West Palm Beach Eligible Metropolitan Area Quality Management Plan

2018-2021

Quality Management Plan

West Palm Beach EMA

Prepared by:

Michael Hager, MPH MH – Hager Health, LLC

Shoshana Ringer – Palm Beach County Community Services

Quality Management & Evaluation Committee Members

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Clinical Quality Management in Palm Beach County

Palm Beach County Community Services (RWHAP Part A Recipient Office) and Florida Health Palm Beach County (RWHAP Part B Lead Agency) has designed a Clinical Quality Management (CQM) Program for the West Palm Beach Eligible Metropolitan Area (EMA) to establish a systematic approach to performance measurement (PM) and quality improvement (QI) that involves its stakeholders. As a cross-part initiative, the combined CQM program is called the Palm Beach County CQM collaborative. This QM Plan is a core component of the Palm Beach County CQM collaborative infrastructure and lays out all aspects of the CQM Program, including performance measurement and QI methodology.

Quality Statement

The mission of the Palm Beach County CQM collaborative is to ensure the highest quality medical care and support services aimed at improving outcomes for people living with HIV (PLWH) who receive care through the EMA's subrecipient providers. Specifically, the EMA CQM Program aims to:

- create a culture of quality within the EMA and within sub-recipient agencies by dedicating resources for capacity building and technical assistance;
- ensure that EMA subrecipient providers adhere to established HIV treatment guidelines;
- maximize involvement of stakeholders in the CQM Program;
- streamline subrecipient collaboration and coordination of HIV services across the EMA;
- ensure that available demographic, utilization, and outcome information is used to monitor progress and trends in the EMA HIV Care Continuum;
- ensure high quality customer service; and
- improve health equity among PLWH in the EMA.

Clinical Quality Management Goals

Routine review of established performance measures leads to the identification of specific CQM goals for each QM Plan. Stakeholders who are internal and external to the Palm Beach County CQM collaborative review measures through formally established mechanisms using evidence-based quality improvement methods. For 2018-2021, the following quality goals have been identified:

1. *Eligibility* – ensure PLWH in the EMA have complete eligibility documentation for all services received. Complete eligibility documentation prevents gaps in care and can help identify additional services for which the client has need. 90% of all clients have accurately completed eligibility documentation by 2021.
2. *Improving Viral Suppression for PLWH* – drive maximum viral suppression for PLWH in the EMA. 90% of PLWH achieve viral suppression by 2021.
3. *Addressing Disparities in HIV Health Outcomes* – ensure equitable access to RWHAP funded HIV services in the EMA for PLWH and ensure equitable results in HIV health outcomes. Using evidence-informed calculators, identify and begin to close disparities for key populations of national and regional priority by 2021.

Quality Infrastructure

The EMA CQM Program includes all stakeholders in the local system of HIV care; the Planning Council, Part A Recipient Office, Part A subrecipient providers, Part B subrecipient providers, the Part B Lead Agency, and local PLWH. The following provides a description of CQM Program roles and responsibilities from program leadership to external stakeholder involvement

Clinical Quality Management Program Leadership

Clinical Quality Management in Palm County EMA is based on a collaboration between the Part A group at Palm Beach County Community Services and the Part B group at Florida Health Palm Beach to represent Tallahassee's interests. The Part A quality manager acts as a keystone in the collaboration to provide a single point of contact and central coordination of activities across Parts A and B. The Part A quality manager works with the program managers of Palm Beach County Community Services and Florida Health Palm Beach to provide leadership to the overall program.

Internal QM Team

The Internal QM Team is made of representatives of the Part A Recipient Office and the Part B Lead Agency through the collaboration referenced above. The Part A representatives include the program manager, quality manager, compliance specialists, evaluation specialist, database manager, and the health planner. The Part B representatives include the program manager and other executive office representation, quality manager, case management/EIS and prevention, and MIS/IT. The team convenes monthly for 60-minute face-to-face meetings. For members who cannot attend in person, there is a conference calling option. The team uses its meetings to review PM data and intensively review each service category by triangulating demographic, utilization, and outcome data quarterly. The team identifies key information to present to the Quality Management & Evaluation Committee (QMEC) and other key stakeholders as needed. In addition, the team provides cross-over training in CQM to contract monitors and other colleagues within the Part A Recipient Office and the Part B Lead Agency. In addition, the internal team ensures alignment with key policy initiatives, such as the Integrated Plan. The overall workplan for this QM Plan is what drives the work for the Internal QM Team.

