assessment process including:

(1) accurate and timely completion of the New to Care and Lost to Care outreach assessments in the SDIS; (2) enhancing communication between counseling and testing site personnel and RWP Outreach workers to facilitate effective and timely linkage to care for newly diagnosed clients in the EMA; and (3) timely receipt and tracking of certified RWP Outreach referrals for lost to care clients.

The Recipient and the subrecipient's assigned OMB Contracts Officer will be notified when subrecipient issues require an on-site TA visit (whether at BSR or the subrecipient's location), and a copy of the on-site report with a summary of the findings and any corrective action recommendations will be provided to the Recipient when the TA is completed.

II.E.4 Best practices and CQM test projects

One of the goals of the Integrated Plan in FY 2018-2019 is to identify useful best practices for retention in OAHS and VL suppression, to replicate that practice in an under-performing subrecipient agency, and evaluate the impact of the replication on the health outcomes of specific at-risk groups. The selection of the best practice will be the responsibility of the CQM Committee and/or the Strategic Planning Committee, based on data already provided by BSR during FY 2017-2018, while the implementation and evaluation of the best practice will be the responsibility of the RWP subrecipient agency who is selected or volunteers to participate. BSR CQM staff will provide assistance, as needed, including establishing implementation guidelines, creating evaluation materials, analyzing resulting data, and making recommendations for program improvements.

II.E.5 Training and Capacity Building

1) Annual Medical Case Management Certification and Proficiency Development

Medical Case Management certification is required by the Recipient annually for all MCMs, in a format approved by the Recipient. This ensures the MCM teams are sufficiently knowledgeable to provide quality services to clients. MCM general knowledge will be assessed through an e-learning platform specifically designed around the RWP Service Delivery Guidelines for Miami-Dade County. MCMs in the RWP Part A/MAI system will be instructed to participate in the certification process by accessing the e-learning platform in August 2018. Upon accessing the e-learning platform, MCMs answer a set of questions on general knowledge of HIV and medical case management duties. Upon answering each question, detailed information will be provided explaining the answer. At the time of the testing, and by the end of the session, MCMs will be graded: 85% correct answers are required to receive the certification and comply with local program requirements. Medical Case Managers who do not pass the certification initially will have the opportunity to re-take the certification test by the end of the testing period. MCM Supervisors of staff who do not pass receive a report which requires appropriate corrective action. Well-trained MCM staff offer clients appropriate resources to help improve their health.

2) Periodic CQM training

CQM training activities are directed toward several key groups: MCMs (both new and experienced), MCM Supervisors, Peers and Outreach Workers. Informing Medical Case

Management staff of current treatment options, adherence best practices, case study troubleshooting, etc. through MCM trainings helps provide the MCM team with useful tools to help improve client health outcomes.

The following trainings are planned during FY 2018-2019:

- **OHC Training**

  Periodic training of OHC clinical staff is also provided, using external trainers as needed. In March 2018, the SF-SEAETC provided a refresher course to OHC providers through the Partnership's OHC Workgroup. Training focused on current oral health care in relation to HIV.

- **Ryan White Program Basic Medical Case Management Orientation Training**

  BSR's Ryan White Program Basic Medical Case Management Orientation Training (MCM Basic Training) consists of an 8-hour face-to-face training seminar conducted at various times throughout the fiscal year. The MCM Basic Training is offered to new Medical Case Managers in the system who must receive basic medical case management training within 120 calendar days of hire. The MCM Basic Training focuses on RWP Medical Case Management Service Definitions and Standards of Care, comprehensive health assessment and eligibility protocols, plans of care, documentation, entitlements, other funding sources, the basics of HIV, and other topics directly related to core MCM competencies. The instruction will be provided by BSR's QM training staff, supplemented by external contracted trainers if appropriate. Local pharmaceutical community liaisons will offer current HIV treatment information and non-branded educational information as available and as needed. The new MCM Basic Trainings will be offered in June 2018, October 2018, and February 2019.

  In addition to the BSR-provided Basic MCM training, thirteen (13) hours of basic case management and cultural competency training as provided through the Southeast AIDS Education and Training Center (SE-AETC) e-learning online educational system are required of any new medical case manager, peer, or outreach worker (see Resources, II.D, above). The modules must be completed prior to Recipient approval for the new MCM to have access to RWP clients and the data system (i.e., SDIS User Access); and proof of completion of the online training must be provided to the Recipient to obtain this approval.

