Quality Management Plan

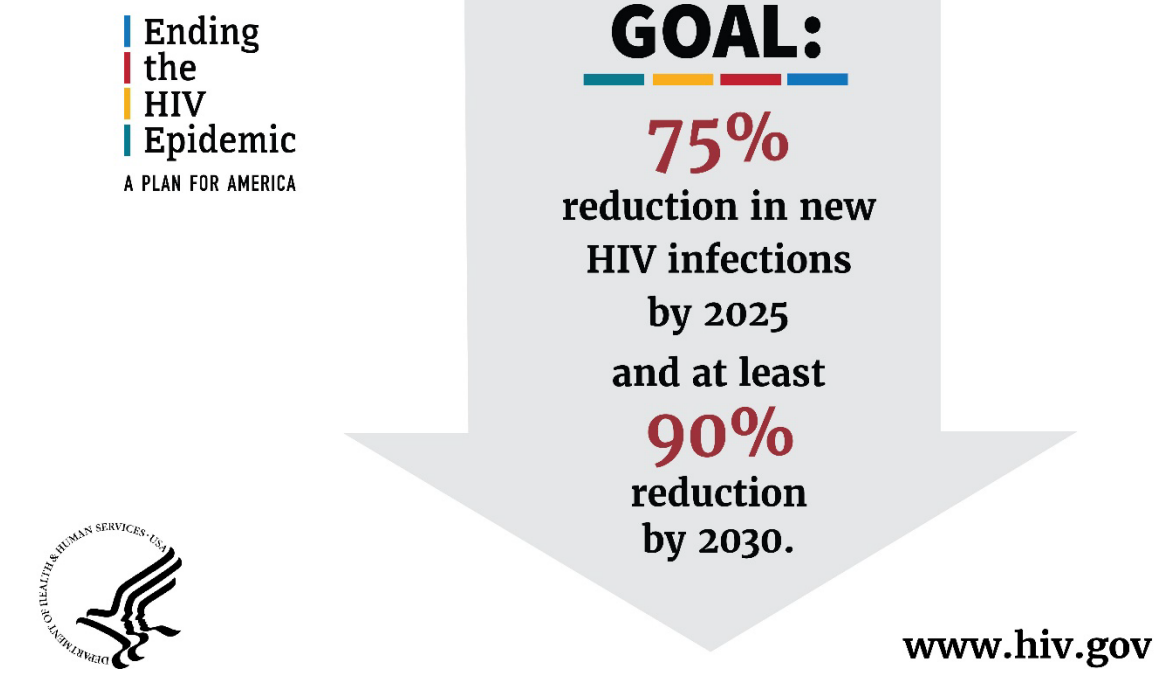
MIRACLE OF LOVE

2023-2024

Adopted March 28, 2023

Amended [See Appendix]

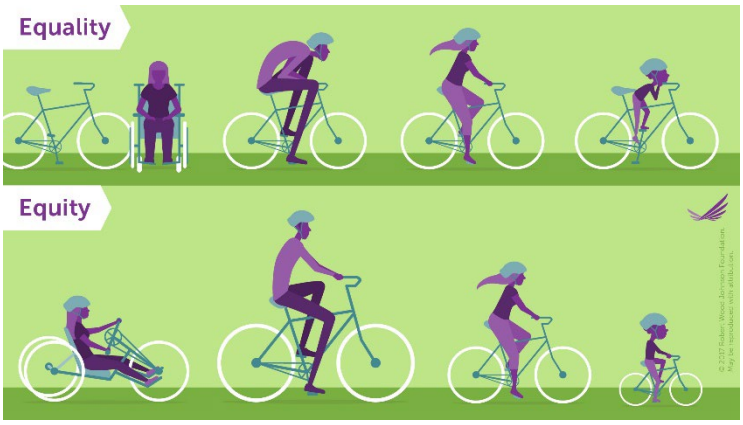
Contents



QUALITY STATEMENT

Miracle of Love Inc., (MOL) is committed to developing, evaluating and continually improving an organizational, quality continuum of HIV care, treatment and supportive services that meet the identified needs of persons living with HIV and their families, ensures equitable access, and decreases health disparities.

MOL has developed this Quality Management Plan (QMP) to ensure adherence to recommended and regulated clinical, non-clinical, and case management services performance measures.



Quality Management is a *continuous process adaptive to change and consistent with other programmatic quality assurance (QA) and quality improvement (QI) activities.*

The Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB) provide guidelines for the administration of quality management plans for agencies providing services to People with HIV (PWH). These guidelines require agencies to adhere to the Health and Human Services (HHS) guidelines for quality management in clinical practice to ensure:

1. program improvement includes support services linked to access and adherence to medical care
2. demographic, clinical, and utilization data are used to evaluate and address the characteristics of the local patient population

Our clients deserve our best efforts to constantly improve.

MIRACLE of LOVE

An effective QMP for MOL should have the following characteristics:

1. Aligns with HAB measures
2. A systematic process with identified leadership, accountability, and dedicated resources
3. A strategy using data and measures to determine progress toward evidence-based benchmarks
4. A focus on linkages, efficiencies, and provider and client expectations in addressing the outcome
5. Enact process and strategies for improvement through Action Plans and re-evaluation
6. Incorporates the training of all staff on the purpose, intent, and actions of the QMP, the Agency Services Quality Management Program (ASQMP), and the Agency Services Quality Management Committee (ASQMC)

TARGETS & GOALS

Targets and goals are set by the Quality Management Committee and by recipient.

EVALUATE

We constantly monitor and evaluate our outcomes and our progress.

IMPROVEMENT

We strive to continuously improve for our clients and the community.

Agency Services Quality Management Program

The Agency Services Quality Management Program at Miracle of Love, Inc. is comprised of individuals that have different responsibilities in the development, implementation, evaluation, and support of the Quality Management Plan. Each member serves an important role in working to ensure accountability and standardization of efforts, identifying gaps in care and fostering collaboration, and sharing knowledge.

To ensure broad participation of key stakeholders (e.g., providers, clients, and other groups) in future and ongoing ASQMP activities, MOL has established the ASQMC.

Vision

To provide a continuum of care and support services that promote optimal health, decreases HIV transmission, eliminates health care disparities and promotes a high quality of care, client empowerment and self-determination.