CARE Council Quality Management & Evaluation Committee

The Quality Management & Evaluation Committee is central to the work of the EMA's CQM Program. Bringing together a core group of stakeholders based on the CARE Council (Palm Beach County EMA's Part A and B combined Planning Council), the QMEC follows key performance measures, sets EMA-quality goals, and advises on EMA-wide QI projects.

Membership

QMEC members are drawn from the broader CARE Council and additional individuals beyond the CARE Council. In addition, representatives from subrecipient organizations, Community Prevention Partnerships (CPP) and Housing Opportunities for Persons with AIDS (HOPWA), PLWH, and affiliated individuals who are not PLWH are included as a part of the QMEC. The committee's work is shepherded by an elected chair with guidance and support from the Palm Beach County EMA Internal QM team.

Roles and Responsibilities

The QMEC determines PM priorities and methods on an ongoing basis. Additionally, the Committee will facilitate cross -Part coordination by collaborating with consumers, representatives from Part A&B, and the AIDS Education Training Center (AETC). This Committee is also responsible for:

- Providing input and direction on the EMA CQM Program.
- Reviewing and updating the Quality Management Plan annually.
- The Committee will develop Service Standards and outcome measures utilizing Palm Beach County HIV CARE Council Committees, in cooperation with the recipient.
- Make recommendations to the Part A Recipient Office and the Part B Lead Agency for appropriate education relating to quality improvement concepts and techniques.
- The QM/QA Coordinators will report cumulative service outcome results to the Quality Management Committee, which will be presented to the Palm Beach County HIV CARE Council.

Meetings

The QMEC meets every other month for up to two-hour face-to-face meetings as stipulated by CARE Council by-laws. Additional meetings are convened as needed. Meetings take place in rotating settings across Palm Beach County.

Work Plan

The QMEC workplan is established by the Internal QM Team and drives QMEC processes and reviews on an annual cycle. The work plan is based on the Quality Goals named above. In the last year of the QM Plan period, QM Plan Evaluation is included in the QMEC work plan. (Appendix A)

Stakeholder Involvement

Beyond the QMEC, there are opportunities for all Part A and Part B collaboration stakeholders to be involved in the CQM Program.

Palm Beach County HIV Planning Council

The Palm Beach County HIV Planning Council was created through an ordinance of the Board of County Commissioners in November 1993. In August of 1997, the Planning Council and the Palm Beach County AIDS Consortium officially merged and became the Palm Beach County HIV CARE Council. Responsibilities of the Palm Beach County CARE Council include to:

- review and utilize service outcome and quality assurance data of services in the prioritization and allocation of RWHAP Part A Grant Award for the EMA;
- review and utilize service outcome and quality assurance data of services in the advisement of the RWHAP Part B Grant Award for the EMA;
- receive training on CQM and QI to enhance their understanding of CQM Program activities in the EMA;
- review and comment on the QM Plan; and

- receive intensive reviews of funded service categories based on EMA CQM Program activities. Reviews of service categories are on a rotating basis and are facilitated by quality managers from the Part A and B programs.

Palm Beach County Community Services (Part A Recipient Office)

The Part A Recipient Office oversees and facilitates all CQM Program activities at Part A subrecipients in the EMA. All Part A Recipient Office staff participate in CQM Program activities at some level however the position primarily responsible for the quality activities outlined in this plan is the QM Coordinator. Other responsibilities of the QM Coordinator include:

- implementation of the CQM Program;
- leading evaluation of the CQM Program;
- facilitating CQM Program participation by subrecipient providers;
- directing technical assistance to subrecipient providers aimed at improving PLWH outcomes;
- providing updates to the Part A Recipient Office and Palm Beach County HIV CARE Council on CQM Program activities within the EMA; and
- reporting PM and special data reports to the QMEC.

