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Ryan White Part A/MAI
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CLINICAL QUALITY MANAGEMENT PROGRAM
Grant Fiscal Year 2025 (March 2025 – February 2026)

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APPENDIX: CQM WORKPLAN

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1. MIAMI-DADE RYAN WHITE CLINICAL QUALITY MANAGEMENT PROGRAM: VISION AND MISSION

Vision Statement: To ensure that every client served by the Miami-Dade County (MDC) Ryan White Program (RWP) achieves and maintains an undetectable HIV viral load, by supporting an open access, continuously improving, high quality comprehensive system of lifesaving HIV care.

Mission Statement: The mission of the MDC RWP CQM Program is to continuously improve the quality of care delivered by each RWP-funded subrecipient in MDC to clients with HIV. The RWP CQM Program will continuously develop/enhance, review/monitor, analyze, measure, implement, and evaluate the delivery of core medical and support services provided to program-eligible clients. CQM efforts will improve client care by following Public Health Service treatment guidelines for HIV, maximizing access to services, and continuously improving the service delivery processes, achieving optimal health outcomes for clients and improving client satisfaction, with the ultimate goal of helping clients link to care, stay in care, adhere to their treatment regimen, get virally suppressed, and ultimately achieve and maintain undetectable viral loads.

2. QUALITY INFRASTRUCTURE

2.A Resources

The Miami-Dade Ryan White Part A/MAI Recipient (Recipient) provides annual support to Behavioral Science Research Corporation (BSR), its contracted Clinical Quality Management (CQM) subrecipient organization, to manage the implementation of the jurisdiction's CQM Program and Workplan. Approximately 2.5% of Miami-Dade County's combined FY 2025 Part A/MAI award is allocated to CQM activities. Recipient staff time and effort are not charged to the CQM contracted allocation since their roles are to oversee the process to ensure compliance with contractual requirements and keep subrecipient QI projects from straying into administrative quality assurance activities.

2.B Positions Responsible for Developing and Implementing the CQM Program

2.B.a CQM Program Leadership

Leadership for the CQM Program resides with the Miami-Dade County Office of Management and Budget, the **Recipient** of Ryan White Program (RWP) funding for the Miami-Dade EMA. Recipient leadership resides with Carla Valle-Schwenk, the Miami-Dade RWP Administrator, whose principal role is to ensure that every core medical and support service provided by the RWP is delivered with maximum sensitivity to the needs of the clients in care, scrupulous attention to the federal, state and local regulations directing the program activities, and constant improvements in the clinical quality management (CQM) of the services delivered, consistent improvement in clinical client outcomes, and ongoing monitoring and improvement of client satisfaction with the process of accessing and receiving Ryan White Program services. The

Recipient oversees the CQM process and provides guidance on program-allowable services, and supports the CQM efforts of Part A/MAI-funded subrecipients. In this role, she directly oversees the work of Behavioral Science Research Corporation, the contracted provider of CQM services for the Miami-Dade RWP.

2.B.b CQM Workplan Implementation

Behavioral Science Research Corporation (BSR) is the contracted subrecipient CQM organization supporting the RWP Part A/MAI CQM Program and is primarily responsible for the implementation of the CQM Workplan. Under the Part A/MAI CQM staffing allocated by BSR to this project, the following BSR staff members provide services as outlined below:

- **CQM Project Director**: The Project Director (Robert Ladner, PhD) is responsible for overall direction of the Part A/MAI CQM Program. He coordinates Part A/MAI CQM activities, provides guidance on QI methodologies and statistical analyses, prepares CQM-related reports and summaries, assists with the provision of technical assistance to subrecipients, and oversees research projects that aid in identifying CQM problem areas (e.g., HIV treatment guidelines, client satisfaction, service delivery, etc.) to be addressed through subrecipient QI projects.