Mission

To ensure equitable access to comprehensive, high-quality care and support services for people living with HIV served by MOL:

- Ensuring adherence to clinical guidelines and Standards of Care
- Maximizing collaboration and coordination of service providers to enhance access
- Promoting partnerships of clients and providers that are respectful and promote client self-determination
- Providing services that are culturally appropriate and focused on individual client need
- Maximizing the efficient use of resources to provide cost-effective services

MOL supports this mission by gathering data and information about the services delivered by MOL and its staff, volunteers, and contractors by:

1. analyzing this information and reports to measure outcomes and quality of services
2. reporting this analysis to identify areas requiring needed improvements
3. implementing improvement activities to meet program goals
4. disseminating related information obtained from outside sources (i.e. Ryan White Planning Council, and related meetings and updates)

Quality Management Program Manager

The Quality Management Program Manager (QMPM) is the liaison for the Agency Services Quality Management Committee. The QMPM has no legal, regulatory, or statutory authority, and exists at the discretion of Miracle of Love, Inc. The QMPM shall be designated by the Executive Director and shall serve as the Recorder on the ASQMC.

The QMPM is responsible for implementing, monitoring, and reporting results from QA and QI activities set by the ASQMC. The QMPM coordinates directly with the Executive Director to ensure quality standards in client services are fully met, assess data to determine potential outcome improvement areas, and to keep all members of the ASQMC apprised of those activities. The QMPM is the representative of the ASQMC and is responsible for conducting assessments, relaying communication from employees to the committee, and vice versa, onboarding new committee members, debriefing departing committee members, and conducting general quality monitoring,

improvement, and evaluation of services provided by MOL, and may work in conjunction with MOL leadership.

Agency Services Quality Management Committee

The Agency Services Quality Management Committee is a key part of the ASQMP at MOL.

The ASQMC is a technical workgroup and has no legal, regulatory, or statutory authority, and exists at the discretion of Miracle of Love, Inc., in accordance with the Ryan White HIV/AIDS Program (RWHAP) Part A office. It serves in an important advisory role, assessing quality data and recommending quality improvement.

Role

1. Develop and revise the Quality Management Plan
2. Monitor implementation of the QMP
3. Oversee specific program and team projects
4. Monitor and measure performance of service standards with regard to clinical treatment, case management and related services to determine effectiveness of the service standards
5. Educate the sub recipient network and team members on the tenants of the Agency Services Quality Management Program
6. Authorize performance improvement initiatives and set forth quality expectations for ongoing monitoring.

Responsibilities

The ASQMC is responsible for the following activities:

1. Informing the Ryan White HIV/AIDS Program Part A office on quality-related activities, including soliciting input and feedback on QMP activities.
2. Monitor progress of goals and objectives of the QMP
3. Develop action plans for continuous improvement
4. Evaluate and assess the QMP annually
5. Update the QMP annually
6. Develop an annual workplan

Procedures and Duties

The MOL ASQMC:

1. follows the Robert's Rules of Order for meetings
    a. nominates and holds election for a chair, vice chair, and parliamentarian
    b. recorder defaults to QMPM
2. reviews and adopts the vision and mission annually
3. develops an annual action plan and timeline
4. conducts annual evaluations of the ASQMP
5. analyzes data and monitors health disparities
6. develops a communication plan which includes the format or instrument of reporting and the intervals of which the findings will be reported
7. utilizes the **Plan** (Quality Planning), **Do** (Quality Control, QC), **Study** (Quality Assurance, QA), **Act** (Quality Improvement, QI) **(PDSA)** model

8. updates the QMP as necessary to monitor and improve the quality of services and include the participation of providers and clients while minimizing the burden on all stakeholders
    a. determine and implement performance measures by March 1 annually
    b. regularly review performance information/data[1]
    c. provide written feedback to staff by June 30 annually
    d. accept feedback from staff by July 31 annually
        i. review, determine, and implement any changes necessary based on staff feedback
9. determine or assess strategy and method for obtaining input from staff to make necessary and noted improvements
10. participate in trainings to improve QM strategies and activities
    a. members must understand the tenets of quality management and the Plan, Do, Study, Act method
    b. members will use continuous learning to gain additional knowledge by attending recommended and relevant training
11. review the results of the client satisfaction survey conducted annually and compare results to previous years to evaluate and determine areas of improvement
12. measure and follow up on employee satisfaction
    a. the measures reviewed will include:
        i. the overall satisfaction with employee position and duties
        ii. satisfaction with direct management
        iii. an assessment of training needs
        iv. an assessment of fatigue and burnout
        v. additional measures determined by the ASQMC
    b. develop an employee satisfaction survey
    c. survey to be conducted anonymously biannually in May and December by QMPM
    d. distribute a formal, written report to organizational leadership within thirty (30) days of completion of employee surveys
13. develop or assess method for measuring and reporting client no show rates
    a. review the results and develop methods to reduce client no shows
14. develop or assess method for measuring and reporting client wait times
    a. review the results and develop methods to improve client wait times
15. develop or assess method for measuring and reporting other selected processes, systems, policies, etc., review the results, and develop methods to improve these processes, systems, policies, etc.

Agency Services Quality Management Committee Members

Engagement of Stakeholders

To ensure ample engagement with stakeholders, community partners, and diversity, MOL ASQMC members are selected using the following recommendations:

- At least one member should be from MOL leadership and familiar with the QMP
- At least one member is from the Ryan White Intensive Case Management and Referral Specialist staff at MOL
- At least one member is from each program within the agency, which includes HOPWA, ICM HOPWA, TOPWA, and Prevention (includes Florida Department of Health EHE and Orange County Government EHE).

[1] All data shall be stratified by gender, age, SES, risk factor, geography, etc.

- A transgendered employee, or a transgendered client currently receiving Ryan White services
- A minimum of two clients currently receiving Ryan White services at MOL

Agency Services Quality Management Committee Composition

The Agency Services Quality Management Committee will be comprised of voting members (described in Engagement of Stakeholders) and non-voting Associate Members.

Associate Members are appointed by the Executive Director and nominated by any member of the ASQMC or a program manager. Associate Members appointed to the ASQMC will complete an onboarding with the committee Recorder and provided all relevant materials and information related to the committee procedures, the QMP, and all planned or ongoing QI projects. Associate Members must attend 80 percent of all scheduled ASQMC meetings in a fiscal year. Associate Member must attend January committee meeting, at which time the committee shall assess the Associate Member on knowledge, willingness to participate, and understanding of policies and procedures. All ASQMC members will be allowed five (5) minutes to question/interview the Associate Member. Should an ASQMC member make a motion to grant the Associate Member full committee membership, and said motion is seconded, the Chair shall call for a roll call vote. Associate Members that are approved for full committee membership are eligible to be considered for a committee officer role and will be appointed to committee during the following fiscal year initial meeting in March.

POSITION	ROLE
Board of Directors Member	Committee Champion | Voting Member
Executive Director	Committee Champion | Voting Member
Quality Management Program Manager	Committee Recorder | Voting Member
HOPWA Program Representative	Voting Member
ICM HOPWA Program Representative	Voting Member
Prevention Program Representative(s)	Voting Member(s)
Ryan White ICM Program Representative	Voting Member
Ryan White RS Program Representative	Voting Member
TOPWA Program Representative	Voting Member
Transgendered Employee or Client	Voting Member
Current Client	Voting Member
Current Client	Voting Member
Associate Member(s)	Non-Voting Member
Advisor/Consultant (if needed)	Non-Voting Member

As described in Procedures and Duties 1.a., voting members will nominate and hold elections for committee officers. All members and relevant information are available to all stakeholders at the website molcfl.org.