Florida Health Palm Beach County (Part B Lead Agency)

The Part B Lead Agency oversees and facilitates all CQM Program activities at Part B subrecipients in the EMA. All Part B Lead Agency program staff will participate in quality management activities at some level however the position primarily responsible for the quality management activities outlined in this plan is the Quality Assurance Coordinator. Other responsibilities of the QA Coordinator include:

- implementation of the CQM Program;
- leading evaluation of the CQM Program;
- facilitating CQM Program participation by subrecipient providers;
- directing technical assistance to subrecipient providers aimed at improving PLWH outcomes;
- providing updates to the Part A Recipient Office and Palm Beach County HIV CARE Council on CQM Program activities within the EMA; and
- reporting PM and special data reports to the QMEC.

Sub-recipients

The Part A Grantee Office and Part B Lead Agency fund a number of community-based health and social service organizations as subrecipients within the EMA. As an integrated CQM program, prevention and STI subrecipients are included, as are HOPWA subrecipients. All subrecipient agencies are required to participate in the collaborative CQM Program by:

- developing QM Plans and CQM activities of their own;
- tracking client demographics, service utilization, and outcome data in Provide Enterprise;
- promoting the annual, standardized, EMA-wide client satisfaction survey;
- contributing to EMA-wide QI projects; and
- collaborating with one another through the monthly provider meetings.

People Living with HIV

PLWH in the EMA participate in the planning process through the Palm Beach County HIV CARE Council. In addition, PLWH are appointed to the QMEC to provide input on EMA service standards, developing PM for all service categories, and updating the Quality Management Plan. PLWH are also encouraged to:

- participate through various feedback mechanisms in place both system-wide and with subrecipient agencies; and
- attend QM training as offered by the Part A Recipient Office, the Part B Lead Agency, or their consultants.

Center for Quality Improvement and Innovation ECHO Collaborative

The Palm Beach County CQM collaborative is participating in the Center for Quality Improvement and Innovations ECHO Collaborative in 2018 and 2019. Palm Beach County is working alongside Broward County Part A, Orange County Part B, and Tampa Part D as a part of the South Florida Regional Group. Through the collaborative, the South Florida Regional Group elected to work on ending disparities for the Youth (13-24) subpopulation. Participation in the collaborative is on several levels, including target population affinity groups, regional groups, and based on other affinities/activities, as well.

Florida International University Collaborative

The Part A Recipient Office has engaged Florida International University in a novel multi-year collaborative around the nuances in medical and non-medical case management in 2018 and 2019. The goal is to evaluate outcomes from a health economics standpoint to efficiently maximize patient HIV health outcomes.

AIDS Education & Training Center

The regional AETC has historically been involved in chart reviews and training adjunct to the CQM program. Through the ECHO collaborative referenced above, in addition to other new activities, it is expected that the AETC will partner with the Palm Beach County CQM collaborative in the clinical education of HIV service providers in the region.

Performance Measurement

Performance measurement is a critical aspect to CQM, because “if it cannot be measured, it cannot be improved”. Candidate performance measures for the EMA are curated by the Internal QM Team for presentation to the QMEC, which ultimately selects the PM for the Palm Beach County CQM collaborative. Per HRSA Policy Clarification Notice 15-02, each funded service category must have at least one HIV outcome performance measure and each highly utilized and prioritized service category must have at least two HIV outcome performance measures.

Performance Measures

The Palm Beach County CQM collaborative includes performance measures from the Part A Recipient Office and the Part B Lead Agency. This list contains performance measures that are collected through

the Part A Recipient Office for clinical quality management purposes (Appendix B). The performance measurement dashboard collected through the Part B Lead Agency is included in the appendix.