- **CQM Project Managers:** Two CQM Project Managers (Karen Hilton and Sandra Sergi) leverage over 35 years' experience in RWP medical case management and their training in CQM techniques to design subrecipient-based QI initiatives, provide technical assistance to individual subrecipients with ongoing QI projects, plan and conduct additional QI projects as prioritized by the CQM Steering Committee, and conduct subrecipient-level and system-wide training as identified by interactions with CQM personnel in subrecipient agencies.

- **Data Analyst/Research Associate:** The Data Analyst/Research Associate (Frank Gattorno, MPH), a public health biostatistician, is responsible for the implementation, maintenance, and improvement of the performance measurement system, reflected in quarterly comprehensive CQM Performance Report Cards monthly subrecipient client data extract files from the PE Miami data management system in support of Part A/MAI subrecipient QI initiatives, and specialized data analyses in support of Recipient and BSR CQM data needs.

- **Operations Manager/Administrator:** The Operations Manager (Morela Lucas) assists with database management, statistical analyses, client satisfaction survey project management, and other direct CQM-related tasks necessary to ensure completion of CQM activities described herein.

These persons are assisted in their work by a cadre of project-based contracted multilingual (English, Spanish, Haitian Creole) research associates and analysts, many of whom have been working with BSR on Ryan White CQM projects for over eight years.

2.C RWP CQM Steering Committee

The Clinical Quality Management Steering Committee (CQMSC), organized during FY 2023, **oversees the strategic planning and prioritization of RWP CQM Program activities**, articulates the vision of the CQM Program leadership in the day-to-day CQM activities, coordinates and communicates with other RWP Parts engaged in CQM activities, and periodically evaluates progress on the execution of the RWP CQM Program and Workplan. The CQMSC meets at least four times per year, by MS Teams virtual format or in person, as determined by the mutual convenience of the members. The CQMSC consists of (1) a representative of the MDC RWP Part A/MAI Recipient; (2) a representative of the Florida Department of Health in Miami-Dade County, the Part B Lead Agency; and (3) the CQM staff of BSR.

From time to time, in response to emergent CQM issues or identified QI needs, the CQMSC may convene a targeted Subcommittee to investigate these issues and/or needs further, with a Subcommittee composition and meeting schedule to be determined by the CQMSC. This targeted Subcommittee may determine the existence of a real QI problem and define it with data from PE Miami or VSR Client Satisfaction Surveys, may determine the feasibility of addressing the problem with a system-wide or focused QI intervention, and may oversee the conduct of this intervention if appropriate. In FY 2024, the OHC CQM Subcommittee was convened to investigate the underlying realities behind low OHC client satisfaction scores; the work of this Subcommittee is still underway in FY 2025.

Meeting agendas, summaries, and copies of all distributed materials, as may be modified based on the meetings, are distributed to all CQMSC participants by BSR.

2.D RWP CQM Workplan

The Miami-Dade County CQM Workplan (incorporated herein by reference, subject to revision) was updated by BSR in FY 2024, based on current QI projects, identified QI intervention needs, and evaluation feedback from the Recipient. A checklist reflecting progress on this plan was provided to the CQM Steering Committee at its October 2024 meeting as part of a semi-annual review. Although the FY 2024 CQM Plan forms the basis for FY 2025 deliverables associated with the current BSR Scope of Work, the final CQM deliverables and activities for FY 2025 must be reviewed by the Recipient. Based on this review, BSR will update the CQM Plan to yield the FY 2025 CQM Plan. The FY 2025 CQM Plan will include a congruence review with the 2022 – 2026 Integrated Prevention and Care Plan through the Integrated Plan Review Team.

3. CQM PROGRAM QUALITY GOALS (FY 2025)

Annually, the CQM Steering Committee reviews and assesses progress on prior year CQM goals, reviews various data sources (e.g., service utilization data, demographic data, comorbidity data, client satisfaction survey results, CQM Steering Committee input, etc.) to identify program goals and priorities for the current FY.

The proposed CQM Program quality goals for FY 2025 are as follows:

3.A Improve System-Wide Client Outcomes.