Meetings

The Agency Services Quality Management Committee meets at least quarterly for an agreed upon minimum period, in a location agreed upon by the members. Additional meetings may be called by the Chair or Committee Champion if necessary.

The ASQMC Chair and Recorder, with input from the Champions and Members, are responsible for composing meeting agendas. The Chair facilitates the meetings. In the absence of the Chair, the Vice-Chair, Parliamentarian, or Recorder (in that order) shall preside as facilitator. The Recorder is

responsible for the recording of the minutes. Minutes of meetings are distributed to each member of the ASQMC and to all necessary Orlando Service Area (OSA) network wide committees. The official agenda and meeting minutes are readily available to all stakeholders at molcfl.org. A recording (if available) is made available to stakeholders at molcfl.org.

The ASQMC must have a quorum to conduct business. The quorum standard, as adopted by the ASQMC, is 50 percent, plus one (1) member of the ASQMC voting members must be present. Proxy voting is permitted by ASQMC voting members if quorum is achieved. Associate Members may not be counted toward quorum.

Quarterly Tasks

Each quarter the ASQMC will include the following tasks in the agenda:

Every Meeting

- Monitor Client Surveys
- Update QMP and post to repository at molcfl.org (as needed)
- Review HAB Performance Measures (current standing)
- Review QI project progress
- Quality Management Reports status
- Review annual performance measures monitored

First Quarter (March, April, May)

- Seat new officers and members (start of new committee session)
- Call to order committee fiscal year session
- Review HAB Performance Measures for prior calendar year
- Designate and begin QI Project
- Certify final version of QMP for submission to the Board of Directors and subsequently to RWHAP Part A office by March 31 each year
- Draft, review, and certify employee survey template for fiscal year
- Approve employee survey submission timeline
- Review Ryan White HIV/AIDS Program Service Report (RSR)
    - Modify QMP as needed to adjust for performance measures and PDSA
- Draft, review, and certify agency staff annual work report
- Conduct employee survey (May)

Second Quarter (June, July, August)

- Distribute annual report to all agency staff (June)
- Draft, review, and certify employee survey written report
- Distribute employee survey written report to agency leadership (July)
- Conduct feedback submission period for agency staff annual work report (July)
- Recorder to compile feedback received and deliver to all members to review

Third Quarter (September, October, November)

- Approve employee survey submission timeline

Fourth Quarter (December, January, February)

- Conduct employee survey (December)

- Draft, review, and certify employee survey written report
- Complete and submit Organizational Assessment Tool (OAT) to RWHAP Part A office by January 31
- Assess and vote on Associate Members and Voting Members (January)
- Accept nominations for Chair, Vice Chair, and Parliamentarian for next fiscal year session (January)
- Conduct elections for Chair, Vice Chair, and Parliamentarian for next fiscal year session (January/February)
- Review results of QI project (February)
- Complete and submit OAT action plan for items indicated at a three (3) or lower to RWHAP Part A office by February 28
- Draft QMP for next fiscal year (February)
- Adjourn committee for fiscal year session

Resources

The ASQMC's resources include the commitment, participation, and expertise of the membership, infrastructure resources provided by MOL and data reports generated by the RWHAP Part A office, as well as internal reports generated from Provide Enterprises and other data sources. MOL will compile monthly reports and other documentation necessary for the purposes of the committee. Technical assistance resources are also available through HRSA/HAB, the Center for Quality Improvement and Innovation (CQII), and other local or national organizations.

ASQMC members are provided additional resources as available from within MOL and all paid ASQMC members are given sufficient time to participate in meetings, QI projects, and all other aspects of the ASQMC and the annual QMP.

MOL has a combined total of one (1) FTE that is dedicated to the quality improvement of the organization. This FTE consists of: Executive Director (20%), Ryan White Intensive Case Management Program Manager (33%), and Quality Management Program Manager (47%).

Quality Management Program Evaluation

The ASQMC collectively is responsible for evaluating the ASQMP.

- Evaluation results are derived from the program monitoring process, client satisfaction surveys (both internally collected and by RWHAP Part A office), and tracking of performance measures quarterly.
- ASQMC reviews the evaluation and recommends a plan for improvement to the QMPM and creates workgroups as needed.
- The QMPM reports updates to the entire agency during staff meetings on behalf of the ASQMC.
- Annually the NQC OAT is completed with results incorporated in the revised QMP as necessary.

Special projects are evaluated as outlined in the Data Sources section. Performance measures continue to be reviewed to ensure high levels of service provision.

Evaluation Activities Focus Points

1. Were there improvements?
    a. What created the improvements and how can they be replicated?
2. What were the improvements?
    a. Identify the improvements in writing.
3. Were goals met?
    a. By whom?
    b. What did they do differently to improve results?
4. Is further action required?
    a. How can the organization ensure positive results are replicated?
    b. What policy or process needs to be changed to ensure comprehensive success amongst all staff that work with clients?
5. Which benchmark(s) were consistently not met?
    a. Why?
    b. What can be done to address the barriers?
6. Were stakeholders informed?
    a. Inform them if they have not been informed.
    b. Do they have any suggestions for better success?
    c. Can they be of assistance?
7. Were goals compared with year-end results?
    a. Did the organization make collective improvements since the previous year?
8. What assessment tools were developed?
    a. Checklists, audits, meetings, reports, and other material should be regularly developed and disseminated.

Establishing and Updating the Quality Management Plan

Initial and Annual Drafting of the Quality Management Plan

The QMP is drafted and presented for review by the ASQMC. Annually, in January, the ASQMC must:

1. examine the status of data collection and reporting for each of the measures included in the QMP
2. include the local HIV Care Continuum Work Plan as part of the QMP
3. include annual data and benchmarks for all priority performance measures adopted in the QMP

In addition to assessing the status of the health performance measures above, the ASQMC may also consider:

1. Reviewing and recommending system-wide strategies/activities identified in the current *Integrated HIV, Prevention, and Care Plan*
2. Adopting a system-wide initiative focused on tracking referrals, including referrals made and their outcomes
3. Exploring participation in regional and/or national QM initiatives and/or training facilitated by the CQII, and other resources, to assist the ASQMC in identifying best practices and/or additional benchmarks against which to assess the quality of care

The QMP must be adopted by the ASQMC, accepted by the MOL Board of Directors, and approved by the RWHAP Part A office each year.