HIV Care Continuum

The HIV Care Continuum is the dominant framework in reviewing and analyzing HIV outcomes since 2011. New reports available in Provide Enterprise allow for the Internal QM Team to identify trends and opportunities for improvement along the HIV care continuum, especially related to retention in care and HIV viral suppression. Service category, subpopulation and linkage to care analyses allow for comprehensive review of available data aimed at achieving the Palm Beach County CQM collaborative quality goals in alignment with its quality statement. Data are compared between the Part A and Part B components of the Palm Beach County CQM collaborative.

Disparity Analysis

Advancing health equity is core to the EMA quality statement and efforts to achieve a better tomorrow for all PLWH. New reports in Provide Enterprise are established to filter and analyze results along the HIV care continuum along lines that allow identification of possible disparities in HIV outcomes. In 2018, the Palm Beach County CQM collaborative enrolled in the Center for Quality Improvement and Innovation end+disparities Collaborative to further this goal. Data are compared between the Part A and Part B components of the Palm Beach County CQM collaborative.

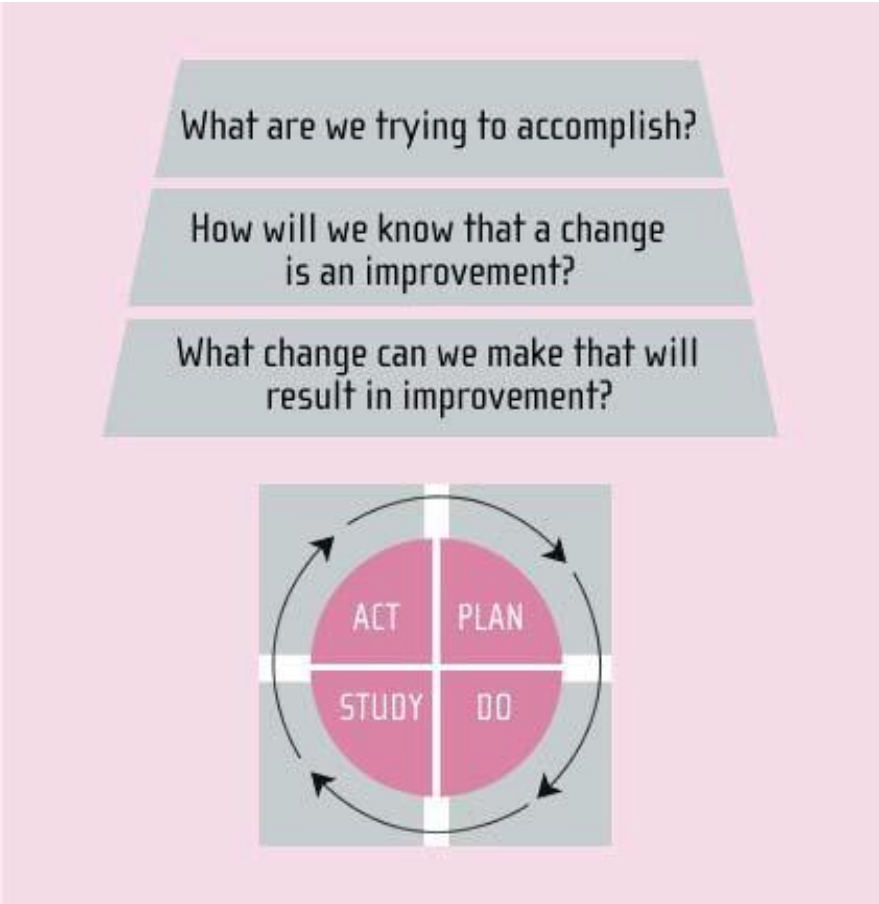
Quality Improvement

QI is the goal of the CQM Program. QI activities include capacity building, EMA-wide QI projects, and ultimately improvement in HIV outcomes for PLWH in the EMA. This section outlines the methods and activities included in EMA QI efforts.