During FY 2025 (see FY 2025 Performance Indicators table, below):

a. For the universe of clients with diagnosed HIV who receive **Medical Case Management** (MCM) through the RWP: the RWP subrecipient providers of MCM services will achieve or exceed target goals of **≥90% Retention in Medical Care** (RiMC) in FY 2025, vs. 89% at the close of FY 2024. and **≥95% Viral Load (VL) suppression** in FY 2025, vs. 92% at the close of FY 2024);

b. For the universe of clients with diagnosed HIV who receive **Outpatient Ambulatory Health Services** (OAHS) through the RWP: the RWP subrecipient providers of OAHS services will achieve or exceed target goals of **≥90% Retention in Medical Care** in FY 2025, vs. 91% at the close of FY 2024, and **≥95% VL Suppression** in FY 2025, vs. 92% at the close of FY 2024).

c. For the universe of clients with diagnosed HIV who receive **Oral Health Care** (OHC) through the RWP: the RWP subrecipient providers of OAHS services will achieve or exceed target goals of **≥75% receiving a clinical oral examination** at least once during FY 2025, vs. 72% at the close of FY 2024).

3.B Continually Monitor the Quality of Client Care (Including Client Access), Client Health Outcomes, and Client Satisfaction with RWP Services.

During FY 2025:

a. In congruence with PCN 15-02, on a quarterly basis, BSR, the contracted CQM provider, will gather and analyze subrecipient-level MCM, OAHS and OHC treatment process data and client health outcome data obtained through Groupware Technologies LLC's Provide Enterprise® Miami (PE Miami) RWP client information system as a **CQM Performance Report Card;** and disseminate these data to all subrecipient agencies providing these services and appropriate stakeholders and collaborators, to identify potential problem areas that could benefit from QI interventions and to track progress toward CQM goals at the program- and subrecipient levels. Data from these analyses will be publicly available through the RWP's CQM Communication Network (see below).

b. In congruence with PCN 15-02, on a monthly basis, BSR will gather and analyze client-level extract file data on the clients served by these subrecipient agencies and engaged in CQM activities within the subrecipients, reporting on salient client characteristics, social determinants of care, and performance indicators as **CQM Dashboard Data,** disseminating these data to the subrecipient agencies on a confidential basis.

c. In congruence with PCN 15-02, on an annual basis, BSR will design and conduct a survey of RWP client experiences with one or more categories of service delivery, through a Client Satisfaction Survey of clients in RWP MCM care, gathering data to reflect the client experiences with individual subrecipient service providers and the RWP in aggregate, to identify potential problem areas that could benefit from a QI intervention, and to communicate these findings and opportunities to the CQM Steering Committee and appropriate subrecipients. Data from these analyses will be publicly available through the RWP CQM's Communication Network (see below).

d. BSR will report these findings to the CQM Steering Committee to prioritize and develop strategies for QI intervention, and to the funded MCM/OAHS/OHC subrecipients engaged in the CQM process, as well as throughout the RWP CQM Communication Network (see below).

3.C Improve Clinical Outcomes for Client Subpopulations with Identified Elevated HIV/AIDS Incidence, Prevalence and Transmission Risks in a Manner Congruent with the Integrated Plan.

a. BSR will engage, coach, and assist the 13 subrecipients with an MCM, OAHS or OHC CQM process in place, in at least one (1) data-driven QI project directed toward client subpopulations with identified and measurable elevated HIV/AIDS incidence, prevalence and transmission risk.

4. PERFORMANCE MEASUREMENT

Performance measurement refers to the periodic evaluation of client outcome data (see A.2, above), consistent with historical HRSA Performance Measures, as may be modified by the CQM Steering Committee in response to local needs. The minimum number of performance measurements for each service category are specified by HRSA according to the percentage of the Miami-Dade County RWP client base receiving at least one unit of service in that category: please note that as of the date of this document, ***Outpatient Ambulatory Health Services is no longer a Level 1 ("two measure") service category for FY 2025,*** primarily because of the shift of clients from medical services billed through RWP medical providers to medical services billed through non-RWP Affordable Care Act medical providers.