Process to Update the Quality Management Plan

The QMP is assessed against its goals at every meeting to determine if any alterations should be made. All QI projects are reviewed to assess progress toward meeting the goals and an annual organizational assessment is performed.

The ASQMC receives a formal update within thirty (30) days after the close of the calendar year. Additionally, the updated plan is reviewed by the RWHAP Quality Management staff to provide recommendations or final approval.

Quality Management Plan Implementation

The QMP identifies the accountable participants and specifies the timeline for implementation. The annual work plan dictates the details of specific QI projects. The progress of the work plan is updated, at least, quarterly by the HSQMC, with feedback from the MOL staff.

Quality Improvement

Upon identifying an opportunity for improvement, the ASQMC works together with program managers to analyze the process and develop improvement plans. In addition, the ASQMC uses a project prioritization matrix to determine which QI initiatives to recommend for implementation. The matrix allows for the selection of optimal improvement projects against their weighted value based on benefit to the client. The matrix also determines relative costs of the project, if any. The matrix is based on the Lean Six Sigma 15 criteria for selecting viable DMAIC (Define, Measure, Analyze, Improve, and Control) Project. Every attempt is made to ensure the process is collaborative. The Continuous Quality Improvement Methodology is used and includes, but is not limited to the following:

- Model for Improvement
- Plan, Do, Study, Act (PDSA)
- Flow Chart Analysis
- Brainstorming
- Observational Studies/Patient Flow
- Activity Logs

ASQMC Improvement Plans are developed and implemented by the QMPM and agency leadership. Improvements may include:

- System Redesign
- Education (Staff/Clients)
- Clinical Guidelines Review, Revision, or Development
- Procedure and Policy Changes
- Form Development or Revision
- Improvement Outcomes

Improvement plans are documented in the ASQMC minutes, in a PDSA chart, incorporated into the annual work plan and communicated to all stakeholders as deemed appropriate. Scheduled

meetings, electronic mail, memos, and informal verbal communication are all considered appropriate methods to communicate the ASQMC's activities and improvement plans.

The team-oriented approach allows the committee members to identify corrective action methods and develop creative solutions for improvement. The quality and utility of an evaluation are dependent upon a well-designed and implemented project. The project cycle provides evidence and data as to whether the intended impact was achieved and informs future components of the program cycle. The project cycle consists of six steps that is based on the PDSA model:

1. Review, Collect, and Analyze Project Data
2. Develop a Project Team
3. Investigate the Process
4. Plan and Test Changes
5. Evaluate Results with Key Stakeholders
6. Systematize Changes

Plan, Do, Study, Act Model (PDSA)

The PDSA model is a widely used framework for testing change on a small scale. Diagram 1 illustrates the four steps required to assess change within the program.

Diagram 1. The PDSA cycle.

1. **Plan** – Create a workable and realistic plan to address identified need. QI plans consist of:
    a. Aim/Objective Statement
        i. What do you hope to learn?
        ii. What are you trying to improve (aim), by how much (goal) and by when (timeframe)?
    b. Predictions/Hypothesis
        i. What do you think will happen?

   c. Plan for change/test/intervention
      i. Who? (Target population)
      ii. What? (Change/test)
      iii. When? (Dates of test)
      iv. Where? (Location)
      v. How? (Description of plan)
   d. Measures
      i. What will you measure in order to meet your aims?
      ii. How will you know that a change is an improvement?
      iii. Will you use outcome or process measures?
   e. Plan for data collection
      i. Who? (Will collect)
      ii. What? (Measures)
      iii. When? (Time period)
      iv. Where? (Location)
      v. How? (Method)
2. **Do** – Deploy steps of the plan
   a. Note when completed, observations, problems encountered, and special circumstances
   b. Include names and details
3. **Study** – Follow up to ensure plan was implemented properly and outcomes are desirable
   a. Summarize and analyze data (quantitative and qualitative)
   b. Include charts and graphs
4. **Act** – Plan is fully implemented and cycle begins again
   a. Document and summarize what was learned
      i. Did you meet your aims and goals?
      ii. Did you answer the questions you wanted to address?
      iii. List major conclusions from this cycle
   b. Define next steps
      i. Are you confident that you should expand size/scope of test or implement?
      ii. What changes are needed for the next cycle?

Quality Improvement Activities

Quality Improvement Activities (QIA) are aimed at improving client care, health outcomes, and client satisfaction, and are conducted for at least one funded service category at any given time. All funded services are assessed through performance measurement to evaluate the effectiveness of the service. If the performance measure is not meeting expectations, a QI project is implemented to address the service.

The QIA selected for FY 2023-2024 will focus on improving data quality. The focus will be on seeking out best practices to ensure case managers are requesting, obtaining, reviewing, and entering client lab results and ambulatory outpatient medical care (AOMC) appointments into the software of record, Provide Enterprises. The QIA can be reviewed in Appendix A of this QMP.

Sustaining Improvements

Regular feedback regarding QI projects is critical to the success in sustaining improvements over time. Once an improvement plan has been successful, a regular monitoring schedule is implemented to determine whether the plan remains successful over time.

Performance Measurement

The HIV Care Continuum

The HIV Care Continuum consists of several steps required to achieve viral suppression. This model measures linkage to care, retention in care, and sustained viral suppression.[2] These steps are illustrated in Diagram 2.

Diagram 2. HIV Care Continuum.

1. **Diagnosed with HIV**
2. **Linked to Care**
    a. HRSA measures linkage to care by the percentage of patients, regardless of age, with a diagnosis of HIV who attended an Ambulatory Outpatient Medical Care (AOMC) appointment within 30 days of the referral to Early Intervention Services (EIS).
3. **Received HIV Medical Care**
    a. HRSA measures a client as receiving HIV medical care by the percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.[3]
4. **Retained in Care**
    a. HRSA measures retention in care by the percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.[4]
5. **Achieved and Maintained Viral Suppression**
    a. HRSA measures viral suppression by the percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year.[5]

The HIV Care Continuum is used as an internal tool to measure success within MOL client populations.

[2] HIV.gov HIV Care Continuum https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum
[3] HRSA Ryan White & Global HIV/AIDS Programs HIV/AIDS Bureau Performance Measures – Core Measures pg. 4
[4] HRSA Ryan White & Global HIV/AIDS Programs HIV/AIDS Bureau Performance Measures – Core Measures pg. 13
[5] HRSA Ryan White & Global HIV/AIDS Programs HIV/AIDS Bureau Performance Measures – Core Measures pg. 2

Additionally, the ASQMC uses four primary goals for HIV related services, as defined by the National HIV/AIDS Strategy Federal Implementation Plan: 2022-2025[6]:

1. Prevent new HIV Infections
2. Improve HIV-Related Health Outcomes of People with HIV
3. Reduce HIV-Related Disparities and Health Inequities
4. Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Stakeholders

Annual Performance Measures

Annual performance measures are identified based on percentage of client accessing specific service categories. Two performance measures are identified for service categories where 50 percent or more client access that service and one performance measure for service categories where more than 15 percent, but less than 50 percent, of clients access those services. Gaps in service will be reviewed annually in order to create quality improvement initiatives to eliminate, or at a minimum, reduce the gaps.