Quality Improvement Methods

Quality Improvement Methods in Palm Beach County are rooted in HRSA Policy Clarification Notice 15-02 and brought to life by the Model for Improvement (Figure 1). Quality Improvement in the Palm Beach County CQM collaborative is governed by this Clinical Quality Management Plan and the dedicated staff and resources that are outlined in it. Performance measures are regularly reviewed by the CARE Council Quality Committee for discussion around what data are most important to drill down further. The internal team, with input from the CARE Council quality committee, convenes focus groups of affected populations to comprehensively examine issues that will drive the improvement project. This includes an exhaustive list of drivers and the change ideas that Palm Beach County subrecipients can test at their local agencies.

Figure 1: The Model for Improvement



Courtesy of the TARGET Center's Center for Quality Improvement & Innovation

Quality Improvement Projects

Quality Improvement Projects are tied to the quality statement and quality goals. In this QM Plan period, the Palm Beach County CQM collaborative has elected to participate in CQII's ECHO Collaborative. Building off the learning from this project early in the QM Plan period, Palm Beach County CQM collaborative will continue to focus on health equity by addressing health disparities. Projects are selected by the Internal QM team and brought to the CARE Council for their input and feedback. In addition, the new FIU and RWHAP collaborative will provide feedback on the nuances between non-medical and medical case management and how these services affect HIV health outcomes.

- Addressing Disparities for Youth (13-24) (2018-2019)
- Florida International University and Ryan White Collaborative (2018-2019)
- Improving Equity in Outcomes Along the HIV Care Continuum (2020-2021)

Capacity Building

For CQM Program activities and corresponding QI efforts to be successful in the EMA, capacity building at several levels is needed.

Staff

The following capacity building opportunities will be leveraged for staff of the Palm Beach County CQM collaborative. Onboarding basic training is an intensive training that lasts for up to a full day in order to orient staff to the importance of CQM and its focus on HIV health outcomes. Training that occurs at staff meetings is 20-60 minutes and focused on specific quality improvement project subject matter.

- Onboarding basic training
    - RWHAP 101
    - CQM 101
- Staff meetings
    - Ongoing training around core CQM concepts
    - Just-in-time training, as needed, on topics tied to specific QI Projects

Subrecipients

The following capacity building opportunities will be leveraged for Part A and Part B subrecipients in addition to relevant prevention, STI, and HOPWA programs. Training for new providers is intensive and takes the form of a special training engagement. Part A has quarterly provider meetings and Part B has annual provider meetings where ongoing training occurs. Ongoing just-in-time training for existing providers is provided through 20-60 minute webinars and telephone discussions.

- Provider meetings
    - New provider boot camp
        - RWHAP 101
        - CQM 101
    - Ongoing training around core CQM concepts
    - Just-in-time training, as needed, on topics tied to specific QI Projects

CARE Council Quality Management & Evaluation Committee Members

The following capacity building opportunities will be leveraged for the CARE Council QMEC members. Onboarding basic training is an intensive training that is included in the overall orientation for new CARE Council members. This training exposes new members to the importance of CQM and its focus on HIV health outcomes. Other trainings are 20-60 minutes and usually occur within committee meetings. Such trainings are focused on specific quality improvement projects.

- Onboarding basic training

    - CARE Council 101
    - CQM 101
- QI Project specific training
    - Just-in-time training, as needed, on topics tied to specific QI Projects

Evaluation

The QM Plan period is a three-year cycle. Toward the end of each three-year cycle, the Internal QM Team and QMEC undertake a systematic review of the CQM Program for the purpose of creating a new QM Plan for the next three-year cycle. Throughout the course of the cycle there are multiple evaluation activities that play into the overall QM Program evaluation.

Evaluation Methods

Evaluation of the QM Plan is based on its workplan (Appendix A). The overall QM Plan period is for a three-year cycle, but work plans are created annually to allow for greater flexibility in CQM Program activities to meet subrecipient and PLWH training needs, QI project selection, and communicating with stakeholders.

The attached work plan includes the capacity building and technical assistance activities of the CQM Program beyond PM and QI project reporting. The workplan is based on the CQM Program quality goals and is aimed at efficiently achieving the EMA quality statement.