Pursuant to PCN 15-02, as may be amended, the minimum number of performance measures reported by BSR in the calculation of client outcomes by service category are in **Table 1**, below, based on billed PE data for the requisite service categories as of the close of FY 2024; **Table 2**, immediately following, illustrates specific performance measures that BSR will use for FY 2025. Note that the specifics of the performance measures detailed in Table 2 were frozen on the TargetHIV web site as of December 2024, and are subject to modification by HRSA in the future.

TABLE 1
Minimum Required Number of Performance Measures For Service Categories over 15% of 9,316 Clients in Care in FY 2024 (source: FY 2024 Needs Assessment data)

Review Group	% RWP clients receiving one or more units of service per category	Minimum performance measures required	Threshold number of clients in FY 2025, based on clients in 2024	Service Category Review Group for FY 2025 based on number of RWP clients served in FY 2024
1	≥ 50%	2	≥4,658 clients served	-- Medical Case Management (8,842 clients)
2	≥15% to <50%	1	1,397 - 4,657 clients served	-- Outpatient/Ambulatory Health Services (4,577 clients) -- Oral Health Care (2,843 clients) -- Health Insurance Premium And Cost Sharing Assistance (1,926 clients)

TABLE 2
FY 2025 Performance Indicators for Service Categories in Review Groups 1 and 2

Service Category	Subrecipient-Based Performance Measures Tracked on the CQM Report Card
Medical Case Management (MCM: Review Group 1, ≥50% of clients)	1. HIV Viral Load Suppression (<200 copies/ml), most recent test (HRSA/HAB) 2. Retention in Medical Care: two OAHS visits or proxies within 12 months, minimum 90 days apart (HRSA/HAB) 3. Tracked but not a CQM measure: Clients with two or more care plans created or updated in previous 12 months (HRSA/HAB) 4. Tracked but not a CQM measure: MCM contact within previous 90 days (HRSA/HAB, modified to improve RiMC early warning)
Outpatient/Ambulatory Health Services (OAHS: Review Group 2, 15% - <50% of clients)	1. HIV Viral Load Suppression (<200 copies/ml), most recent test (HRSA/HAB) 2. Retention in Medical Care: two OAHS visits or proxies within 12 months, minimum 90 days apart (HRSA/HAB)
Oral Health Care (OHC: Review Group 2, 15% - <50% of clients)	1. % of OHC clients with annual clinical oral examination (HRSA/HAB, OHC providers only) 2. Tracked but not a CQM measure: % of MCM clients referred for OHC services (HRSA/HAB, MCM providers only
Health Insurance Premium and Cost Sharing Assistance (HIPCSA: Review Group 2, 15% - <50% of clients)	1. HIV Viral Load Suppression (<200 copies/ml), most recent test (HRSA/HAB) 2. Retention in Medical Care: two OAHS visits or proxies within 12 months, minimum 90 days apart (HRSA/HAB)

a. Performance measures are generated according to the percentage of the RWHAP client base included in each service category, as annually reviewed by the CQM Steering Committee. The performance measures are drawn from HRSA's HIV/AIDS Bureau Performance Measure Portfolio, as may be modified by the CQMS Committee to meet local CQM needs.

b. The performance measurement data are generated by the PE Miami data management system, used by Part A as the primary source of local RWP data and a mechanism for accounting for client service activity. The aggregated PE Miami data are extracted for QI purposes using Structured Query Language (SQL) by the BSR Data Analyst. Periodic cross-checking is done by the Part A/MAI Recipient and the BSR Data Analyst, to ensure that the results obtained by the BSR SQL queries and/or by the Recipient's PE Miami pre-programmed reports are the same, and discrepancies are referred to Groupware Technologies LLC technicians for reconciliation.

c. Results and findings from BSR's SQL queries are organized and presented according to MCM, OAHS and OHC service sites in the CQM Report Card and QI Dashboard (see goals, above), which are distributed via email on a quarterly or monthly basis to all subrecipients and outside stakeholders within the MDC RWP, as appropriate.

d. The CQM Steering Committee will periodically review these measures, and may add to, delete, or modify them from time to time.