For the 2023-2024 fiscal year, the ASQMC will be monitoring the following performance measures:

Area of Measurement: Service Category	**Tool/Method for Measurement: Indicators**	**Target**	**2020**	**2021**	**2022**	**2023**
Intensive Case Management	Viral Suppression Annual Retention in Care	**88%** **65%**	90% 74%	86% 63%	80% 61%	+10 +5
Referral for Health Care and Support Services	Viral Suppression Annual Retention in Care	**94%** **67%**	91% 74%	87% 65%	80% 60%	+10 +6
Food Pantry/Card	Client Satisfaction	**90%**	--	--	--	Baseline
Early Intervention Services	Linked to Medical Care (AOMC)	**90%**	--	--		
Agency – Client	Client Satisfaction	**95%**	97.8%	95.6%	96%	+2
Agency - Employee	Employee Satisfaction	**85%**	--	--	82.1%	+5

Performance Measure Standards

Annual Retention in Care	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.
HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/mL at last viral load test during the measurement year.
Employee Satisfaction	Using a Likert Scale with five options, employees rating above the median are considered satisfied.
Client Satisfaction	Using a Liker Scale with five options, clients rating above the median are considered satisfied.
Linked to Medical Care (AOMC)	Percentage of patients, regardless of age, with a diagnosis of HIV who attended an Ambulatory Outpatient Medical Care appointment within 30 days of the referral to EIS.

[6] National HIV/AIDS Strategy Federal Implementation Plan: 2022-2025 https://files.hiv.gov/s3fs-public/2022-09/NHAS_Federal_Implementation_Plan.pdf

Excluded Service Categories
MOL has opted to not monitor the following service categories:

Oral Health Care: The agency does not receive direct funding for this service category—clients are referred to directly funded oral health providers.

Data Sources

MOL case managers (CM) are required to enter client level data in the Provide Enterprise Care Management Database and/or CAREWare Database, and/or Labcorp Link, and/or ClientTrack.

Client satisfaction surveys are distributed by RWHAP Part A office, as well as by the ASQMC. Employee satisfaction surveys are created and distributed by the ASQMC in partnership with Human Resources.

To the extent possible, data for the aforementioned performance measures are extracted from Provide Enterprise, CAREWare, Labcorp Link, and ClientTrack, client satisfaction surveys, and employee satisfaction surveys and feedback. The responsibility for generating all reports for review falls to the QMPM. Reports are presented to the entire body of staff during staff meetings. In the event the data does not reflect the target outcomes, a representative number of case reviews are conducted to identify the root cause(s) for clients not meeting the identified outcome.

Selection of the performance measures for the major functional areas require regular review of data from a variety of sources. The ASQMC members coordinate these activities.

HAB Performance Measures	Executive Director, RW ICM Program Manager, or designee	Provide Enterprise, OAHS sub-recipients	Quarterly
Client Satisfaction Survey Data	RWHAP Part A office, QMPM	Survey Survey	Biannually Quarterly
Employee Satisfaction Survey Data	ASQM	Survey	Biannually

Additional sources and data may be sought by the ASQMC that may not be included in the QMP.

Data Analysis

The ASQMC utilizes the Root Cause Analysis[7] method to analyze data. This method includes multiple tools and processes, including, but not limited to:

- Cause and effect diagram (aka fishbone diagram or Ishikawa diagram)
- Five whys
- Positive deviance
- Pareto analysis
- Process mapping
- Patient journey mapping

[7] Center for Quality Improvement and Innovation (CQII) Root Cause Analysis for Quality Improvement https://targethiv.org/library/root-cause-analysis-quality-improvement

2023-2024 Quality Goals

The ASQMP goals are selected to continue the development of the MOL ASQMP and to achieve improvements in quality throughout the agency.

1. Identify and onboard two clients to be active members of the ASQMC
2. Improve engagement from agency staff with the Program
3. Identify causes for client no-shows and improve overall agency no-show rate
4. Improve engagement of agency case managers with the Quality Management Report
5. Improve referral engagement for MOL Early Intervention Services.

Communication

Communication between the ASQMC, agency leadership, program staff, and the board of directors is key in having successful outcomes and ensuring ongoing improvements. To this end, several people within the agency and the ASQMC are responsible for communicating current and accurate information.

Between ASQMC and Agency Employees

To ensure that all employees of MOL have access to the information needed, the QMPM will maintain a repository of approved meeting agendas, approved meeting minutes, summaries of QI projects, and the approved QMP in digital format at molcfl.org. Agency employees may access the website at any time.

An annual report will be provided to each agency employee by June 30 annually that will identify the committee members, associate members, summary of the QMP, identify performance measures being monitored, summary of current and/or planned QI projects, results of previous QI projects, and detail the annual work plan.

The QMPM is responsible for presenting a summary of each committee meeting and QI projects at agency meetings.

Agency employees that wish to provide input to the ASQMC will be able to do so through multiple mediums. A form to request time to speak at a committee meeting is available at molcfl.org. Employees may be invited to speak in person at committee meeting or have their input entered into record via a written submission or pre-recorded video. Any written submissions are presented by the ASQMC Recorder during the “Employee Comment” section of the agenda (*prior to Old Business section)*.

Agency employees will be given an opportunity to provide feedback to ASQMC regarding the annual report during the period of July 1 – July 31 annually. This feedback will be accepted via electronic form at molcfl.org, and may be anonymous. The feedback submitted will be presented to the ASQMC at the first meeting scheduled after August 1 annually.

Agency employees are encouraged to suggest topics, provide input on QI projects, present barriers to effective client services, or seek basic information from any member of the ASQMC.

Agency employees will be given an opportunity (time permitting) to provide input during agency meetings after QMPM provides their summary to the employees.

Between ASQMC and Agency Leadership

The leadership within the agency will be given regular briefings about QI projects, including what will be monitored, what will be implemented for testing, progress, and results. The QMPM will be responsible for providing briefings to agency leadership at a time, place, and method agreed upon by leadership and QMPM. This may include in-person briefings, teleconferences, or written reports (hardcopy or electronic mail).

During briefings, agency leadership will be given an opportunity to provide input and feedback, which will be communicated to QI project staff and ASQMC by the QMPM at the next meeting, or individually, if urgent information has been provided. Agency leadership may request to speak at an ASQMC meeting via the same form used by agency employees.

Between ASQMC and Board of Directors

The Executive Director (ED) will be responsible for presenting and seeking board approval for the annual QMP.