- **Quarterly Medical Case Manager Supervisor Trainings**

  Capacity Building regarding quality improvement for MCM Supervisors and Lead Case Managers will be provided on a quarterly basis throughout the grant fiscal year. Every attempt will be made to schedule training sessions in convenient locations and to accommodate supervisors' time constraints. As in the case of the new MCM training, training activities and exercises provided by BSR may be supplemented by external contracted training as appropriate. In collaboration with ADAP staff, MCM Supervisor trainings will also focus on early detection of lapses in adherence and persistent high viremia (Integrated Plan activity V1.3.a.).

The Supervisor trainings will be conducted in May 2018, August 2018, November 2018, and February 2019.

- **Semi-annual Mandatory Outreach Training**

  BSR will provide a mandatory semi-annual training for Ryan White Program Outreach Workers, at which time BSR staff will address outreach issues identified through linkage to care team meetings with FDOH-MDC testing personnel, expressed concerns of Medical Case Managers, or findings during TA reviews and on-site visits. The Outreach Trainings will be conducted in August 2018 and February 2019.

II.E.6 CQM Support to the Recipient

1) Program Performance Measures – Program Terms Report and Annual Progress Report (APR)

On an annual basis, BSR will assist the Recipient in completing the federal Program Terms Report (PTR; planned) and Annual Progress Report (APR; actual) on sections related to CQM activities only. The process will start with BSR and the Recipient deciding on the appropriate program performance measures to include in the PTR and agreeing on the operational definitions of each measure. Once approved by the Recipient, BSR will conduct analyses for each outcome indicator and will provide these data to the Recipient to complete the PTR and APR. Data for the APR will be generated in May 2018. At the request of the Recipient, or if deemed necessary to assist the CQM Committee in its program performance monitoring activities, BSR can subdivide the data in these reports by subrecipient.

2) Affordable Care Act (ACA) Enrollment Support

BSR CQM staff will provide ACA enrollment trainings for Ryan White Part A/MAI Medical Case Management Supervisors and Medical Case Managers during the months of September, October and November 2018, track total number of ACA enrollments, monitor enrollment data, serve as enrollment process support for the 2018-2019 Part A/MAI ACA enrollment agency and subrecipient Medical Case Management agencies, and generate and distribute "Gap Cards" – identification cards validating ACA health insurance enrollment and access to allowable HIV-related physician office visit co-payments, lab/diagnostic co-payments, and non-ADAP medication co-payments for drugs on the local Ryan White Part A/MAI Program Prescription Drug Formulary for the purpose of ensuring smooth enrollment processes for clients and access to mainstream medical care to treat their HIV. In addition, to facilitate client access to medical care through ACA health insurance, BSR CQM staff will provide programmatic support and guidance to Miami Beach Community Health Center (MBCHC), the Recipient's contracted provider of Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (Health Insurance Assistance) services, Ryan White Program Medical Case Management subrecipient agencies, the ACA enrollment agency (American Exchange), Ryan White Program clients throughout the open enrollment period, and the Recipient. BSR will participate in ACA coordination meetings with the Recipient, MBCHC, the ACA enrollment agency, and ADAP in preparation for the 2019 plan year enrollment process.

Note that this element of BSR's CQM work is a labor-intensive activity throughout a six month period, from the pre-enrollment planning starting in September 2018, through the ACA open enrollment (TBA; usually mid-December) and post-enrollment technical assistance to clients and subrecipients through February 2019. This CQM-related assistance from BSR is designed to improve client access to outpatient medical care and medications (therefore, suppressing Viral Loads), and improved retention in care.

3) Linkage to care monitoring, FDOH-MDC support and CQM

BSR CQM staff will monitor Ryan White Program Outreach Performance Reports to assess linkage to care rates and identify areas in need of improvement. As needed, BSR and the FDOH-MDC will re-initiate joint reviews with the Ryan White Program-funded Outreach Services subrecipients to ensure compliance with the established linkage to care protocols. The new-to-care and lost-to-care linkage statistics for individual subrecipients will be reported quarterly as part of the QM Performance Report Card reports (Section III, below).