5. QUALITY IMPROVEMENT PROCESS

5.A QI Methodology.

The CQM Program will use various methods and tools to help improve access to quality care and client satisfaction with the local service delivery system of care. The core paradigm for the Miami-Dade RWP CQM program is the Model for Improvement (MFI), one of several Plan-Do-Study-Act protocols used by RWP CQM programs across the country. The MFI protocol was expanded by the Institute for Healthcare Improvement as its primary framework for quality improvement in healthcare, where there may be an uneven distribution of CQM capacity among the clinical practitioners seeking to apply QI methods to their service delivery problems.

The MFI Plan-Do-Study-Act (PDSA) implementation sequence leads QI teams to ask simple questions about problems that appear in their client care statistics, to improve their understanding of client care processes by looking at issues affecting various clinically identifiable populations in care and identifying possible root causes. These questions guide QI teams through establishing indicators, detecting differences, understanding what success looks like, using data to measure the reality of change, and focusing on what is necessary to export the change idea to other parts of their health care organization. The reader is directed to Langley *et al., The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, a reference book used by every CQM practitioner at BSR. A simplified outline of the MFI appears below.

Figure 1: Model for Improvement

Model for Improvement

Asks three questions:

- What are we trying to accomplish? – Provides an aim for improvement efforts
- How will we know a change is an improvement? – requires measurement and sustainability
- What changes can we make that result in improvement? – testing is done here to predict the effect of a change if its implemented

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

5.B. Key Elements of the MFI QI Implementation

The QI process is data-driven, based on the quarterly comparative subrecipient-level CQM Performance Measurement Report Cards and the monthly client-level QI Dashboards. Individual QI projects begin with comparisons of client outcome data, identifying weaknesses in service delivery as reflected in the Report Card data for all subrecipients, and comparisons are provided to the CQMSC. The Dashboard Data allows the subrecipients to drill down in their own data using a standardized reporting format based on PE Miami, rather than the individual subrecipient-level electronic medical record systems that may or may not be congruent with the data required by the RWP through PE Miami.

The QI Process includes capacity-building general and subrecipient-specific training and technical assistance, constantly re-assessed on an individual subrecipient basis during the monthly technical assistance (TA) calls provided by BSR's CQM Project Managers and Data Analyst, and reinforced in quarterly Medical Case Manager Supervisor training. Based

on the system-wide and subrecipient-specific training and TA needs identified in FY 2024, BSR has drafted a ***service quality capacity-building training agenda*** for FY 2025. These training needs include: 1) establishing an on-line library (a "QI Toolkit") of instructional materials created by BSR, including uploaded videos and other self-paced QI skills training, to allow subrecipients to train their new staff in rudimentary CQM skills using standardized training materials; 2) providing individualized subrecipient-level instruction in basic data analysis techniques, showing CQM participants how to think through client outcome data and tease out root causes; 3) refresher instruction on identifying and implementing a QI evidence-based intervention and documenting the impact (or lack) of such an intervention QI intervention on client outcomes.

The CQM process and the development of QI interventions make use of a full spectrum of QI tools. BSR CQM personnel are all trained in (and use) a wide variety of CQM tools and techniques, including the TargetHIV catalogs of evidence-based and evidence-informed interventions, "Five Whys" and Ishikawa (fishbone) diagrams to isolate potential root causes, process mapping, affinity diagrams and systematic brainstorming. Driver diagrams are used to identify 1) the ultimate aim of the QI project, 2) the drivers which will affect accomplishing the aim, and 3) the interventions that affect the identified drivers. These tools along with other CQM resources are included in BSR's CQM Toolkit, accessible by individual CQM practitioners in each individual subrecipient with a CQM program.