A member of the Board of Directors will serve as a Committee Champion, and will present any information, comments, concerns, or other communications from the Board of Directors. This board member will provide the Board of Directors regular updates on ASQMC meetings, projects, and other pertinent information.

The ED shall be responsible for conveying communications should the ASQMC Board of Directors member be unable to do so. The ED is responsible for presenting information to the Board of Directors on behalf of the ASQMC and to present information to the ASQMC on behalf of the Board of Directors.

Orange County Health Services Ryan White Part A Office

The ED and/or RW ICM Program Manager and/or RW RS Program Manager and/or QMPM and/or a designee, shall be responsible for communicating required and requested information to the RWHAP Part A office. The ED and/or RW ICM Program Manager and/or RW RS Program Manager and/or QMPM and/or a designee will be responsible for presenting any input, feedback, suggestions, program policy, or other communication to the ASQMC from the RWHAP Part A office.

Other Stakeholders

Communication between the ASQMC and all other stakeholders will be facilitated by the ED and/or RW ICM Program Manager and/or RW RS Program Manager and/or QMPM, through any medium of confidential communication, as well as at molcfl.org.

National, State, Local Emergency, Disaster, and Exigent Circumstances

The ASQMC may temporarily be suspended during national, state, and/or local emergencies and/or disasters and/or exigent circumstances.

The suspension of the committee may be authorized by a unanimous consensus of the ED, RW ICM Program Manager, and the QMPM and only during those circumstances which the safety and well-

being of the committee may be placed at risk, or operational decisions must be determined during such circumstances.

All committee members will be given notice of committee suspension and will be given notice when the committee shall be reinstated.

Glossary

Acronyms

Some acronyms may not appear in the QMP but are included for reference.

ART/HART	Antiretroviral Therapy/HIV Antiretroviral Therapy
AOMC	Ambulatory Outpatient Medical Care
ASQM(C)(P)	Agency Services Quality Management (Committee) (Program)
CAG/CAB	Client Advisory Group/Client Advisory Board
CM	Case Manager
CQII	Center for Quality Improvement and Innovation
FDOH	Florida Department of Health
EHE	Ending the HIV Epidemic
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FTE	Full-Time Employee
HAB	HIV/AIDS Bureau
HHS	Health and Human Services
HOPWA	Housing Opportunities for Persons with AIDS/HIV
HRSA	Health Resources and Services Administration
I/HCM	Intensive/Housing Case Manager
ICM	Intensive Case Manager
OAT	Organizational Assessment Tool
OSA	Orlando Service Area
PDSA	Plan, Do, Study, Act
PE	Provide Enterprise
PHS	Public Health Service
PLWH	People/Person Living With HIV
PWH	People with HIV
QA	Quality Assurance
QI(A)(I)(T)	Quality Improvement (Activity/Activities) (Initiative) (Team)
QM	Quality Management
QMP	Quality Management Plan
QMPM	Quality Management Program Manager
RFP	Request for Proposal
RS	Referral for Health Care and Support Services
RSR	Ryan White HIV/AIDS program Service Report
RWHAP	Ryan White HIV/AIDS Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TOC	TOPWA Outreach Coordinator
TOPWA	Targeted Outreach for Pregnant Women Act
VL	Viral Load

Definitions

ATTRITION

The percentage of program clients lost for any reason. Evaluation and quality activities should assess why.

BENCHMARK

A point of reference to use for comparison (also referred to as Baseline).

CLIENT

A person who is receiving the benefits, services, etc., of a social service agency, a government bureau, etc.

CORE SERVICES

- Outpatient/Ambulatory Medical Care (Health Services) including Early Intervention Services under Ryan White Part C/D
- AIDS Drug Assistance Program (ADAP)

AIDS Pharmaceutical Assistance (local)

- Oral Health Care
- Early Intervention Services (EIS) (other than parts C/D)
- Health Insurance Premium & Cost Sharing Assistance
- Home Health Care

Home and Community-based Health Services

- Hospice Services
- Mental Health Services
- Medical Nutrition Therapy
- Medical Case Management services (including treatment adherence)

Substance abuse services outpatient

PERFORMANCE MEASURES

The routine measurements of planned activities, and assessment of their outcomes and results. A developed standard to measure program outcomes.

STAKEHOLDER

A person or entity with interest in a program's activities or outcomes

SUPPORT SERVICES

- Case Management (non-medical)
- Child care services
- Pediatric developmental assessment and early intervention services

Emergency financial assistance

- Food bank/home-delivered meals
- Health education/risk reduction
- Housing services
- Legal services
- Linguistics services
- Medical Transportation services
- Outreach services

Pregnancy planning

- Psychosocial support services
- Referral for health care/supportive services
- Rehabilitation services
- Respite care
- Substance abuse services-residential

Treatment adherence counseling

QUALITY ASSURANCE

A systematic process used to identify potential mistakes and threat to program success.

QUALITY IMPROVEMENT

A systematic process for measuring the degree to which services are provided at the expected levels of quality, satisfaction, and consistency.

QUALITY MANAGEMENT

A continuous process adaptive to change and consistent with other programmatic quality assurance and quality improvement activities.

QUALITY PLANNING

The process by which the activities for quality management are discussed, developed, and arranged to facilitate ways to reach goals.

Programs and Services at Miracle of Love

Ryan White Part A	Provides medical case management and referrals for services for HIV positive clients
Ryan White Part B	Provides Early Intervention Services to locate and reconnect clients to HIV care with Ryan White Part A
HOPWA	Provides housing case management for HIV positive clients
ICM HOPWA	Provides housing case management for HIV positive clients under the Homeless Services Network program
TOPWA	Provides targeted case management for women with high-risk pregnancies
Prevention	HIV/STI screening and education, Peer services, Support groups
Administration	Executive Office, Human Resources, Accounting, Quality Management, Reception, Board of Directors

Appendix A
PDSA for QIA

Model for Improvement Worksheet

What Are We Trying to Accomplish?

Increase the successful input of client lab reports and ambulatory outpatient medical care (AOMC) appointments, to increase accuracy of data and client viral suppression and annual retention in care.

How Will We Know a Change Is an Improvement?

A reduction in the missing viral loads as well as CD4s and an increase in viral suppression. HRSA HAB Performance measures should show a significant improvement in viral suppression and annual retention in care. FY 2022-2023 performance measures were below target.

Intensive Case Management (MCM)	Viral Suppression	Target: 92%	Actual: 80%
	Annual Retention	Target: 65%	Actual: 61%
Referral Specialist (RS)	Viral Suppression	Target: 93%	Actual: 80%
	Annual Retention	Target: 70%	Actual: 60%

What Change Can We Make That Will Result in Improvement?