Back in FY 2016-2017, as part of the Integrated Plan concentration on linkage of new clients to care as a combined FDOH-MDC/Part A concern, BSR initiated an Outreach Linkage to Care (OLTC) Team, combining the resources of FDOH-MDC linkage specialists, and Part A/MAI outreach linkage workers, with its primary objectives of: (1) identifying OLTC barriers for newly-diagnosed clients entering the RWP, (2) strengthening the coordination between FDOH-MDC and the RWP to ensure seamless client movement from diagnosis to care, and (3) developing strategies and quality improvement activities to address barriers to linkage as they may be identified. RWP Part A/MAI and FDOH-MDC linkage personnel on the team meet monthly. Although both new-to-care and lost-to-care linkage rates are monitored routinely by BSR, in FY 2017-2018, the OLTC Team concentrated on newly-diagnosed PLWHA, with a relatively small base of potential clients and existing robust linkage rates. In FY 2018-2019, with the implementation of the FDOH-MDC enhanced OLTC detection and re-linkage processes, re-linking lost-to-care clients will become the focus of activities for this team.

BSR CQM staff will continue to facilitate a productive working partnership between the FDOH-MDC's Counseling and Testing Program and the RWP Part A/MAI Outreach Workers. Additionally, BSR CQM staff meet monthly with FDOH-MDC Counseling and Testing personnel, as part of the HIV/AIDS 501 Update, and BSR will continue to work closely with the FDOH-MDC in mutual reporting and data sharing activities. This collaboration and data exchange is facilitated by the cooperative data-sharing agreement in place since 2016 between FDOH-MDC and the Recipient. The data sharing agreement was expanded in 2018 to include the FDOH-Tallahassee.

While this may not be considered an administrative support function, the practical consequences of this linkage emphasis is to shift a substantial part of the burden of new client linkage management from the FDOH-MDC to the RWP.

4) Assistance in Reviewing and Updating Service Delivery Guidelines

In FY 2018-2019, BSR will assist the Recipient in reviewing and updating the Service Delivery Guidelines for OAHS, MCM and Outreach, making recommendations to reflect

changes in treatment guidelines, service delivery standards, and improving access to and retention in care for clients. As a parallel activity, BSR CQM staff will assist the Recipient in reviewing and updating client-centered care standards for these services before the annual changes are brought before the Partnership's Care and Treatment Committee and Medical Care Subcommittee for Partnership approval. Note that MCM and Outreach Service descriptions have been revised based on PIAT recommendations for system access improvements in past years, and will be brought before the CQM Committee in the future. Review and updates of these should be completed by January 2019.

5) Subrecipient Forums

BSR will organize and staff at least three Subrecipient Forums during the program year to assist with the presentation and exchange of relevant HIV-related information within the community. Subrecipient Forums will focus on presentations specific to the RWP as determined between BSR and the Recipient. Presenters will include BSR and the Recipient staff, subrecipients, local researchers, and contracted consultants as deemed necessary. Attendance is mandatory for all Ryan White Part A and MAI-funded subrecipients in Miami-Dade County.

Among other functions, BSR uses the Subrecipient Forums to periodically recognize subrecipients that have significant performance-driven accomplishments (e.g., subrecipients with the best retention in care rates or highest rates of suppressed VL levels among clients; the RWP MCM provider with the most frequent documented provision of adherence counseling; the RWP outreach provider with the best linkage to care rate for newly-diagnosed PLWHA; and others as determined by BSR and/or the Recipient). Recognition of superior performance can provide a feeling of accomplishment and identify best practices for those who are recognized and promote a desire to improve among those who are not recognized. Recognitions for those with the highest rates of improvement in a particular area may also be included. The Subrecipient Forums are scheduled for April 2018, October 2018, and January 2019.

II.F CONSUMER INVOLVEMENT

Consumer (direct service clients) involvement is strongly encouraged at all levels of the CQM planning, implementation, and evaluation processes. At least three consumers of RWP services will be members of the CQM Committee, but this does not limit the number of consumers who can attend meetings and provide feedback. Note that the Strategic Planning Committee and the Integrated Plan Review Committee include PLWHA members as participants; PLWHA from the CQM Committee are invited to attend the Subrecipient Forums as well. As the RWP must adhere to the Florida in the Sunshine Law, all meetings are noticed and open to the public.