Updating the Quality Management Plan

The Internal QM Team takes the lead in updating the QM Plan. First, a systematic review of the evaluation of the prior plan is considered to identify potential changes to the structure of the CQM Program infrastructure, including the QM Plan and the QMEC. This also includes consideration of QI methodology, capacity building methods, and data collection plans for potential changes. Second, performance measures for each service category are reviewed for relevance and importance in linking subrecipient services to optimal HIV outcomes for PLWH. Finally, the overall quality goals for the EMA CQM Program are reviewed and updated.

Potential changes to the QM Plan are presented to the QMEC for their review and feedback. Next, the draft QM Plan is presented to the Palm Beach County HIV CARE Council for feedback. Once all changes are made to the QM Plan based on stakeholder input, the new version is signed off by leaders.

Communication and Community Sharing

An important aspect of a culture of quality is transparency and routine communication of effort and results. This section outlines the methods the EMA will use to communicate about the CQM Program and the results of its activities.

Dissemination Audiences

The following groups are targeted to receive periodic updates from the Palm Beach County CQM collaborative. This list constitutes the *who* of dissemination.

- Palm Beach County HIV CARE Council
- Part A Grantee Office
- Part B Lead Agency
- HRSA-HAB
- Subrecipient Providers
- PLWH
- Local HOPWA
- Community Prevention Partnerships
- Health Professional Workgroup (non-funded allies/providers; i.e., high-risk OB and other medical specialties)
- Integrated Planning Focus Groups (PLWH with vested interest in funded services)

Dissemination Reports

The following reports will be distributed to audiences that are listed above. This list constitutes the *what* of dissemination.

- Service Utilization and Outcomes Report
- Retention in Care Report
- HIV Care Continuum Report
- Part B Dashboard Results

Dissemination Activities

The following activities represent the specific dissemination opportunities to distribute the reports above to the audiences above. This list constitutes the *how* of dissemination.

- Publicly-accessible website (www.carecouncil.org)
- Social media (Facebook and Twitter)

Appendix A

Month	CQM Collaborative Stakeholders		
	Internal QM Team	**CARE Council QM Committee**	**Subrecipients**
July 2018	QM Plan Review.	QM Plan Review and feedback. QI Project Updates.	Standard data entry as services are delivered in the field.
August 2018	In-service CQM Training. Performance measurement abstraction and analysis.	CQM Training using QM Plan as model.	Standard data entry as services are delivered in the field.
September 2018	Pilot new data reports from PE	QM Plan Review and feedback. QI Project Updates. Performance measurement review	Standard data entry as services are delivered in the field.
October 2018	Performance measurement abstraction and analysis.		CQM Training. Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
November 2018	QM Coaching for subrecipients	QI Project Updates. Performance measurement review	Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
December 2018	Performance measurement abstraction and analysis. QM Coaching for subrecipients		Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
January 2019	QM Coaching for subrecipients	QI Project Updates. Performance Measurement Review	Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
February 2019	QM Coaching for subrecipients		Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
March 2019	QM Coaching for subrecipients	QI Project Updates	Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team.

April 2019	Performance measurement abstraction and analysis. QM Coaching for subrecipients		Standard data entry as services are delivered in the field. QI Project updates submitted to internal QM team
May 2019	QM Coaching for subrecipients	Performance Measurement Review	Standard data entry as services are delivered in the field.
June 2019	QM Coaching for subrecipients		Standard data entry as services are delivered in the field.

APPENDIX B – PERFORMANCE MEASURES

Systemwide- Care Continuum				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Ever in Care:	HIV+ clients that ever had medical care service* documented.	All Ryan White Part A clients.		HRSA
In Care:	HIV+ clients that had a medical care service* documented within reporting period.	All Ryan White Part A clients.		HRSA
Retention in Care:	HIV+ clients that had two or more medical care service* at least three months apart in reporting period.	All Ryan White Part A clients.	*Patients newly enrolled in care during last six months of the measurement year.*	HRSA
On ARV Therapy:	HIV+ clients that have ARV therapy set to one or more at any time during reporting period.	All Ryan White Part A clients.		HRSA
Virally Suppressed:	HIV+ clients with most recent viral load as of end of reporting period less than 200 copies/mL.	All Ryan White Part A clients.	*Patients with unknown or unreported viral loads.*	HRSA