Potential Changes to test:
-Provide targeted test reports to CMs and designate a specific time to work on report.
-Provide CMs a checklist for each client to mark off progress during a specified year.
-Designate a CM to make lab requests each day.

PDSA Worksheet

Plan	
What change are you testing with the PDSA cycle(s)? What do you predict will happen and why? Who will be involved in this PDSA? (e.g., one staff member or resident, one shift?). Whenever feasible, it will be helpful to involve direct care staff. How do you plan a small test of change? How long will the change take to implement? What resources will they need? What data need to be collected?	By February 28, 2024, we expect the number of missing viral loads and CD4s to reduce, resulting in an increase of documented viral suppression and reduce gap by at least 5% to target of 92%. The people involved in the PDSA will be the ICM program manager, RS program manager, and Quality Management Recorder, as well as the Referral Specialists and Intensive Case Managers. Small tests will be conducted with one to two CMs from each team before expanding. A full change in process would take 2-3 weeks. Resources would include Provide reports. Data is HRSA HAB measures.
Do	
Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage.	
Study	
Study and analyze the data. Determine if the change resulted in the expected outcome. Were there implementation lessons? Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.	
Act	
Based on what was learned from the test: Adapt – modify the changes and repeat PDSA cycle. Adopt – consider expanding the changes in your organization to additional residents, staff, and units. Abandon – change your approach and repeat PDSA cycle.	

Appendix B
Resolutions

QMC.001 Jobs Inclusion Resolution

QMC.001 – Jobs Inclusion Resolution

4th Committee (2023-2024) Approved with Amendment on March 28, 2023
Sponsor: Wyatt Haro Introduced: February 2023 Status: Approved

SECTION 1. SHORT TITLE.

This Resolution may be cited as the “Jobs Inclusion Resolution”.

SEC. 2. FINDINGS.

Quality Management Committee finds the following:

(1) Following the creation of the Quality Management Program in 2019, there has been ongoing attempts to improve data quality and reduce gaps in performance measures.
(2) According to a recent report of performance measures, there are several areas in which the agency can improve outcomes and performance evaluations.
(3) An ongoing Quality Improvement Project known as the Quality Management Report has been being utilized as a tool to make these improvements since March 2020.
(4) There have been modifications to the procedures and methods to use the tool based on input from case managers and program managers.
(5) The feedback and input have been welcomed, but based on recent conversations and engagement with the various Quality Management activities, there are many within the agency that are unfamiliar with the purpose of the Quality Management Program and their role in it.

SEC. 3. REVIEW OF JOB DESCRIPTION.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this resolution, the Executive Director should instruct Human Resources to determine the appropriate wording and placement within all job descriptions within the agency to include a clear explanation for each person’s role within the Quality Management Program (“Program”), the Quality Management Committee (“Committee”), and Quality Improvement Projects (“Projects”), to include—

(1) All employees and volunteers are responsible for participating in Program tasks and Projects when designated by the Committee and/or a Program Manager.
(2) All employees and volunteers are responsible for providing input and feedback to appropriate Program or Committee representatives when they have identified a potential improvement method, including, but not limited to—
    (i) Modification of procedures and/or policies to improve client services, employee performance, and data quality;
    (ii) Production or elimination of materials used while providing services;
    (iii) Modification of workspace, workgroup, and/or work methods;
    (iv) Creation of equitable services;
    (v) Creation of collaboration and partnerships; and
    (vi) Creation, Modification, Elimination of any and all things that increase our ability to meet the agency Vision and Mission.

SEC. 4. GUIDANCE.

(a) GUIDANCE FOR HUMAN RESOURCES AND PROGRAM MANAGERS.—The Executive Director shall issue guidance for Human Resources and Program Managers on how to—

(1) Identify specific roles within the agency and identify their role in the Program;

(2) Define each person's individual responsibility to the Program and Miracle of Love, Inc. ("Agency") for engagement in quality improvement in services, work environment, and client and employee satisfaction;
(3) Identify and define specific tasks within a role that are crucial to maintaining quality improvements and accurate data; and
(4) Identify methods the individual can shape and support future improvement.

(b) GUIDANCE RELATED TO THE COMMITTEE.—The Executive Director shall issue guidance to Human Resources and Program Managers on how any interested employee, volunteer, or client may participate in, and become a member of, the Committee and Projects.

SEC. 6. ENFORCEMENT.

(a) Not later than 180 days after the 90 day period in SEC. 3.(a), the Executive Director and Human Resources should finalize and approve updated job descriptions.
(b) Upon the final version of job descriptions, each employee and volunteer should be provided a copy by their Program Manager and allowed ample opportunity to inquire about any changes, express concerns, or voice their opinion, prior to signing.
(c) Engagement of each employee and volunteer with the Program, Committee, and Projects will be documented and reported to Program Managers on a regular basis, not less than once per month, by the designated Quality Management Program representative, and shall include participation status—
    (1) In a designated Project;
    (2) In a designated Task;
    (3) In meetings; and
    (4) In feedback.
(d) It will be the responsibility of each Program Manager to provide direct feedback to the employee or volunteer, and take appropriate action to correct any areas of poor performance, and celebrate areas of excellent performance.
    (1) <u>In conjunction with Human Resources and the Executive Director, Program Managers will draft wording and evaluation scoring to employee performance reviews at ninety (90) days and annually for Quality Management engagement.</u>
        (i) <u>The Executive Director and Human Resources shall provide guidance to the Quality Management Program Manager for data to be provided to Program Managers to complete employee evaluation.</u>
(e) All reports made by the designated Quality Management Program representative to a Program Manager will be provided to the Executive Director for follow up with the Program Manager.
(f) When appropriate, the Quality Management Program representative will submit reports to the Office Manager/Human Resources.

SEC. 7. INTENDED PURPOSE.

(a) It is the intention of the Quality Management Committee to foster an environment where all stakeholders of Miracle of Love, Inc., are able to feel empowered to seek ways to improve services provided to the community, improve employee work flows, and introduce those ideas to the Committee and agency leadership.
(b) It is the intention of the Quality Management Committee to remind every employee and volunteer of their responsibility to strive for continuous improvement within all areas of the agency.
(c) It is the intention of the Quality Management Committee to demonstrate to funders, clients, and any person that may be impacted by Miracle of Love, Inc., that continuous improvement is a top priority at the Agency.

Amended March 28, 2023
SEC. 6. (d)(1) Adds instruction for adding Quality Management engagement assessment to employee ninety (90) day and annual employee reviews.
SEC. 6. (d)(1)(i) Adds instruction for providing guidance to Quality Management Program Manager on data to be provided to Program Manager to use for completing assessment described in SEC. 6. (d)(1).