II.G STAKEHOLDER INVOLVEMENT ACROSS ENTITIES

The local Ryan White Part A/MAI Program (RWP) has an open and permeable planning and data sharing process, cooperating and collaborating fully with ADAP/Part B and Part C, as well as non-Ryan White Program-funded entities (e.g., FDOH, Florida General Revenue) in Miami-Dade County. The periodic Subrecipient Forums – at which CQM activities, data, barriers, challenges, and improvement strategies are discussed in detail – are attended by Part A/MAI subrecipients, ADAP/Part B representatives, and Part C provider senior executives as well as medical case management supervisors and other direct service personnel. Furthermore, the

CQM Committee has representation from ADAP, Part C, and Part D providers who have a strong interest in the CQM activities, and whose cooperation is frequently solicited when data need to be collected outside the Part A/MAI system for comparison and planning purposes.

All aspects of the CQM Program are also discussed with the Partnership and its Prevention, Care and Treatment, and Strategic Planning Committees, based on the topic or QM activity. This ensures a coordinated approach during the Client Satisfaction Survey, Needs Assessment, Priorities and Allocations, and Integrated Plan activities.

CQM data are regularly shared between ADAP, FDOH-MDC, and the RWP. ADAP provides data to the CQM Program on Part A/MAI clients who are ADAP service recipients and who may be in danger of disenrollment (i.e., losing access to antiretroviral and other ADAP medications) because of delays in eligibility re-certification. The data are uploaded into the RWP's SDIS data system and disseminated to Part A/MAI-funded medical case managers, who can alert their clients of the deadline and importance for maintaining ADAP eligibility. ADAP's notification process has been synchronized through an automated data system interface, so that notifications are sent electronically directly to the assigned MCMs.

These collaborative efforts and processes help ensure on-going access to quality care and treatment for RWP clients.

II.H EVALUATION

One of the major changes in the CQM structure is the re-purposing of the former Performance Improvement Advisory Team (PIAT) into the CQM Committee. As outlined in II.B, above, the expanded CQM Committee is a vital part of the management of the CQM process, from providing input into the future construction and modification of the CQM plan, to evaluating the progress of BSR and stakeholders in implementing the Plan and providing feedback as to the reasonableness of specific objectives in the Plan and its intertwining with the FDOH-MDC / RWP Integrated Plan that forms the basis of programmatic activities in the RWP.

In consultation with the Recipient and BSR, the CQM Committee reviews data and makes recommendations to the annual CQM work plan, monitors progress on the plan, and assesses and evaluates results of CQM activities conducted under the plan. As an evaluation committee, the CQM Committee would plan and evaluate pilot replications of subrecipient best practices or quality improvement initiatives as they are identified, and add oversight from a broader cross-section of stakeholders and PLWHA than the PIAT had provided. There is a firm distinction between the CQM Committee and its review of systemic CQM issues in relation to the Recipient's role of enforcing contractual requirements, service quality and standards of care. Because so much of the CQM research and evaluation functions impact service delivery and client outcome objectives in the Integrated Plan, the CQM Committee will interface with the Integrated Plan review Committee at its quarterly meetings.

The CQM Committee should review the CQM Plan implementation process at least quarterly. At issue is whether the CQM is having its desired effect on improving the delivery of HIV/AIDS care and treatment services in the Miami-Dade EMA, and consequently improving client outcomes for the PLWHA in care. This evaluation depends on more than producing data analyses or TA reports: it requires the full cooperation of the subrecipients as well as the support of stakeholders who understand the need for a continuous quality improvement as part of the fabric of activity within the RWP. Innovative CQM processes, improved subrecipient operating procedures and

the replication of best practices in care will require more than BSR recommendations. It will require subrecipient service providers to adopt the same plan-do-check-act (PDCA) model to actual service delivery, and not simply to tinker with internal processes or create a "CQM by exception" approach to a CQM Performance Report Card deficiency or an identified shortcoming in client outcomes.

II.H.1 Subrecipient Staff Acceptance of Change

On an annual basis, the CQM Committee will assess the response of the subrecipients to the CQM evaluation process outlined above, seeking to measure: (1) the usefulness of the CQM evaluations in strengthening subrecipient internal CQM activities; (2) the willingness of subrecipients to serve as pilot sites for CQM innovations or "best practice" replication; and (3) the openness of the CQM process to suggestions and concerns by subrecipients. This survey is under development by the CQM Committee, and will be provided to subrecipients in early January 2019.