Outpatient Ambulatory Medical Care (OAMC)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Viral Load Suppression:	Number of patients in the denominator with a viral <200 copies/mL at last viral load test during the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.		HAB

Medical Visits Frequency:	Number of patients in the denominator who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior six-month period and the last medical visit in the subsequent six-month period.	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first six months of the 24-month measurement period.	*Patients who died at any time during the 24-month measurement period.*	HAB
Gaps in Medical Visits:	Number of patients in the denominator who did not have a medical visit in the last six months of the measurement year.	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first six months of the measurement year.	*Patients who died at any time during the measurement period.*	HAB

Medical Case Management (MCM)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Medical Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received MCM services during the reporting period that are not new to care (first service was over a year form the end date of the reporting period).		HAB
Medical Case Management (MCM) Care Plans:	Number of MCM patients who had a MCM Care Plan developed and/or updated two or more times which are at least three months apart in the measurement year.	Number of MCM patients, regardless of age, with a diagnosis of HIV who had at least one MCM encounter in the measurement year.	*1. MCM patients who initiated MCM services in the last six months of the measurement year.* *2. MCM patients who were discharged from MCM services prior to six months of service in the measurement year.*	HAB
MCM Medical Visits:	Number of MCM patients in the denominator who had at least one OAMC visit in each six month period of the 24-month measurement period with a minimum of 60 days between first OAMC visit in the prior six month period and last medical visit in the subsequent six month period.	Number of MCM patients, regardless of age, with a diagnosis of HIV with at least one OAMC visit in the first six months of the 24-month measurement period.	*1. MCM patients who dies at any time during the 24- month measurement period.*	HAB

Non-Medical Case Management (NMCM)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Achieving POC Goals:	Clients in the denominator whose closed action plan goal was successful, and was completed by the target date.	Clients that received non-MCM services during the reporting period, and had at least one action plan goal closed during the reporting period.		PBC Indicator
Scheduled Appointments Every Six Months:	Clients in the denominator that had an appointment record for "medical care" that was created within one day of the "date completed" in the Ryan White certification.	Clients that received an Eligibility service during the reporting period, who had a Ryan White certification completed during the reporting period and who had not had a medical appointment in the status of "kept" in the six months prior to the certification "date completed".		PBC Indicator
Retention in Care:	Clients in the denominator that had documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received non-MCM services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Oral Health Care				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Oral Health Education:	Number of HIV-infected oral health patients who received oral health education at least once in the measurement year.	Number of HIV-infected oral health patients that received a clinical oral evaluation at least once in the measurement year.	*1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.* *2. Patients who were <12 months old.*	HAB
Periodontal Screening or Examination:	Number of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year.	Number of HIV-infected oral health patients that received a clinical oral evaluation at least once in the measurement year.	*1. Patients who had only an evaluation or treatment for a dental emergency in the measurement year.* *2. Edentulist patients (complete).* *3. Patients who were <13 years.*	HAB

AIDS Pharmaceutical Assistance (LPAP)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Prescription Pick-Up:	Clients in the denominator that have the "client contact" in a prescription record set to "attempted" or "made" and the "date contact attempted" is within 14 days from the "date returned to stock".	Clients that have a prescription record during the reporting period in a status of "returned to stock".		PBC Indicator
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received local pharmacy assistance services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Mental Health				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received mental health services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Substance Abuse Counseling				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received substance use counseling services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Food Bank				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received food bank services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Legal				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received legal services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB
Improving Financial Stability:	Clients in the denominator who won their case.	Clients who received legal services for representation at a Social Security Administrative Law Judge hearing during the reporting period.		PBC Indicator

Emergency Financial Assistance (EFA)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received EFA services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Early Intervention Services (EIS)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received EIS services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Emergency Housing				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received emergency housing services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Health Insurance Continuation				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received health insurance continuation services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Home & Community Based Health Care (HCBH)				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received HCBH services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Medical Transportation				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received medical transportation services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