6. IDENTIFICATION AND ENGAGEMENT OF STAKEHOLDERS

The CQM Program engages a wide variety of internal and external CQM stakeholders in review of CQM data, discussions about the implication of these data for RWP service delivery, and recommendations for future CQM strategies and priorities. While these stakeholders may often weigh in on the operational implications and strategic importance of CQM data, with the exception of the subrecipients who are engaged in service delivery and QI projects relating to that delivery, there is no subrecipient-specific input solicited from these community representatives: such matters remain the purview of the Recipient.

A. **RWP Part B:** The RWP Part A/MAI CQM Program engages with the Part B program through the Florida Department of Health in Miami-Dade County, the lead Part B agency. Representatives from Part B attend Partnership meetings, Care and Treatment Committee meetings and Integrated Plan Review Team meetings where CQM data are routinely presented, and serve on the CQMSC as outlined above. Close liaison with Part B is an integral part of the Part A/MAI TA provided to one subrecipient whose MCM activities are not funded by Part A, but need to be coordinated with Part A because of the close relationship between Part B-funded MCM personnel and Part A-funded OAHS and OHC services.

B. RWP MCM, OAHS, OHC and HIPCSA subrecipients: Funded subrecipients are required to identify internal CQM champions/representatives to interface with the Recipient and BSR in the CQM Program. These stakeholders are specifically engaged in CQM activities through monthly TA calls, BSR CQM training, and inclusion on all outbound communication regarding CQM activities.

C. **Members of the Miami-Dade HIV/AIDS Partnership and its committees:** non-Part A stakeholders representing Part C, Part D, the FDOH-MDC, and the Florida Agency for Health Care Administration, receive information on CQM data and directions during meetings of the Partnership, the Care and Treatment Committee, the Medical Care Subcommittee and the Community Coalition Roundtable.

D. **Consumers and other persons with lived experience:** stakeholders with lived experience – both RWP clients and persons with HIV who are not RWP clients -- participate as CQM stakeholders through their membership on the Partnership and Community Coalition Roundtable. In addition, two client stakeholders with RWP OHC lived experience serve on the CQM OHC Subcommittee.

7. THE RWP CQM PROGRAM COMMUNICATION NETWORK

The RWP CQM Program communication network includes the direct communications to stakeholders as outlined above. Note, however, that there is an extensive outbound communication to providers on the Partnership's web site (https://aidsnet.org/providerhub/), including extensive information on the CQM Program (https://aidsnet.org/cqmprogram/training) and the QI Toolkit cited above. N***ote that the contents of the Aidsnet.org CQM web pages are under review to remain compliant with various federal Executive Orders, and some of the links to TargetHIV and CQII resources may be under revision.***

8. ONGOING DEVELOPMENT AND EVALUATION OF THE CQM PROGRAM DOCUMENT AND CQM WORKPLAN

The CQM Program description and the CQM Workplan implementation documents are drafted by BSR, based on current QI projects, identified QI intervention needs, and evaluation feedback from the CQMSC members. A final draft is submitted to the Part A/MAI Recipient and Part B Lead Agency for a technical review to ensure quality, consistency, and adherence to local, state, and federal guidelines. This process is expected to be conducted annually.

The CQM Workplan is moving from a once-a-year written document to an iterative process of performance measure review, subrecipient QI project review, and QI project prioritization by the CQMSC.

Evaluation of the CQM Program will involve three elements in FY 2025:

a. **Monthly status reports** on the progress of Part A CQM activities, including snapshots of client health outcomes for clients engaged in the QI processes, provided by BSR to the Recipient.

b. **Semi-annual evaluation reports** provided to the CQM Steering Committee members, itemizing (a) the progress made on the CQM Program goals itemized in

Section 3 above, based on a goal-by-goal itemization of progress; (b) review of BSR activities listed in the CQM Program and Workplan; and (c) feedback on BSR's training, production of outcome measures, and provision of technical assistance to the subrecipients, based on an evaluation survey to be conducted in December 2025. These reports will be provided to the CQM Steering Committee in April 2025 and February 2026.

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