II.H.2 Improved Clinical Performance

As outlined above, the most relevant test of the impact of the CQM system in the RWP is whether there are improvements in linkage rates, improvements in retention rates, and improvements in VL suppression over the course of the program year. These measurements are embedded in the existing systems of program quality assessment, through the annual periodic reports, through the quarterly CQM Performance Report Cards, and through the oversight of the CQM Committee.

III. PERFORMANCE MEASUREMENT: THE "CQM PERFORMANCE REPORT CARD" MODEL

Performance measures are embedded in all service categories funded through RWP Part A and MAI contracts as a contractual requirement. These services include: Outpatient/Ambulatory Medical Services, Medical Case Management, Oral Health Care, Substance Abuse Services (Residential and Outpatient), Health Insurance Premium And Cost Sharing Assistance For Low-Income Individuals, AIDS Pharmaceutical Assistance (Prescription Drugs), Food Bank, Outreach Services, Mental Health Services, Legal Services And Permanency Planning, and Medical Transportation. Where appropriate, performance measures reflect improvements along the HIV Care Continuum in linkage, adherence to and retention in care, or improvements in viral load suppression.

Other measures pertain to maintaining appropriate levels of enrollment for the service as a measure of non-disparity in service provision. One comprehensive review of all measurements is made on an annual basis through BSR's annual service delivery and client-centered analyses. Data from this review are provided to the Recipient and are intended to trigger program-specific site visits by the Recipient to identify any shortcomings in service provision, need for technical assistance site visits by BSR or other entities, and the creation of corrective action plans, if indicated. Additional measurements of viral loads and reviews of retention in care and adherence counseling levels by RWP provider are run on a quarterly basis as a mechanism for internal quality management review and improvement. The subrecipients receive a grade based

on their performance measurements (see M8 – M13, below), and if they receive a failing grade or are otherwise noncompliant with a particular clinical service quality standard, are required to provide BSR with a corrective action plan. As discussed above (Section II.E.3), BSR would provide TA to assist in diagnosis and remediation of the service quality problem, and may recommend replicating specific CQM interventions by other subrecipients.

Subrecipient performance measure data will be reported quarterly. The quarterly analyses will enable the ongoing review of key quality indicators (clinical and non-clinical) and measurement of outcomes that impact successful engagement in care and overall client health. The core analyses will be based on clients receiving Medical Case Management within the Part A/MAI-funded subrecipient agencies, using the client/MCM relationship as the fulcrum for intervention and client support, but BSR will provide additional subrecipient data on out-of-network clients and "total subrecipient" data as well. Un-blinded data will be provided to the Recipient, and – after review – subrecipient-specific data will be provided to individual RWP subrecipients. Blinded data will be made available to the CQM Committee for discussion and development of program enhancements. Subrecipients will actively participate in the review of their performance towards improving service delivery and client health outcomes, and will work with BSR CQM staff to identify specific training needs, identify best practices and participate in quality improvement projects, as outlined in Section II.B, above.

The CQM Performance Report Cards will be generated in April/May 2018, July 2018, October 2018, and January 2019. The CQM Performance Report Card will include the following performance measures:

RYAN WHITE PROGRAM CQM PERFORMANCE REPORT CARD MEASURES	
HIV Care Continuum Measurements	
C1.	**Total active RWP clients**: Number of RWP clients receiving at least one RWP service during the reporting period.
C2.	**In medical care (Target goal ≥95%)**: Percentage of active RWP clients in medical care. Denominator: all active RWP clients (C1). Numerator: active RWP clients receiving 1 or more medical visits with a provider with prescribing privileges, a CD4 or VL test in the past 12 months.
C3.	**Retained in medical care (Target goal ≥90%)**: Percentage of active RWP clients retained in medical care. Denominator: all active RWP clients (C1). Numerator: active RWP clients receiving 2 or more medical visits with a provider with prescribing privileges, CD4, or VL test at least 3 months (90 days) apart in the past 12 months.
C4.	**Suppressed VL (Target goal ≥80%)**: Percentage of active RWP clients with a suppressed viral load (<200 copies/mL). Denominator: all active RWP clients (C1). Numerator: active RWP clients with a documented suppressed viral load (<200 copies/mL) in the most current reported lab in the reporting period. Missing viral loads are reported as unsuppressed.