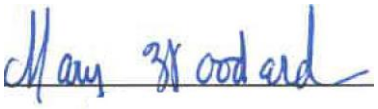
Medical Nutritional Therapy				
Performance Measure	**Numerator**	**Denominator**	**Exclusions**	**Source of Measure**
Retention in Care:	Clients in the denominator that had a documented "kept" medical appointment during the first six months of the reporting period and also a "kept" medical appointment during the second six months of the reporting period.	Clients that received medical nutritional therapy services during the reporting period that are not new to care (first service was over a year from the end date of the reporting period).		HAB

Data Collection Plan

Type	Data Element / Measure	Selections	Relevant Service Category	QI Goal	Data Sources	Data Entry	Freqency
Demographics	Patient Gender	Male, Female, Male-to-Female Transgender, Female-to Male Transgender, Unknown	All services	Reduding Disparities	Patient reporting, verifying documents	Provide Enterprise	intake
Demographics	Patient Age	0-12, 13-24, 25-44, 45-65, >65	All services	Reduding Disparities	Patient reporting, verifying documents	Provide Enterprise	intake
Demographics	Patient Race	White, Black, Asian/Pacific-Islander, Native American/Eskimo, Multiracial, Unknown	All services	Reduding Disparities	Patient reporting, verifying documents	Provide Enterprise	intake
Demographics	Patient Ethnicity	Hispanic, Not-hispanic	All services	Reduding Disparities	Patient reporting, verifying documents	Provide Enterprise	intake
Demographics	Patient Address	full patient address, including apartment number, and zip code	All services	Eligibility	Patient reporting, verifying documents	Provide Enterprise	biannual
Demographics	Proof of HIV	Yes/No	All services	Eligibility	EMR, EHR, paper charts	Provide Enterprise	intake
Care Continuum	Ever in Care	Yes/No	All services	90-90-90	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Care Continuum	Currently in Care	Yes/No	All services	90-90-90	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Care Continuum	Retention in Care	Yes/No	All services	90-90-90	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Care Continuum	On ARV Therapy	Yes/No	All services	90-90-90	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Care Continuum	Viral Supression	Yes/No	All services	90-90-90	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Medical Encounter	Yes/No	OAMC, MCM	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	CD4 Count	Yes/No	OMAC	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Viral Load	Yes/No	OAMC	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Viral Suppression	Yes/No	OAMC	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Medical/Dental History	Yes/No	Oral	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Dental Treatment Plan	Yes/No	Oral	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Oral Health Education	Yes/No	Oral	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Periodontal Screen/Exam	Yes/No	Oral	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Retention in Medical Care	Yes/No	All services	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	MCM Care Plans	Yes/No	MCM	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	MCM Medical Visits	Yes/No	MCM	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Achieving POC Goals	Yes/No	nMCM	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Prescription Pick-Up	Yes/No	LPAP	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Eligibility	Sched Appt ea 6 Mo	Yes/No	nMCM	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly
Clinical	Improving Financial Stab.	Yes/No	Legal	General Performance	EMR, EHR, paper charts	Provide Enterprise	Quarterly

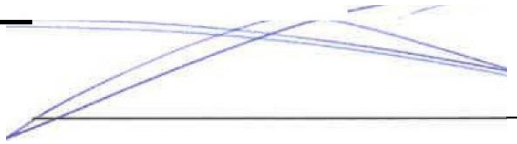
Signatures

Leadership guidance and support is critical to ensure a culture of quality in the EMA. The signatures on this page represent the review and approval of key leaders important to the CQM Program in the EMA. Approval is provided by all members ofthe Palm Beach County CQM collaborative and signed off by leaders of the Part A and B programs and the CARE Council.



Mary Wooda rd
Program Manager
Palm Beach County Community Services (Part A Recipient Office)

Psyche Doe
Program Manager
Florida Health Palm Beach C t - B Lead Agency)



Chris Dowden
Chairperson
CARE Council (Part A and Part B Planning Council)