QMC.002 Fair Distribution of Workload Resolution

QMC.002 – Fair Distribution of Workload Resolution
4th Committee (2023-2024) Approved with Amendment on March 28, 2023
Sponsor: Wyatt Haro **Introduced:** February 2023 **Status:** Approved

SECTION 1. SHORT TITLE.
This Resolution may be cited as the "Fair Distribution of Workload Resolution".
SEC. 2. FINDINGS.
Quality Management Committee finds the following:
(1) The methods currently used by Ryan White case management to assign clients to case loads distributes unevenly among the case managers, resulting in higher case loads for some case managers, thereby reducing quality of services to clients.
(2) In addition to service quality degradation, data entry quality is impacted when case managers have unbalanced caseloads.
(3) In a recent change to the Ryan White Part A program policies enacted by the Central Florida HIV Planning Council, Medical Case Managers should have a maximum of 30 clients on their case load, which went into effect March 1, 2022 at the start of the 2022-2023 fiscal year.
(4) Case managers have been found to have the ability to open cases at their discretion, increasing the chances that a case manager may find their case load to be much larger than their colleague.
(5) In surveys conducted by the Quality Management Program, employees report a dissatisfaction with the fairness of the distribution of work.
SEC. 3. REVIEW OF CURRENT CASE MANAGEMENT ASSIGNMENT PROCEDURE.
(b) IN GENERAL.— Not later than 90 days after the date of enactment of this resolution, the Executive Director should instruct all Program Managers to provide to the Quality Management Committee ("Committee") the following—
(1) Current policies and procedures in place for the assignment of clients to case managers, including—
(i) Who has the authority to assign clients and/or open clients with the agency.
(ii) How far a case manager is expected to travel to meet a client.
(iii) How case loads are reviewed for possible client reassignments.
(iv) How often a case load is reviewed.
(v) Procedures case managers follow to request a case management transfer.
(vi) Procedures case managers follow to close a client's case and services with the agency.
(2) Current case load totals for all case managers.
(3) Total number of clients receiving services outside the county the case manager occupies an office in.

(4) An additional ninety (90) days will be automatically granted at the completion of the initial ninety (90) day guideline in SEC. 3. (a), should agency administration and Program Managers not have all data collected and submitted.

(i) The additional ninety (90) day extension shall not delay the assembly of the Workgroup described in SEC. 4. (b).

SEC. 4. GUIDANCE.

(c) GUIDANCE FOR EXECUTIVE DIRECTOR AND PROGRAM MANAGERS.— The Executive Director shall issue guidance for Program Managers to submit requested information to the committee not later than 90 days after the after the 90 day period in SEC. 3.(a)—

(1) Program Managers should make readily available to the Committee all requested documents for review by the Committee in hard copy and/or digital copy format.

(2) Program Managers should explain procedures and methods in a summarized report if they lack official documentation of these procedures.

(d) The Committee shall appoint a Workgroup consisting of case managers and/or leadership, under the direction of the Quality Management Program Manager, to review all procedures and policies and provide the Committee with any proposals for modifications.

a. The Workgroup shall be a group of at least three (3) people in addition to the Quality Management Program Manager.

b. The Workgroup shall be granted a minimum of two (2) hours each week to meet without disruption to conduct review and assessment.

c. The Workgroup shall be provided a workspace for meetings as available and when needed.

(i) The Workgroup may conduct some meetings via telephone or video conferencing, in addition to in-person meetings.

SEC. 6. ENFORCEMENT.

(g) Not later than 180 days after the enactment of this resolution, the Executive Director should determine if all documentation has been provided to the Committee.

(h) The Workgroup described in SEC. 7.(b) shall conduct a review of all documentation received and notify the Committee of missing documentation or additional documentation requests.

(i) The Workgroup will be provided a time, no longer than 90 days, to conduct their review and assessment of policies and procedures.

a. Time shall be allotted to the Workgroup members as described in SEC. 7.(b)(2) by agency leadership.

(j) At any time, the Committee may demand a progress report from the Workgroup and will provide a day and time for the presentation of the final report of the Workgroup to the full Committee.

(k) The Workgroup shall be dissolved at the conclusion of the review and assessment.

SEC. 7. INTENDED PURPOSE.

(d) It is the intention of the Quality Management Committee to foster a work environment where employees do not feel that they are carrying more of the work load than their colleagues.

(e) It is the intention of the Quality Management Committee to study and review policies and procedures for areas of improvement or correction of flawed or outdated policies and procedures.

(f) It is the intention of the Quality Management Committee to ensure the ability of a case manager and agency staff to provide the highest quality of service to the client, while

preventing case manager and agency staff burnout, “compassion fatigue,” and encouraging self-care.

Amended March 28, 2023
SEC. 3. (a)(4) Adds an automatic extension to the ninety (90) days set in SEC. 3. (a) if needed by agency administration and Program Manager(s).
SEC. 3. (a)(4)(i) Clarifies that amended SEC. 3. (a)(4) does not delay the assembly of Workgroup should extension be activated.

Amendments

Amendment 1 | Approved May 19, 2023

Page	Heading	Subheading	Modification
15	Quality Management Plan Implementation	Quality Improvement	INSERT [Bullet Point] “Model for Improvement”
19	Performance Measurement	Annual Performance Measures	INSERT [Column 1, Row 3] “Food Pantry/Card” INSERT [Column 2, Row 3] “Client Satisfaction” INSERT [Column 3, Row 3} “90%” INSERT [Column 4, Row 3] “—” INSERT [Column 5, Row 3] “—” INSERT [Column 6, Row 3] “—” INSERT [Column 7, Row 3] “Baseline”
20	Performance Measurement	INSERT “Data Analysis”	INSERT “The ASQMC utilizes the Root Cause Analysis [INSERT Footnote 7] method to analyze data. This method includes multiple tools and processes, including, but not limited to:” INSERT [Bullet Point] “Cause and effect diagram (aka fishbone diagram or Ishikawa diagram)” INSERT [Bullet Point] “Five whys” INSERT [Bullet Point] “Positive deviance” INSERT [Bullet Point] “Pareto analysis” INSERT [Bullet Point] “Process mapping” INSERT [Bullet Point] “Patient journey mapping” FOOTNOTE 7: “Center for Quality Improvement and Innovation (CQII) Root Cause Analysis for Quality Improvement https://targethiv.org/library/root-cause-analysis-quality-improvement”
34	INSERT “Amendments”	INSERT Date	INSERT Table

Amendment 2 | May 22, 2023 (No vote/approval necessary)

Page	Heading	Subheading	Modification
19	Performance Measurement	Annual Performance Measures	{Based on EMA targets} CHANGE [Column 3, Row 1] from 92% to 88% (Viral Load Suppression Target-MCM) CHANGE [Column 3, Row 2] from 93% to 94% (Viral Load Suppression Target-RS) CHANGE [Column 3, Row 2] from 70% to 67% (Annual Retention in Care-RS)