RYAN WHITE PROGRAM CQM PERFORMANCE REPORT CARD MEASURES (continued)	
Medical Case Management (MCM) Performance Measurements	
M1.	**Total active MCM clients**: Number of active RWP clients (C1) with an assigned MCM site; excludes outreach-only clients, clients whose cases were closed during the reporting period, out-of-network clients, and clients with an unassigned MCM site.
M2.	**MCM clients in medical care (Target goal ≥95%)**: Percentage of MCM clients (M1) in medical care.
M3.	**MCM clients retained in medical care (Target goal ≥90%)**: Percentage of MCM clients (M1) retained in medical care.
M4.	**MCM clients with a suppressed VL (Target goal ≥80%)**: Percentage of MCM clients (M1) with a suppressed viral load (<200 copies/mL).
M5.	**New MCM clients**: Percentage of MCM clients (M1) new to the RWP for 6 months or less as determined by the first ever RWP service billed to client.
M6	**MCM clients with an unassigned MCM**: Percentage of MCM clients (M1) without an assigned MCM.
M7.	**MCM clients with a detectable VL**: Percentage of MCM clients (M1) with a detectable viral load (≥50 copies/mL). Missing viral loads are reported as detectable.
M8.	**MCM client without a suppressed VL**: Percentage of MCM clients (M1) without a suppressed viral load (≥200 copies/mL). A<6%; B=6%-15%; C=16%-25%; D=26%-35%; F>35%.
M9.	**MCM clients without a current VL (F >10%)**: Percentage of MCM clients (M1) without a current (7 months or less) VL in the reporting period. F = Noncompliance-correction plan required (> 10%).
M10.	**MCM clients with a due CHA >7 months**: Percentage of MCM clients (M1) with a CHA older than 7 months (215 days) in the reporting period. A<6%; B=6%-15%; C=16%-25%; D=26%-35%; F>35%.
M11.	**MCM clients with NO update (contact) >90 days**: Percentage of MCM clients (M1) with no MCM or PESN service billed to them in more than 90 days in the reporting period. A<6%; B=6%-15%; C=16%-25%; D=26%-35%; F>35%.
M12.	**MCM clients with NO FFE contact >7 months**: Percentage of MCM clients (M1) without either a MCM or PESN face-to-face contact in more than 7 months (215 days) in the reporting period. A<6%; B=6%-15%; C=16%-25%; D=26%-35%; F>35%.
M13.	**MCM clients with NO contact >7 months (case closure req.)**: Percentage of MCM clients (M1) without any RWP service billed to them in more than 7 months (215 days) in the reporting period. A<6%; B=6%-15%; C=16%-25%; D=26%-35%; F>35%.

RYAN WHITE PROGRAM CQM PERFORMANCE REPORT CARD MEASURES (continued)	
Outpatient/Ambulatory Health Services (OAHS) Performance Measurements	
N1.	**Total active OAHS clients**: Number of active RWP clients (C1) who had at least one (1) face-to-face (FFE) OAHS visit (a medical visit with a provider with prescribing privileges) billed to the RWP in the reporting period. Agency assignment is based on the agency where the most recent OAHS FFE service of the reporting period was billed and not necessarily where client is receiving case management. Excludes clients whose cases were closed in the reporting period, new clients in the RWP for 6 months or less, or identified out-of-network clients.
N2	**OAHS clients in medical care (Target goal ≥95%)**: Percentage of OAHS clients (N1) in medical care.
N3	**OAHS clients retained in medical care (Target goal ≥90%)**: Percentage of OAHS clients (N1) retained in medical care.
N4.	**OAHS clients with a suppressed VL (Target goal ≥80%)**: Percentage of OAHS clients (N1) with a suppressed viral load (<200 copies/mL).
Outreach - data in this category are based on the last three months of the cycle	
O1.	**New to care linkage (F <50%)**: Percentage of new clients referred to RWP Outreach services linked to RWP MCM or OMC services in the reporting period. F = Noncompliance-correction plan required (<50%).
O2.	**Lost to care – linked to care (F <50%)**: Percentage of RWP clients lost to care who, after being referred to RWP Outreach services, were linked back to RWP MCM or OAHS services in the reporting period. F = Noncompliance-correction plan required (<50%).